

# **Support and Responses for Police and Emergency Services Personnel with Alcohol and other Licit Drug Problem**

**Katherine Mann**

Senior Policy Officer  
Drug and Alcohol Coordination  
Queensland Police Service  
2006



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The views contained in this report are not necessarily those of the Queensland Police Service; they are a reflection of the views expressed by people taking part in the consultation phase of the research.

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## Introduction

Misuse of alcohol is one of key causes of drug-related harm in Australia and is second only to tobacco as a preventable cause of death and hospitalisation. While the positive contribution of responsible alcohol consumption is acknowledged, this research focuses on the misuse of alcohol, especially as it impacts on the workplace. In the context of this study, misuse spans dependency problems and abuse, including bingeing and hangovers.

This report is the latest of a series of research projects examining the issues surrounding alcohol and other drugs in a police workplace. The first project, *National Guidelines for Police Workplace Alcohol Policy* was undertaken in 1997, and was followed by the *Australian and New Zealand Guidelines for Police Workplace Substance Use Policy* in 1998. The first report focused on alcohol, and the second report incorporated illicit drug use. These two initiatives concentrated on police workplace alcohol and drug policy development.

In October 2000, as Senior Project Officer, Drug and Alcohol Coordination, I was successful in obtaining funding from the National Drug Strategy Law Enforcement Funding Committee (NDSLEFC) to undertake further research on substance-use in police workplaces. The research identified workplace responses other than policy, and looked particularly at the efficacy of drug testing for police.

As part of the research undertaken for that project, I conducted consultations in six law enforcement jurisdictions in the United States – Denver, Washington DC, New York, Milwaukee, Chicago and Los Angeles. I visited national, state, city and county policing authorities in each jurisdiction.

The aim of those consultations was to review and document key aspects of workplace drug-and-alcohol policy and procedures in a police environment, looking particularly at workplace drug testing. The project also reviewed the implementation of drug testing in the two Australian jurisdictions that had already adopted testing – NSW Police and Australian Federal Police.

During that research, it became apparent that those jurisdictions that had successfully implemented drug testing had also developed a solid infrastructure of education and support. They were also endeavouring to meet the needs of those officers who had been identified as requiring assistance for their substance use.

The report of the above research project, *Substance Use in a Police Workplace: Emerging Issues and Contemporary Responses*, was released in 2003.

*Support and Responses for Police and Emergency Services Personnel with Alcohol and other Licit Drug Problems* follows on from the emerging issues that the earlier report identified and takes a more in-depth look at some of the critical problems, such as workplace stress and substance use. This report also expands on previous research by examining the needs of other emergency services personnel – such as ambulance officers and firefighters – and, to a lesser extent, Australian Defence Force (ADF) personnel.



This report does not cover the problems associated with illicit drug use, except where that use intersects with alcohol and licit drug misuse.

This study complements the currently limited body of knowledge available in Australia on treatment and support services for police and emergency services. The study also identifies the infrastructure needed to support policy, including training and high-quality treatment services for police or emergency services personnel with a suspected or identified substance-use problem.

By documenting case studies from Australia, New Zealand, Canada and the United States, the study provides police and emergency services with some good practice models. It also informs police and emergency services about innovative practices that their own organisations could adopt.

The research for this study looked at existing support infrastructure (including policy and procedures) within police, ambulance, fire and emergency services in Australia and New Zealand. The results of that review are included in this report.

Also included in this report is a profile of the ADF alcohol and drug policy and procedures. The defence sector has features in common with police and other emergency services, and much can be learnt from their endeavours to develop sound policy and practices.

This report follows a similar format to *Substance Use in a Police Workplace: Emerging Issues and Contemporary Responses*, and includes material on responding to alcohol and other licit drugs in the workplace, case studies from Australia and overseas, and a lengthy bibliography. Where relevant, research from the previous study has been included in this report, and updated or expanded on where necessary.

The other focus of this report is on the impact of organisational and operational stress in police and emergency services workplaces, and the interplay between stress and alcohol and/or other licit drug misuse. This is a synergy most police and emergency services organisations have yet to adequately deal with. The debate on managing critical incidents – outlined in this report – highlights the urgent need for some organisations to review their existing policy and practice in this area.

One of the more interesting comments I encountered during my research was, 'It's not as bad as it used to be'. This comment was interesting for several reasons:

- It was repeated frequently.
- It came equally from police, firefighters, ADF and ambulance officers, both here and overseas.
- It speaks volumes about the historical level of misuse entrenched in these workplaces.
- It represents a possibly false sense of complacency that 'everything's OK now'.

While many may argue that 'it's not as bad as it used to be' – and there is no doubt some truth in this, especially in relation to drinking on the job and drink-driving – there are no data to support a claim of reduced consumption.

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Even if the incidence of on-the-job drinking has decreased, there is still a potential problem if employees arrive for duty while still under the influence of alcohol, or suffering the effects of a hangover.

Another interesting aspect of the consultations was the almost universal focus on responding to individual pathology rather than tackling the more difficult task of changing workplace culture.

It became clear during the research for this project that most organisations have at least some strategies in place to assist employees with identified alcohol dependency problems. However, by focusing on the more easily identified dependent drinker, an organisation may inadvertently support a workplace culture which enables high levels and risky patterns of consumption as the norm. This is especially problematic in a workplace with high tolerance for excessive alcohol consumption.

It also means that individuals are usually only assisted when they reach a level of dependency where they can no longer be ignored (or transferred). However, the more dependent they become, the more difficult the treatment becomes. This approach does little to deal with the significantly larger proportion of officers and staff whose levels and patterns of consumption place them, the organisation and the general public at risk.

Of all the issues to emerge during this research, organisational cultural change is potentially the most challenging. However, achieving organisational change could have a significant positive impact on reducing workplace harms.

To change a workplace culture that has a high tolerance for excessive alcohol consumption, all aspects of the organisational culture need to be considered. This will allow the organisation to identify those aspects which may be enabling, encouraging or reinforcing unhealthy patterns of consumption.

Organisational change does not occur in a vacuum – it needs to be tackled within the context of the wider community culture, which in Australia is one of high benchmarks and tolerance for intoxicated behaviour.

These are some of the future challenges for police and emergency services workplaces.

## Background

Alcohol plays a significant role in Australian society and is an integral part of numerous rites of passage and celebrations. The following data from the 2004 National Household Survey indicates that over 83% of Australians had consumed alcohol in the previous 12 months. The impact of alcohol use in the workplace needs to be examined in the light of the cultural place of alcohol as integral to the Australian way of life.

### ***Overview of licit drug use in Australia***

The following data is taken from the *2004 National Drug Strategy Household Survey: First Results*, published by the Australian Institute of Health and Welfare (AIHW) in April 2005. Approximately 30 000 Australians aged 12 years and older participated in the survey, in which they were asked about their knowledge of and attitudes towards drugs, their drug consumption histories, and related behaviours.

### Alcohol

Nine out of ten Australians aged 14 years and over had tried alcohol at some time in their lives, and 83.6% had consumed alcohol in the 12 months before the survey.

The proportion of the population drinking daily remained stable (8.9%) between 2001 and 2004 as did the average age at which people had their first full serve of alcohol (17 years of age). The proportion of teenagers drinking at least weekly (around 25%) declined over the period.

One in seven people admitted having driven a motor vehicle and one in 17 had verbally abused someone while under the influence of alcohol. One-quarter of Australians aged 14 years and over had been verbally abused and 4.4% had been physically abused by someone under the influence of alcohol.

Alcohol was thought to be associated with a 'drug' problem by one in ten

Australians (10%) aged 14 years and over, whereas 77% accepted the regular use of alcohol by adults. Alcohol was the most accessible drug: four in five Australians aged 14 years and over had been offered or had had the opportunity to use alcohol in the last 12 months.

High-risk and risky drinkers were more likely than low-risk drinkers or abstainers to experience high or very high levels of psychological distress.

### **Snippets from the summary document:**

- Ten per cent of the population consumed alcohol in a way considered risky or a high risk to health in the long term by the National Health and Medical

Research Council (NHMRC 2001).<sup>1</sup>

- People in the 20-29 years age group were most likely to consume alcohol in a way that put them at risk of long-term (chronic) alcohol-related harm. This age group was also the least likely to abstain from consuming alcohol.<sup>2</sup>
- At all ages, greater proportions of the population drank at risky or high-risk levels for short-term harm.<sup>3</sup>
- Overall, about one-third (35.4%) of people aged 14 years and over had put themselves at risk of short-term alcohol-related harm on at least one occasion during the last 12 months.<sup>4</sup>
- Males aged 20-29 years (17.4%) were the most likely group to consume alcohol at risky or high-risk levels for short-term harm at least once in the last week.<sup>5</sup>

### ***Snippets from the draft Towards Safer Drinking Cultures – National Alcohol Strategy 2005-2009***

- Over the past decade there has been a steady increase in the proportion of the Australian population who drink, reaching 83% in 2004.<sup>6</sup>
- In 2004, 1.46 million Australians consumed alcohol daily and 6.8 million weekly.<sup>7</sup>
- One in five (20.6%) Australians drink to intoxication at least once a month. This is particularly evident among young adults.<sup>8</sup>
- Around one-third of males (30.5%) and one-quarter of females (25%) aged in their 20s drink at risky or high levels for short-term harm at least once a month.<sup>9</sup>
- Between 2001 and 2004, the proportion of Australian women who drank at least weekly increased from 33% to 35%.<sup>10</sup>

### **Health impacts of alcohol**

- The adverse health outcomes from alcohol consumption range from acute problems – such as injuries from road accidents and violence – to chronic health problems, such as liver disease, cancers and alcohol dependence.
- Alcohol has been shown to be causally related to more than 60 different medical conditions.
- In addition to the estimated 16 756 Australians who had died from acute conditions, there were estimated to have been 14 377 deaths in Australia from

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<sup>1</sup> 2004 National Drug Strategy Household Survey: First Results, p. 20

<sup>2</sup> *ibid.*

<sup>3</sup> *ibid.*, p. 21

<sup>4</sup> *ibid.*

<sup>5</sup> *ibid.*, p. 22

<sup>6</sup> AIHW, 2005

<sup>7</sup> *ibid.*

<sup>8</sup> *ibid.*

<sup>9</sup> *ibid.*

<sup>10</sup> *ibid.*

chronic conditions due to drinking at risky or high risk levels between 1992 and 2001.

- Alcohol dependence was the most common alcohol-related chronic condition that led to hospitalisation.
- Long-term consumption of alcohol at harmful levels is also a causal factor of a number of mental health conditions, including alcoholic psychosis, alcohol dependence syndrome and alcohol-related dementia. Recent research provides more evidence of the association between prior alcohol dependence and current depression.<sup>11</sup>
- Risky and high-risk alcohol consumption also increases the risk of self-harm and suicide attempts.<sup>12</sup>

## Over-the-counter and prescription medications

The National Household Survey provides data on prescription drugs used for illicit purposes, but does not quantify accidental misuse of prescription or over-the-counter medications, or their misuse in combination with alcohol.

The survey indicated that in 2004 31% of Australians aged 14 years and over had used analgesics (pain killers) in the preceding 12 months and that 1% of Australians 14 years and older had used tranquillisers (sleeping pills). There was an increase in the reported age at which Australians first used those medications for non-medical purposes.

Eight per cent considered the non-medical use of use of painkillers acceptable and 5% considered the non-medical use of sleeping pills acceptable. Only 0.5% of the population associated the non-medical use of painkillers or sleeping pills with a drug problem.

Although these figures do not tell us much about the misuse of licit drugs in the workplace, they do flag that there is generally a very low association between licit drug use and the concept of misuse. This highlights the need for workplace education that alerts employees to the potential risks associated with the misuse of prescribed and over-the-counter medications, especially in combination with alcohol.

The National Health and Medical Research Council (NHMRC)<sup>13</sup> list the following areas of concern regarding the use of medications in combination with alcohol:

- antidepressants and other medications prescribed for the management of mental illness and mood disorders, as they may cause a range of side effects when combined with alcohol
- antihistamines, which may cause drowsiness in combination with alcohol
- benzodiazepines, as they, like alcohol, also depress the central nervous system
- medicines that already contain alcohol, thereby increasing the amount of alcohol consumed

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<sup>11</sup> Caldwell et al., 2002; Hasin and Grant, 2002

<sup>12</sup> Borges et al., 2004

<sup>13</sup> 2001, pp. 55-56

- cough medicines that contain antihistamines, codeine and alcohol
- drugs for high blood pressure or angina, which can cause dizziness when combined with alcohol
- medications to lessen the risk of blood clotting and stroke, as drinking can affect the control of blood clotting
- some medications used for epilepsy, arthritis, and diabetes
- arthritis medicines, which may cause stomach upsets in combination with alcohol
- some antibiotics.

## Alcohol and licit drug use in the workplace

The (Australian) *National Alcohol Strategy Consultation Paper* suggests:

The workplace is emerging as a site that may contribute to or address alcohol-related harm. It has been estimated that industrial costs related to the misuse of alcohol represent between 50-87% of the total cost of alcohol misuse to the economy, exceeding even health-related costs.<sup>14</sup>

The following section is adapted from the chapter 'Alcohol and other drug use in the workplace' in *Substance use in a Police Workplace; Emerging Issues and Contemporary Responses*, 2003.

Given the prevalence of alcohol use in the community, there must be concerns about its potential impact in the workplace, either by coming to work affected by alcohol, hangover effects, or consuming alcohol while at work. There is also potential for individuals to be negatively affected by prescription or over-the-counter medications, particularly in instances where they are either deliberately or unknowingly abused.

There is a wealth of published material on the impact of alcohol in the workplace. There is, however, less information available on alcohol misuse in a police workplace, and even less available on alcohol use among emergency services personnel. Even more lamentable than the lack of research on alcohol in police or emergency services organisations, is the lack of information on the impact of misuse of prescription and over-the-counter medications.

Much of the research on workplace-related alcohol and drug (licit and illicit) use that is available comes from the United States and may not be fully applicable to the Australian context, although some similarities certainly exist. The following information is indicative of the concerns expressed in the literature on this topic.

The International Labour Office and World Health Organisation have reported that:

- of people with alcohol- and drug-related problems, 60-70% are in full-time employment
- of all work fatalities, 15-30% are related to alcohol and other drugs
- of all work accidents, 20-25% involve intoxicated people
- employees with alcohol and other drug problems have 200-300% more absenteeism than other employees.

Studies are finding that when alcohol or drug use disturbs any of a variety of basic performance functions (e.g. gross and fine motor functions, reaction time sensory and perceptual ability, attention, concentration, motivation), the result can be a decrease in accuracy, efficiency, productivity, worker safety and job satisfaction. In addition, the problems of the hangover effects of drugs, withdrawal symptoms, and chronic long-term use, even when not accompanied by on-duty intoxication, are increasingly being

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<sup>14</sup> 2005, p. 3

identified as having a negative impact on performance .... Various studies have credited alcohol and other drug use with contributing to increased turnover, accidents, absenteeism, workers' compensation and sick benefits, insurance claims, loss of productivity and human potential, low-quality products and services, theft and trafficking. They also have a negative impact on corporate culture, morale and image, and increased corporate liability regarding employee and public safety and the environmental impacts associated with accidents.<sup>15</sup>

A study by Mangione (1998) found 21% of workers reported being injured or put in danger, having to redo work, cover for a co-worker, or needing to work harder due to others' drinking. Nearly a third of workers who considered their job to be dangerous reported 'second hand' alcohol effects.<sup>16</sup>

Drinking is known to be associated with loss of productivity, absenteeism, injury, and common and catastrophic accidents. Workplace drinking is thought to be influenced by the presence or absence of alcohol policy, level and consistency of supervision, the visibility and work schedules of the worker, type of occupation, job stress, degree of powerlessness, and the pressure of sub-cultural drinking groups. Drinking norms in the form of drinking permissiveness are believed to have a major influence on workplace drinking.<sup>17</sup>

The 2001 National Drug Strategy Household Survey found that 3% of respondents aged 14 years and over had missed at least one day's work or study for alcohol-related reasons in the three months before the survey. Alcohol-related absence is more likely to occur with employees who get drunk frequently, drink at work, and have reported alcohol-related problems.<sup>18</sup> with absentee rates for high-risk drinkers greater than the general population.

Those who miss work due to alcohol- or other drug-related causes are not only of concern, but so too are those who attend the workplace in a drug-affected condition, or those suffering the effects of a hangover. 'Hangovers affect cognitive and motor functions, creating risks of bad judgment, interpersonal conflict, and injuries.'<sup>19</sup> One study found that pilots whose performance was tested in a flight simulator showed signs of impairment 14 hours after they reached a BAC (blood-alcohol concentration) of between 0.10 and 0.12, and significant impairment eight hours after reaching a BAC of 0.10.<sup>20</sup> Hangovers are also linked to an elevated risk of heart attack.

It is not just the small percentage of chronically alcohol-dependant drinkers who are of concern in the workplace; light and moderate drinkers cause 60% of alcohol-related incidents of absenteeism, tardiness and poor quality of work, while dependent drinkers cause 40%.<sup>21</sup>

It is not just the small percentage of chronically alcohol-dependant drinkers who are of concern in the workplace
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<sup>15</sup> Butler, n.d., p. 2

<sup>16</sup> Mangione et al., 1998

<sup>17</sup> Allsop et al. 2001, p. 111

<sup>18</sup> Henderson et al., 1996, cited in National Drug Strategy, 2001, p. 15

<sup>19</sup> Moore 1998, cited in Roman & Blum, 2002, p. 52

<sup>20</sup> Yesavage et al., 1986

<sup>21</sup> Harvard School of Public Health Corporate Alcohol Study, 1998



The NHMRC (1997) discovered that although up to 22% of employees drank at harmful or hazardous levels, up to 27% of the working population experienced alcohol-related problems in any one year.<sup>22</sup>

Specific instances of binge drinking are also of concern. The NHMRC defines bingeing as occasional bouts of heavy drinking by young and/or non-dependent people, or drinking 'bender' engaged in by an alcohol-dependent person that may last for days or weeks.

There is evidence that the effects of alcohol, such as impaired balance and reflexes, lack of co-ordination, and lack of sense of danger, contribute to work injuries.<sup>23</sup> 'Up to 40% of industrial fatalities and 47% of industrial injuries can be linked to alcohol consumption and alcoholism.'<sup>24</sup>

In 1998 the National Occupational Health and Safety Commission published a number of reports based on the second work-related fatalities study, which looked at 2389 work-related deaths in Australia from 1989 to 1992. They were classified as:

- accidents in a workplace (1220 deaths)
- accidents on roads during work (541 deaths)
- accidents when commuting to or from work (628 deaths).

The study also included 778 deaths of bystanders in work-related accidents. Raised BAC appeared to contribute to at least 4% of all working deaths.

Zwerling refers to widely used figures on absenteeism and productivity – absenteeism (16 times more for misusers than the average employee) and impaired workers functioning at approximately half their normal capacity'.<sup>25</sup> Berry and Boland (1977) in dated but often-quoted research also suggest significantly higher absentee rates for all classifications of alcoholism (known, suspected, recovered), alerting us to possible problems in productivity even in the recovery stage.<sup>26</sup> Although caution is urged in the use of these statistics, there is certainly a substantial body of literature that highlights the potential impact and cost of alcohol misuse in the workplace.

Drugs, including licit drugs, have been shown to have an impact on cognitive functions, including emotion and mood, learning, memory, and intellectual functioning. 'The general consensus that any psychoactive substance may affect judgment or performance is a safe and cautious one',<sup>27</sup> especially for the workplace.

McVicar and Associates (1995) compiled a literature review for the Alberta Alcohol and Drug Abuse Commission in collaboration with the Canadian Centre on Substance Abuse. The review attempted to identify the methodology and concepts for assessing the workplace costs of drug and alcohol misuse. While it was concluded that it would be

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<sup>22</sup> Allsop & Pidd 2001, p. 8

<sup>23</sup> NHMRC, 1996

<sup>24</sup> Bernstein & Mahoney 1989, pp. 223-232

<sup>25</sup> *ibid.*

<sup>26</sup> Cited in McVicar et al. 1995, p. 10

<sup>27</sup> Osterloh & Becker 1990, p. 2

impossible to definitively attribute specific costs of substance use either to the workplace or to society generally, they did concede such costs would be high, and debated the range of costs that would need to be included in the calculations. The costs included:

premature death, fatal and injury accidents, absenteeism, extra sick leave, employee turnover, medical costs, disciplinary procedures, loss of industry, household and military production, tardiness, unemployment and drug testing.<sup>28</sup>

The literature review cites research by Shahandeh (1985), which states:

an employer's expenses are increased by compensation for injured workers, by damage to property and equipment, by material waste from negligence, by increased grievances and deteriorating working relationships, as well as from decreased output. Even if the worker is dismissed or resigns there are both apparent and hidden costs. The obvious costs lie in the search, interviewing, recruitment and training, ... as well as the initial lowered productivity for a new employee, especially an executive. The hidden costs relate to the individual skills, business acumen, knowledge and experience in which the employer has invested heavily.<sup>29</sup>

Berry and Boland suggest that:

the cost of alcoholism to industry is made up of several components, including loss of efficiency, absenteeism, lost time on the job as well as off the job, faulty decision making, accidents, impaired morale of co-workers, and the cost of rehabilitation and programs. A large and significant portion of the economic impact of alcoholism also includes premature disability and death, resulting in the loss of many employees in their prime who have skills that are difficult to replace.<sup>30</sup>

It has been suggested that loss of productivity and human potential, and low-quality products and services, may be associated with alcohol and drug use in the workplace. Hidden costs of workplace substance use include diverted supervisory and managerial time, friction among workers, personnel turnover, poor decision making, and damage to the organisation's public image. These factors have a significant human or social cost as well as a financial one.

Australia is facing increasing insurance costs, in terms of personal and public liability, and health insurance, and these amounts also need to be taken into consideration in determining the total cost of workplace substance use. These factors become more significant when we try to argue the cost-effectiveness of various workplace interventions.

As employers are increasingly expected to take the initiative in ensuring a safer working environment, dealing with drug and alcohol problems in the workplace, including implementing a breath-testing option, can be seen to contribute towards fulfilling an employer's duty of care. An employer's failure to implement a system to ensure a safer workplace once a problem has been identified may be regarded by the court as *prima facie* evidence of culpability in an occupational health-and-safety prosecution.

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<sup>28</sup> p.6

<sup>29</sup> *ibid.*, p.17

<sup>30</sup> 1997, p. 37

While mindful of the need to exercise caution in estimating the impact and cost of alcohol and other drug misuse (especially if referring to overseas data), there is now a substantial body of research in the drug and alcohol field which concludes that substance misuse in the workplace can be a problem, and may be a costly one.

## Alcohol and licit drug use by police in Australia

This section is taken from the previous research report, *Substance Use in a Police Workplace: Emerging Issues and Contemporary Responses*, 2003. There has not been any additional substantial research published on alcohol and other licit drug use by police in Australia since the previous report was published.

While research on police use of alcohol and other licit drugs in Australia is extremely limited, it is almost non-existent for emergency services. However, given the similarity of personnel profiles and workplace conditions, much of what has been written about police consumption also applies to other emergency services personnel, especially firefighters.

Police rates for alcohol consumption are reasonably well documented. Given the risk factors associated with alcohol abuse and occupations, e.g. social pressure to drink; separation from family due to work commitments; collusion in excessive drinking by colleagues; stress; recruitment from those predisposed to drink heavily, it is not unreasonable to suggest firefighters would have a similar high-consumption profile.<sup>31</sup>

This section is included to demonstrate the extent and seriousness of the problem and to highlight the necessity for organisations to develop responses that best meet the needs of their members.

Misuse of alcohol and other licit drugs can be problematic in any workplace, but is especially so for workers in safety-sensitive occupations.

Excessive alcohol consumption impedes reaction time, can cause thinking and coordination to become sluggish, and may lead to aggressive behaviour particularly in the presence of threat. Hence the presence of alcohol, even low levels of residual alcohol, can impact greatly on police work, placing both police officers and members of the public at unnecessary risk.<sup>32</sup>

A risk with self-administered questionnaires is that they may be subject to under-reporting and underestimation by the respondents. This is exacerbated in alcohol-use surveys by the widespread lack of knowledge of what constitutes a standard drink. Therefore, the figures quoted in the following studies are likely to be conservative, and not necessarily a true reflection of the extent of the problem.

Van Iwaarden makes an interesting point in relation to prevalence data: 'The extent of drinking in the workplace is not the most important factor; the frequency and quantity of drinking in general by employees is much more decisive'.<sup>33</sup>

The following studies of police drinking indicate unacceptably high levels of consumption, on all too frequent occasions.

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<sup>31</sup> Risk factors adapted from M Plant, 1981, in Brown and Campbell, 1994, p.61

<sup>32</sup> Davey, Obst & Sheehan 2002, p. 205-206

<sup>33</sup> 1989, p. 1208

## Studies on police workplaces

### Queensland

In 1995 a statewide study was conducted by the University of Queensland on alcohol consumption by Queensland police officers. The survey yielded 4193 responses, a 67% response rate. Data indicated that police drank at levels higher than the community norm. Although 24% of general population in the 2004 National Household Survey sample did not drink, only 9% of the police in the University of Queensland sample did not drink.

The incidence of binge drinking is particularly concerning; 34.7% of officers reported binge drinking, with 23% of officers bingeing at least once a week. Of these, 3% drink to excess every day.

The quantities of alcohol consumed and tendency towards binge drinking have not declined within the police force within recent years, but rather appear to have increased.

The results of this survey indicate that the quantities of alcohol consumed and tendency towards binge drinking have not declined within the police force within recent years, but rather appear to have increased.<sup>34</sup>

This is an interesting finding in the light of comments by management of most police and emergency services that 'it's not as bad as it used to be'.

Male officers reported drinking more than female officers. However, when consumption levels are adjusted for gender according to NHMRC guidelines, the data indicate that more female officers, when they drink, usually drink at hazardous or harmful levels. Almost two-thirds of female officers drink at hazardous or harmful levels compared to just over a third (38%) of male officers.<sup>35</sup> 'Older officers appear to drink more frequently. However, younger officers, while drinking less frequently, drink in much greater quantities when they do drink.'<sup>36</sup>

In addition to the statewide survey, police in two divisions – one metropolitan and one regional – were asked to complete a more detailed questionnaire on alcohol and law enforcement, their personal drinking, and drinking and work performance. The additional survey resulted in 749 returns. Results from that survey yielded similar results to the statewide survey and indicated that 33% of respondents were at risk of harm from excessive alcohol consumption. Three and a-half per cent of respondents indicated alcohol dependency, and 26% of officers reported having consumed alcohol on duty. Twenty-three per cent of the sample reported being affected by a co-worker's drinking during the previous year. Of those, 44% stated the co-worker drank before a shift, 20% during a shift, and 36% after a shift.<sup>37</sup>

<sup>34</sup> Davey, Obst & Sheehan, 2000, p. 205

<sup>35</sup> Davey, 1996

<sup>36</sup> Davey, Obst & Sheehan, 2000, p. 210

<sup>37</sup> Davey et al., 2001

This study represents one of the most extensive conducted in an Australian police workplace. It would have been interesting to replicate this study ten years on to gauge if there has in fact been a change in real consumption levels and patterns.

## **Victoria**

Elliott and Shanahan conducted seminal research in 1992 regarding police and drinking. This research, done in co-ordination with the Victoria Police Force, differed from the Queensland study in that it did not seek to document consumption levels based on a quantitative approach, but relied instead on a qualitative approach, which included focus groups, and interviews with police spouses.

Their results indicated similarly high levels of alcohol consumption by police, and suggested that although drinking was not as 'heavy' or as frequent as in the past, patterns of drinking, such as binge drinking, and higher-than-usual rates for female officers, were of particular concern.

Although drinking was not as 'heavy' or as frequent as in the past, patterns of drinking, such as binge drinking, and higher-than-usual rates for female officers, were of particular concern.

In 1995 the Australian Drug Foundation conducted another Victorian Police study as part of a demonstration project looking at alcohol and drug consumption in two Victorian workplaces. Their report points out:

approximately one-third of all Workcover claims are classified as stress related. In discussions with health and welfare providers it seems apparent that these 'stress' claims often involve alcohol misuse and at times 'stress' is the term used to provide members with paid leave to engage in treatment for alcohol problems, or to remove them from their duties when their alcohol use is problematic. Estimates about the percentage of these stress claims that were alcohol related varied, but there was consensus that at least half of them involved alcohol misuse, to varying degrees. It should also be mentioned here that there was anecdotal evidence that benzodiazepines were also of concern to health-service providers.<sup>38</sup>

A survey of 555 sergeants and senior sergeants conducted as part of the above project found that 47% of respondents had consumed alcohol on the day of the survey, or the day before the survey, and 86% had drunk alcohol in the previous week.<sup>39</sup>

Forty-six per cent of respondents stated that they had been affected by a workmate's excessive alcohol consumption, and of the respondents 64% said the workmate had been drinking before the shift, and 34% said the workmate had been drinking during the shift.

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<sup>38</sup> p. 16-17

<sup>39</sup> Flynn 1995, p.20

## **New South Wales**

NSW Police is the largest police organisation in Australasia, with approximately 17 000 employees, including 13 500 sworn officers.

As a result of the 1996 royal commission into corruption within the NSW Police, the commission recommended the immediate introduction of drug and alcohol testing of police officers. The commission reported excessive use of alcohol and illicit drugs by police.

Considerable evidence has been gathered of 'liquid' lunches, heavy drinking by police on and off duty and the expectation of some groups of officers that they could attend clubs and other premises, as they wished, to obtain free alcohol. The evidence gathered supported various studies which have suggested that the problem of alcohol misuse is linked to broader, police cultural issues.<sup>40</sup>

Before the introduction of the New South Wales Police Drug and Alcohol Policy (1995-96), a research study of 852 officers from the Sydney metropolitan area was conducted by St Vincent's Hospital. The study found that 48% of NSW male officers and 41% of female officers drink at harmful levels (as defined by the NHMRC), compared with 16% of men and 10% of women in the general population. The study found that one-third of males and one-quarter of females reported binge drinking.

This is particularly concerning given that excessive consumption has potentially serious consequences for police, leading, as it can, to slower reaction times and impaired work performance. Specifically, there is a need to consider the potential risk of injury from road trauma or mishandling firearms.<sup>41</sup>

The study also found that the death rate of police from alcoholic liver disease was twice that of the general community.

The study also found that the death rate of police from alcoholic liver disease was twice that of the general community.

It is interesting to note that research conducted before and after the introduction of the drug-testing program in the NSW Police shows two significant outcomes from the introduction

of the program.

Firstly, the number of officers who drink at harmful or hazardous levels has substantially reduced since the introduction of the policy. In 1995-96, 48% of police surveyed drank at harmful levels, but a 1997-98 study saw this figure reduced to 27%.

This reduction may be attributed to a range of factors, including increased awareness of the risks and harms associated with alcohol use, and the deterrent impact of breath testing.

There was also a substantial increase in the number of officers coming forward for drug and alcohol counselling – a 68% increase during the first 12 months, and subsequent referrals running at 20% higher than immediately before the commencement of the policy.

<sup>40</sup> Royal Commission into the NSW Police Service Interim Report, February 1996

<sup>41</sup> Parliament of Victoria, 2004, p.50

## ***Northern Territory***

Daulby (1990) surveyed 400 Northern Territory police and found that 28% of police consumed between 5 and 8 drinks per day, placing them at moderate risk, and 12% consumed nine or more standard drinks, placing them at high risk. These figures indicated that police were drinking at higher levels than the Territory and national levels. Again, it would be interesting to replicate this research to track any changes in consumption levels.

## ***National police study***

A study by McNeill and Wilson (1993), which revealed similar concerns regarding police alcohol consumption, focused on stress and its impact on drinking. The study included a telephone survey of 895 officers Australia-wide, and face-to-face interviews with 54 South Australian police. This study highlighted a cult of masculinity and the pressure that was placed on female officers to drink to the levels of the males. It also highlighted the influence of alcohol in the socialisation of work groups. A number of officers said that if you wanted to feel part of the group there was immense pressure to drink.<sup>42</sup>

Interestingly, two recommendations of the study were that consideration should be given to implementing random breath testing for police, and that officers on duty who appear to be affected by alcohol should be breath tested.

The anecdotal evidence of high use of benzodiazepines highlighted in this research was also a concern for police workplaces. Long-term benzodiazepine use may cause drowsiness, difficulty in thinking clearly, aggression, and increased risk of accidents.

In summary, the research on police drug use indicates two types of drug use – work-related, that is, as a consequence of work, such as to relieve stress or to perform work-related tasks more effectively; and recreational drug use. We do not currently have the data to gauge which is the more prevalent, nor do we have the data to gauge levels of dependency.

## ***Illicit drug use: police and emergency services***

This study does not cover the use of illicit drugs, including steroid use, in policing or emergency services workplaces. However, much of what has been written regarding the efficacy of different approaches to treatment and providing support services for alcohol and licit drugs would also apply to illicit drug-dependency problems.

Where illicit drug use is of relevance to this study is in the context of polydrug use. If an employee is suffering from problems with illicit drugs as well as, for example, alcohol, referral to treatment and case management can be complicated if the employee is concurrently undergoing a discipline process.

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<sup>42</sup> McNeill 1996, p. 32



## ***Pharmaceutical use: police and emergency services***

Most people at some time will have a legitimate need for prescribed or over-the-counter medication. However, even small amounts of medications – such as antidepressants, benzodiazepines, antihistamines and analgesics – can impair cognitive and behavioural functioning. The multiple-use of these drugs, particularly in combination with alcohol or illicit drugs, can significantly further impair performance.<sup>43</sup>

In examining prescription-drug use within a workplace, it is important to acknowledge that people may also experience impairment when not taking prescribed medication, or when modifying a prescription regime. As well, the effects of withdrawal from a drug may be as impairing as the drug itself.<sup>44</sup>

Although little has been written on the relationship between shiftwork and substance use by police and emergency services personnel, research on other industries indicates that there is a correlation between irregular hours of shiftwork and the use of medications to 'switch on' (stimulants) and 'switch off' (sleeping tablets).<sup>45</sup>

Due to the often very physical nature of much police and firefighting work, those groups may experience a higher-than-usual rate of workplace injuries, particularly back injuries, and may be taking strong painkillers over prolonged periods of time. This is of particular concern when painkillers are used in combination with alcohol and/or other drugs.

The relationship between levels of drug use and impairment is not yet well understood, except in the case of alcohol. Little is known of the level of impairment caused by the use of different amounts of pharmaceutical drugs, such as antihistamines, and medicines containing pseudoephedrine. It is generally accepted that any substance which interferes with the body's normal functioning in a negative way, such as slowing reflexes or impairing judgment, should not be condoned in the workplace, particularly in safety sensitive roles.

## **Disclosure of personal details related to use of medications**

One problem that has arisen with the introduction of workplace drug and alcohol policy is the obligation of workers to report taking prescription drugs that might compromise their work performance. The matter was raised in *BHP Iron Ore Pty Ltd v Construction, Mining, Energy, Timberyards, Sawmills and Woodworkers Union of Australia West Australian Branch*.<sup>46</sup> The West Australian Industrial Relations Commission found that there could be no rational objection to that requirement, and that employees could have such an obligation placed on them, even if it were not set down in policy.

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<sup>43</sup> Fenlon, Davey and Mann, 1997

<sup>44</sup> Doweiko, 1996

<sup>45</sup> Hagen & Egan, 1992

<sup>46</sup> *BHP Iron Ore Pty Ltd v Construction, Mining, Energy, Timberyards, Sawmills and Woodworkers Union of Australia West Australian Branch* (1998) W AIRC 130 CR 274 of 1997

The *Queensland Police Service Alcohol and Drugs Policy and Procedures* states that:

'if a member believes they are unable to perform usual or allocated duties without danger to self or others, they should report this to their supervisor/manager, who may wish to make alternate work arrangements', (2005)

The policy also requires an employee who is being drug tested to provide in writing the details of any medication that may affect the outcome of their drug test.

## Characteristics of police and emergency services workplaces

Police and other emergency services workplaces share several characteristics that need to be considered when looking at the problems of alcohol and other licit drug use. Some of those characteristics are inherent in the job – the shared characteristics of employees, the nature and culture of the organisation, and the availability of licit drugs. Specifically, they are:

- danger preparation – 24-hour readiness and availability for recall to duty
- extended and irregular hours of duty – shiftwork
- high-risk and stressful situations over prolonged periods, often alternating with periods of boredom
- split-second decision making – management of critical incidents and emergency situations
- potential for critical-incident stress – dealing with victims of crime, violence and accidents
- high levels of stress associated with a bureaucratic and hierarchical organisation – rapid organisational change, promotion systems, internal investigations
- safety-sensitive roles for operational personnel, such as high-speed driving
- security-sensitive situations
- close-knit specialist groups working closely for extended periods of time
- employee profile – predominantly young, male, high-risk taking
- use of alcohol for both males and females higher-than-community norm
- working in isolated or remote locations with limited access to health and support services
- a culture conducive to alcohol use – alcohol seen as a bonding and debriefing mechanism.

As well as the above characteristics, which are common to police and other emergency services workplaces, there are also some characteristics which are more specific to police:

- carriage and use of firearms
- perceptions of public negativity – development of an us/them mentality

Unlike many other occupations, police officers cannot fade into anonymity after their shift. Police officers are bound by their oath of office and compliance with rules and regulations, such as their various codes of conduct, which apply 24 hours a day, 7 days a week.

With civilianisation, many traditional police roles are being devolved to staff who are increasingly working in security and safety-sensitive, stressful and highly accountable areas. Staff within police and other emergency services are frequently subject to many of the same conditions and stressors as operational staff, and any policy and practice developed to deal with workplace substance use should accommodate this group.

### ***Police and emergency services drinking cultures***

In spite of increasing gender equity, police and firefighting cultures are still (generally speaking) male oriented and consider drinking to be an important part of socialising and reducing stress.<sup>47</sup> 'Drinking with colleagues is-also used to test an officer's loyalty, trustworthiness and masculinity; and to symbolise and reinforce the links between members.'<sup>48</sup>

It is also frequently referred to in discussions with police as a debriefing mechanism. I was assured during my consultations with emergency services personnel that alcohol was similarly used as a debriefing strategy and was very much part of the cultural socialisation of the workplace.

Police and emergency services cultures are characterised by a set of informal rules and behaviours. Positive aspects of workplace culture may include loyalty to fellow officers, teamwork, unity and fraternity. Such features arise from several factors, including;

- close proximity for extended periods of time
- the perception (or reality) of physical danger
- the group's expectation of loyalty as a precondition of acceptance.<sup>49</sup>

Positive features such as loyalty and unity can, however, be transformed into negative aspects when they encourage a code of silence or cover-up. This is particularly true in the case of inappropriate alcohol and licit drug use in the workplace.

An Australian study by Hagen (1992) found:

in many parts of the force a cover-up mentality exists. Officers will hide co-workers with a drinking problem from senior officers to prevent colleagues being disciplined ... Within the service, alcohol and drug problems are not treated as an OHS issue. Responses tend to be punitive rather than offering a rehabilitative approach. If an officer comes to work under the influence of alcohol they are likely to be charged, demoted, fined or sacked rather than offered help.<sup>50</sup>

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<sup>47</sup> Royal Canadian Mounted Police, 1986, p. 6

<sup>48</sup> *ibid.*

<sup>49</sup> James and Campisi, 1994, pp. 26-28

<sup>50</sup> p. 62

Historically, and anecdotally, officers with a 'problem' may have found themselves transferred, particularly after an alcohol-related incident, to a more remote location, thus effectively ensuring reduced access to much-needed treatment.

A major impediment to reporting a colleague's suspected misuse to a supervisor is the potential for severe consequences for the user. Programs that encourage self-referral and adhere to the strictest codes of confidentiality are most likely to be embraced by police and others.

Drinking cultures will persist where alcohol consumption is used as a ritual to entrench communal solidarity, and as a marker or symbol of a group's identity. Smithers and Trice (1996) write how intemperate drinking rituals reinforce a sense of occupational community and enhance group identity, and how these cultures are self-perpetuating.

Occupational cultures develop within work groups as those groups develop patterns of behaviour and belief systems that serve them to function in their role. Some workplaces – such as those of police, firefighters and Defence – because of the nature of their work, tend to draw tighter boundaries around their work groups, and expect higher conformity to the group culture.

Some work groups socialise outside work hours predominantly within their professional stream, reinforcing group solidarity and norms.

Members of occupational communities build their sense of self around their work role, take members of the occupational community as their primary reference group, and, preferring to spend time with their own kind, integrate their work and leisure activities.<sup>51</sup>

### ***Transforming workplace drinking cultures***

Culture is characterised by shared beliefs and meanings that influence action and is defined by the symbols, rituals and stories of its members. Cultural drinking norms include aspects of reciprocity, such as drinking in rounds. Culture is, however, fluid and responds to intervention. The rate of response varies according to the strength of the stimulus for change.

Those workplaces which identify (and are identified) as supporting a heavy drinking culture, such as police and firefighters, do not necessarily consider their high consumption levels as deviant, but as the norm.
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Those workplaces which identify (and are identified) as supporting a heavy drinking culture, such as police and firefighters, do not necessarily consider their high consumption levels as deviant, but as the norm. This high benchmark for consumption is difficult to shift. The trick is in moving high-risk consumption patterns to responsible patterns while retaining positive aspects of group solidarity and support.

Organisations wishing to affect cultural change may need to moderate some drinking rituals, such as the end-of-shift barbeque, or the unofficial debrief. Sonnenstuhl suggests:

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<sup>51</sup> Sonnenstuhl, 1996, p. 24

The transformation of intemperate drinking rituals requires a conscious effort to construct a new definition of drinking within the occupational community and the mobilisation of resources to teach members that new meaning, and to sustain it until the old rituals fade and the new meaning replaces it. That is, the belief that one does not have to drink to be a member of the occupational community becomes a social fact.<sup>52</sup>

However, just changing limited and specific aspects of the workplace culture, such as those associated with drinking rituals and patterns, may only have limited success. If an organisation is serious about creating a healthier workplace, it will need to examine the full range of management practices to determine which practices are impacting negatively on alcohol and other licit drug use, and which aspects can be used to affect positive change.

In his book, *Working Sober*, Sonnenstuhl refers to three stages of change:

- unfreezing
- transformation
- refreezing.<sup>53</sup>

The first phase may be precipitated by a significant policy change, such as the introduction of random breath testing, as occurred in Queensland Police, and is characterised by a shift in absolute beliefs to a gradual acceptance of potential for change. The next phase may be characterised by the old and new workplace cultures in conflict, while the last phase occurs as old rituals lose their hold and is characterised by acceptance and consolidation of new norms and new meanings.

Significant organisational change is facilitated by:

- a long-haul approach
- active support of leadership – at the top, and front-line supervisors
- union and mainstream support for change
- congruence between the organisational culture and the wider culture
- continuity of positive aspects of organisational culture.

The above factors can be problematic, and are heavily dependant on commitment, personal attitudes to alcohol consumption by key change agents, and overcoming a wider culture which emphasises personal choice and has a high tolerance for excessive alcohol consumption.

It is interesting to note that one of the anticipated outcomes from the implementation of the NSW Police Drug and Alcohol Policy is cultural reform within the organisation. The holistic approach adopted by NSW Police – which includes testing, education, counselling and rehabilitation, and is embedded within a healthy-lifestyles approach – aims to overcome the historically entrenched culture of cover-up. The healthy-lifestyle approach was introduced to complement the drug and alcohol policy, and offers:

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<sup>52</sup> *ibid.*, p. 30

<sup>53</sup> *ibid.*

opportunities for recovering employees to change their behaviour in an organisational framework, eventually dominating the dysfunctional organisational culture.<sup>54</sup>

One strategy which has proved successful has been the dissemination of information on alcohol and other licit drugs within the context of general health promotion.

The nesting of alcohol issues within larger health concerns is a highly effective means of motivating behavioural change toward less risky drinking and a healthier lifestyle in general.<sup>55</sup>

Another strategy that the NSW Police have found effective in responding to employees with substance-use problems has been to offer an amnesty to officers who identify themselves as users, and to guarantee confidential referral to Service-paid treatment.

## **Stress**

Elephants can swallow a watermelon, but choke on a peanut – sometimes it's the little things that bring us unstuck.

– *Fort Worth Community Policing Officer, 2004*

In the literature on the police workplace two factors have been highlighted as having a role to play in fostering harmful substance use. These are occupational (organisational and operational) stress and a workplace culture of substance use.

Stressors inherent in police work can contribute to depression, neurosis, lack of job satisfaction, feelings of alienation, higher-than-average divorce and suicide rates, increased incidence of alcoholism, and other drug misuse.<sup>56</sup> Research has indicated that alcohol misuse, smoking and taking other drugs, are negative coping mechanisms used by police to cope with the pressures of their work.<sup>57</sup>

Unlike positive coping mechanisms – such as social support, counselling, stress-management strategies and exercise – which enhance ability to cope with stress, negative coping mechanisms, including substance use, increase the damage from stress. Substance use may also exacerbate existing stressful conditions, such as financial or relationship problems.

Violanti, Marshall and Howe (1985) identified three coping mechanisms used by police to deal with occupational demands. These were cynicism, secrecy and deviance. These faulty coping mechanisms increase levels of stress, and can contribute to increased alcohol consumption.

Although it is well documented that high levels of stress reduce productivity, the emphasis of this research is on the impact of stress (organisational and operational) on an employee's licit substance use. The other focus of this research is to review how police and other emergency services personnel address operational stress and associated licit substance use,

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<sup>54</sup> Bassingthwaighe, 1997, p. 31

<sup>55</sup> Roman & Blum 2002, p. 53, referring to findings by Shain and colleagues, 1986

<sup>56</sup> Davidson and Vena, 1980

<sup>57</sup> Davey, Obst & Sheehan, 2001

and to suggest ways in which organisations might minimise the risk of substance use through an evidence-based response to critical incidents.

Assumptions about the nature of police stress in the literature includes:

- Police work is inherently stressful and police officers suffer the negative effects of stress to a significant degree.
- Police work is more stressful than other types of work.
- The police deserve special attention to reduce causes and consequences of stress.
- Police work will become even more stressful in the future<sup>58</sup>

These assumptions are not necessarily true, but have had an impact on the way police organisations respond to stress. Similar assumptions have been made about other emergency services workplaces.

## Organisational stress

In my 21 years of service, I have found far more stress involved in administrative problems than work on the street. These problems include incompetent and over-ambitious superiors, work-place restructuring, excessive workloads, and the tendency of the Service to follow 'flavour-of-the-month' programs, irrespective of whether or not these programs are applicable to a particular situation.  
– a 39-year-old male sergeant<sup>59</sup>

The Steinberg, Tyman, Gill and Williams (1996) review of occupational stress in police distinguishes between organisational (job-context) stressors and operational (job-content) stressors. They concluded, after reviewing the literature, that organisational stressors tend to be perceived as more stressful than operational stressors, and that they have a greater impact on psychological distress. This position is questioned by Rallings, who does not believe there is sufficient evidence to warrant assertions about the comparative importance of organisational and trauma-related stressors.<sup>60</sup>

Organisational stressors identified in the literature include:

working with insufficient and poor equipment,<sup>61</sup> unnecessary paperwork, competitiveness generated by a strict promotion system,<sup>62</sup> and inadequate supervisory and management practices.<sup>63</sup>

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<sup>58</sup> Adapted from Molloy and Mays, 1984, pp. 197-224

<sup>59</sup> Rallings, 2002, p. 6

<sup>60</sup> *ibid.*, 2000, pp. 142-143

<sup>61</sup> Coman & Evans, 1998

<sup>62</sup> *ibid.*, 1991

<sup>63</sup> Brown & Campbell, 1990; Davey et al., 2001



Organisational stressors reported in a sample of British police include staff shortages, shift work, working with civilians, time pressures, lack of consultation and communication, managing and supervising people, long hours, work overload, inadequate resources/finance, and the demands of work impinging on home.<sup>64</sup>

In a similar study conducted by Brown, Cooper and Dudman, managers (superintendents and chief superintendents) reported similar sources for routine stressors. Having too much work to do headed the list, followed by staff shortages and an unsettling turnover rate, insufficient finances or resources, lack of consultation or communication, mundane administrative tasks or paperwork, factors not under your direct control, characteristics of the organisation's structure, attending meetings, keeping up with new techniques, and misuse of time by other people.<sup>65</sup>

Other organisational stressors include rapid organisational change, internal investigations, harassment and perceptions of public negativity. The perception of public negativity is interesting in the context of this study, in as much as it raises a significant difference in the way the public perceive police and other emergency services. Police suggest there is strong public support for firefighters and ambulance personnel, but less overall support for their own organisation. This perception by police reinforces an us/them mentality which encourages police to socialise with colleagues. Socialising predominantly with their workmates helps set social drinking norms, norms which the research indicates are above community consumption levels.

This feeling of alienation from the community can also make it more difficult for police to access mainstream support services when needed. When police do access outside services, natural reticence combined with feelings of separateness can make it difficult for them to maximise the opportunities counselling can provide.

## Operational stress

Paton distinguishes between 'work-related' and 'work-induced' stress, defining work-related stress as *traumatic events or conditions that happen at work, and work-induced stress as pre-existing conditions (including trauma) that can be reactivated at work*.<sup>66</sup> These distinctions are not critical in the context of this report, as the condition, whether work-related or work-induced, still impacts on the workplace and needs to be solved.

Police-specific operational stressors include attending the scene of a sudden death, arresting violent people, dealing with victims of violence, informing relatives of a sudden death, searching for a missing person, answering a call for officer assistance, appearing as a witness in court, dealing with victims of sexual assault, and attending a large-scale public-order event.<sup>67</sup> Brown and Campbell (1994) refer to three types of traumatic incidents: criminal injury or violence, accidents, and public disorder.

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<sup>64</sup> *ibid.*, 1994, p. 24

<sup>65</sup> 1992, cited in Brown and Campbell, 1994, p. 27

<sup>66</sup> Paton & Violanti, 1996, p. 209

<sup>67</sup> Brown and Forde, 1989, cited in Brown and Campbell, 1994, p. 33

Such incidents are typically sudden and can affect even the most experienced officers. Incidents that involve the death of a co-worker, life threatening incidents, exposure to extreme crime scenes, police shootings or suicide are some of the incidents most commonly cited as those most likely to cause trauma, but one officer suggested 'any situation in which an officer's expectation's of personal infallibility suddenly become tempered by imperfection and crude reality can be a critical incident.'<sup>68</sup>

Factors that increase the stressfulness of traumatic incidents or disasters include:

- a lack of warning about the event
- an abrupt contrast of scene
- technological disasters versus natural disasters
- the nature of the destructive agent
- degree of uncertainty and duration of the threat
- time of the event
- scope of the event
- traumatic aspects, such as involvement of children, prolonged contact with the dead, distressing sights, sounds, smells
- human error, which might be seen as being preventable
- features of the post-disaster environment, such as weather conditions, hazards,
- poor living conditions, frustrations.<sup>69</sup>

An officer's reaction to an incident is affected by the extent of the incident, the severity of the incident, and their proximity to the incident.

Hillas and Cox (1986) point to three main factors to be considered in relation to traumatic incidents:

- (a) how the incidence of severely stressful situations and adverse reactions to them might be reduced
- (b) how the organisation's immediate response might be developed to be more cathartic and supportive, and
- (c) how the treatment and rehabilitation of officers might be made more effective.<sup>70</sup>

Brown & Campbell suggest the following factors be considered:

- internal factors: operational, organisational and managerial
- external factors: a specific incident or string of incidents
- an individual's own pathology.<sup>71</sup>

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<sup>68</sup> Cross & Ashley, 2004

<sup>69</sup> Myers, 1989, cited in Brown and Campbell, 1994, p. 47

<sup>70</sup> Cited in Brown and Campbell, 1994, p. 40

<sup>71</sup> 1994, p. 20

In relation to an individual's own pathology, the degree of stress an individual is already under will impact on their ability to process traumatic incidents. Individual characteristics – such as hardiness, coping skills and resilience – and whether an individual already has high consumption rates for alcohol or relies on alcohol or other licit substances as a coping mechanism, will affect how they respond to an incident.

Rallings (2000) refers to the interrelationship of the event, and personal and environmental variables when gauging the impact of occupational stress. He suggests that some occupational events, such as the death of a colleague, a police shooting or traumatic events involving children, for example, are more likely to have an ongoing impact. The suddenness of the event and the response to the event will also contribute to its impact.

Environmental factors include existing workplace policy and practices; how a workplace responds to organisational and occupational stress; how a workplace responds to traumatic incidents; and what support structures (formal and informal) are in place.

Organisational norms that emphasise invulnerability or which generate a professional belief suggesting that emotional disclosure Signal personal weakness could heighten the tendency to engage in denial or avoidance-based attempts at coping.<sup>72</sup>

A failure to look at the organisational culture of the workplace, either in the organisation's attitude to stress, or its post-trauma practices, can contribute to loss of operational effectiveness, demonstrated by, for example, absenteeism, compensation claims and burnout. Burnout is characterised by a deterioration in job performance and job satisfaction, and emotional exhaustion; 'EMS workers may be especially at risk.'<sup>73</sup>

In addition to the negative outcomes recorded for some emergency responders who have been involved in critical incidents, some have reported positive outcomes, including pride at being able to assist victims of the disaster, and personal growth.<sup>74</sup>

See the 'Debate on providing critical-incident debriefing for police and emergency services' (p. 41) for more detail on operational stress and trauma.

## Critical-incident stress and post-traumatic stress disorder (PTSD)

The terms *critical-incident stress* and *post-traumatic stress* are frequently used synonymously in the literature. Critical incident stress refers to stress from either one incident, or cumulative stress as a result of a series of incidents. Critical incidents, such as horrific road or other accidents, certain crime scenes, major disasters, or death of a fellow officer are among those that have the potential to produce post-trauma symptoms.

The term *post-traumatic stress disorder* was first used in the diagnostic manual (DSM-111) compiled by the American Psychiatric Association in 1980, and was revised in 1987. Some of the symptoms listed include:

- persistent and intrusive memories of the event

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<sup>72</sup> Paton & Smith, in Paton & Violanti, 1996, p. 41

<sup>73</sup> McCammon, in Paton & Violanti, 1996, p. 59

<sup>74</sup> Rallings, 2000, p. 16

- avoidance of feelings and situations associated with the event
- loss of interest and feelings
- difficulties in sleeping and concentrating
- hypervigilance.<sup>75</sup>

PTSD has also been defined as 'the adverse somatic, behavioural and emotional sequelae<sup>76</sup> of extremely stressful events, such as shooting incidents, major public disorders, multiple car accidents as well as other large-scale disasters'.<sup>77</sup> The onset of symptoms for PTSD may not occur immediately after the incident, and delayed PTSD might even occur after a similar, later incident.<sup>78</sup>

Stress responses and the symptoms resulting from such incidents can be cognitive (confusion, difficulty concentrating, or intrusive thoughts); physical (fatigue, headaches, or changes in appetite or sleep patterns); behavioural (withdrawal, acting out, or substance use); or emotional (anxiety or fear, depression, anger or guilt, or feelings of helplessness). Most often, a combination of these symptoms emerges – frequently worsening and compounding as multiple traumas occur over time.<sup>79</sup>

### **Incidence of PTSD**

Most people experience a traumatic event sometime in their lives, with estimates in the general community ranging from 51% of women and 61%<sup>80</sup> to 84%<sup>81</sup> of men. Rallings (2000) suggests that prevalence rates of PTSD in the general population are much lower, between 6% and 10%.

Not all individuals exposed to the same incident will suffer PTSD, and the incidence of clinically diagnosed PTSD is relatively small. Most studies agree that police and emergency services personnel are an occupational group at higher risk of exposure to traumatic incidents and subsequent development of PTSD.<sup>82</sup> A pilot study with Queensland Police indicated that work-related traumatic events were common, with 95% of participants reporting experiencing a work-related traumatic event at some time during their career, though only a small percentage of those officers go on to develop PTSD.<sup>83</sup>

'Simply being exposed to critical incidents is not distressing for all officers who attend, nor is it equally distressing for those who are affected.'<sup>84</sup> Rallings suggests that although work-related traumatic events were found to be ubiquitous, subjective severity ratings of these events was quite low.<sup>85</sup> Paton suggests that responding to disaster situations may provide for some 'an enhanced sense of professionalism, an opportunity for personal growth,

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<sup>75</sup> Cited in Brown and Campbell, 1994, p. 460

<sup>76</sup> Morbid conditions resulting from a previous disease or diseases

<sup>77</sup> Brown & Campbell, 1994, p. 1

<sup>78</sup> Brown and Campbell, 1994, p. 52

<sup>79</sup> Cross & Ashley, 2004, p. 25

<sup>80</sup> Kessler et al., 1995

<sup>81</sup> Vrana & Lauterbach, 1994

<sup>82</sup> Adams & Stanwick, 2002

<sup>83</sup> Rallings, 2000

<sup>84</sup> Mitchell, Stevenson & Poole, 2000, p. 26

<sup>85</sup> 2000, p. 376

stronger emotional bonds with significant others, and a heightened awareness of the need to live life to the full'.<sup>86</sup>

Estimates of the prevalence of PTSD among police officers varies; however, the consensus is that the rate of PTSD for officers is 'four to six times higher than the general public'.<sup>87</sup> Research suggests that while there are no definitive studies of the prevalence of PTSD among police officers, it has been suggested that around 12-35% of police officers suffer from PTSD,<sup>88</sup> compared with only 1-2% of the general (US) population.<sup>89</sup>

Robinson, Sigman & Wilson (1997) found that 13% of their sample of serving police officers had diagnosable PTSD. Everly and Mitchell (1997) commenting on the situation in the United States, estimate that at any given time 15-32% of emergency responders will be dealing with post-traumatic stress. Bledsoe believes this figure is exaggerated, and suggests that the incidence of PTSD in US adults (aged 18-54 years) is about 3.6%, with the incidence of Gulf War veterans up to 8%.<sup>90</sup> He suggests that police and other emergency services would be somewhere around this figure.

The discrepancies above are indicative of the lack of hard data on the incidence of PTSD among police and emergency services personnel, and show the need for more research in this area.

### **Acute stress disorder (ASD)**

Acute stress disorder refers to a disorder that occurs within a month of an individual being exposed to a traumatic incident, where that individual responds with feeling of extreme fear, helplessness or horror. Three or more of the following dissociative symptoms need to be present for a diagnosis of ASD:

loss of emotion, numbing or detachment; diminished awareness of surroundings, depersonalisation, derealisation; and dissociative amnesia. The traumatic event should also be persistently re-experienced through recurrent images, thoughts, dreams, flashbacks or a sense of reliving the experience. The diagnosis also requires marked avoidance of stimuli that arouse recollections of the trauma, and marked symptoms of anxiety. This disturbance lasts for a minimum of two days and lasts a maximum of four weeks. If symptoms last longer than four weeks, a diagnosis of PTSD may apply.<sup>91</sup>

Although they are not synonymous, most of the literature on police and other emergency services refers to PTSD rather than ASD, which is a more recent term in the literature. A diagnosis of ASD, in the absence of treatment, appears to be an accurate predictor of subsequent PTSD.

All controlled studies to date which have attempted to gauge the efficacy of early supportive counselling (education, non-directive support, and general problem solving) for those with ASD have found it to be ineffective. Cognitive behavioural therapy, on the other

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<sup>86</sup> Paton & Violanti, 1996, p. 222

<sup>87</sup> Green, 2004

<sup>88</sup> Boyle, 1987; Mann and Neece, 1990

<sup>89</sup> Brown and Campbell, 1994, p. 53

<sup>90</sup> 2002, p. 277

<sup>91</sup> Devilly, unpub., 2004

hand, has proved to be very effective, demonstrating treatment gains up to four years after treatment.<sup>92</sup> Providing cognitive behavioural therapy soon after a trauma may have long-term benefits for individuals who are at risk of developing PTSD.

### **Prevention of PTSD**

It was suggested during consultations here and overseas that recruitment and selection processes can and should be tailored to identify recruits with the potential for high resilience, strong coping mechanisms, and good support systems.

It may also be possible to provide some pre-trauma training during general pre- and in-service training (NZ Police provide a training module on trauma). But it would be difficult to evaluate the preventive impact of such an intervention. Paton and Stephens suggest training 'to enhance the capacity of workers to manage the psychological impact of emotionally distressing events on themselves and others ... and promote their ability to adapt to the atypical demands of traumatic events and disasters and their long-term implications'.<sup>93</sup>

Grant Devilly is currently researching the links between exposure to traumatic incidents and substance use by police.<sup>94</sup> This research is funded by the National Drug Law Enforcement Research Fund (NDLERF). Devilly suggests that police may be 'inoculated' against traumatic events, or the negative impacts of those events minimised, through training that focuses on their expectations about traumatic incidents and teaches them about positive coping strategies.

Mitchell, Stevenson and Poole (2000) emphasise the role of supervisors in minimising the stress associated with incidents: 'Support and recognition by supervisors during and after a threatening incident is crucial to subsequent psychological resolution'<sup>95</sup> This is an area where specific training may assist supervisors who are called on to provide support after traumatic incidents. Supervisors modelling good coping strategies can have a positive impact on staff behaviour, especially, for example, responsible alcohol use.

It may be possible to prevent or alleviate substance use resulting from exposure to a traumatic incident by reducing the impact of the incident. However, if reducing the impact of an incident is not possible, it should still be possible to reduce the use of alcohol to self-medicate after an incident. Education on what to expect and where to access help should be part of routine training, as well as included in the response to specific incidents.

Stewart and Hodgkinson suggest that support from families, friends and colleagues also reduces the stress of critical incidents.<sup>96</sup> Workplaces should therefore develop strategies to involve and strengthen these informal support systems. Support also needs to be available for families who are at risk of facing secondary trauma reactions.

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<sup>92</sup> Bryant, Moulds & Nixon, 2003

<sup>93</sup> Paton & Violanti, 1996, p. 174

<sup>94</sup> Swinburne University, 2005

<sup>95</sup> p. 44

<sup>96</sup> 1994, cited in Rallings, 2000

A number of studies<sup>97</sup> have been conducted on the short- and long-term impact on those involved in body-retrieval exercises. These studies suggest good practice procedures to reduce the negative impacts of such experiences. Jones, for example, made a number of recommendations for dealing with disaster-victim recovery operations, including:

partnering younger personnel with older, more experienced personnel; providing day-to-day emotional support; facilitated non-threatening group discussions; normal termination for the group, who are given recognition by the appropriate and valued authorities; debriefings should be provided; follow-up mental health care should be made available.<sup>98</sup>

While opponents of critical-incident stress management (CISM) may not support all of these strategies (such as group discussion), they do support some of the strategies listed, including respected superiors recognising a job well done, and partnering younger employees with more experienced personnel.

Rather than mandating group psychological debriefing, police and emergency services organisations need to review overall management and organisational practices as a preventive measure to lessen the impact of critical incidents. For example, organisations may wish to review their selection criteria and recruitment processes to actively attract recruits with attributes associated with resilience and strong coping skills.

Employees should be provided with a written policy, prior to an incident occurring, which sets out the organisation's procedural response to critical incidents, individual employee responsibilities, and sources for ongoing assistance if required.

Police and emergency services organisations that fail to plan for the potential negative impacts of either organisational or critical-incident stress may experience personnel problems, such as reduced productivity, absenteeism, apathy and substance abuse, including increased reliance on alcohol, pain killers and sleeping tablets.<sup>99</sup> Violanti suggests a four-phase stress-management model incorporating education, prevention, support and research.<sup>100</sup>

Organisations that take a preventive approach are less likely to have to deal with the above personnel problems on a large scale. Prevention initiatives include overall appropriate management practices, effective management of critical incidents, and an integrated approach to training, information dissemination, and provision of support services.

## Resilience: police and emergency services personnel

In the last few years the role of resilience in ameliorating the response to traumatic incidents has achieved greater recognition. Resilience refers to the capacity of individuals to overcome diversity. Resilient people possess strengths and skills which help them process situations in a more positive way.

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<sup>97</sup> e.g. Jones, 1985; Alexander and Wells, 1991

<sup>98</sup> Cited in Brown and Campbell, 1994, p. 51

<sup>99</sup> Cross & Ashley, 2004, p. 26

<sup>100</sup> 1996, p. 103

Resilience skills may be enhanced through training that at least in part prepares personnel for traumatic experiences by giving a clear understanding of their role and procedures to follow during and immediately after an event.' A key factor in promoting resilience, that is the ability to impose coherence and meaning on atypical experiences, is training.<sup>101</sup> Such training should include technical (practical) and psychological preparedness and should develop the capacity to respond flexibly in emergency situations.

Another factor in developing resilience is the role of exposure. Being involved in an incident will not necessarily prepare an officer to deal with a similar situation in the future, especially if that incident was not properly processed. That is, exposure alone will not necessarily increase an officer's resilience, and prolonged exposure to traumatic incidents that are not properly resolved may increase an officer's vulnerability to PTSD.

It has been suggested that people who apply for law enforcement and emergency services positions may already have higher-than-average resilience skills. This hypothesis needs to be tested.

## Co-morbidity: PTSD and substance abuse

Patients who evidence co-morbid disorders of PTSD and SUDs (substance use disorders) have more severe levels of psychopathology, with greater symptomatology for each disorder; more life stressors (e.g. more medical problems, higher unemployment, higher arrest records); higher health-care utilisation; less effective coping strategies; and poorer response to treatment than do patients with either PTSD or SUD alone.<sup>102</sup>

Most of the studies linking PTSD and substance use have been cross-sectional studies that provide prevalence estimates, and that consistently document a PTSD / substance use co-morbidity.<sup>103</sup> While there have been fewer prospective studies,<sup>104</sup> the link has been reinforced. Other research has included 'disaster' studies,<sup>105</sup> and studies of combat veterans.<sup>106</sup> Kulka's study suggests the most prevalent co-morbid disorder in a study of Vietnam veterans with PTSD was substance abuse or dependence:

Military personnel with combat-related PTSD have even higher rates of co-morbidity. The National Vietnam Veteran's Readjustment Study<sup>107</sup> reported that 73% of Vietnam veterans with current combat-related PTSD met criteria for co-morbid alcohol abuse/dependence at some point after developing PTSD. Further support for a PTSD-addiction association is provided in studies of civilians presenting with current substance abuse disorders, in which the estimated rates of PTSD vary from 29-59%.<sup>108</sup>

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<sup>101</sup> Driskell & Salas, 1996; Paton, 1994

<sup>102</sup> Meichenbaum, in Ouimette and Brown, 2003, p. xi

<sup>103</sup> e.g. Helzer et al., 1987; Cottler et al., 1992; Kessler et al., 1995

<sup>104</sup> e.g. Chilcoat & Breslau, 1998

<sup>105</sup> North et al., 1999

<sup>106</sup> e.g. Kulka et al., 1990

<sup>107</sup> Kulka et al., 1990

<sup>108</sup> Triffleman, 1998, cited in Best, 2004, p. 3



Violanti writes of the similarities between combat and police work, and the high correlation between trauma-related stress and substance use.<sup>109</sup> He draws on the commonality of experience between Vietnam veterans and police, citing similarities in work conditions and exposure to trauma, and an environment of perceived lack of public support and isolation.

Much of the literature on occupational stress lists substance use as a co-existing morbidity.<sup>110</sup> PTSD is frequently associated with depression, anxiety, alcohol and substance use, anger and guilt.<sup>111</sup> Depression and substance abuse are frequently observed associated features of PTSD.<sup>112</sup> A number of studies<sup>113</sup> have identified changes in smoking, drinking and eating habits as psychological or physical impact of an incident; 'continued stress may result in undesirable behaviour changes, such as drug dependency, substance abuse (usually alcoholism)'.<sup>114</sup>

A strong body of empirical evidence demonstrates that rates of alcohol-use disorders are significantly higher in individuals with PTSD, compared with trauma-exposed individuals without PTSD, and non-exposed community samples, raising concerns about PTSD-related alcohol co-morbidity in police officers. In a nationally representative sample of American adults, among those with a lifetime history of PTSD, an estimated 52% of men and 28% of women have a history of co-morbid alcohol abuse or dependence.<sup>115</sup>

Clinical studies have shown that having PTSD increases the risk of having a substance-use disorder and vice versa.<sup>116</sup> Stewart and Conrod suggest 'PTSD arousal symptoms motivate PTSD patients to abuse alcohol, prescription depressant drugs, or both, in an attempt to self-medicate their hyperaroused state'.<sup>117</sup> They further argue that:

hyperarousal symptoms may be the specific feature of PTSD that renders certain PTSD patients particularly likely to resort to substance abuse and to prove additionally resistant to traditional SUD (substance-abuse and dependence disorders) treatment.<sup>118</sup>

The authors also suggest that 'the use of alcohol and prescription depressant drugs could interfere with recovery from PTSD by interfering with the integration of the traumatic event into a contextually based system of memories and beliefs'.<sup>119</sup>

Having PTSD increases the risk of having a substance use disorder and vice versa.

Most of the literature on PTSD and substance-abuse co-morbidity suggests that patients who have been diagnosed with substance-use problems should be screened for PTSD, and vice versa. This could be particularly relevant for police and

<sup>109</sup> Paton & Violanti, 1996

<sup>110</sup> Brown et al., 2000; Breslau, Peterson & Schultz, 1997; Ivezia, Bagariae et al., 2000

<sup>111</sup> Forbes, Creamer et al., 2003; Brown and Campbell, 1994

<sup>112</sup> Figley, 1985, p. vii

<sup>113</sup> e.g. Berah, Jones and Valant, 1984, cited in Brown and Campbell, 1994, p. 52

<sup>114</sup> Brown and Campbell, 1994, p. 18

<sup>115</sup> Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995, cited in Best, 2004, p. 3

<sup>116</sup> Stewart & Conrod, in Ouimette and Brown, 2003, p. 29

<sup>117</sup> *ibid*, p. 32

<sup>118</sup> *ibid*, p. 54

<sup>119</sup> *ibid*. p. 71

emergency services personnel who drink at levels higher than community norms, and who are routinely exposed to traumatic situations.

Although police alcohol-consumption rates are indisputably higher than the community norm,<sup>120</sup> not all substance use is related to stress or trauma. However, although it is not possible to measure the exact extent to which instances of substance use are related to ongoing exposure to trauma, the two are clearly linked. Police and emergency services organisations record substantial levels of occupational stress and above-average alcohol consumption rates. The literature points to a strong link between these two issues:

researchers have identified four occupational demands that can trigger alcohol use by law enforcement officers, namely depersonalisation (reacting unemotionally to the everyday stresses of the job), authoritarianism (officers' behaviour governed by a set of regulations, making them feel as if they are not in control), organisational protection (the structure in place to protect law enforcement agencies from criticism), and danger preparation (the stress related to officers knowing that their lives potentially are in constant danger).<sup>121</sup>

Using alcohol to self-medicate as a result of stress from an incident or series of incidents is well documented, and even small amounts of alcohol may cause dysfunction due to its depressive nature; however, use only becomes abuse if certain features are present: (i) if the individual cannot stop or cut down their use; (ii) work, family or social life is negatively affected; and, (iii) the substance-abuse problem has lasted for at least a month.<sup>122</sup>

In his thesis *Police and Trauma*, Rallings<sup>123</sup> writes that co-morbidity with PTSD is prevalent, with the most common conditions being affective, dissociative and substance-abuse disorders: 'PTSD is usually associated with co-morbid conditions, including effective and dissociative disorders, somatoform disorders,<sup>124</sup> social and occupational dysfunction as well as substance-abuse problems.<sup>125</sup> In his study, Rallings found that hazardous drinking rates increased from 13% to 22% after commencement of police work and subsequent exposure to traumatic incidents, and interestingly, that smoking rates increased from 8% to 15%. There is very little in the workplace literature on the impact of trauma related stress on smoking rates, but tobacco-related harms are another concern for police and emergency services workplaces to consider when looking at stress-related licit drug harms.

Tobacco-related harms are another concern for police and emergency services workplaces to consider when looking at stress-related licit drug harms.

Also of interest, Best reports, 'we found no gender differences in PTSD symptom levels'.<sup>126</sup> It would be worthwhile for future studies to examine whether females employ different coping mechanisms, or score differently on resilience scales, compared to males who are in similar occupations, and who

<sup>120</sup> Mann, 2003

<sup>121</sup> Cross & Ashley, 2004, p. 27

<sup>122</sup> Brown and Campbell, 1994, p. 61)

<sup>123</sup> 2000, p. 138

<sup>124</sup> Physical symptoms that seem to stem from a general medical condition, but are actually the result of a psychological conflict.

<sup>125</sup> Malt, p. 1994, cited in Rallings, 2000, p. 68

<sup>126</sup> 2004, p. 8

are exposed to similar potentially traumatic situations, and then to measure their use of alcohol to self-medicate as a result of those incidents.

Mitchell, Stevenson & Poole refer to a study they conducted on stress and substance use:

Rating alcohol as helpful in managing the incident after it is over is significantly related to higher post-trauma symptoms, suggesting that its use does not have the effect of reducing post-trauma symptoms. Alcohol may be used as an anaesthetic by people experiencing distress ...<sup>127</sup>

The study also found that the more negative the coping strategies that were used (such as drinking alcohol), the greater the distress.

The number of units of alcohol consumed correlates with the number of post-trauma symptoms, and with an inability to get to sleep, so the person experiencing post-trauma symptoms also has difficulty getting to sleep, and then uses alcohol in order to get to sleep. The effects of alcohol, and of disturbed sleep, both have an impact on day-to-day functioning at work and both are associated with reporting post-trauma symptoms..<sup>128</sup>

Whether an incident has a significant or ongoing negative impact on an officer's continuing ability to function productively without recourse to negative mechanisms – such as alcohol or other licit drugs – can depend on many factors, such as the severity of the incident, past experience with similar incidents, and existing positive coping mechanisms and support infrastructure.

Sadly, however, some officers believe that substance use and abuse may offer the best way to cope with their otherwise unbearable feelings<sup>129</sup> ... If officers continue along this path, then major depressive symptoms begin to increase, feelings of hopelessness and helplessness abound, suicidal ideation and rates increase, and, all too often, substance abuse to dull these feelings leads to addiction and dependence.<sup>130</sup>

In discussing PTSD and substance abuse, Brown and Campbell suggest that suicidal thoughts are not uncommon.<sup>131</sup> In Australia, the national average for suicide is 11.8 deaths per 100 000 population.<sup>132</sup> whereas the average number of police suicides in Australia is 21.6 per 100 000 population.<sup>133</sup> The problems of stress, substance use and suicide for police and other emergency services personnel in Australia is not well covered in the research literature.

Mitchell, Stevenson & Poole (2000) conducted a study to assess the incidence and the effects of post-trauma reactions to critical incidents in two police services, the Strathclyde Police and the Royal Ulster Constabulary (RUC):

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<sup>127</sup> 2000, p. 48

<sup>128</sup> *ibid*, p. 50

<sup>129</sup> Cross and Ashley, 2004, p. 24

<sup>130</sup> *ibid.*, p. 26

<sup>131</sup> 1994, p. 52

<sup>132</sup> ABS, 2003

<sup>133</sup> Cantor, Tyman & Slater, 1995

Having a sense of control over work, a positive state of mind, commitment to the organisation and job satisfaction were all found to be protective against post-trauma symptoms<sup>134</sup> .... With regards to coping, in the Strathclyde sample it was found that the use of alcohol to intentionally put the incident out of one's mind ... [was] related to higher levels of psychological distress ... In the RUC sample the use of alcohol was also related to higher levels of psychological distress. Talking with colleagues about the incident and their feelings about it, and getting positive recognition from supervisors were all related to lower levels of psychological distress.<sup>135</sup>

### **Treatment of PTSD and substance use**

As mentioned, any diagnosis of substance abuse for police and emergency services personnel should look at the possibility of PTSD or other stress-related illnesses. Alcohol and other substance abuse may occur as a result of a stressful incident, without the clinical diagnosis of PTSD. The existence of alcohol or other substance abuse may mask PTSD and make diagnosis difficult.

Most clinical researchers recognize that SUD (substance-use disorder) and PTSD symptoms are interwoven and emphasise the need for concurrent treatment of substance-use problems and PTSD symptoms ... moreover, one recent study found the majority of SUD-PTSD patients preferred concurrent SUD and trauma treatment.<sup>136</sup>

Stewart & Conrod, recommend brief motivational interventions for substance use in combination with PTSD treatment.<sup>137</sup> Ouimette, Moos and Brown suggest that several cognitive-behavioural treatments (including cognitive therapy, anxiety management, and real-world or imaginary exposure) have been shown to be effective in treating PTSD, while cognitive-behavioural interventions are effective in reducing substance use.<sup>138</sup> Foa, Rothbaum, Riggs and Murdoch (1991) found that stress-inoculation training (which included controlled breathing, cognitive restructuring, guided self-dialogue, covert modelling, and behavioural rehearsal) proved significantly more effective in reducing symptoms of PTSD than supportive counselling.<sup>139</sup>

The International Society for Traumatic Stress Studies (ISTSS) published the first practice guideline for PTSD in 1997. This guideline recommended cognitive behavioural therapies and medication. The next guideline (1999) from the Expert Consensus Guideline Series recommended exposure therapy, cognitive therapy, and anxiety management as effective psychotherapeutic techniques for PTSD, and anti-depressants as the best medication treatment for PTSD.<sup>140</sup>

Good practice guidelines for PTSD treatment also suggest that patients who remain in outpatient care longer (regular sessions are for three months or longer) tend to have better outcomes,<sup>141</sup> as do those who engage in individual rather than group sessions. Ouimette,

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<sup>134</sup> p.7

<sup>135</sup> *ibid.*

<sup>136</sup> Ouimette, Moos, & Brown, 2003, p. 93

<sup>137</sup> *ibid.*, p. 55

<sup>138</sup> *ibid.*, p. 97

<sup>139</sup> Paton & Violanti, 1996, p. 220

<sup>140</sup> Ouimette, Moos & Brown, 2003, p. 107

<sup>141</sup> Ouimette, Moos, & Finney, 2000, cited in Ouimette & Brown, 2003, p. 110

Moos and Brown also recommend an holistic approach to the client, which considers, for example, gender-specific needs.

As well as the treatments mentioned above, the (mainly American) literature recommends that if a substance dependency is identified and acknowledged, participating in a self-help group such as Alcoholics Anonymous may be beneficial.

While evaluations of CISM variously report success (or otherwise), very few try to gauge the impact of psychological debriefing on subsequent substance use. While accepting that a definitive analysis might be difficult, some conclusions may be made. If we agree that debriefing – at least for some – is effective in that context, we can extrapolate that substance use that results from, or is exacerbated by, a traumatic incident may be alleviated by debriefing. This leads to the debate on the efficacy of debriefing, which is discussed in the next section.

## **Debate on providing critical-incident debriefing for police and emergency services**

*Primum non nocere.* First, do no harm.

The following section does not refer to operational debriefing, which normally covers the procedural response and more practical aspects of an incident.

There has been considerable debate in the literature about best practice in managing the impact of critical incidents. This debate is significant in a study of treatment and support services for police and emergency workers with alcohol and other licit drug problems because of:

- the nature of their work – ongoing exposure to trauma, or exposure to significant one-off incidents
- the culture of the organisation
- the profile or characteristics of most operational staff
- high levels of organisational stress
- historically ad hoc responses to critical incidents – responses not necessarily based on evidence
- the link between stress and self-medicating
- the link between stress and alcohol use
- the potential for stress to contribute to bingeing and escalating substance use
- duty-of-care imperatives
- risk of litigation
- compliance with occupational health and safety legislation.

It is incumbent on policing and emergency services organisations to ensure that evidence-based strategies are in place to respond to critical incidents, and high-quality support services are provided to treat single-incident or cumulative stress.

For the above reasons, it is necessary to review this debate to be able to recommend the best organisational responses to critical incident stress.

### ***Critical Incident Stress Debriefing (CISD) – the forerunner of CISM***

The process for CISD was developed in the early 1980s by Jeffrey Mitchell to relieve post-traumatic stress in emergency services personnel. Its two main goals were to:

- lessen the impact of distressing critical incidents in the personnel exposed to them
- accelerate recovery from those events before harmful stress reactions have a chance to damage the performance, careers, health and families of emergency services personnel.

The CISD process is organised to review the facts, thoughts, impressions and reactions following a critical incident, and to provide information on normal reactions to abnormal events. Everly (1995) adds that it provides an opportunity for early identification of those persons who may require more intensive psychological support.<sup>142</sup>

Opponents of CISD suggest that this would only be relevant if the facilitator was trained to determine such a need.

CISD, implying a single debrief, evolved into critical-incident stress management (CISM), which is a supposedly more comprehensive response. CISM was purported to not only lessen the impact of stressful events, but to prevent PTSD, to act as a screening tool, to facilitate verbalisation of experiences, to normalise reactions to stressful events, and to improve peer-group support and cohesion. These claims have been vigorously debated.

Much has been written about the efficacy of psychological debriefing sessions, and whether they should be compulsory, whether they should be conducted by someone from within or external to the organisation, when they should be conducted, and how many sessions are desirable. The efficacy of early intervention (i.e. at the scene, at the time) is part of this debate.

## Mandatory versus voluntary

It has been suggested that mandatory attendance at a debriefing may have the advantage helping an officer who may not have sought the help they needed. Secondly, no stigma is attached to attendance at a mandatory session, and thirdly, 'the potential experience of psychological distress is normalised and seen to be accepted by the institution'.<sup>143</sup> If debriefing is not mandatory, an opportunity to identify personnel who may benefit is lost, and another system for identifying those in need of a debriefing process must be put in place.

In a study by Martin, 61% of respondents stated they thought it would be best if post-incident counselling were compulsory.<sup>144</sup> The same study which asked 206

British police if they would consider using a Force counselling scheme if they had been distressed by a critical or traumatic incident, showed that only 53% said they would consider using such a service. Reasons they gave for reluctance to access such a service included:

- they thought they would be able to handle the situation alone
- lack of confidence in the system
- they would prefer to use their own support networks
- lack of trust in the confidentiality of the system (85% )
- belief that using such a service would be detrimental to their career
- that it would be unacceptable to the police-service culture.

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<sup>142</sup> Mitchell, Stevenson & Poole, 2000, p. 80

<sup>143</sup> Brown and Campbell, 1994, p. 115

<sup>144</sup> 1990, cited in Brown and Campbell, 1994, p. 117

A similar study in North America suggested that mandatory counselling 'overcomes the problem that, if officers are questioned about post-shooting counselling in court later, that it cannot be seen as indicative of any personal instability, but as routine departmental policy'.<sup>145</sup>

Opponents of compulsory psychological debriefing refer to the research suggesting that at best it has no effect on preventing PTSD, and at worst, may be harmful. They maintain that psychological debriefing should not be mandatory. One of their arguments is that mandatory debriefing promotes an expectation of trauma, and increases concerns officers may feel if they do not experience the 'symptoms' described.

New South Wales Health, in preparation for the 2000 Sydney Olympics, published best-practice guidelines for emergency mental health, based on thorough research by a world-wide panel of experts.<sup>146</sup> They concluded that 'most investigations have found that debriefing at best has no effect and some have found psychological debriefing may actually interfere with recovery'.<sup>147</sup> They therefore suggested that best-practice principles would indicate that if a critical incident occurs, psychological debriefing should not be mandatory.

## Group or one-to-one?

Ideally, the form a debrief takes would be flexible to the incident, and the number and individual needs of personnel involved. It is important not to mix those directly involved in an incident with those indirectly involved during a debrief process.

Supporters of CISM suggest that informal defusing, which may be carried out by a supervisor, and usually involves everyone at the incident, can be the first step in a multi-phase strategy. But this should not be a substitute for a more thorough approach, which would include ongoing monitoring and referral to expert intervention where needed.

Defusing has historically entailed checking what happened, what personnel did, checking how they felt, letting them know what they could potentially experience, and what further services are available. Opponents of this process do not support group discussion of how participants felt and what they may potentially experience. It may, however, be an appropriate forum to make sure harm minimisation strategies are in place for participants planning an 'informal' debrief over a drink.

## Who conducts debriefing?

One of the more controversial aspects of debriefing is the rigor of the qualifications and experience of the person performing the function. Anyone providing debriefing services should be specifically trained for that role, and while levels of training may vary, there should be minimum acceptable levels set. In the context of substance use, it is preferable that those providing ongoing support are alert to the risk of self-medicating or abuse, and are qualified to administer diagnostic tools.

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<sup>145</sup> Anderson and Bauer, 1987, cited in Brown and Campbell, 1994, p. 117

<sup>146</sup> Gist, 2002, p. 275

<sup>147</sup> *ibid.*



Debriefs are usually conducted by a welfare officer (or equivalent), a trained peer supporter, counsellor, psychologist or medical officer. Again, opponents of CISM stress that any form of psychological debriefing must be carried out by a trained and experienced mental health professional. 'Crisis intervention is best supplied by a professional mental health worker whose aim would be to restore the individual, whose coping resources are swamped, to their usual level of functioning as quickly as possible.'<sup>148</sup>

Deahl et al. (1994) suggest that debriefings conducted by 'outsiders' may discourage disclosure, while Everstine and Everstine (1993) suggest that whether a debrief is conducted by an outsider or a colleague is of little relevance compared to the fear of those involved in an incident losing control over their emotions.<sup>149</sup>

Anderson and Bauer suggest that for professional counsellors to have credibility in a police work environment, it may be necessary for them to be exposed to routine police work.<sup>150</sup> This sentiment was expressed during the overseas consultations with police and emergency services, and some organisations formalise participation of outsiders who are members of crisis-response teams in exercises and patrols to ensure they are familiar with workplace culture and procedures.

## Timing of debriefings

The timing of debriefing varies, but most organisations attempt to conduct a psychological debriefing, if not immediately, then between 24 and 72 hours after an event. This practice is debated by Gist and other opponents of CISM, who suggest that 'the heavy emphasis on reconstruction of the traumatic episode and articulation of the most distressing emotional reactions experienced may overload coping systems at times when cognitive distancing may represent a far more functional approach'.<sup>151</sup>

Most experts now agree that psychological debriefing should not occur until operational needs and other practical considerations have been addressed: 'Concern about practical problems tends to render the provision of psychological or welfare support less relevant. Other studies too have found that if individuals are concerned about practical or medical issues then psychological intervention is not relevant or useful until these matters are resolved.'<sup>152</sup>

Follow-up varies between none being offered, to the form of a questionnaire, a letter, phone or personal contact. Timing of follow-up may vary, as will the number of times personnel may be contacted. In some organisations, it may well be incumbent on the officer to initiate further counselling.

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<sup>148</sup> Brown and Campbell, 1994, p. 54

<sup>149</sup> Paton & Stephens, in Paton & Violanti, 1994, p. 190

<sup>150</sup> Cited in Campbell & Brown, 1994, p. 117

<sup>151</sup> Gist, 2002, p. 276

<sup>152</sup> Mitchell et al., 2000, p. 92

## The case against CISM

(See also interviews with Gist and Bledsoe, p. 48.)

Research evidence that mandatory group psychological debriefing within 72 hours of an incident is helpful in reducing the subsequent distress of a traumatic incident is limited, indeed some would say absent.<sup>153</sup> Furthermore, there is no evidence that it can actually prevent PTSD. Several field studies of debriefing following occupational incidents – in law enforcement, fire and rescue services and emergency medical workers (reported in referred research journals) – found debriefing inert at best with respect to preventing PTSD.<sup>154</sup>

Carlier et al. (1998) studied 243 traumatised police officers in the Netherlands who were assigned to a debriefing group or one of two control groups. Their results indicated a negative outcome for the debriefed group, who displayed higher levels of disaster-related hyperarousal well after the event. Macnab et al. in a similar evaluation on the effectiveness of CISM among medical responders to a traumatic incident concluded that CISD did not appear to affect the severity of stress symptoms.<sup>155</sup>

Van Emmerick, Kamphuis, Hulsbosch and Emmelkamp (2002) conducted a meta-analysis of seven studies evaluating single-session debriefing a month after the event. Six of the studies incorporated non-intervention controls.

Non-CISD interventions and no intervention were found to have improved symptoms of PTSD, but CISD did not improve symptoms and may have retarded natural resolution for some. Furthermore, they found that CISD did not improve natural recovery with respect to other trauma-related disorders.<sup>156</sup>

The Cochrane Reviews reported on a meta-analysis of 11 critical incident and debriefing studies. They found single debriefing sessions did not reduce psychological distress or prevent PTSD. They further found that there was a significantly increased risk of PTSD in those who received debriefing; 'There is no current evidence that single-session individual psychological debriefing is a useful treatment for the prevention of post-traumatic stress disorder after traumatic incidents',<sup>157</sup> and 'because of the potential for harm, compulsory debriefings should cease.'<sup>158</sup>

Mitchell, Stevenson & Poole cite a study by Hutt (1998) which showed that although a third of those surveyed found debriefing helpful, two-thirds were neutral. The procedure was not enthusiastically endorsed overall, and most importantly had no effect on symptoms.<sup>159</sup> The research literature cautions against the use of self-reported satisfaction surveys as indicators of efficacy.

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<sup>153</sup> Mitchell, Stevenson & Poole, 2000, p. 82

<sup>154</sup> Carlier, Voerman, and Gersons, 1998; Macnab, Russell, Lowe, & Gagnon, 1998, cited in Gist, 2002, p. 275

<sup>155</sup> Bledsoe, 2002, p. 275

<sup>156</sup> *ibid.*, p. 273

<sup>157</sup> Rose, Bisson & Wessely, 2004

<sup>158</sup> Bledsoe, 2002, p. 66

<sup>159</sup> 2000, p. 82

Another study by Deahl, Gilham, Thomas et al. (1994) studied British soldiers whose responsibilities included recovery and identification of bodies in the Gulf War. The study found soldiers who were provided with psychological debriefing were no less prone to psychiatric problems.<sup>160</sup>

Many other studies have yielded similar results, concluding that psychological debriefing does not reduce psychological distress or prevent PTSD, and may have harmful consequences.<sup>161</sup> Bisson et al. found that a quarter of the debriefed group were diagnosed with PTSD 13 months later, compared with only 9% of the control group. Hobbs et al. found that 'at four months post-accident, levels of anxiety and somatisation<sup>162</sup> had declined more in the non-treatment group, while levels of hostility and psychiatric symptoms had actually risen in the treatment group'.<sup>163</sup>

The Australian Critical Incident Stress Association, which was initially a supporter of CISD, concluded in their 1999 Geelong Declaration that 'experience and systematic investigations have revealed a marked discrepancy between outcomes once presumed to be achievable<sup>164</sup> and those that can be reliably delivered<sup>165, 166</sup>.

Just as Mitchell criticises some of the less-than-favourable evaluations conducted on the efficacy of CISD (and later on CISM), opponents of what has become known as the Mitchell model cite flaws in the positive evaluations conducted by or on behalf Mitchell and his supporters. Bisson and Deahl (1994) summarise the shortcomings of the research which supports CISD as:

they are not prospective; small sample sizes; no control group; variation in diagnosis; no random allocation; confounding variables ignored; low response rates; sampling bias; lack of uniformity of CISD method; variation in timing; and the use of questionnaire rather than interview in subsequent assessment.<sup>167</sup>

One indicator of rigor in the debate is the quality of the publications where findings are reported. Supporters of the CISM process, such as Mitchell and Everley, are largely published in trade magazines, non-referred journals, obscure mental health journals and self-published books and research, such as the International Journal of Emergency Mental Health, edited by Everley and published by Chevron Publishing, an arm of the Critical Incident Stress Foundation.<sup>168</sup> These sources have to be evaluated against publications such as the Cochrane Reviews, which are widely respected, evidence-based, critical reviews of research reports.

As a result of this debate, many organisations are reviewing and modifying their response to critical incidents. Gist (2002) cites the British National Health Service as one of the

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<sup>160</sup> Cited in Mitchell, Stevenson & Poole, 2000, p. 83

<sup>161</sup> Bisson, Jenkins, Alexander and Bannister, 1997; Hobbs, Mayou, Harrison and Worlock, 1996; Hobbs and Adshear, 1997; Rose, Brewin, Andrews and Lirk, 1999

<sup>162</sup> Converting mental experiences or states into bodily symptoms

<sup>163</sup> Bledsoe, 2002, p. 275

<sup>164</sup> Mitchell and Everly 1995

<sup>165</sup> Rose and Bisson, 1998

<sup>166</sup> Gist, 2002, p. 275

<sup>167</sup> Mitchell et al., 2000, p. 83

<sup>168</sup> Bledsoe, 2002, p. 67

growing international community entities that now lists psychological debriefing as 'contraindicated' for victims of trauma, along with the U S Department of Defence, the National Institute of Mental Health, the American Psychological Association and the American Red Cross.

## Litigation

Claims through the courts for stress-related compensation have been successful in most US states, and police, ambulance and emergency services in Australia need to be aware of the risk of litigation for failing to provide high-quality debriefing programs and suitable ongoing support. Please note here the emphasis on high quality. Organisations outsourcing counselling services need to be confident that the service provider is providing a high-quality service, based on the best available evidence, and tailored to the specific needs of the client organisation and the individual client.

Although organisations previously felt vulnerable to litigation if they did not provide compulsory psychological debriefing (as per the Mitchell model), they are now more liable to litigation if they uncritically apply that model. This is because of the substantial body of research that suggests that the model is not only ineffective in preventing PTSD, but may even be harmful, and may reduce the individual's capacity to spontaneously get over the trauma.

Bledsoe points out:

In addition to being possibly ineffectual and potentially harmful to employees, forced debriefing holds the potential for legal complications related to the issue of informed consent. Although CISM was originally developed to help normal people with normal feelings and emotions deal with a catastrophic event, it later evolved to prevention of PTSD and other psychiatric symptoms. With that change, it functionally became a form of mental health care, and with that came the requirement that personnel who undergo CISM/PD must provide informed consent ... Even with a signed informed consent, forced debriefing may pose a civil liability if an employee who perceives that he or she is harmed by the forced debriefing demonstrates that the scientific literature has shown that CISM may cause iatrogenic<sup>169</sup> harm. The lack of quality studies in respected peer-review journals supporting the efficacy and safety of CISM would further inhibit defence of the case.<sup>170</sup>

## The debate continued: Interviews with Dr Gist and Dr Bledsoe

The following section is collated from material obtained during interviews with Dr Richard Gist (1-2 June 2004), as well as from his writing in this area.

**'We have now reached the point where counsellors swarming about any major disaster have begun to outnumber even the lawyers.'**

– Gist

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<sup>169</sup> Induced in a patient by a physician's activity

<sup>170</sup> Bledsoe, 2002, p. 67

Dr Gist is the Principal Assistant to the Director, Kansas City Fire Services, and an expert in critical-incident stress management. Dr Gist is an outspoken opponent of the Mitchell model.<sup>171</sup> and of compulsory attendance at (non-operational) debriefs.

His main concerns are as follows:

- Debriefs do not normally allow for an individual approach; individuals respond to an incident in different ways.
- Personnel conducting debriefs are not necessarily trained and accredited.
- There is a lack of empirical evidence indicating a demonstrable, preventive effect.
- There is a risk of doing more harm than good.

Dr Gist believes that the Mitchell model is more a social movement that has become a social institution, rather than a scientific and rigorously tested model. A scientific model will look for exceptions and ask 'why?', whereas the Mitchell model has not responded well to scrutiny. 'Fact has never been some plural derivative of 'anecdote'; repetition does not establish validity, nor is persuasion a suitable substitute for precision.<sup>172</sup>

Gist believes that the ready acceptance of the Mitchell model by law enforcement was due to several factors:

- It filled a gap.
- It was relatively inexpensive and easy to implement.
- It was easy to understand and seemed to be based on commonsense.
- Implementing 'something' seemed to fulfil an employer's duty of care and protect them from legal liability.
- It seemed to work. Dr Gist referred to the placebo effect, and suggested that compulsory CISD 'worked' because organisations (and individuals) wanted it to.
- There was little opposition to the model in the early days of its implementation and it was aggressively marketed.
- It was not until the model was well established that research findings emerged indicating that not only did the model not prevent post-traumatic stress disorder, but that it may contribute to increased harms.
- It underestimated individuals' levels of resilience.
- The process fulfils a need for ritual.

Dr Gist pointed out that most articles in support of CISM have appeared in trade magazines and non-peer reviewed publications, and findings are not based on rigorous research or scientifically tested hypothesis.

Dr Gist also stated that there is a difference between volunteer and career services, especially in terms of selection, training, experience and support from co-workers. This may impact on the services that organisations elect to provide. There are also differences

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<sup>171</sup> The Mitchell model refers to the provision of mandatory group psychological debriefing, preferably within 48 hours of the incident.

<sup>172</sup> Gist, 1998, p. 9

between the fire, police, ambulance and Defence services, such as the nature of their exposure to critical incidents, and the roles they perform. He acknowledged, however, that there were clear similarities, such as the male-dominated and hierarchical nature of those organisations, which will also impact on the nature of the support services provided.

Dr Gist maintains responses to critical incidents can be frantic or focused. Whether an officer can move quickly from frantic to focused is partly individual, but largely a matter of training and management styles. Firefighters for example need to be able to move from relative inactivity to high activity and cope with sudden highly dangerous and high-adrenalin situations. Firefighters in those situations need a mechanism or strategy to 'wind down' without automatically turning to alcohol.

Dr Gist suggested that (firefighting) officers are like an elastic band – if the band is already stretched when additional pressure or pull is applied, it can snap, or may not go back to full elasticity. Organisations need to keep officers emotionally strong and resilient, as well as physically fit. If an officer has resilience they will not only cope better during an incident, but in the aftermath as well. He believes this is a management responsibility, as well as an individual responsibility.

Studies of coping styles<sup>173</sup> show previously underestimated levels of resilience of people involved in critical incidents, especially those with repressive coping styles; 'Shalev suggests that coping styles should be taken into consideration in making decisions about the appropriateness of debriefing and argues that denial, avoidance and repression may represent an appropriate strategy for some individuals.'<sup>174</sup> Dr Gist suggested that repression followed by gradual confrontation is now shown to be an effective way to deal with trauma. Dr Gist spoke of a natural resolution curve that is steeper and more rapid than previously suspected.

Dr Gist also believes that the Mitchell model sets up an expectation of trauma and may facilitate the creation of PTSD in vulnerable individuals. He is also concerned that the emphasis on PTSD establishes a climate where those who are disaffected with the workplace or are unscrupulous can use PTSD, which is easily diagnosed but not easily challenged, as the basis of a claim in compensation cases. Dr Gist suggested that if debriefs are compulsory, the organisation may be taken to have admitted liability.

Clearly organisations need to have systems in place to support officers before, during and after an incident. Such support needs to be provided by competent, fully qualified staff, who are skilled across the range of mental health issues, including post-incident stress, and substance use. Dr Gist identified a need to review the peer support component of the critical-incident response. While some peer involvement may be worthwhile, it is most valuable when peers have expertise in the operational debriefing process, and have experience in that particular type of incident.

Initial debriefing should be confined to immediate operational problems, with minimal analysis. The next debrief should include practical aspects, including how officers responded, lessons learnt, prevention strategies, confirmation that a correct course of action was taken, what worked, and what could improve responses in a similar future incident.

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<sup>173</sup> e.g. Shalev, 1994

<sup>174</sup> Cited in Paton & Violanti, 1996, p. 189

Associated support matters, such as what can be done for affected families, can also be covered at this time. Dr Gist recommends a CARE model that provides practical support, but not counselling. The CARE model identifies the elements of community, the health system, self-management support, delivery-system design, decision support and clinical information systems.

If the incident involves the loss of an officer, or officers, there is an added dimension of personal loss and/or threat. Rank and file need to be reassured by the presence of a respected high-ranking officer and a public show of support as soon as possible.

After the initial operational debrief, officers need the space and opportunity to talk to each other. This is best done among officers who were similarly involved in the incident. It is not necessary for this to be a facilitated process.

In the context of CISM, Dr Gist believes that it is important for organisations not to over-intervene. He distinguishes between distress and disorder: 'there is no need to treat distress, which passes, as a disorder.'<sup>175</sup> 'The very nature of the procedure has been suggested to medicalise the entire process of exposure, reaction, and reconciliation, casting the experience as a matter of personal threat rather than of occupational challenge.'<sup>176</sup> This approach results in over-intervention.

Dr Gist suggests that informal debriefing over a drink is not necessarily a bad thing, provided alcohol consumption is kept to a responsible level and officers have made arrangements regarding travel home, and are aware of their responsibilities on return to work.

Dr Gist believes the best way to minimise alcohol misuse after a critical incident is to impact on the culture of the organisation as a whole. That is, management should not wait for a critical incident to remind employees that alcohol is a depressant that can adversely affect sleep patterns, and that dependency is progressive.

The organisation needs to have processes in place to follow up officers either individually if considered appropriate, or in small groups, to ensure they have access to additional support, such as referral to a qualified counsellor, if required. Counsellors used in this situation should have expertise in CISM and familiarity with the relevant workplace.

Organisations may wish to use an assessment tool to help identify officers who would otherwise slip through the cracks. Such a follow-up is best conducted at about four to six weeks after an incident to allow natural resilience to take effect. The screening tool could be a simple ten-question test to gauge the extent of ongoing trauma. If six or more effects are noted from the previous week, counselling may be suggested. Dr Gist recommended a short course (around five sessions) of cognitive behavioural therapy, including graded exposure, four to six weeks after the event as a possible clinical intervention.

Dr Gist recommends further research on coping styles of law enforcement and other emergency services personnel, and development of programs tailored to accommodate those styles. He advocates more research on those individuals who do function well after an incident, and who rely on positive coping mechanisms. He also suggests that more

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<sup>175</sup> From an interview, 1 June 2004

<sup>176</sup> Gist, 2002, p. 276

information on coping styles and the role of resilience could feed into the selection and training processes.

The following section is compiled from an interview with Dr Bryan Bledsoe (9 June 2004) as well as from his writing on this area.

Dr Bryan Bledsoe is also an outspoken opponent of the CISM 'industry' and the uncritical application of the Mitchell model. His comments, while similar to Dr Richard Gist, are included because Dr Bledsoe comes from an emergency medical services (ambulance) background, as opposed to Dr Gist, whose views reflect his experience with firefighters.

Dr Bledsoe, during his interview, pointed out that research conducted since the introduction of CISM did not support the extent to which the CISM industry had taken off: 'Few researchers are able to prove the efficacy of CISM. Even more worrisome are studies that have shown with statistical significance that CISM may actually be harmful.'<sup>177</sup>

He reiterated that perceived satisfaction surveys were not indicative of the efficacy of the process and stressed, as did Dr Gist, the lack of rigor of the research which supported CISM, and the lack of professional credibility of the publications reporting that research.

Dr Bledsoe spoke of the risk of vicarious traumatisation, especially in the context of group debriefs where not all participants experienced the trauma in exactly the same way, and where peer-debriefers were used. He was also concerned that compulsory debriefings had an element of self-fulfilling prophecy that could encourage a deeper trauma reaction than might normally be experienced.

Like Dr Gist, Dr Bledsoe stressed the role of natural resilience, and suggested that in most circumstances 'less is best'. Dr Bledsoe pointed out that PTSD only occurred in a very small number of people, and 'providing an intervention that could possibly increase the chances of an employee developing PTSD is highly unethical'.<sup>178</sup>

Dr Bledsoe suggested implementing an organisational response to critical incidents which included screening by mental health professionals for up to two months after an incident. He believes that qualified mental health professionals should screen affected personnel for signs of later psychiatric morbidity. If personnel show signs of morbidity, then the medics should refer them to the proper evidence-based treatment. As an alternative to the Mitchell model, and for those members who do demonstrate a need for ongoing intervention, Dr Bledsoe supports Dr Gist's preference for cognitive behavioural therapy, with five to eight sessions provided by a qualified mental health professional.

When an incident occurs, Dr Bledsoe recommends providing psychological first aid in the form of comfort, information and support. This includes meeting immediate physical needs, such as offering to contact someone to let them know the officer is OK, and providing hot or cold drinks. He stressed the importance of having someone in authority on the scene to dispel rumours and convey factual updates. He also suggested a policy of rotating personnel in and out of a scene as an example of a procedural strategy that can be established before an incident occurs.

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<sup>177</sup> Bledsoe, 2002, p. 66

<sup>178</sup> 2002, p. 67



Like Dr Gist, Dr Bledsoe is concerned about the organisational risk police, defence and other emergency services organisations face if they uncritically continue to implement debriefings based on a flawed model of care. 'Because of its possible iatrogenic<sup>179</sup> injury, CISD, CISM and PD should be utilised with extreme caution, if at all, in emergency services until adequate, quality scientific research can verify its effectiveness or lack thereof'<sup>180</sup>

Dr Bledsoe affirmed the strong link between organisational and occupational stress and substance use, and suggested that a diagnosis of either should include consideration of the other. Organisations need to have risk-management and prevention strategies in place so that employees with substance-use problems can receive the right help.

Dr Bledsoe believes that 90 days is the minimum time for effective treatment of alcohol dependency. He suggests the first 30 days be intensive in-patient treatment, followed by 30 days of less intensive in-patient treatment, at which time family may become involved in the treatment process. He suggests the remaining 30 days be spent in intensive out-patient care, followed by up to two years monitoring while the employee is on a return-to-work contract.

Dr Bledsoe believes that the success of most treatment interventions is at least partially dependent on the ongoing support and monitoring offered through the workplace. He pointed out that ambulance services may be provided by the city, or by a private company, as is the case in Palm Springs. If they are a private company, they may not provide high-level health insurance. Dr Bledsoe also pointed out ambulance services were not as likely as the larger law enforcement and fire services to have extensive employee assistance programs (EAPs). This may mean that they outsource their EAP services, in which case he strongly recommends only using services which have experience in providing support to that particular employee group and have a good knowledge of their organisational culture.

## Managing critical incidents – how the FBI responds

The following summary was compiled from consultations with (employee assistance program) (EAP) agents and qualified external counsellors who work closely with the organisation.

The FBI holds end-of-shift debriefings at major disasters. They may be interdepartmental, and are open to police, emergency services, fire officers and others as required. If considered necessary, separate briefings are held for supervisors. Critical-incident debriefings within the FBI are voluntary, but attendance is encouraged. Any officer can request additional confidential counselling.

While there are official FBI protocol and standardised procedures for critical-incident stress management (CISM), there is a diversity of views expressed by FBI personnel (and ex-personnel) working in the EAP area. It would therefore be misleading to write of an 'FBI perspective' in relation to CISM.

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<sup>179</sup> Induced in a patient by a physician's activity

<sup>180</sup> Bledsoe, 2002, p. 278

This diversity of views is a reflection of the debate in academic and professional counselling circles on good practice in preventing or minimising the negative outcomes potentially generated by critical incidents.

The FBI must have the capacity to respond immediately and effectively to large-scale and horrific incidents at home and abroad. When an incident such as the Oklahoma bombing or September 11 occurs, the FBI deploys personnel from across the country. This means that there will be agents in close proximity to the incident who are immediately involved, and agents and other personnel who are suddenly deployed to an incident.

The speed with which agents may be deployed to an incident means that those agents who are brought into an incident may be as affected as those who were immediately involved. All agents spoken with agreed that you did not need to be immediately and intimately involved with an incident, such as September 11, to be deeply affected by the incident. Deployed agents also have the additional burden of being removed from their usual support systems, such as family.

While some individuals still debate approaches to CISM, as an organisation, the FBI maintains that they have evolved beyond the debate stage, and have developed a good-practice response based on a modified Mitchell model, adapted to suit the needs of the organisation.

The FBI has developed a Crisis Preparation and Intervention Program (CPIP), which is more comprehensive than the Mitchell model, and allows for a case-by-case rather than a one-size-fits-all approach. CPIP was introduced in May 2004, at the CPIP conference in Philadelphia.

To better manage critical incidents, the FBI has divided the country into sectors □ such as north east; east coast; west coast; southern and mid-west – and has allocated regional teams. CPIP team management includes the Employee Assistance Administrator; CPIP Clinical Advisor, who maintains quality control; CPIP Program Manager, who manages selection and training; and the CPIP Regional Program Manager. The CPIP Regional Team Leader and CPIP Event Team Leader manage the operations of an incident.

CPIP teams include special agents, chaplains, employee-support personnel from the International Critical Incident Stress Foundation (ICISF) who are trained in the Mitchell model, Red Cross or National Organisation of Victim Assistance (NOVA), and outside mental health professionals who work closely with the FBI.

Team members are selected and undergo in-service training in addition to the training above. Because CPIP teams include agents who may have previously been involved in a similar incident, the teams encompass a strong peer-support component.

Debriefings are situational and individual and usually last from one to two hours. Attendance at non-operational debriefs is not compulsory except for an agent who is directly involved in a shooting incident. Agents being debriefed are usually given an update on the operation, including process and procedures. One of the greatest needs identified in a debrief situation is the need for accurate information: what is really going on and what is expected. Attendees are also briefed about what support is available to them and how to go about accessing resources or services.

CPIP team members watch for agents who look as though they may benefit from referral to individual counselling. Referral is part of the organisation's continuity of care, and entails ongoing liaison between the organisation and the external contractor. Agents who attend debriefs are followed up on a case-by-case basis.

Previously debriefs included a discussion of possible symptoms of stress to watch out for; however, critics of this process maintain that by highlighting potential symptoms, agents may expect those symptoms, and the process becomes a self-fulfilling prophecy. It can also cause concern for agents who do not experience those symptoms and wonder why they are not reacting in a way they have been led to expect as being normal. The risk of this happening is increased if the message is delivered by an authoritative figure, or a perceived expert.

Agents attending debriefs are alerted to the fact that alcohol is a depressant and can negatively affect sleep patterns. Agents are also warned about binge drinking.

The following good-practice principles were identified during an interview with the FBI EAP coordinator for the San Francisco area:

- strict adherence to confidentiality
- using a team approach with a mixture of skills and experience; fostering growth as a team
- good selection process for team members; members need to apply for the right reasons, not just to build up their CVs
- knowing your CPIP team members' strengths, and employing those strengths
- including qualified clinical advisors to ensure quality control.

Barriers to achieving good practice are:

- vicarious traumatisation
- compassion burnout
- lack of management support, including lack of full financial support
- inappropriate selection criteria or flawed processes for selecting team members.

The following material is taken from an interview with a clinical psychologist who assists as an 'outside' member of an FBI CPIP team.

The interviewee suggested that psychological debriefing was not just a clinical priority, but an organisational priority. From a clinical perspective, debriefing provides an opportunity to identify and treat agents who display symptoms of post-traumatic stress. From a clinical perspective, the main priority is to adhere to good clinical practice, and above all, do no harm. From an organisational perspective, providing high-quality psychological debriefing allows the organisation to fulfil its duty-of-care responsibilities. Conducting debriefings based on good-practice guidelines ensures the organisation has met its responsibilities in this area.

Litigation is expensive, but can be avoided if the correct procedures are in place. The organisation invests heavily in initial and ongoing training and maintenance of staff; staff are an organisation's most valuable asset, and it is incumbent on an organisation to protect

this asset. Trained and experienced staff with high levels of expertise are not easily replaced.

Law enforcement agencies have a culture of looking after their members, and critical incidents create a situation where this is especially necessary.

Law enforcement personnel have historically debriefed with alcohol. It needs to be recognised that this practice will continue, and strategies, to avoid bingeing for example, need to be implemented for the wellbeing of members.

The culture of drinking in an organisation is problematic when alcohol is seen as the usual response to trauma or stress, and the agent becomes reliant on alcohol to wind down or blot out situations or events. Any pattern of drinking or circumstances contributing to alcohol misuse needs to be dealt with by the organisation as well as by the individual.

It was suggested that it would be interesting to examine more closely whether law enforcement and similar occupations attract, recruit and retain certain personality types which are susceptible to alcohol misuse, or whether it is the organisational culture involving alcohol-based debriefs and end-of-shift barbeques, which contribute to some policing organisations having alcohol consumption rates at roughly double the community norm.

It would also be interesting to examine the extent to which police and similar occupations are protected against the impact of trauma by their psychological characteristics, and a workplace culture that highly values mateship and teamwork. It has to be acknowledged, however, that law enforcement, firefighting, emergency services and Defence are still predominantly male-dominated work environments. Males in those work environments are not necessarily known for their desire or ability to freely and openly express their feelings. This is exacerbated in a law enforcement environment, where agents are trained not to disclose.

Law-enforcement workplace culture is not always supportive of 'outside' intervention, and is sometimes mistrustful or what they perceive as 'psychobabble'. This can sometimes make it more difficult for mental health professionals to conduct debriefings, especially if they are unfamiliar with the law enforcement workplace culture, and come into the situation using language that alienates their client group.

Aspects of culture, such as police humour, can also be difficult for outsiders to come to terms with, especially in what are sometimes horrific circumstances.

There is substantial discussion around the issue of mandatory versus voluntary attendance at debriefings. If attendance is mandatory, the group should be small, with attendees having a relatively similar experience, that is, not a mix of primary and secondary exposure to an incident.

Even if the group is small and the experience similar, not everyone in the group will share a similar response to the incident that triggered the debrief – responses to incidents are highly individual, and not everyone will be affected to the same degree. Also, for some, the critical incident may not have necessarily been a negative situation, but the culmination of a successful operation ..

Organisational stress and/or cumulative stress are more frequent than critical-incident stress. Therefore, it is not good enough for an organisation to have in place procedures for a critical incident, but to have little support infrastructure for the more common ongoing problem of organisational stress. It is sometimes easier for an organisation to deal with a traumatic incident where well-known, set procedures are immediately activated, than it is to deal with less well-defined circumstances.

This is not unlike the problem of the (relative) ease with which an organisation can respond to the needs of the heavily dependent drinker, for whom there is a (relatively) clear treatment path, compared to dealing with the much greater proportion of their workforce who are routinely consuming alcohol at high-risk levels, or in a high-risk manner.

One approach an organisation can embrace is a wellness model, which allows for a broader public health response. Such a response could even allow for an assessment to be undertaken after an incident to gauge if alcohol use has become problematic.

It was also suggested that getting in touch with families is another way organisations can identify and assist employees with a suspected substance-use problem associated with a stressful or traumatic incident. For this strategy to be effective, it would first be necessary to overcome an employee's initial mistrust or reluctance for their spouse to liaise with the organisation.

The FBI constantly reviews and modifies its human-resource management policy and practice. One of the difficulties for organisations such as the FBI in developing guiding principles for service delivery is the divisions in clinical circles as to what constitutes good practice. This is an ongoing debate.

## Responses to workplace substance use

There is a variety of responses that police and other emergency services can provide to meet the needs of employees with suspected or identified substance-use problems, including:

- structural and cultural change
- recruitment practices
- policy and procedures
- information dissemination and training
- capacity to confidentially self-report
- early identification systems
- physicals and fitness-for-duty testing
- safety-sensitive assessments
- brief and early interventions
- random breath testing and drug testing
- employee assistance programs (EAPs)
- peer support and positive peer pressure
- critical-incident stress management
- referral to health services
- rehabilitation and reintegration
- compassionate termination.

### Structural and cultural change

Workplaces hoping to bring about a significant shift in levels and patterns of alcohol consumption need to examine the culture of their workplace to determine those factors which support or encourage unsafe practices.

It is important for organisations to not just provide support services, but to ensure that the organisational systems and culture support and sustain their use.<sup>181</sup> Most Australian policing and emergency services organisations have support services in place, but the culture of the organisation may not encourage their use.

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<sup>181</sup> Paton, in Paton & Violanti, 1996, p. 217

Changing the entrenched culture of a workplace can be difficult, but not impossible. It is certainly more difficult when the workplace sits within a larger culture with a high acceptance of excessive and dangerous patterns of consumption (see 'Transforming workplace drinking cultures', p. 23).

## Recruitment practices

A workplace free of alcohol and licit drug misuse begins with sound recruiting processes. It is important that applicants are aware of the ethical and safety standards that the workplace demands as a condition of employment. There is a community and organisational expectation that police and other emergency services personnel will adhere to the highest standards of personal and professional integrity. Public expectations and high levels of accountability, along with sometimes-intense public and media scrutiny mean that police especially need to maintain standards that are sometimes higher than those expected of the general community.

## Policy and procedures

There are a number of strategies and structures policing and emergency services organisations can put in place to strengthen the positive aspects of workplace culture, while lessening the risk of negative cultural aspects becoming the norm. The first of these is the development of a clear, comprehensive substance-use policy that has been developed in consultation with the key stakeholders and is widely known and equitably applied to all.<sup>182</sup> Policy that clearly outlines employees' and employers' responsibilities, regarding alcohol and other licit drugs, and procedures for dealing with specific circumstances of misuse are essential first steps in providing support.

## Information dissemination and training

Preceding and accompanying policy is the need for whole-of-organisation information and training. A US study by the Department of Health and Human Services found that in those occupations with the highest rates of drug information and policies in the workplace, employees reported significantly lower rates of current drug use and heavy drinking.<sup>183</sup> Lack of information on the extent of the problem, and on the risks and harms associated with alcohol and licit drug misuse was seen by many who were consulted as a barrier to changing the culture of substance use in the workplace.

Taking a preventive approach by promoting healthy lifestyles and awareness of the risks associated with substance use, including the misuse of over-the-counter and prescription drugs, is a cost-effective strategy. Providing health promotion programs that focus on alcohol and licit drug use, exercise and stress management, and that provide for personal

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<sup>182</sup> For more detail on the development of police drug-and-alcohol workplace policy see Australian and New Zealand Guidelines for Police Workplace Substance Use Policy, Martin, Davey & Mann, 1998.

<sup>183</sup> SAMHSA, 1999

follow-up, can motivate individuals to review their alcohol use in a less confrontational manner and encourage them to adopt a healthier lifestyle generally.

Training and disseminating information needs to be a continuous process, from recruit training to in-service training for specialist roles and tasks, and must be tailored to the specific needs of each level, especially front-line managers. Numerous studies, such as Shanahan (1992) and Flynn (1995), have highlighted the significance of front-line supervisors, such as sergeants, as role models and leaders. Supervisors would benefit from training in:

- identifying employees who may be at risk of substance use
- recognising emerging problems
- developing strategies for timely referral to support services.

One of the structural features of police and emergency services organisations that can be strengthened is the role of front-line supervisors. In the case of workplace alcohol and licit drug misuse, the supervisor can play a key role in setting ethical standards, detecting breaches, and providing early intervention. Although many jurisdictions agree that training front-line supervisors would be advantageous, few jurisdictions conduct such training.

As well as providing information on substance use, organisations need to examine related issues, such as workplace stress and critical-incident stress management, in level- and task-specific training.

## Capacity to confidentially self-report

The jurisdiction with the most comprehensive support for employees who wish to report an alcohol or drug problem is NSW Police. They provide an amnesty and access to fully funded private treatment to any employee who seeks assistance with alcohol or other drug-use problems. NSW Police program has been successful: many officers have accessed the amnesty. Most other jurisdictions state they have the capacity for employees to self-report under their EAP or peer-referral systems, but these systems have not been effective, and have had few, if any, referrals.

## Early identification systems

Organisations should look at initiating early identification systems for staff with alcohol or other licit drug problems. Early identification systems may, for example, identify members with unusually high rates of sick leave without a medical certificate and flag certain patterns of misconduct. They could also include measures to detect failure to perform. Sophisticated systems may also detect aberrations in group behaviour.

Early identification-system reports do not in themselves make any conclusions regarding performance problems, but are a resource to help employers and supervisors identify and assess potential problems and take remedial steps.



Methods of identifying substance use may include:

- voluntary identification – employees self-refer to either an internal or external assistance program
- peer (unofficial) or peer-support program
- family members
- supervisor / manager
- alcohol or drug testing
- performance management systems
- human resources or health services.

Chicago Police Department operates a behavioural intervention system, which is a systematic review of a member's behaviour to alert supervisors to the need for a possible intervention.

Conducting regular fitness-for-duty examinations or physicals that include psychometric testing can also be part of an early identification system.

## Physicals and fitness-for-duty testing

A number of overseas policing jurisdictions conduct physical fitness examinations as part of their ongoing duty of care for their staff. Physical fitness examinations conducted every two to three years, for example, provide an excellent opportunity for identifying a substance-use problem early within the less threatening context of healthy-lifestyle testing. They also provide an excellent opportunity for a timely,

brief intervention and an opportunity to refer a staff member to a more detailed assessment or treatment if indicated.

To complement physicals, and to help handle substance-use problems, policing organisations may consider fitness-for-duty evaluations (FFDEs). Potential recruits undergo psychological testing to assess suitability, and FFDEs would be an extension of this concept. 'Every law-enforcement agency should have in place a procedure for psychological fitness-for-duty evaluations.'<sup>184</sup>

Every law-enforcement agency should have in place a procedure for psychological fitness-for-duty evaluations.

FFDEs have evolved over the last 30 years in the United States, and although they don't necessarily provide a definitive or stand-alone mechanism for detecting substance misuse, they have isolated core psychological characteristics, the absence or presence of which predict a police officer's performance.<sup>185</sup> FFDEs can be conducted as part of a regular physicals program, or can be conducted when supervisors have a reasonable suspicion of substance misuse.

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<sup>184</sup> Trompetter, 1998, p. 98

<sup>185</sup> Ibid, p. 97

FFDEs need to be conducted by a qualified and experienced mental health practitioner who is familiar with policing functions. If an officer is found to be unfit for duty, the assessment should include recommendations for remedial action, including treatment for substance use, if needed.

## Safety-sensitive assessments

See the profile of the Bellwood Health Services on p. 137.

## Brief and early interventions

Sixty per cent of alcohol-related work-performance problems can be attributed to employees who are not alcohol dependent, but who occasionally drink too much on a work night or drink during a weekday lunch.<sup>186</sup>

Most individuals do not require sustained, intensive and long-term interventions to treat their alcohol or other licit drug use. For people with lower levels of dependence or lower levels of related harm, brief interventions have been shown to be effective and cost efficient.<sup>187</sup> Examples of brief interventions include:

- providing educational materials and information on the health, social and economic impacts of alcohol and other licit drug misuse
- assessing and giving feedback on an employee's substance use and its potential harm
- providing interactive resources, such as an alcohol-consumption diary.

The workplace that overemphasises the disease model of alcoholism and exclusively encourages abstinence runs the risk of not meeting the needs of all employees, and of overlooking preventive and structural strategies that would encourage more responsible use.

## Random breath testing and drug testing

One of the more significant workplace changes to occur in recent times in Australia is the introduction of alcohol and drug testing in some policing jurisdictions. It is not the intention of this study to focus on the efficacy of testing, though it is relevant in that sometimes testing brings abuse problems to the attention of management.<sup>188</sup> The question posed by this research is: if employees are identified as having a substance-use problem, what is the best support and treatment to help with that problem?

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<sup>186</sup> Mangione, 1998, p. 1

<sup>187</sup> Heather, 1995, cited in Allsop et al., 2001

<sup>188</sup> For more detail on the efficacy of workplace drug testing, see Substance use in a Police Workplace: Emerging Issues and Contemporary Responses, Mann, 2003.

## Employee assistance programs (EAPs)

EAPs provide assessment, referral, and follow-up services for employees. A strong independent EAP, with guarantees of confidentiality, will safeguard employees' health and wellbeing, while contributing to a supportive work environment generally.

... a value system that does not tolerate substance abuse, and [that has] a capable EAP, are the only means to deal with substance-abuse issues.<sup>189</sup>

During the 1970s in the US there was widespread development of the EAP model. Most of the American EAPs are closely linked to the principles of Alcoholics Anonymous (AA). It was not, however, until 1984 that an Australian EAP model and National Guidelines for Employee Assistance Programs were widely adopted. The guidelines call for:

management and union commitment; provision of voluntary assessment and counselling services using qualified and experienced counsellors; clearly defined policies and procedures; training for management, supervisors and staff in the use of EAP; tailoring of programs to suit the organisation's needs; self- and supervisor-initiated referral and access to independent counselling services.<sup>190</sup>

Employees may voluntarily participate in an EAP, regardless of whether they feel their problems are affecting their work, or they may be referred by a supervisor as a result of diminished work performance. This model is supported by the Australian Chamber of Commerce and Industry, the Australian Council of Trade Councils, the Confederation of Australian Industry, and governments at all levels, along with management and employees.

The Australian Chamber of Commerce and Industry recommends that:

before an EAP is established, employers must negotiate confidentiality, arrangements for fee payment, leave provisions, performance reviews, the independence and qualifications of counsellors, and options for further action in the event of continued poor performance.<sup>191</sup>

The purpose of EAPs is to:

- provide accessible and confidential assessment, referral and follow-up services to employees, along with education, prevention and counselling
- provide expert advice about employees' needs to the organisation.

EAPs may be funded exclusively by the employer, or the union, or a combination of both. Some organisations provide peer referral and support. For example, the New York Police Department has internally funded health services and provides a union run Member Assistance Program (MAP).

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<sup>189</sup> Zwering, 1993, cited in McVicar et al. 1995, p. 30

<sup>190</sup> Webb & Presta, 1994, p. 102

<sup>191</sup> Wood, 1996, p. 12

There has been some debate in the literature about the use of EAPs as a disciplinary tool, or as an alternative to discipline.<sup>192</sup> Accessing EAP services should not protect an employee with diminished work performance or significant workplace drug-and-alcohol breaches. However, compliance with an EAP contract may be taken into consideration when determining a response to an incident, particularly an alcohol-related incident.

One of the problems with EAPs is that some organisations assume that as long as they have an EAP in place, they have effectively met their workplace needs and responsibilities. EAPs alone will not prevent a workplace culture that accepts a high level of alcohol use.

Another problem with EAPs is that where they do operate within a wider culture of acceptance of high personal consumption, the EAP may only end up assisting those employees who have a high dependency. Where an individual's drinking is considered a personal choice (provided it doesn't impact too significantly on their work performance), the workplace (EAP) may be reluctant to intervene.

### Who should provide support services?

The response to this question varies according to who is asked. Those who provided in-house services stated that police would only speak freely with other police who understood the nature of the job and who, in the case of agents, had the same security clearance. While this may be less of an issue for other emergency services personnel, there may still be some stigma felt in accessing internal support services.

Those who provided outside services (i.e. off-site and not directly responsible to management) maintained that because of confidentiality, police in particular were more comfortable accessing services off-site, and without close ties to management. Outside service providers maintained they were able to provide a more cost-effective service.

Ideally, organisations will provide a choice between internal and external support. If internal services are used, mental health professionals should have expertise in addictions. If support is provided by an external agency, that agency needs to provide staff who have knowledge of the nature of police and emergency services work and workplace cultures.

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If staff support services are located within the workplace, EAP staff have easy access to management. A significant role for EAP services should be to advise management of staff needs and alert management to potential (structural rather than individual) problems. A close rapport between management and EAP services also strengthens support, including financial and infrastructure support.

Some US law-enforcement organisations, such as the FBI, use agents in a part-time capacity, with EAP being a (usually voluntary) collateral duty; this model was not recommended. The main concern was that EAP staff needed to be available all the time to provide the best service to agents.

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<sup>192</sup> Loomis, 1986; Monroe, 1998, cited in O'Connor-Herbert & Lyman, 1994, pp. 9 and 12

Another related concern regarded the rank of officers who were placed as EAP staff. Lower-ranking staff did not necessarily have credibility with older staff and were subject to more frequent transfer. Providing a continual service was seen as important in encouraging officers to maintain contact with support services.

Most of the police and emergency services personnel who were consulted agreed that it was necessary for support professionals to have a good understanding of the nature of the job and the culture of the organisation. But they also said that it was possible for this knowledge to be obtained over time. Those providing in-house services have the advantage of understanding the organisation and the nature of the job.

Some of the individuals consulted felt that recovering alcoholics were best placed to support others experiencing similar problems (a number of EAP services include recovering alcoholics on their staff). But there was also a clear message that the critical prerequisite for staff was that they be qualified, experienced, and have an understanding of the nature of police/emergency services work and the culture of the organisation. It is not necessary to be a recovering alcoholic to counsel others in that position, and in some cases, it may be detrimental if the counsellor is unable to maintain an objective position.

In addition to being fully qualified and accredited counsellors, it was felt by most of the service providers I consulted that it would be beneficial for counsellors to hold additional qualifications specifically in addictions.

It was identified that although 10-20% of all EAP referrals clearly and predominantly related to alcohol, many of the other problems which were the primary stimulus for referral – such as stress, financial or family problems – also had the potential for associated substance use.

The main consideration with using sworn or non-sworn staff was that they must be fully trained to a credible level in addictions counselling. Although most EAP and peer-support staff maintain their key functions are initial assessment, brief counselling (some staff have set limits on the number of times they can see or speak to a client), and referral to expertise, most agree that they often provide on-going counselling.

EAP providers should closely scrutinise their staff's credentials before hiring them. Malpractice insurance should be carried to cover all EAP personnel.<sup>193</sup>

## Peer support and positive peer pressure

'Such arrangements tend to be ad hoc, patchy and inconsistent.'<sup>194</sup> On the plus side, peer support officers will have a good understanding of the organisation and the nature of the job, and may even have experienced the same situation, such as a shooting, or death of a colleague on duty.

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<sup>193</sup> O'Connor-Herbert & Lyman, 1994, p. 13

<sup>194</sup> Brown and Campbell, 1994, p. 109

Peer support staff are most likely to have limited training in this role. It is important to point out that officers or other unqualified staff who become peer supports are not qualified to provide counselling. To avoid any misunderstanding about their role, officers or staff performing this function should be called 'peer supports', and not 'peer counsellors'.

Licit substance misuse needs to be controlled in the workplace by self-regulation and positive peer pressure. Organisations can foster this by ensuring employees are aware of expected standards of behaviour by means of the selection process, during recruit and in-service training, through management modelling of expected standards, and through careful monitoring by front-line supervisors.

Some workplaces visited during previous studies suggested peer confrontation as a legitimate option for dealing with a co-worker's substance use. However, none were confident that it operated effectively in their workplace. Molloy (1989) suggests the arguments for peer confrontation include concern for fellow workers, safety considerations, and equitable input by all team members. Obstacles to confrontation include fear of ridicule or hostility. It would seem on brief review that peer confrontation is a system that should work. It does in theory, but anecdotal evidence suggests that it falls short in practice. A NSW building-industry alcohol program includes a peer-confrontation component, but it has not undergone rigorous evaluation.

One way to overcome some of the barriers to peer confrontation is to have identified trained personnel whom concerned workers can approach. It is difficult, however, to see how this would differ from the role of an EAP. Clearly, confidentiality is a significant factor in the success of any model and it is difficult to see how confidentiality can be maintained in any peer-centred program.

The other difficulty in any hierarchical organisation, particularly police and defence, are the obstacles posed by the rank system: 'Because of the hierarchical nature of police forces, it is difficult for a truly 'peer' system to work. It is most unlikely that senior officers would consult junior officers and vice versa.'<sup>195</sup>

## Critical-incident stress management

(See also 'Stress', p. 25.)

## Referral to health services

All policing and other emergency services in Australia and New Zealand provide access for employees to either internal or external health services. Referral and any financial support, however, is generally confined to work-related illness or accidents. Most employees are expected to manage non-work-related illness independent of the workplace, although most workplaces will usually endeavour to accommodate rehabilitation needs as identified by a qualified medical practitioner. This raises the question of to what degree (if any) an individual's substance use is linked to the work environment. NSW Police have

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<sup>195</sup> Brown and Campbell, 1994, p. 110

overcome this dilemma by offering access to fully funded assessment, counselling and treatment for substance-use problems, irrespective of their cause.

## Rehabilitation and reintegration

If return to work is an option after treatment for alcohol or other licit drug misuse, a system for return-to-work assessment, follow-up and support must be developed.

There are a number of questions that need to be asked when determining how best to support and monitor employees undergoing rehabilitation. For example, should an employee be on probation after the rehabilitation program? (This is often a consideration in discipline-related situations.) If so, for how long? How should an employee's progress be monitored if on probation? Should breath testing will be part of the monitoring program?

Other questions include: Should an employee be made to sign a rehabilitation contract to cover period of rehabilitation? If so, what should such a contract include? If contracts, or case management agreements are initiated, how should a breach of agreement be dealt with? How many second chances should an employee be afforded?

One of the more important questions to ask is how should an employee who has been on a case-management contract be assessed as fit for duty? If an employee is not considered fit for their usual role, options for other duties need to be explored. Access to firearms and departmental vehicles, for example, may need to be reviewed. Confidentiality for employees on reassignment during rehabilitation also needs to be considered.

## Compassionate termination

An employee's alcohol or licit drug use may ultimately result in termination, but this should be a last resort, and should be based more on unacceptable associated behaviours than the addiction itself. In the event that an employee's alcohol or other licit drug misuse results in a recommendation for termination, there needs to be a process in place whereby, regardless of the nature of the termination, the employee is offered access to support services.

The needs analysis following outlines how some of these responses are being implemented by Australian and New Zealand police and emergency services organisations.

# **Needs-analysis of support services for police and emergency services personnel with alcohol and other licit drug problems (Australia and New Zealand)**

## ***Rationale***

To date there has been no Australia-wide review of the support services available to police and emergency services personnel with a suspected or identified alcohol or other licit drug problem. In order to make recommendations regarding support and treatment services, it was first necessary to determine what is already in place, and the adequacy or otherwise of those services.

## ***Process***

The first challenge was to locate the right person to direct enquiries to. Contact (initially by phone, then email), was made with the relevant sections (usually the human resources area) in each state and territory police, fire and ambulance services.

The next challenge was to convince organisations that the information provided would not incriminate them. Individuals were sometimes reluctant to disclose information that could be construed as being critical of their organisation, so much of the information received was off the record.

To encourage contacts to respond, only three questions were asked.

1. Please describe your organisation's existing support infrastructure (such as identification, assessment, referral, treatment and return-to-work support) for members with a suspected or identified alcohol or other licit drug problem.
2. Do you consider existing arrangements adequate to meet your organisation's needs in this area? (Please consider aspects such as training, expertise in drug and alcohol issues and resourcing).
3. What additional infrastructure, resourcing or support systems would you like to see in place?

To ensure those who responded were happy with the information collated from their response, responders were emailed a draft of what had been written about their jurisdiction for confirmation or amendment where necessary before completion of the final report.



## **Outcomes**

Responses to the above questions were received from police, ambulance, fire and emergency services in all Australian states and territories, and from New Zealand. Although the survey achieved an almost 100% response rate, some responses were more detailed than others. The following section draws on those responses and endeavours to identify some of the main themes.

### **Denial of a problem**

A number of the Australian and New Zealand workplaces contacted in the context of the needs analysis stated that employee alcohol use had not been identified as a problem and specific infrastructure was not considered necessary. In the absence of comprehensive baseline data, it is difficult to determine whether this is an accurate understanding or a denial of the problem. However, given the admittedly sketchy information available from existing data sources, such as the National Household Survey, and studies referred to previously in policing workplaces, alcohol use impacting on the workplace would seem a valid concern. It was certainly expressed as a concern in face-to-face meetings, indicating a reluctance of some workplaces to acknowledge what can be a contentious and potentially expensive problem to solve.

One outcome of the lack of a realistic knowledge or acceptance of a problem is the difficulty in persuading an organisation to conduct baseline research on consumption levels or patterns of drinking of their employees. This data is necessary to properly evaluate the efficacy of workplace interventions, such as education, training or random breath testing.

Denial of alcohol or other licit drug misuse in a workplace can lead to an under-resourcing of relevant support, and does not create a workplace conducive to self-reporting.

Some workplaces grapple with the dilemma of determining what is work related and what is an employee's personal problem. Some organisations interviewed considered misuse of alcohol by an employee outside work hours as a workplace concern only if it impacted directly on the workplace, for example, if it led to drinking during work hours. This approach does not acknowledge the cost of lost productivity and absenteeism to the workplace. It also fails to acknowledge the interplay between alcohol misuse and workplace factors such as work-related stress, or a workplace conducive to excessive consumption.

Determining work-related stress claims was even more contentious. Some workplaces are reluctant to carry the costs associated with stress-related illness, including alcohol misuse, unless it can be demonstrated to be directly linked to a specific work situation, such as a specific traumatic incident, or series of incidents.

## Competing agendas

Meeting the needs of competing agendas from a range of stakeholders – such as management, employees, and the unions – will be more problematic in some workplaces than others. Genuine involvement of stakeholders in determining effective policy, support and treatment is critical in identifying and dealing with alcohol and licit drug problems in the workplace.

Many of the jurisdictions visited elaborated on the positive role the unions played in the development of policy, and more importantly, in providing services for staff. In some cases union and management had signed memorandums of understanding, or had similar agreements whereby they jointly determined and managed the equivalent of EAPs.

Not all policing and emergency services bodies have an active and strong union infrastructure. However, those policing organisations that did embrace joint union-management participation in the design and delivery of services seemed able to provide a service to staff that met the needs, and were acceptable to both management and other staff.

Some conflict was expressed where the union offered support services to staff separate from those offered by management. A danger in offering a separate service is that it consolidates any perception of lack of confidentiality in the management-offered service. Duplicating employee assistance services may also lead to unhealthy comparison between services and confusion for staff.

## Client mix

Responses varied as to whether group counselling should be gender specific, and whether sworn and non-sworn staff, and commissioned and non-commissioned ranks should be separated. Client mix was more a difficulty for police than other emergency services. There was some support for at least a mix of sworn and unsworn staff, but this was based on the premise that sworn staff may prefer to be counselled by other sworn or ex-sworn staff (though there is no research to verify this). Generally it was felt that these concerns were not critical, and that in most cases, scarce resources would dictate service delivery.

Equally, the observation was made that officers with a substance-use problem are more receptive to someone they perceive as an expert in that area, and are less concerned with their status as a police officer. It was suggested that police with a substance-use problem would prefer to deal with someone external and with no links to the system. Comment was made about gossip being a feature of police workplaces, and the fear that regardless of confidentiality, word of an employee's problem would inadvertently get back to management.

## Legal concerns

Most responders to the needs analysis had not considered the legal concerns of providing support services. However, workplaces need to be aware of the risk of liability for the negligent acts of employees under the influence of alcohol or licit drugs. Workplaces may be held liable if they knew, or should have known, that an employee, as a result of substance use, presented an unreasonable risk of harm to others.<sup>196</sup> Sound policy and procedures, including the provision of support services and referral to external assessment and treatment, will reduce this risk.

## Policy

Policing and emergency services organisations in Australia and New Zealand are clearly at different stages of developing and implementing drug and alcohol policy, but most acknowledge the need for supportive policy to drive service delivery. The three policing organisations with the most comprehensive policy in Australia are the Australian Federal Police, NSW Police, and Queensland Police. These organisations are the only police services with an extensive drug testing program in place. Their workplace policies were developed in association with the introduction of drug testing, which was also the stimulus for a review of support services offered.

While most organisations can point to fairly clear (albeit sometimes minimal) alcohol policy, few police or firefighting organisations have detailed policy or procedures to deal with other licit drug abuse. Misuse of prescription or over-the-counter medications is rarely adequately addressed in policy, but appears to be dealt with in a similar manner as alcohol. It would seem (some) ambulance services have the most comprehensive policy related to licit drug misuse, no doubt due, at least in part, to their ready access to medications. Polydrug use is also largely overlooked by most organisations when developing substance use policy.

Policing organisations in particular (most of whom are in the process of developing workplace policy) suggested that the lack of a comprehensive policy resulted in some fairly ad hoc responses, and indicated that alcohol and drug use policy should improve training and support services. 'It is still a loose and informal system but hopefully the protocols being developed will make a difference' (Tasmania Police). 'The Drug and Alcohol Policy which is still in draft form does provide for a more specific infrastructure' (NT Police, Fire and Emergency Services). The officer who responded from Victoria Police stated, as did others, that because their policy was in development, their response was reflective of the current situation rather than an expected (improved) situation.

Some of the police and emergency services that did not have a comprehensive policy in place indicated that my request for information had stimulated them to examine their policy and procedures. Some organisations realised that their policies were perhaps inadequate to fully meet the needs of their organisation: 'Your enquiry has in fact prompted

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<sup>196</sup> Carter & Stephens, 1988, p. 80

us to perhaps consider such a formal structure in the future.' Most responders indicated they would be interested to see the final project report, and are keen to develop a more formalised approach to providing support and access to treatment.

The Fire & Emergency Services Authority of Western Australia placed their drug and alcohol policy in the context of fit-for-duty testing. This is interesting as it encourages a holistic and subtler approach to what can be a difficult and confronting workplace-management problem.

An important lesson learnt from the overseas consultations and the needs analysis is that policy needs to be clear and cover all contingencies. The best policies, both on paper and in practice, are those which are closely adhered to, and do not include a 'case-by-case' or 'at the discretion of the commissioner' (or similar) clause. Such clauses can leave the policy open to charges of inequitable application or discrimination, as well as leaving the department open to litigation and public condemnation. Including a case-by-case clause does allow for flexibility, but this is not necessarily a desirable feature for a drug and alcohol policy. Unless the policy is equitably applied, it will not be credible or acceptable to employees or the general public.

A number of departments who replied to the needs analysis stated that they did deal with problems on a case-by-case basis. This ad hoc approach and lack of clear procedures do not encourage employees to self-refer, and without clear procedures in place, managers are often ill equipped to deal with complex and sensitive matters outside their area of expertise.

## Approach to alcohol and other licit drug use in the workplace

While most organisations have procedures in place to assist members demonstrating more severe alcohol dependency, they are less able to deal with personnel whose use does not fall into the higher dependency range. Few organisations adequately deal with binge drinking or hangover effects.

Most organisations deal reactively, rather than proactively, with the many consequences of alcohol and other licit drug use in the workplace. As noted above, most organisations only identify members with a significant dependency problem; 'Way too much info/support at the end and no info/support at the start' (Tasmania Fire Service).

While most organisations have procedures in place to assist members demonstrating more severe alcohol dependency, they are less able to deal with personnel whose use does not fall into the higher dependency range.

The reactive nature of this approach is problematic on several counts. It means that individuals are only assisted when they reach a level of dependency where they can no longer be ignored (or transferred). The more dependent they become, the more difficult the treatment. This approach does little to satisfy the needs of the significantly larger proportion of staff whose levels and patterns of consumption place them, the organisation and the general public at risk.

By focusing on the more easily identified, heavily dependent drinker, the organisation inadvertently supports a workplace culture which enables high levels and risky patterns of consumption to become the norm. This is especially problematic in a workplace with high benchmarks for what is considered normal consumption.

If an organisation opts for a zero-tolerance approach to alcohol or other licit substances, and relies solely on discipline solve all workplace substance-use problems, they risk creating a workplace climate of cover-up and fear. Such an approach may also lead to an under-resourcing of other organisational strategies, such as EAPs or performance management.

The culture of silence or protection within police and other emergency services needs to be turned around to create an environment where it is the accepted norm for individuals to seek help for themselves or a peer without fear of reprisal. This is most likely to occur in a workplace that offers rehabilitation, rather than discipline only. However, there are circumstances when discipline will be necessary, possibly in parallel with welfare. When regulations are breached (for example, by being intoxicated on duty or by driving a work vehicle while intoxicated), organisations need recourse to unambiguous, equitable and consistent disciplinary processes which are well known and equitably applied to all employees from the outset of their employment.

An equitable and transparent appeals process should be a part of any workplace drug and alcohol policy and procedures. A range of appeals options or models should be developed, debated and refined as part of policy development.

## Organisational change

The contact who completed the needs analysis for Victoria Police stressed that the Service had trained counsellors, but had not yet ensured that staff accessed those counsellors when necessary. This is an organisational change problem that is by no means unique to Victoria Police. Most organisations remarked on the reluctance of staff to report their misuse of alcohol.

All police, ambulance and fire services provide some form of employee assistance, but consultations indicated that employees (for a number of reasons) were sometimes reluctant to access those services, especially in the case of substance use. Some organisations felt that existing infrastructure was adequate, but that a strategy was needed to encourage members to voluntarily access those services.

The only policing organisation that could claim to have had some success in this area was NSW Police, who identified a significant increase in police self-reporting (between 150 and 180 per year) after the introduction of their drug and alcohol policy and the introduction of an amnesty, which offered confidential, organisationally funded access to a range of high-quality treatment options.

## Spread and coverage of services

Some EAPs attempt to provide services to families and retired members but, with scarce resources, priority is usually given to serving members. Most policing organisations have brief contact with a member's family at key times, such as inductions, where brochures promoting EAP services can be displayed and distributed. It was also suggested that EAPs do direct mail outs to families, encouraging them to access the EAP as required. There was some opposition expressed to this suggestion as it was felt some officers might feel that it was 'I going behind their back'.

Jurisdiction-wide coverage is a particular problem for the larger states with vast areas and where there are a number of small, isolated stations in remote locations. The isolated nature of policing in states like Queensland, Northern Territory, South Australia and Western Australia is another rationale for using physicals to help identify and remedy a substance-use problem. If an employee is identified as needing specialist treatment or counselling, it may be necessary to transfer them to a location where they have access to services. Improved access to the intranet and internet may also provide some form of ongoing support for some employees.

Some jurisdictions indicated that they had difficulty identifying the right high quality service providers for counselling and treatment. In some overseas jurisdictions (e.g. Colorado State Patrol), the state identifies a group of preferred service providers. It is a complex process to go outside those providers. There was some discussion about whether the state or organisation-nominated services had the capacity to meet the level of service required, particularly in relation to meeting the complex needs of law enforcement. This potential problem can be overcome by a vigorous tendering and selection process for treatment providers and by close ongoing liaison between the department and the selected service providers.

## Sworn/non-sworn staff and differences between ranks

An interesting aspect noted in reviewing the responses from the needs analysis was that most police responders referred to officers and not public servants. In most cases, although responders used the term officers, policy and procedures also covered public servants. It is important when reviewing organisational needs not to assume the needs of non-sworn members are the same as sworn members, and more importantly, not to focus exclusively on the needs of sworn members at the expense of non-sworn members. With a policy of civilianisation in policing organisations, many public servants are working in safety-sensitive and often highly stressful situations, such as communications, front counters in police stations, or the watch house.

The other interesting aspect of alcohol use by non-sworn staff in policing and emergency services organisations is the potential, through association with Police / firefighters, for higher benchmarks for misuse, higher consumption levels and potentially more dangerous patterns of consumption.

Some policing organisations also consider an employee's rank or the time they have served. In some organisations, trainees may fall under a different award, and have more limited access to support for alcohol or licit drug problems. They may well face termination for breaches of their code of conduct.

## Confidentiality

One matter that has significant bearing on the provision of services is confidentiality. There is a legislative basis for ensuring confidentiality between an accredited health professional and their client that does not exist between a lay counsellor and their client. Most non-accredited EAP personnel overcome this problem to a degree by not maintaining written records, although there are some potentially serious legal problems with this strategy.

As confidentiality is only afforded to a specified level of health professional, perhaps that should determine the minimum level of service delivery. However, what would this mean for peer-support services, or part-time officers on collateral duty, or ex-sworn officers acting as substance-use counsellors -models that operate with varying degrees of success in other jurisdictions?

The most significant problem expressed with peer-support services was that it is not possible for peer-support officers to be trained to a level where they can do much more than suggest the person seek help through an EAP. It was suggested that few employees would self-report a substance-use problem to a peer-support person. It should also be noted that peer-support staff are not protected under professional counsellor-client confidentiality.

A number of policing and emergency services organisations operate a peer-support program, but their training in substance use and addictions is very limited, and the legal status of their claim to confidentiality may be tenuous. Some overseas jurisdictions, such as the New York Police Department, require their peer-support officers, most of whom work with other officers with alcohol-abuse problems, to have completed all of the requirements leading to state certification as alcohol counsellors. 'Certification serves an advantage by making conversations between peer-supporters and other officers privileged communication.'<sup>197</sup>

There have been a number of other problems identified with confidentiality, including a possible perception by police and emergency services personnel that internal employee-support services may not be entirely confidential. It has been suggested that police may be reluctant to self-report to an internal service provider for fear of disclosure to management. This perception has also been referred to by other emergency services personnel.

In the US confidentiality applies in most counselling situations, with some important qualifications. For example, in the FBI confidentiality would be breached if there were a threat to national security, the individual themselves, members of their family or the general public, or if there were instances of child or elder abuse. Similar limits to confidentiality apply to counselling situations in Australia.

One strategy for ensuring confidentiality is to keep medical records separate from personnel files. Knowing that a visit to employee support services and, particularly, that the details or nature of their visit would not be recorded on a personnel file may encourage employees to access those services. Separating medical and personnel records would also encourage disclosure of use of prescription drugs. One problem that was identified during

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<sup>197</sup> Finn & Tomz, 1998, p. 14

the overseas consultations was reluctance for staff to disclose the use of prescribed medications for an illness that they perceived would be viewed in a negative way. That is, they would be far more comfortable disclosing medication prescribed, for example, for a bad back (often a work-related injury) or for high blood pressure (common among their peers) than they would be disclosing medication for a mental illness, such as depression. Some organisations seal medical or other sensitive information before placing it with a member's personnel file.

Most experts and EAP staff agree that confidentiality is a necessary element of every EAP and that without it employees will not use the program.

Durity (1991) reports that the most difficult challenge for an EAP is to get employees to actually believe that it is confidential.<sup>198</sup>

Questions have been raised regarding situational confidentiality. For example, should EAP and other counsellors provide information to other areas, such as supervisors or an internal affairs section, in the following circumstances:

- a threat to public safety
- a threat to self, colleagues or family
- where disciplinary action is indicated
- in instances of mandatory referral
- for fitness for duty
- for supervisory needs.

'Records can be subpoenaed and court orders may force disclosure of confidential information obtained in counsellor-patient therapeutic relationships.'<sup>199</sup> 'Employers and EAP providers should acknowledge limits to confidentiality at the onset of treatment.'<sup>200</sup> 'Confidentiality is not absolute, and certain defined situations warrant and even mandate disclosure.'<sup>201</sup>

At the Canadian Workshop on Police Employee Assistance Programs (Toronto, April 1993) it was suggested that in situations where confidentiality must be breached, the procedures for doing so need to be clearly defined.<sup>202</sup>

Problems surrounding confidentiality were consistently raised in the needs analysis. Maintaining confidentiality is seen as critical in encouraging people to self-report, and in their willingness to undertake treatment. This needs to be considered when weighing up internal versus external EAP services.

There are provisions in legislation applying to most police services that require police to report instances of misconduct, including, for example, intoxication in the workplace, or misuse of licit drugs. This creates a tension for officers in peer-support programs, and is an

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<sup>198</sup> O'Connor-Herbert & Lyman, 1994, p. 3

<sup>199</sup> Wilson, 1978

<sup>200</sup> O'Connor-Herbert & Lyman 1994, p. 3

<sup>201</sup> Ibid. at p. 7

<sup>202</sup> p.23



impediment for police self-reporting to a fellow officer. Staff (sworn and non-sworn) need to feel confident that in coming forward for assistance, information regarding their substance use will be treated in a confidential manner.

A key feature of the NSW Police Drug and Alcohol Policy is the guarantee of confidentiality for those taking advantage of the amnesty. This has undoubtedly contributed to the relatively high numbers of staff self-reporting and accessing treatment.

Queensland Police have enacted legislation to allow staff to self-report. The legislation exempts<sup>203</sup> an employee to whom another employee self-reports an alcohol or drug dependency problem. Such a situation might normally compel disclosure of such information. The legislation relating to the Queensland Police Service Alcohol and Drug Policy and Procedures limits the disclosure of information and documents that relate to an employee's self-reporting an alcohol or drug dependency.

Another consideration is the extent to which confidentiality applies if the employee is already involved in a disciplinary process: 'The EAS [employee assistance service] is able to support officers with counselling and advice in confidence unless there is a disciplinary action commenced. In the latter case there would be considerable restrictions to the confidentiality offered' (SAPOL). The capacity for policing organisations to offer full confidentiality may be limited when there is a parallel discipline process occurring.

In regards to confidentiality, most policing organisations expressed a preference for private treatment providers where their members are less likely to meet their previous client group. Most police organisations will refer to private treatment providers 'to avoid the mainstream organisations and maintain confidentiality for our staff' (WA Police). This has significant resource implications. Access to private support or treatment may be less of a problem for ambulance and fire services (contact with their previous client group would not be concern), but is still important in providing access to a full range of high-quality services.

## Stress and licit drug use

The other problem that is uniformly inadequately dealt with in policy and procedures is that of stress and licit substance misuse. While most organisations I spoke with had policy regarding workplace stress and procedures for critical incident debriefing, few made the link between organisational and occupational stress, and licit substance misuse.

It was also clear from discussions with police and emergency services that most organisations were uncritically implementing group psychological debriefing immediately after critical incidents – this is problematic (see 'Debate on providing critical-incident debriefing for police and emergency services' on p. 41).

Stress and licit drug misuse is discussed in 'Stress', p. 25.

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<sup>203</sup> from section 7.2 of the Human Resources Manual (Duty concerning misconduct or breaches of discipline)

## Resourcing and access to treatment

Resourcing was seen by several jurisdictions as a barrier to delivering effective support services. Employee-funded health insurance and private health insurance provides the most comprehensive cover. However, there are often restrictions on the number of times such funds can be accessed for counselling and other treatment. In some overseas jurisdictions, union members finance support services through a pay levy (.25% for Washington DC Police), or have negotiated providing services as part of enterprise bargaining agreements.

The level of support available and the consistency of application of procedures varied between organisations. Most organisations acknowledged the pressure of competing demands for limited fiscal resources. Although most expressed some satisfaction at the support services and access to treatment for severe dependency cases, many expressed a need for more staff, or staff with greater expertise in the alcohol and drug area.

The level of support offered to staff was raised by a number of responders to the needs analysis. They mentioned that although some funding was offered for external professional assistance, some organisations limited the number of visits, for example, for counselling. Although it is widely acknowledged (particularly for operational police) that access to private treatment is desirable, not all organisations fund access to private facilities.

## Training and information dissemination

Most jurisdictions considered the area of training as requiring more effort and more resources. All policing organisations have compulsory ongoing training, such as firearms training, and operational skills and tactics training, which require attendance and time off from normal duties. Police are also required to complete compulsory computer-based training in areas such as emerging and amended legislation and procedures. Because police have difficulty fitting in compulsory training, any training that is perceived as less critical (a category that 'health promotion' falls into) is difficult to place on their already overcrowded agenda. The following quote, although from South Australia Police, is representative of the other police jurisdictions:

Resources at present are barely adequate. SAPOL [South Australia Police] could certainly use more resources for training managers and supervisors in this area. At present it competes with a number of other high-priority areas for time and resources in the training area.

One area where training is needed is for front-line supervisors in managing staff with alcohol dependency. Most managers are reluctant to discuss substance use with staff and it is often not until a problem impacts significantly on the workplace that action is considered.

It is a difficult decision for a manager to make as to whether to refer concerns about drug or alcohol use to senior management. Our managers are not trained in how to determine whether someone may be under the influence or incapable of working.<sup>204</sup>

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<sup>204</sup> SAPOL

Another area identified was the need for health services officers (HSOs) and peer support officers (PSOs) and chaplains to receive specialist training in alcohol and other licit drug misuse: 'Most HSOs, PSOs, chaplains could not claim to have expertise in such matters' (QPS).

Consultations showed that employees have shown most interest in prevention, indicators of dependence, effects of alcohol misuse, and where to access assistance. They also expressed a need for guidance on how to deal with a co-worker's substance use.

Employees are generally not well informed about the risks and harms related to their alcohol or other licit drug consumption. The results of the needs analysis clearly indicated that almost all organisations had inadequate education/information strategies in place, and did not educate their members on aspects such as:

- standard drinks
- National Health and Medical Research Council (NHMRC) guidelines for low-risk drinking, and
- the risks associated with polydrug use – particularly alcohol and prescription and over-the-counter medications – which may be a significant concern for this cohort.

Specific information on the potential impact of alcohol and other licit drugs (and hangover effect) in the context of the relevant workplace would be useful.

If the organisation is going to provide referral to support and treatment services, this also needs to be promoted. Members need to know what assistance and services are available to them, and how to access those services. They also need clear guidelines on limits to confidentiality.

## **General**

I would be interested in how other emergency services, particularly ambulance, manage these issues.<sup>205</sup>

Several responses to the needs analysis indicated an interest in what other organisations and other jurisdictions were doing, which suggested a need for improved networking and information sharing between similar workplaces. One responder wrote that he would like to refer one of his staff to the Queensland Police Service to gain an appreciation of what the QPS is doing in the development of workplace drug and alcohol policy. An unexpected outcome from the contacts made during the needs analysis has been a two-way sharing of information during the calls made, and in the exchange of policies. This contact will be continued, with responders receiving copies of this report.

An interesting point was that the Queensland Fire and Rescue Service, given that they had not measured the extent of the problem, had difficulty in responding to questions regarding the adequacy of services, and what else was needed. Few police, ambulance or fire services have conducted prevalence surveys among their staff, and are generally unaware of the extent of the problem.

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<sup>205</sup> NZ Ambulance

The University of Queensland conducted a very comprehensive alcohol consumption survey of the Queensland Police Service in 1998, which yielded excellent data, but this survey has not been replicated. NSW Police have also undertaken some prevalence research in conjunction with the implementation of their alcohol and drug testing policy, but there is clearly a need for more accurate and up-to-date data from the other organisations and jurisdictions.

## **Profile of support services offered by police and emergency services in Australia and New Zealand**

The following information was compiled from the data obtained through the needs analysis conducted as part of this project, and from ongoing communication with contacts identified during that process.

### **ACT**

#### **Australian Federal Police**

*Policy status: alcohol and drug policy (including testing) in place.*

#### **Employment Policy on the Inappropriate Use and/or Abuse of Pharmaceutical Products (.July 1996)**

This policy is part of the original Illicit Drug Free Workforce Model and is applied to the use of any pharmaceutical product that exceeds the norms of clinical and therapeutic activity, as set out in the guidelines of the pharmaceutical manufacturers published in MIMS. The Therapeutic Goods Advertising Code Council also assesses these guidelines.

Pharmaceutical products may include, but are not restricted to, anabolic steroids, benzodiazepines and any dispensed medication. Inappropriate use and/or abuse include use for non-prescribed purposes and misuse of prescribed dosages.

The Australian Federal Police (AFP) drug policy does not prohibit the lawful use of narcotic substances, as long as the use is within parameters set by a registered medical authority and conform to accepted treatment regimes.

As with other licit substances, the AFP will organise support for any appointee who voluntarily seeks assistance. Assistance is assessed, consistent with the application of administrative law, on a case-by-case basis. Rehabilitation includes a rehabilitation contract and counselling and/or participation in a rehabilitation program.

Where an appointee is inappropriately using and/or abusing pharmaceutical products, and has declined to seek or continue assistance, the appointee's suitability for continued employment with the AFP will be assessed.

#### **Requirement for an AFP employee or special member to undergo a breath analysis under Australian Federal Police (Discipline) Regulations 1979**

Amendments to the *Australian Federal Police Act 1979* and the *Australian Federal Police (Discipline) Regulations 1979* provide for an AFP employee or a special member to undergo a breath analysis under certain circumstances, such as after certain incidents.

## Support services

There is a range of support services available to AFP employees: an EAP, welfare officers, counselling, and other external health service providers as necessary.

Because the AFP does not yet randomly test for alcohol, there are no instances of referral to the EAP service as a result of a positive alcohol test. However, it was estimated that 8-9% of staff (sworn and non-sworn) self-refer to the service, and that the percentage of those accessing the service because of substance use was small. Although employees may not initially identify their primary problem as being substance use, further assessment frequently discloses underlying substance-use problems.

AFP contract external service providers Davidson Trahaire for their EAP services. The AFP pay Davidson Trahaire a flat annual fee, irrespective of the number of people who access the service. Davidson Trahaire provide AFP with quarterly and annual reports detailing:

- the number and broad location of people (and families) who access services
- a breakdown of work and personal cases
- the number of mediation sessions, critical-incident debriefs and training sessions delivered
- -total counselling appointments
- manager assistance consultations.

They also provide a breakdown of demographics, including:

- gender
- length of employment
- age
- occupational category (sworn, non-sworn, family).

These figures are forwarded to the Deputy Commissioner and general managers for them to assess what problems fall under their area of responsibility. These reports are not disseminated outside the AFP. A briefing can also be provided to the general managers by their local EAP office, and needs such as training can be dealt with at the local level.

The decision to use external service providers was based on cost effectiveness and the need to access personnel who were qualified, skilled and experienced in psychology and welfare in areas outside Canberra. Confidentiality was also a consideration, as it was felt that the perception of confidentiality would be stronger in an outsourced service.

Davidson Trahaire provides initial assessment and short-term counselling for a fixed number of visits (six), which can be increased by a request to the Director of Employee Assistance and Psychological Services, or by the approval of an employee's manager. Such a request would include a rationale for the need for further counselling, without disclosing the employee's identity.

This service is provided free of charge to employees and their families. However, if specialist drug and alcohol or other services, including treatment and rehabilitation, are

required, they would usually have to be paid for by the AFP employee. This is unlike the NSW Police, who meets the cost of all support, treatment and rehabilitation services, irrespective of the number of visits required, or the nature of the substance involved.

The AFP EAP service is heavily marketed, and provides presentations to agents, staff and managers on a range of workplace subjects, such as time management, stress management, and healthy lifestyles.

The AFP promote their testing with a healthy lifestyle and fit-for-duty approach, and the Director of Medical Services develops standards of fitness for both sworn and non-sworn staff. Medical screening is undertaken for special (for example, overseas) placements. Duty-of-care provisions also allow for psychological fit-for-duty testing when needed. The human services area also closely monitors use of sick leave. These provisions may reveal substance-use problems, as would usual performance management monitoring and appraisal.

The AFP contact who responded to the needs analysis stated that the AFP had had very few incidents involving alcohol or other licit drug misuse, but that if an individual was identified the AFP has in place the following avenues for assistance:

Employee Assistance and Psychological Services, the external EAP, Welfare Network, chaplaincy, Confidante Network. They may also be referred elsewhere depending on the need for further specialist advice/support. These areas could also be supplemented with supervisor's support (with advice from the abovementioned teams), peer support etc.

AFP only funds access to external service providers for alcohol and other licit drug misuse, and cannabis use. The AFP suggested that given the limited number of identified individuals requiring intervention, current resources were adequate.

Employees in rehabilitation are subject to special follow-up testing for three years. The employee is not notified before a test. If rehabilitation is not completed or a second verified positive test is returned within three years, the employee's suitability for continuing employment is assessed.

Education and training are an important component of the program, and packages designed specifically for managers/supervisors and rank and file have been developed and delivered. The AFP also provide online learning packages for ongoing staff education.

Evaluation and review are also significant parts of the program, and detailed data and records are maintained.

One aspect of the AFP system that was noted was the lack of integration between training, information dissemination, testing and support services. It is necessary to access a number of different contacts to obtain information on these areas. This is unlike NSW (Health Services Unit) and Queensland Police (Alcohol and Drug Awareness Unit), where the above services are coordinated through one unit.

## ACT Ambulance Service

The contact who responded to the needs analysis for the ACT Ambulance Service indicated that misuse of alcohol and other licit drugs was not a concern, and was dealt with as needed on a case-by-case basis. He stated that employees who had a problem were referred to external service providers and that current provisions were adequate to meet the needs of staff.

## Fire Brigade

Consultations with the manager of the human resources section confirmed that since July 2004 the ACT Fire Brigade has been under the umbrella of ACT Emergency Services Authority. They have a draft of brief policy statement pertaining to sobriety in the workplace, and an EAP service for employees requiring assistance with substance-use problems.

## ***New South Wales***

### NSW Police

*Policy status: drug and alcohol policy and testing in place since March 1997. 'The policy places an emphasis on rehabilitation and offers assessment, counselling, in-patient treatment and referrals to private providers and/or support groups on a needs basis.'*

The NSW Police has a comprehensive workplace policy in place, which includes alcohol and drug testing. The introduction of testing was the stimulus for the introduction of the amnesty, which was in itself the stimulus for the formalised and very comprehensive support services. From the NSW experience much can be learnt about developing and implementing policy, and providing support services to accompany policy.

The NSW drug and alcohol policy was initiated by the Woods Royal Commission that had been established to investigate corruption within the NSW Police. As a result of its investigations, it was identified that drug and alcohol misuse by officers was a significant problem. In 1996 the Commission recommended the immediate introduction of drug and alcohol testing of police officers.

Concurrent with the Royal Commission's enquiries, St Vincent's Hospital undertook an independent research study that indicated that the drinking levels of police officers were significantly higher than those of the general community. This was further stimulus for the introduction of drug and alcohol policy.

The NSW policy was finalised in March 1997 and was put in place on 1 July 1997. It clearly articulates the NSW Police's expectations of officers in relation to drug and alcohol use. Also, the policy applies to all staff (sworn and non-sworn), although only sworn staff are tested. The policy complements the NSW Police Code of Conduct and Ethics launched in February 1997.



The policy states, 'no officer of the Police Service is permitted to use any prohibited drug'. The policy also cautions officers about drinking at levels hazardous to health.

The policy was introduced in three phases.

### **Phase 1 – amnesty for officers who seek assistance for drug and alcohol problems**

Phase 1 also includes a six-month education program, which included:

- a drug and alcohol policy workshop for all non-commissioned officers
- posters and articles in internal publications
- external media coverage
- workshops for recruits and supervisors.

Testing was not carried out during this phase and officers with dependency problems were encouraged to seek confidential assistance from the Service drug and alcohol counsellors.

### **Phase 2 – random and targeted alcohol testing and mandatory drug and alcohol testing of police involved in critical incidents, as well as targeted drug testing**

### **Phase 3 – random drug testing, which was introduced in September 2001**

Phase 3 also saw the formal evaluation of the effectiveness of drug and alcohol testing protocols conducted 12 months after implementation.

The key feature of the NSW policy is its placement within a healthy-lifestyle context, and its focus on rehabilitation. This is consistent with the desire of the Service for the policy to bring about cultural change within the organisation.

Another feature of the NSW policy is the provision of an amnesty for officers who voluntarily seek help for a substance-use problem. That is not to say that officers who have not come forward voluntarily and test positive to either alcohol or other drugs will not be disciplined. The amnesty applies only while the officer is a current client of a NSW Police drug and alcohol counsellor, and they are complying with the rehabilitation program agreed to by the counsellor.

On a counsellor's recommendation, the NSW Police may pay the full cost of reasonable in-service treatment (for sworn and non-sworn staff) at a private rehabilitation centre, or the cost of other professional medical and community support. Such support is negotiated through the Service's drug and alcohol counsellors. The usual confidentiality provisions bind counsellors, as outlined in the Code of Practice for Drug and Alcohol Counsellors.

Officers taking prescribed or over-the-counter medications that may interfere with their ability to carry out their duties are required to check with their medical practitioner and, if necessary, discuss alternative duties with their supervisor.

## Testing protocols

Random, targeted and mandatory alcohol testing sets a .02 limit for on-duty officers, and a zero tolerance for all illicit drug use. Research undertaken by NSW Police indicated that .02 was the most appropriate cut-off level for alcohol testing in a police workplace.

All recruits are tested at their pre-employment physical examination.

Random and targeted alcohol testing is conducted on a 24-hour, seven-day-a-week basis. When a testing team arrives at a station, all police on duty, irrespective of rank, are tested. Random and targeted drug tests can also be conducted on a 24-hour, seven day-a-week basis. When the team arrives at a station, they obtain the roster and select 12-15 officers at random for testing.

Mandatory drug and alcohol tests are conducted following any police operation in which a person is killed or seriously injured. An authorised police officer or an authorised officer from the Healthy Lifestyles Branch can conduct the mandatory test for alcohol. If a targeted test is for alcohol, the commander or manager arranges for the test to be conducted by a qualified member of staff.

A reading over .02 on the first occasion would not normally result in an officer being disciplined, providing the alcohol was consumed off duty. Officers who test over .02 would be relieved of their duty for the remainder of their shift and would not be paid for that portion of their shift. The officer would also be referred to an alcohol and drug counsellor for assessment. The Regulations do not require the Commissioner to offer rehabilitation if, given the circumstances, another course of action is more suitable.

An officer who chooses not to undergo counselling, fails to attend an interview or counselling session, or fails to participate in a rehabilitation program may face disciplinary action. The officer would also be subject to unscheduled testing for three years.

The roles and responsibilities of supervisors/commanders, officers and the Healthy Lifestyles Branch are defined in the policy.

## Union view

The Association sees these matters as clear occupational health-and-safety issues. Members who are impaired whilst working due to the influence of any drug, legal or illegal, should not be on duty as they represent a potential risk to other members or the public. At the same time, where members have a dependency problem which may have been exacerbated or caused by the stresses of policing, then they have the right to be offered the opportunity to receive assistance on a confidential basis to overcome such addictions.<sup>206</sup>

The NSW policy combines education, training, testing and rehabilitation and has shown to be widely accepted by members. Steps have been taken to ensure that police officers in regional areas are no more than two hours from professional help if needed.

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<sup>206</sup> Chilvers, 1998, p. 29

Discussions with the Director, Health Services Directorate and the Police psychologist, revealed that about \$100,000 per annum was spent on referring employees with drug and alcohol problems to private hospitals and providers. This figure does not include costs of in-house or external counselling, or of prevention initiatives, such as education or training, which are also conducted by that branch.

The NSW Police has outsourced their EAP service, based substantially on the need to reinforce the perception of confidentiality.

One of the very positive features of the support and other services for NSW Police is that the Service pays the full cost of whatever medical response is considered most suitable for that client. There are no restrictions on the number of times a client, or family members, can access a service. If the client has private medical insurance, the Service will pay any gap, ensuring the client is not out of pocket.

If a drug and alcohol counsellor agrees, the Service may pay for the full cost of reasonable in-patient treatment at a private rehabilitation centre or the cost of other professional medical and community support. This is irrespective of whether an alcohol or other drug-related problem is claimed to be related to the officer's duty. This assistance applies to both sworn and non-sworn staff and includes support for an employee's family.

The type of rehabilitation offered by NSW Police drug and alcohol counsellors may include:

- assessment of current personal situation and future needs
- counselling to reduce harm or to moderate drinking
- referral to in-patient or out-patient centres
- after-care and relapse-prevention counselling
- introduction to alcoholics! narcotics anonymous meetings.

All officers are expected to encourage colleagues who appear to have a drinking or other drug problem to seek help from the Service's drug and alcohol counsellors.<sup>207</sup>

## **Amnesty**

The NSW Police amnesty is ongoing. During the first six months of drug testing, anonymous data on results were collected for research and evaluation purposes, but no discipline sanctions were applied. NSW Police receive about 150-180 referrals each year, mainly for alcohol-related problems. The amnesty only applies while the officer is a current client of a Service drug and alcohol counsellor, and they are complying with an agreed rehabilitation program.

A key feature of the NSW policy is the guarantee of confidentiality for those taking advantage of the amnesty. This, along with the offer to fully fund treatment, has undoubtedly contributed to the relatively high numbers of people self-reporting.

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<sup>207</sup> NSW Police Service Policy, 2001, p. 5)

## **Treatment/rehabilitation/counselling**

Police are offered referral to confidential and fully funded assessment, counselling and treatment for licit and illicit drug use. Preferred private providers have been selected. There is no limit on the number of times a person can access services under the amnesty. Cost of treatment to the Service is about \$200 000 per year. All costs associated with support and treatment are met by the NSW Police, provided staff comply with the rehabilitation programs that have been developed for them. This is in addition to counselling and support services provided by specialist drug and alcohol counsellors within the Health Services Directorate.

## **Education**

The introduction of the NSW Police drug testing program was accompanied by an extensive education and training strategy that ensured all members, sworn and non-sworn, had a clear indication of the Service's stand on alcohol and drug use, and a good knowledge of the services available to them if they choose to come forward to seek assistance for their substance use.

## **Adequacy of services**

It was stated that current programs, infrastructure and resources meet the needs of the organisation, and importantly, have the support of the unions.

The NSW Police alcohol and drug policy and provision of support services are considered by many to be a model of best practice for support and treatment service delivery.

## **Achievements of the program**

- relatively low incidence of officers returning positive readings in the alcohol testing program
- a substantial increase in the number of officers voluntarily coming forward for drug and alcohol counselling (a 68% increase in counselling referrals during the first 12 months)
- independent research showing that the number of officers who drink at harmful or hazardous levels has substantially reduced since the introduction of the policy
- substantial anecdotal evidence suggesting that officers are no longer prepared to work with officers who are affected by drugs or alcohol
- the Service spending over \$200 000 per annum on the provision of professional treatment for officers with substance-use problems.

A copy of the policy is available on the NSW Police website, [www.police.nsw.gov.au](http://www.police.nsw.gov.au).

## Ambulance Service of New South Wales

NSW provided a written policy, *Ambulance Service of New South Wales Instructional Circular – Ambulance Service Policy and Procedures for Dealing with Drug and Alcohol use by Staff (2003)*. The policy includes:

- introduction
- aim
- scope
- relevant legislation and policies
- minimum requirements
- responsibilities
- ways to recognise that an employee may have a drug or alcohol problem
- procedure to be followed if you suspect that an employee has a drug or alcohol problem or is affected by drugs or alcohol on duty
- self-referral
- intoxication on duty
- poor performance as a result of suspected drug or alcohol use
- critical incident related to suspected drug or alcohol use
- referral to the police
- employee assistance services
- discipline
- nurses and medical practitioners
- further information
- review

Ambulance Service of New South Wales return-to-work coordinators (who primarily manage workers' compensation cases) can provide support for an employee with a drug and alcohol problem if the employee wishes to participate, although this is not yet formal organisational policy or procedure.

Employees can self-refer to the EAP for free, professional and confidential counselling, or can contact a local peer-support officer or Service chaplain for support.

It is intended under the Ambulance Service of New South Wales sick-leave policy (currently being drafted), that employees with alcohol and drug dependency will be eligible to use their sick leave for therapy, training, counselling or rehabilitation, where there is evidence of their need and of attendance (i.e. a medical certificate).

Under this policy, managers will also interview employees who have prolonged or unexplained absences. This will help to identify and refer employees with drug and alcohol problems earlier, and will backup the Dealing with Drug and Alcohol Use by Staff Policy, and will complement the support provided by return-to-work coordinators.

An interesting aspect of this policy is the need for the operations manager to determine whether withdrawal of an officer's authority to administer schedule 8 and schedule 4 drugs should occur if the officer is experiencing alcohol or drug problems.

## NSW Fire Brigades

NSW Fire Brigades replied:

We currently don't have any real infrastructure to support a program, though our HR section was developing a policy framework on which to base such a program. We have internal policy which states that our personnel are not to be under the influence of alcohol and other drugs (both prescribed and illicit) whilst operational. We also utilise the State Government's alcohol and other drugs policies and systems.

The responder did not believe that existing arrangements were adequate to meet the needs of the organisation:

We are lacking in all areas related to the identification, assessment and treatment/control of alcohol and other drug problems. We do however, have an Employee Assistance Program which enables free and confidential self-referral, family support, supervisor referrals, and manager assistance in dealing with known or suspected alcohol and other drug issues.

I would like to see the development, promulgation and implementation of a holistic and systematic approach to the nature of alcohol and drug issues, along with the introduction of training/education to increase individual and organisational awareness and empathy towards these matters. We need to be better resourced within this area in order to ensure that the emotional and psychological needs of our personnel can be met.

## **Queensland**

### Queensland Police Service

*Policy status: drug and alcohol policy and procedures (including drug testing) in place.*

The Queensland Police Service (QPS) is taking a multi-strategy approach to minimise the negative impacts of alcohol and other licit drugs in the workplace. The alcohol and drug workplace model adopted by the QPS is loosely based on the successful random breath testing model, which takes a three-pronged approach of legislation, education and enforcement.

The QPS Alcohol and Drug Policy and Procedures focuses on the procedures for alcohol and drug testing, but also details the support services available for police and staff who either self-report, or test positive to an alcohol or targeted substance test.

The policy is based on the following guiding principles:

- **Health, welfare and safety:** Ensuring the health, welfare and safety of staff is the key principle of the QPS response to alcohol and drugs in the workplace.
- **Collaboration:** This policy and the accompanying legislation and procedures have been developed in consultation with the key stakeholders, including unions, management, and representatives from across the QPS.
- **Early intervention:** If problems escalate, they are more difficult to deal with. The QPS strongly supports members who believe they may have a problem with alcohol or other drugs coming forward for Service-funded assistance.
- **Confidentiality:** Information from members will be treated in a confidential manner.
- **Natural justice and equity:** This policy applies to all members of the QPS. Processes to ensure confidentiality and procedural fairness have been built into the alcohol and drug testing procedures.
- **Harm minimisation:** This policy adheres to the principle of minimising the risks and harms associated with misuse of alcohol or other licit drugs in the workplace, and the use of illicit drugs.

The legislation allows for workplace alcohol and drug testing in Part SA of the *Police Service Administration (Alcohol and Drug Testing) Amendment Act 2003* and Regulations. This legislation allows for random alcohol testing and targeted drug testing of police, and public servants in safety-sensitive positions. It also allows for all staff to self-report and receive access to Service-funded assessment, counselling and treatment.

The policy is accompanied by an awareness and information strategy that is designed to raise knowledge of the risks and harms associated with alcohol and other licit drug misuse.

The discipline component of the policy relates predominantly to illicit drug use, while alcohol and other licit drug use is mainly approached from a health-and-welfare perspective. Sworn or non-sworn staff who have a BAC above the limit set for their area will be referred to the Alcohol and Drug Awareness (ADA) Unit for initial assessment. If considered necessary, they will then be referred to an external service provider for further assessment and treatment.

Previously, employees who used private treatment services funded the treatment themselves. With the introduction of the policy, employees who participate in Service-endorsed treatment are eligible for QPS-funded assessment, counselling and treatment to help them access the most suitable services.

One of the key aims of the QPS approach is to bring about organisational change. Research (Davey, 2000) demonstrated that alcohol consumption among Queensland police, especially women, was unacceptably high. Binge drinking was of particular concern. As well as reducing high consumption levels and high-risk patterns of consumption, the QPS is hoping to create an organisational climate conducive to early intervention and self-referral.

## **Current treatment/rehabilitation/counselling**

Each region/command has a human services officer who has qualifications in either social work or psychology. Human service officers do not necessarily have qualifications specific to the drug and alcohol area. This was identified as a gap to be filled with the introduction of the new policy and the establishment of the specialist ADA Unit within the Health Services Branch. Training has since been provided to human service officers to update their assessment and referral skills in this area, and further training is planned.

Human service officers provide short-term (limited) interventions, counselling and referral. They also provide debriefing/defusing services. They do not normally provide services to family members, although if the matter is clearly work related, they may. Service chaplains, however, can provide support to family members irrespective of the nature of the problem.

The QPS also operates a peer-support program, but it should be remembered that peer-support officers are not protected by the same confidentiality provisions as human service officers, and do not necessarily have expertise in the alcohol and drug area.

Human service officers have their own lists of service providers to refer staff:

Staff are often referred to external service providers with expertise in D&A [drugs and alcohol]. Most often these services are private, as police frequently report dissatisfaction with public providers or community agencies.

A more formal response is being developed with the introduction of the alcohol and drug testing policy. One of the main roles for the ADA Unit will be to establish a network of qualified specialist services able to provide assessment and treatment to police statewide. It is expected that service providers will receive information about conducting assessments in a safety-sensitive environment, along with information about the unique policy provisions for self-reporting. It may also be necessary to strengthen existing human service officer services and increase the number of staff if the response in QLD is proportionally similar to NSW.

Feedback provided through the needs analysis completed by a QPS Senior HSO indicated the following possible shortfalls in the system before the introduction of the new policy and procedures:

- It relied on self-referral or notification by an officer in charge or peer. These people were sometimes reluctant to report suspected misuse, as they felt they would be seen as getting their fellow officer or workmate into trouble. They were more likely to cover for a workmate with substance use problems.
- QPS had limited expertise in drugs and alcohol. Most human service officers, peer-support officers and chaplains did not have expertise in such matters.
- The system needed more intensive support and case management in drugs and alcohol. Human service officers, peer-support officers and chaplains (HSOs/PSOs/Chaplains) involved in supporting a D&A client are often removed from their normal duties during the initial assessment and treatment phase as well as during the client's other vulnerable times. As such, in-patient treatment or treatment through a multidisciplinary clinic is preferred.



Advantages of the existing system identified by the same responder included:

- Connections with the Absence Management Committee mean that alternative duties and return-to-work plans are more readily negotiated, and negotiated confidentially, with only key personnel being involved. Often, arrangements can be made directly with an assistant commissioner or district officer or other senior officer without others being privy to the details.
- Using the existing peer-support network fits well with the organisational culture – it's well accepted, all staff can become their 'brother's (or sister's) keeper', and often do.
- Support personnel who are on-site provide a ready entry point to treatment. Some personnel might otherwise be missed without a system of (early) workplace identification.
- Officer in charge or other staff suspecting a workmate is suffering an addiction can readily seek confidential advice on management or referral to external services. This is particularly useful when the employee does not acknowledge they have a problem or is refusing treatment.

The establishment of the new ADA Unit (2004) will substantially alleviate the concerns noted above, while strengthening the advantages of the existing system.

In responding to the needs analysis, the point was also made that re-establishing a police-specific alcoholics anonymous or other self-help group may greatly enhance the existing support infrastructure.

Another identified need was for after-hours on-call access to services. Previously there had been a negotiated arrangement with a hospital in Toowoomba to provide in-patient assessment and treatment services for police and emergency services personnel. This meant that there was an easily identified contact point for emergency situations. It also meant that there was a facility that was particularly experienced in meeting employees' needs.

## Queensland Ambulance Service

The information on Queensland Ambulance Service (QAS) was obtained by interview with the Director and a counsellor from QAS Staff Support Services.

It was agreed that the police and ambulance cultures were in many ways similar. For example, both cultures have occupational and organisational stress, both are predominantly male, both are hierarchical organisations, and they have similar employee profiles. It was also agreed that, similar to police, the organisational culture of QAS had undergone significant change since 1991, reflected in generally lower levels of alcohol consumption.

Since the introduction of the *National Transport Act* in 1991, there has been a nil alcohol level for ambulance drivers. Over 50% of current staff have been employed since 1991, and accept the concept of a 'dry' workplace.

Previously, ambulance officers who were identified with alcohol-dependency problems were referred for detoxification to a facility at Toowoomba (the same one police used).

When that facility closed down they were referred to Qld Health's Alcohol and Drugs Services. The comment was made that these services were largely inadequate in meeting the sometimes specific needs of ambulance officers.

It was agreed that it was not only those officers who required detoxification who were a concern, but also the (likely) greater number who needed to recognise that they were drinking at hazardous levels and who may need assistance to reduce their alcohol consumption.

Also of concern are the officers whose consumption patterns placed them at risk, such as those who were binge drinking or were impaired by a hangover while not necessarily over the limit at work.

This group is traditionally harder to recognise, and in some ways, harder to reach, as their drinking is not necessarily seen to influence their work. (Therefore, is it any of their employer's business?). Or their drinking is not inconsistent with the drinking norms they see among their peers or in society generally.

The need for background data on consumption was discussed, along with the need for greater knowledge of what constitutes a standard drink, to make that data meaningful.

QAS do not provide recruit or staff information or training on alcohol or drug use, although they did feel that this was a strategy that would be worth pursuing. The topic of QAS employing more females was discussed, and it was agreed that there could be a need for information on the risks and harms associated with females misusing alcohol.

The other area of discussion was stress management, including critical-incident stress (one-off and cumulative), and self-medicating. QAS have an accredited occupational stress module, but it does not link back to substance use. This link was identified as needing further development.

## Queensland Fire and Rescue Service

DES (Department of Emergency Services) does not currently have a program to specifically manage staff with a suspected or identified alcohol or licit drug problem. This issue is currently managed under a combination of policies, such as performance management, the employee assistance programs, and workplace rehabilitation.

However, a discussion paper recommending the formation of a working party to examine the matter and make recommendations was recently submitted to the Director-General, so the area is set for future development.

The responder pointed out that it was difficult to comment on the adequacy of services, or additional infrastructure required, without a better understanding of the nature and extent of the problem. Lack of good baseline data was a common factor across the organisations contacted.

## **South Australia**

### **South Australia Police**

*Policy status: no alcohol testing in place or planned.*

#### **Treatment/rehabilitation/counselling**

South Australia Police (SAPOL) has a Health, Safety and Welfare Branch, which have a staff of 29, including five sworn staff. The branch includes an Employee Assistance Section, staffed by a manager, two psychologists (one of whom is a sworn officer), and three welfare officers. The branch also has a senior case manager and six staff, a senior OHS administrator and four OHS coordinators, a senior rehabilitation coordinator and medical officer.

If a substance-use (licit or illicit) problem is suspected, the officer (or staff member) may be referred to Karlin House (in Adelaide) – a private service provider. Karlin House provides detoxification, in-house, outpatient and counselling services. Participation in their program is voluntary, and contracts are between the service provider and the client, not SAPOL.

Officers may access sick leave, annual leave or leave bank, and the costs of their treatment are usually fully covered by the SAPOL Health Scheme, which also covers family members. However, 'it is a problem if members are not health insured, as programs cost around \$10 000 for residential treatment.'

While SAPOL do have a reasonably good support infrastructure, and endeavour to meet the needs of their staff, 'resources at present are barely adequate. SAPOL could certainly use more resources for training managers and supervisors in this area. At present it competes with a number of other high-priority areas for time and resources in the training area.'

See note under *confidentiality* in the summary section.

### **South Australia Ambulance Service**

South Australia Ambulance Service (SAAS) support infrastructure for staff who need assistance with drug and alcohol problems is generally handled through the Staff Support Service (a peer-support program). The Medical Director also assists staff with support and referral, as does the Clinical Director (a clinical psychologist) of the peer-support program, along with three other contracted clinical psychologists.

The contact who responded to the needs analysis commented that SA AS had not experienced much of a problem with alcohol and drug use by staff, but 'that is not to say they don't exist'. He went on to say, 'intervention with staff members who have had these problems has been very successful over the past 10 years, as confidentiality is maintained for the individual. The only information that is supplied to the organisation relates to fitness for duty.'

In reference to critical incident stress:

Our pre-incident education and pro-active response to operational staff regarding CISM has (we believe) been a significant factor in the low incidence of stress related Work Cover claims over the last financial year, i.e. we processed only one claim across the organisation. When one considers the types and numbers of traumatic cases that our operational staff attend, the result is significant, given that we have 750 operational staff and approximately 1400 volunteers across the state. This factor could also have an impact on the negligible number of D & A [drug and alcohol] problems we see organisationally.

At recruit level, information is supplied on the risks associated with alcohol and drug use in the workplace and resources from SA Drug and Alcohol Services are distributed. Staff also attend a one-day competency-based pre-incident educational program, Managing Personal Stressors in the Work Environment. After the training, staff are required to answer a series of questions related to CISM in a personal stress management plan workbook, which is marked for competency.

The responder felt that their current practices appear to meet their needs in this area at this time, but expressed an interest in the outcomes of the Alcohol Education and Rehabilitation Foundation project.

## South Australia Fire Services

The SA Fire Services responded that they did not have any specific programs in place to deal with staff with alcohol or other licit drug problems, other than their EAP. The EAP allows for three sessions with a clinical psychologist, who can refer employees to further treatment if required.

A case-management approach is adopted for staff who need to go back to work following treatment.

The responder did not comment on the adequacy of existing services, or what additional infrastructure would be useful.

## ***Northern Territory***

### Northern Territory Police, Fire and Emergency Services

*Policy status: no current drug and alcohol policy or testing; policy in development.*

Contact with NT Police suggested their most pressing need was for a comprehensive workplace policy that could formalise service delivery:

There is no specific formal infrastructure to deal with members who have alcohol-/drug-related problems. Each case is in fact assessed on an individual basis. In relation to identification, if a police member has been identified as possibly having a problem, he (sic) would hopefully be approached in the first instance by either a colleague or supervisor to address (sic). The member at the time would be offered

assistance in the form of counselling through our chaplain, welfare coordinator or clinical psychologist.

If indicated, they are also offered treatment and rehabilitation, and all costs are met by the Service. Some officers have been referred to Karlin House in Adelaide.

Assuming the member admits he (sic) has a problem, the agency provides assistance with arranging appropriate treatment. In the past, members attended clinics interstate due to the nature of their position, i.e. " don't necessarily want to be identified as police in any of the local rehab centres. As far as the costs are concerned, the agency generally assists with payment of the fare interstate, return, and also the difference of the cost of the treatment that cannot be claimed through private health insurance/Medicare.

Policing and other emergency services usually have the capacity to direct an employer to assessment to determine their fitness to continue or resume duty.

If the member does not admit to having a problem, our legislation provides for the Commissioner or delegate to direct a member to undergo a medical examination. Any such examination would then identify any problem and recommended treatment.

'Naturally whilst a member was undertaking any rehabilitation, he (sic) would be removed from operational duties.' This is a particular consideration for workplaces where employees perform safety-sensitive functions.

With regard to NT Fire Service and NT Police civilian support staff, a Similar process would occur. However, there are limitations on contributions to costs. In these instances, each case is assessed individually.

This is the first response that suggested that non-sworn members were treated different! y to sworn members.

## Northern Territory Ambulance (St John Ambulance and NT Health Services)

St John Ambulance (Northern Territory) has a Drug and Alcohol Policy that includes information on their procedures for dealing with breaches of policy and referral to professional counselling. The policy includes:

- aim
- purpose
- definitions
- testing criteria and procedures
- alcohol and drug limits
- counselling procedures
- prescription drugs
- non-prescription drugs
- education
- review.

Officers can self-report to the external employee assistance service (EAS). St John Ambulance has an agreement with EAS whereby staff experiencing difficulty with a range of work-related difficulties, including addictions, have access to counselling with complete confidentiality. Management is told by EAS how many staff accessed the service, and provides an account that does not include names, or the nature of the referral.

If peers raise concerns regarding an officer's alcohol use, the operations manager/deputy operations manager will attend the centre to determine the extent of the problem.

If through the testing process staff are identified as having a problem, they are either referred to EAS, or to Amity House, which runs different programs to assess and treat addiction problems.

During the early stages of paramedic training, staff attend an information session conducted by Amity House, which includes coping with stressors, and drug and alcohol awareness.

In recent years we had one significant problem with alcohol abuse and associated issues. As a last resort prior to termination of employment, the officer was instructed to attend a live-in program interstate with written reports back from the facility to the CEO. The officer is still employed and generally doing well.

I'm not sure what other resources I would like to see other than additional paramedics on the road and EMDs in Communications. The under-resourcing in these areas potentially impacts quite negatively on our staff, particularly during weeks where the workload is heavier. Extra staff in these areas would be more beneficial for us than dedicated resources for other purposes,

This response was interesting because it flagged a problem that the literature and a number of other responders referred to; that is, the impact of organisational stressors (such as inadequate staffing levels) on staff, and indirectly, on their alcohol consumption.

## **Western Australia**

### **Western Australia Police Service**

*Policy status: no testing as such. Policy for targeted testing has been developed, but the legislation necessary to implement policy is yet to be drafted. Recruits are tested as part of their application process, and the Service has the capacity to test after a critical (road) incident.*

In relation to current case management provisions, the Service employs qualified clinical psychologists and rehabilitation officers.

Health and Welfare has a support structure of 18 including two rehabilitation counsellors who are psychology graduates. Once a week we have an occupational physician and a psychiatrist who attend to review staff. We also have two welfare sworn officers. As well, we have OSH personnel who have worked with drug and alcohol policies and procedures in other organisations as well as with police. There

are also affiliated psychologists in country areas and metropolitan areas to support external counselling services.

Critical-incident debriefing is normally provided in-house, unless geographically distant, in which instance, may be conducted by an outside service provider.

Initial assessments for alcohol misuse can be conducted in-house, or an officer may be referred to an outside service provider for assessment at the Service's expense. WA Police Service (WAPS) usually refer employees to private service providers 'to avoid the mainstream organisations and maintain confidentiality for our staff'.

If treatment or ongoing counselling is needed, the Service will usually only cover all costs if the problem is at least in part work related, such as a problem resulting from critical-incident stress. There are two private hospitals in Perth that may provide home detoxification services free of charge if the officer does not have private health insurance.

Return to work is managed by a counsellor from the Health and Welfare Branch. It is acknowledged that most rehabilitation officers may have limited expertise in the drug and alcohol area and may not be experienced in, for example, dealing with relapse problems. It could be effective to target this group across police and other emergency services for specialised training.

"The areas of education and training, and rehabilitation and support are being reviewed in the context of the development of the alcohol and drug testing policy." This was a common response, indicating that most organisations that were developing or reviewing existing policies were taking the opportunity to review other aspects of support.

## St John Ambulance (Western Australia)

St John Ambulance (Western Australia) have a peer-support program whereby staff can speak to a colleague or be referred to a psychologist. The ambulance service pays the costs associated with referral to a psychologist. 'The only drawback with this system is that the employee must instigate the process', which with alcohol misuse can be a significant problem.

The responder suggested that if alcohol misuse were suspected, the employee would be advised to seek help through the human resources area. The responder also suggested that given the training the paramedics receive on dealing with drug- and alcohol-affected persons, they were well equipped to identify similar problems with colleagues. The responder suggested that, 'a set procedure made available to all staff on exactly what to do and who to see should they have suspicions or need help themselves would be beneficial'.

## Fire and Emergency Services Authority of Western Australia

Consultations with the Fire and Emergency Services Authority of Western Australia (FESA) showed that their formal drug and alcohol policy is in development, and is anticipated to be in place by mid-2005.

FESA is working on a fitness-for-work policy that will include issues of drug and alcohol. This will be developed in conjunction with the United Firefighters Union. FESA is strongly of the view that these matters cannot be resolved without the open involvement of both staff and the union.

The responder noted:

I am pleased to say that FESA has not had many issues with employees who have been suspected or identified as having problems with alcohol or other drugs. For example, in the last three years we have only had one issue with a volunteer firefighter .... In the one instance that we had, counselling was provided to the volunteer and the matter was resolved.

Where there is a report from a senior officer or volunteer that an employee or volunteer is suspected of having such a problem, FESA refers the employee or volunteer to a private consultant for testing and counselling. FESA pays for the cost of the testing and counselling. If the person was under the influence during work time or the person admits to a problem, FESA would ensure that they receive counselling and treatment to help resolve the matter.

FESA would seek the assistance of a private consultant on the type of counselling or treatment that would be required or useful for each specific situation, as FESA does not have anyone with specific expertise in this area.

The responder suggested that existing arrangements had been successful in resolving past issues, but felt there was a need to consider training for managers in this area.

It is a difficult decision for a manager to make as to whether to refer concerns about drug or alcohol use to senior management. Our managers are not trained in how to determine whether someone may be under the influence or incapable of working.

During the development of the fit-for-duty policy, FESA plan to identify gaps in knowledge and expertise and will determine what additional resources or training are required. As indicated, alcohol and drug use was not seen as a major problem, and it was felt that few additional resources would be required. In relation to additional infrastructure, resourcing or support systems, the responder noted that:

FESA will be reviewing its chaplaincy and peer-support programs over the next 12 months and these issues will be part of the review.

FESA has very strong peer-support systems in place already dealing with all issues that arise, in particular personal issues and attendance at incidents. The peer-support system includes qualified peer-supporters who assist their colleagues with anything needed, a full-time chaplaincy program throughout the State, and access to an Employee Assistance Program. It may be that employees who know they have a problem may use our existing support networks. Obviously these are dealt with in a confidential manner and detailed information is not available.



## **Tasmania**

### **Tasmania Police**

*Policy status: drug and alcohol policy (with testing) in development.*

The *Police Service Act 2003* replaced the *Police Regulation Act 1898* from 1 January 2004 and provides for integrity testing of police officers, trainees and junior constables, including a requirement to furnish a financial statement and to submit to alcohol and prohibited drugs testing when on duty. A draft drug and alcohol policy is currently being developed and will put in place a comprehensive policy and support infrastructure.

It is expected that once the policy is developed, it will include more formalised infrastructure and training mechanisms.

Tasmania Police have a Staff Support Unit that includes occupational health, safety, and welfare and a trained psychologist.

If someone is suspected/identified as having a dependency problem they could be referred by the Dept to an outside medical specialist for assessment. The assessment is not done through the Staff Support Unit. The Unit's role (and the role of the psychologist) is to provide any support and guidance the client is willing to accept. This is done on a confidential and independent basis.

Employees with a suspected dependency problem are referred to that unit for initial assessment. If further assessment or treatment is indicated, the employee is referred to external specialist services. "Who pays is determined on a case-by-case basis."

### **Tasmania Fire Service**

The responder for Tasmania Fire Service noted that there was 'very little in place', but 'if a Shift Supervisor feels that one (or more) of their firefighters is under the influence of drugs they can (through duty of care) organise a breath test'. The officer could then be stood down from duty. If this were an ongoing situation, the officer would be offered externally provided support and treatment, funded by Tasmania Fire Service.

The responder also noted that this was not necessarily an adequate response, as 'way too much info/support at the end, and no info/support at the start'.

The latest enterprise bargaining agreement 'has indirectly put in place an undertaking of management and fires to develop and implement a full drug and alcohol policy (incorporating procedure),. In addition to sending a clear policy message, it will include information on how to identify an employee potentially caught up in this issue; how an individual can self-assess; legal requirements (duty of care); roles and responsibilities of management; and support programs to meet the needs of employees. It is expected that the policy and accompanying programs will be developed in consultation with the union.

## **Victoria**

### **Victoria Police**

*Policy status: drug and alcohol policy (with testing) in development.*

As with other policing organisations, Victoria Police has an EAP to support and refer members who are experiencing problems linked to their alcohol use. Referrals are made to the Clinical Services area, either by the employee themselves, or by a colleague/manager. If considered necessary, the police medical officer will assess the employee's fitness for return to work.

Victoria Police has recognised that their policy and support infrastructure is not currently adequate to meet the organisation's needs in this area, but a comprehensive welfare-based policy is being prepared. The new policy will include a comprehensive educational strategy, and will provide access to confidential counselling and other treatment as required.

### **Metropolitan, Rural and Air Ambulance Services, Victoria**

Victoria is served by three ambulance services – the Metropolitan Ambulance Service, Rural Ambulance Victoria (RA V), and Air Ambulance Victoria. RA V responded that they have

no formal structure in place for dealing with staff with alcohol or licit drug problems. The issue has not been of enough significance for RAV to put into place its own structure. If there is a situation that arises in relation to this issue, it is dealt with on a case-by-case basis.

### **Victorian Fire Services**

#### **Metropolitan Fire and Emergency Services Board**

The Metropolitan Fire and Emergency Services Board (MFESB) have a policy Guidelines for Preventing Alcohol and Other Drug Abuse (March 1997), which outlines the Board's and the members' responsibilities in relation to alcohol and other drug use. The Board encourages members who believe they have a problem to seek confidential assistance through their employee assistance coordinator, and grants sick leave for the employee to undergo treatment.

The Board has developed an Impairment at Work (Alcohol and other Drugs/Fatigue/Dehydration etc.) Draft Policy Framework, for which it is currently seeking union support. The draft policy recognises, 'Given the camaraderie, the tight-knit culture of the organisation and the inherent Australian dislike of "dobbing" on a mate, it seems unlikely that this policy (Guidelines for Preventing Alcohol and Other Drug Abuse) can be assessed as effective or sufficient for managing the issue.'

The policy under development also includes a comprehensive education strategy, which is expected to be delivered by peer trainers. The point was made that peer trainers were considered critical to the acceptance of the message.

### **Country Fire Authority**

The Country Fire Authority (CFA) does not have any formal drug or alcohol policy or procedures in place. The responder did not consider alcohol or drug misuse to be a major problem, but noted that there are plans to develop a policy and related position in the future.

The CFA has a welfare program covering confidential access by employees to peer support, chaplains or other professionals for assistance with drug and alcohol problems, or stress associated with critical incidents. Assistance is limited to brief intervention (up to four visits).

## ***New Zealand***

### **New Zealand Police**

The responder for New Zealand Police advised that they did not have a formal drug and alcohol support system in place, but that reviews were conducted on critical incidents where there is a suspicion of drug or alcohol involvement. New Zealand Police do have a welfare/employee assistance program, but I currently no rehabilitation or treatment program is in place to assist an officer, and those identified as having a problem are likely to face disciplinary action'. Historically, misuse of alcohol in most police workplaces would result in discipline. Many workplaces still have difficulty balancing discipline with a health-and-welfare approach.

The responder noted that existing measures were not adequate to meet the needs of either the organisation or individuals within the Service, but that

currently we are developing a proposal paper for an alcohol- and drug-free workplace program within Police. This will include training, rehab, support and testing. This is still very much in draft stage and has yet to be presented to our commissioner.

### **St John Ambulance (New Zealand)**

The drug and alcohol question is an interesting one. From our perspective as a provider of ambulance services it does not appear to be a big problem for us in NZ.

Although there does not seem to be a problem at present, the responder suggested that if cases were identified (for example, through random alcohol and drug testing), they would be managed on an individual basis in a manner appropriate to the circumstances.

St John Ambulance (New Zealand) has a number of support mechanisms in place that are available to members, such as their Member Assistance Program and their Peer Support Program, which are being further developed to ensure they are meeting the needs of the staff.

Referral to services provided through the Member Assistance Program can be made by the individual (self-referral) or by a manager as part of the management-of-a-performance issue. Members who arrive for duty under the influence of alcohol or drugs (prescription or illegal) would be stood down by their manager and, depending upon the circumstances, the matter may be subject to our disciplinary procedures.

It was interesting that the New Zealand responder included information about their organisation's infrastructure for responding to critical incidents, automatically making the link between critical-incident stress and drug and alcohol use.

If the abuse of alcohol or drugs is related to a traumatic event we have in place critical-incident-debrief and psychological-support services to assist members work through the issues around the incident. Members involved in traumatic incidents have access to support services such as peer-support or other counselling through the Member Assistance Program. Some incidents would also have compulsory diffusing sessions conducted by a clinical psychologist if required.

Whilst this does not appear to be much in the way of systems, at present it is meeting the need of the organisation. The only area we are looking to develop further is that of training and information for supervisory members and information about recognition of a problem and how to access support.

The need for training for supervisors on the recognition of alcohol- and drug-related problems was a frequent response. This is an area where historically managers have been reluctant to intervene.

## New Zealand Fire Service

New Zealand Fire Service attached a Staff Support Policy in their response that covers very well the mechanisms that they use to manage situations where staff support is required. Although they do not have a specific drug and alcohol policy, the above policy can be applied for substance misuse.

The Fire Service provides a range of support services, including critical-incident stress-management teams, occupational health and safety officers, regional medical officers, human resources staff, and chaplains. The policy details the roles and responsibilities of those key personnel.

There is also a Firefighters Welfare Society, and employees can be referred to outside welfare or counselling assistance if needed. There is a specific EAP for national headquarters staff, which regions can access if needed on a fee-for-service basis.

An interesting aspect of this policy is the way it refers to minimum national standards:

These statements represent the minimum National Standards relating to the provision of support for all employees of the New Zealand Fire Service.

Some form of support services will be available to ALL staff, both paid and volunteer, and both uniformed and non-uniformed. The level is to be determined but as a general rule, support will be available where the need is a result of workplace distress. Where the problems are caused by issues outside of the workplace, some form of support will be offered where there is direct detrimental impact on the person at work.

The services offered must adhere to accepted professional and ethical standards of similar external services such as EAP, or ITIM Industrial Chaplains.

The personnel involved in the provision of the service must be fully trained, and may be internal or, if appropriate, external.

The support service must guarantee confidentiality.

The service provision should be able to access, where needed, a full range that includes (but is not necessarily limited to) counselling, psychiatric or psychological assistance and rehabilitation.

The first priority will be to use internal mechanisms for support.

External provision of support services will be used where there is a requirement for specialised skills and expertise, which the Fire Service is unable to provide internally.

Support should be offered to staff member's immediate families, where this is appropriate.

This policy is also interesting as it states as its first key principle: 'Earliest intervention is desirable. If problems or issues escalate without being addressed then remedy becomes correspondingly more difficult.' This was one of the few policy documents received that stresses an early-intervention approach.

The policy also allows for self-referral:

Self-referral is an important feature of any support provision. If a staff member feels that they may require assistance or support to deal with a problem then they should be advised that self-referral is an option.

With self-referral the person would contact the appropriate agency direct. Alternatively they may contact your Human Resources Consultant, if they are unsure what to do, or are not comfortable approaching their own manager.

Where self-referral is undertaken, then funding of the support will be limited to the first three (3) sessions for any staff member. At that point, if further assistance is required, this will be at the staff member's own cost. The individual's identity and details will remain confidential at all times.

The completion of the needs analysis was a valuable tool in determining the status of policy and procedures for the relevant organisations in Australia and New Zealand. It also showed the commonality of problems and responses across those organisations, and highlighted the inadequacy of some existing procedures and support infrastructure.

## **Providing treatment services for police and emergency services**

It is not the intent of this report to critique treatment methods as such, but rather to review the efficacy of responses to alcohol and other licit drug misuse by police, ambulance and firefighters.

Two questions to be asked in this discussion are: do police and other emergency services personnel have special needs that should be taken into consideration when determining responses to alcohol or other licit drug problems? Can mainstream services always meet the needs of these groups, and if not, what else is required?

### ***Alcoholics Anonymous***

Some US police jurisdictions, as part of their official response, refer employees to compulsory residential treatment and Alcoholics Anonymous (AA) meetings after any alcohol-related incident. This is not necessarily appropriate, and not necessarily cost effective. A drink-driving incident, for example, may be the result of circumstances unrelated to dependency. Similarly, a common response to an alcohol related incident in the US is mandatory attendance at AA. The efficacy or otherwise of AA is not the issue here, rather, the appropriateness of mandatory attendance at AA as part of case management.

It was suggested that police would be less willing to attend AA if they were likely to encounter members of the public who they had apprehended, or who had previous negative experiences with police and who may have an attitude problem. Unfortunately it is not always practical to run police-only AA meetings as often as they would be needed (some police in the US are on personal contracts that require attendance at AA meetings five times a week), or in all the locations needed. So, attendance at some outside meetings may be necessary.

There is also a school of thought that suggests that while police-only AA is positive early in treatment and counselling, prolonged isolation becomes counterproductive. It has also been suggested that police should not be told that they are special, their substance use is special, or that they require special treatment.

### ***Residential***

The issue of residential rehabilitation was usually discussed during the meetings I had with service providers in the US. It appears that there is a tendency in the US to refer employees to residential treatment for a wide range of alcohol-related incidents. Sometimes such a referral was an excessive response to what may have been more of a one-off event.

There were several responses to this suggestion. The first response was that it was easier to organise and fund residential treatment than 'lesser' responses. This mainly refers to health insurance and sick leave requirements. The second response suggested that by the time an alcohol problem is identified, residential rehabilitation is usually indicated. However, as noted above, this may not always be the best response for an incident such as driving under the influence.

### ***Gender-specific services***

In the past, treatment programs predominantly catered for men. It wasn't until the 1970s that the differing needs of men and women received widespread consideration and organisations began to create treatment programs developed specifically for women.

Because woman's dependence on drugs or alcohol has traditionally been less socially acceptable than a man's, it has been a hidden problem, with greater reluctance for a woman or her family to seek outside help. This is significant in the addictions area where the more long-term and entrenched the dependence, the greater the degree of difficulty in solving the problem. Also, *instead of recognising that the use/abuse is a symptom of the disease of addiction – and needs to be treated as such – lots of euphemistic causes' are cited when it comes to drug abuse by women, for example, the need to cope with physical pain or emotional problems.*<sup>208</sup>

There is a growing body of research that supports the contention that that drug abuse may begin and progress differently, have different consequences, and require different prevention and treatment approaches for women and men. While there are commonalities of experience in addiction and recovery, a woman's experience will generally be different from a man's. Those differences are manifest in society's attitudes to a woman's addiction, the physiological effects on a woman's body, and other social, psychological and economical impacts.

Women will generally become more intoxicated than men after consuming equal quantities of alcohol (adjusted for body weight). Women with alcohol dependence are likely to present complex psychological issues. Most women with addictions were abused physically, sexually or emotionally earlier in their lives<sup>209</sup> and most have low self-esteem – all these problems need to be dealt with simultaneously with their treatment for addiction.

Experience has shown the counsellors at the Betty Ford Centre that female patients were reluctant to discuss their failures, fears, anger, shame, guilt, experiences of abuse and other personal aspects of their addiction in mixed groups. Counsellors also contend that both genders find mixed groups distracting. Working and residing in gender-specific groups provided women the physical and psychological space they needed to share their life stories and participate fully in the recovery process.<sup>210</sup>

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<sup>208</sup> Ford, 2003, p. 2

<sup>209</sup> *ibid.*

<sup>210</sup> Ford, 2003, p. 8

In recognising that women with addictions may need special consideration, we must also acknowledge that men with addictions have special needs. In Australia, males have been socialised to value toughness, competition and the ability to cope. It is less common for men to seek professional assistance for their problems or to articulate their fears or perceived weaknesses.

There are a number of gender-specific treatment facilities in the US. On their website, Michael's House (Palm Springs) includes a selection of quotes from previous residents supporting the centre's gender-specific approach: 'It is just less complicated. I do not have to be distracted by any sexual attractions. I want to concentrate exclusively on my recovery', and 'I just didn't want women around when I talked about my failures as a man, husband and father'.

While some of the research on the efficacy of gender-specific treatment is generally inconclusive, it may suit some men. The topic of gender-specific treatment is a particularly interesting one in the context of police and other emergency services, which are traditionally male-dominated workplaces.

It is desirable for employees to have access to trained and experienced substance-use counsellors of both genders, but again, expertise in the area is the more critical criteria.

### ***Purpose and efficacy of compulsory treatment and contracts***

'There is some research evidence to suggest that employees who enter treatment involuntarily do just as well as those who self-refer.'<sup>211</sup> A 1996 study by the Pennsylvania Centre for Studies of Addiction found employees who are required to enter alcohol-treatment programs perform as well in treatment as employees who voluntarily seek treatment. Drinking dropped 74% after six months of coerced treatment and 78% after six months for those who self-referred.

During consultations with service providers it was noted that police success rates for detoxification, treatment and counselling were slightly above the success rates for the general public. It was suggested that police will generally commit to treatment and in some cases ongoing attendance at AA, if they perceive there is a very real risk of losing their badge (and benefits).

A number of policing support services use personal contracts or case-management agreements with clients to check that clients comply with conditions that have been negotiated for their ongoing sobriety. Contracts may specify completion of treatment, continuing counselling, attendance at AA or regular reporting to the relevant EAP. Compliance may also be monitored through random drug tests.

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<sup>211</sup> Chopra et al., 1979, cited in Allsop et al., 2001, p. 93



## ***Good-practice principles for providing counselling***

The following is from M. Megranahan (1989).<sup>212</sup>

### Principles which should underpin a workplace counselling scheme

1. Any counselling service needs to have the support of top management in order to be accepted and survive.
2. A written policy statement of overall philosophy concerning the health and wellbeing of employees ... should be available. This creates a positive climate in which clients can seek help.
3. Managers and supervisors should be trained to identify employees with problems at an early stage and know how to confront them and make referral to the counsellor.
4. Access to the counselling service should be available to all staff at all locations.
5. The service should be credible in the eyes of the employers, managers, trade unions, and employees.
6. Confidentiality should be explicitly stated, accepted, and understood by everyone.
7. Ongoing care should be available, which includes referral and follow-up.
8. The emphasis should be on self-referral.
9. The counselling service should be independent of any specific or single treatment centre.
10. A system should exist for evaluating the counselling service.

### Application of quality practice guidelines in the Queensland Police Service

This research project (Support and Responses for Police and Emergency Services Personnel with Alcohol and other Licit Drug Problems) was being undertaken while the Queensland Police Service (QPS) was developing their Alcohol and Drug Policy and Procedures. In developing the policy and procedures, quality practice guidelines for supporting and treating employees who come to the attention of management as a result of a positive alcohol or drug test, or who were referred for assistance, were written.

During the development of the QPS policy and procedures, presentations were made to the QPS Alcohol and Drug Policy and Procedures Case Management Working Party, and to the QPS Alcohol and Drug Policy Steering Committee.

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<sup>212</sup> Cited in Brown and Campbell, 1994, p. 118

A list of desirable qualities of treatment service providers was developed from consultations with police and emergency services EAP personnel (overseas and Australian), and alcohol treatment service providers:

- qualified and experienced staff – licensed providers, with practitioners registered with the relevant professional board
- staff to include medical and mental health specialists who have expertise in addictions.
- continuous program, continuous intake.
- 24-hour intake
- statewide coverage. There is a need for a network of services that reaches as far as possible across the state. If affiliated services can't be found, facilities that provide a similar range and quality of services need to be identified to ensure consistency of in the quality of treatment provided.
- various types and levels of treatment for different types and stages of dependence. Dependence is progressive and individual, and officers may need access to a range of stepped services, including detoxification, residential, outpatient and extended (after) care.

## Approach

- Treatment needs to be client matched and encompass a range of approaches that includes, for example, abstinence (and incorporation of the 12-step approach), cognitive behavioural interventions, and motivational interviewing.
- Treatment should offer a mix of individual and group programs.
- Treatment service providers need to be able to manage polydrug use (such as, a combination of alcohol and pharmaceutical drugs) and co-morbidity. Mental health issues such as stress and depression frequently accompany alcohol dependency, and treatment service providers need to be able to deal with both.
- Treatment providers need to offer specific services if required.
- Treatment programs should allow clients to access family programs.

## Key points in reference to treatment

- In New South Wales, the contract for providing treatment is between NSW Police and the treatment service provider. Therefore NSW Police is the client, which entitles them to more detailed reporting on the progress of personnel being treated. The employee referred would need to sign a waiver authorising the disclosure of limited information. This is necessary for effective ongoing case management, including fit-for-duty assessment.
- It is advantageous for the ADA Unit and regional senior health services officers (SHSOs) to have an established relationship with selected treatment services. To refer staff to the most suitable treatment, the ADA Unit needs to have visited those services and have a good knowledge of the range of services provided. Treatment providers should be able to nominate someone to maintain ongoing contact with the ADA Unit and regional SHSOs. Ongoing contact between the treatment service provider and the

ADA Unit allows the ADA Unit to educate the treatment provider in aspects of police work that can impact on treatment.

- It is desirable that police be treated, if possible, with a similar professional cohort, to ensure minimal contact with an officer's previous client group.
- It may also be desirable for one service to conduct assessments, and another to provide treatment. This can avoid a situation where it is financially advantageous for a service to recommend more prolonged or intensive treatment than may be necessary.

It was suggested that the above points be considered in developing the tender and selection of treatment service providers.

## **Section 2 – Case studies**

## **Policy, procedures and support services**

### Australia

#### **Australian Defence Forces**

See also 'Needs Analysis' (p. 68-106) for details of policy, procedures and support services for police and emergency services in Australia and New Zealand.

### Canada

#### **Law-enforcement and emergency services**

##### *Vancouver*

Royal Canadian Mounted Police  
Vancouver Police Department  
Toronto Police Service

##### *Toronto*

Toronto Emergency Medical Services (ambulance)  
Toronto Employee Assistance and Rehabilitation Program

#### **Treatment facilities**

##### *Toronto*

Bellwood Health Services Inc.

### United States

#### **Law-enforcement and emergency services**

##### *National*

Federal Bureau of Investigation (FBI), Department of Justice

##### *Washington*

Metropolitan Police Department

##### *New York*

New York Police Department  
Suffolk County Police Department

##### *Milwaukee*

Milwaukee Police Department  
Waukesha Police Department

*Chicago*

Chicago Police Department

*Los Angeles*

Los Angeles Police Department

Los Angeles County Sheriff's Department

Los Angeles Fire Department

*San Francisco*

San Francisco Police Department

*Fort Worth*

Fort Worth Police Department

City of Fort Worth Employee Assistance Program

*Las Vegas*

Las Vegas Metropolitan Police Department

**Treatment facilities**

*Palm Springs*

Betty Ford Center

Michael's House

*Las Vegas*

Las Vegas Recovery Center

*Texas*

Summer Sky

*Chicago*

St. Michael's House

## Policy, procedures and support services

I am mindful of the social and legislative differences between overseas jurisdictions – such as Canada and the United States – and Australia, and the need to be cautious when identifying good-practice policies and programs from overseas. I would be similarly cautious not to imply programs would be suitable for other Australian jurisdictions when describing programs within Australia.

However, it is worthwhile examining the policies and practices of other comparable organisations to see how they have solved similar problems and, in particular, how they have overcome generic barriers to implementing high-quality practice.

It was apparent during the consultations that the similarities between policing and emergency services here and overseas were greater than the differences.

Profiles of the Australian jurisdictions are included in the needs-analysis section on p.81.

The following section is a snapshot of policies and procedures in selected US and Canadian policing and emergency services agencies, and in some cases, the city EAP that also provides referral and support services to those organisations. Where relevant, information from profiles completed during a previous research project (*Substance Use in a Police Workplace: Emerging Issues and Contemporary Responses, 2003*), has also been included, and is referred to as 'previous consultations'.

Information was obtained during meetings with representatives from the organisations I visited and from copies of the policies and procedures they passed on to me. The information on treatment facilities in the following section has been compiled from visits to the centres, their websites, discussions with their staff, and from the books and articles that have been written about their work.

A notable difference between the US and Australia is the way in which the health insurance system or health funds operate. In the US there is a proliferation of employer-funded health insurance services, all of which offer different benefits. Most will meet the costs for alcohol or other drug treatment, rehabilitation or counselling, although there may be conditions or limits, such as the number of treatment episodes funded. Cost is a factor when an organisation is determining what action to take when an employee is identified as requiring assistance, particularly if the problem appears to be ongoing and resistant to intervention. Organisations must also consider how support services or treatment are to be funded.

There is also a substantial difference in the way police, fire and ambulance services operate in the US, with management of those services devolved to a local, and in the case of policing, a state and national level. This means that the support services that can be offered will vary substantially between similar organisations.

While Australia takes a harm minimisation approach to drug and alcohol problems (National Drug Strategy 2004-2009), the US national policy focuses on abstinence.

This is reflected in the US case studies in the emphasis on abstinence models, and attendance at AA meetings during residential and non-residential treatment.

Importantly, all treatment centres visited and discussed in Part 2 were recommended by policing and emergency services organisations in those jurisdictions as being 'police/emergency-services friendly' and had a history of experience and success with that client group.

## **Australia**

### **Australian Defence Forces**

The role of the ADF is to protect Australia and its interests. To meet this role, the ADF is required to maintain a level of operational capability that demands a healthy, efficient and effective fighting force. The ADF is also responsible for providing a working environment that protects the health and safety of its members. Promoting healthy living programs, including the responsible use of alcohol, is part of this process.<sup>213</sup>

The following summary of the Australian Defence Forces (ADF) response to workplace alcohol and drug use was compiled from a meeting with the Director Military Personnel Policy (and others), ongoing email correspondence, access to Defence Instructions and other policy, conference presentations, the Department of Defence Occupational Health and Safety Manual, and the Defence Forces website.

The Department of Defence Occupational Health and Safety Manual 1, 1203 and 1204, states:

The legislative provisions of the *Occupational Health and Safety (Commonwealth) Employment Act 1991* (OHS Act) place a statutory responsibility on the Defence Organisation, as an employer, to provide and maintain workplaces that are safe, healthy and without risk to all persons at the workplace. This includes a duty of care to take all reasonably practical steps to promote the health and safety of all employees. Therefore there is a responsibility to recognise the implications of substance abuse and implement measures to assist the affected employee.

It is recognised that in normal circumstances the Defence Organisation has no right to intrude upon an employee's lifestyle. However, where that lifestyle results in poor work performance, security risk, behaviour which is potentially dangerous and/or has a negative impact on other employees, other agencies or the public, defence has the responsibility to take appropriate action.

Similar to police and emergency services, the ADF (army, navy, air force) is predominantly made up of young males with high disposable incomes – a mobile workforce of over 50 000 members, sometimes working in remote locations. The workplace culture of defence also shares many of the characteristics of police and emergency services, including relatively high alcohol consumption.

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<sup>213</sup> Directorate of Military Personnel Policy, 11 December 2003



The ADF previously had an Alcohol Rehabilitation and Education Program (AREP), established in 1979, to provide a residential treatment facility for alcohol-dependant ADF members. The AREP was a continuous 42-day clinical intervention and education program for up to 12 clients at anyone time. It was based on a 12-step model, and adapted from the US Navy Drug and Alcohol Program.

In 1984 the Royal Australian Navy (RAN) established an alcohol and drug program. This program took a prevention approach and established a team of Alcohol and Drug Team Advisors (ADTAs) who provided basic assessment, education, and aftercare support, and provided advice to commanders. This peer-support program was supported by five full-time Alcohol and Drug Program coordinators (ADPCs) who were responsible for education, assessment, treatment referral, and overall management of the RAN program.

For some time however, alcohol and drug treatment and support services were inconsistent across the three services, with only the RAN providing an integrated program (above). This inconsistency of treatment was rectified in May 2002 with the introduction of the ADF comprehensive and integrated Drug and Alcohol Program (ADFD&AP), which was renamed in 2004 and became the ADF Alcohol, Tobacco and Other Drugs Service (ADF ATODS). This program is a component of the ADF Mental Health Strategy (ADFMHS), and sits within the multi-disciplinary, tri-service Directorate of Mental Health in the Defence Health Service Branch, signifying a health rather than a discipline-based approach.

The ADF ATODS is a multi-level approach to the prevention and management of alcohol and other drug dependence in the ADF. It has responsibility for conducting health promotion campaigns and producing health promotion materials, providing advice and support to commanders and allied health professionals, development and coordination of all training and awareness packages for ADF members, and policy development. ATODS also conducts alcohol- and drug-related research and evaluation and specialist training for health and allied health professionals to build internal capacity to deal with drug- and alcohol-related problems.

The ADF deploy personnel across Australia and overseas, and one of their challenges is to provide access to treatment and support services in diverse locations:

The needs of the great majority of ADF members are dealt with by ADF health and allied health professionals in locality. To ensure access to high-quality treatment services, the ADF ATODS provides training for ADF health and allied health personnel to ensure that they are up to date with current, best-practice treatment methods and concepts. For members with an ATOD-related concern, the first point of call is medical or psychology sections locally. The clinicians working in these facilities have sound professional skills and the knowledge to deal with most ATOD-related issues. Where a member's needs are most appropriately dealt with by an ATOD specialist, the ADF ATODS has established formal links with external provider agencies in local areas and referrals to these expert providers can be arranged through the senior medical officer in the area.<sup>214</sup>

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<sup>214</sup> [www.defence.gov.au](http://www.defence.gov.au), 12/8/05

The ADF ATODS draws on current best practice; uses evidence-based intervention strategies and is supported by theory-informed policy.<sup>215</sup> The four pillars of the program are clinical services, education and training, research, and management and policy. The program is consistent with the ADF's value of zero tolerance for illicit drugs, and is an effective health-based response for problematic alcohol use (including dependence).

Alcohol misuse is defined in the ADF policy as

use which leads to an individual's misconduct, unacceptable social behaviour, impairment of health, financial responsibility or personal relationships, or interferes with performance of duty or with safety or security.<sup>216</sup>

The policy stresses that commanders and junior leaders at all levels are to exercise their command and responsibilities by ensuring members are aware of the consequences of misuse of alcohol.<sup>217</sup>

Departmental Personnel Instruction 1/97 refers to the role of supervisors in monitoring and managing deteriorating work performance suspected of being related to alcohol misuse. The Instruction states, 'The appropriate course of action will be a matter of judgment according to the circumstances', and distinguishes between an isolated incident, and when a member repeatedly reports for duty in an unfit state, presenting signs of alcohol or other substance misuse.

The program objectives are:

- to deliver a multi-level education and training program, as a component of the ADF Mental Health Strategy education and training program, that is provided at regular intervals and that will ensure an adequate level of knowledge about alcohol and other drug (AOD) use
- to positively influence attitudes and beliefs about AOD use through the provision of accurate, credible and up-to-date information that is based on evidence
- to provide specialist advice to commanders and health professionals on strategies to minimise the risks, to individuals and the community, associated with problematic AOD use
- to play a role in ensuring that ADF policies relating to AOD use are consistent with facilitating an environment in which problematic use of AOD is minimised
- to offer a range of accessible, evidence-based clinical interventions for ADF members using AOD in a problematic manner.<sup>218</sup>

## **Aim**

Through workplace education and clinical intervention, to minimise problematic use of alcohol and other drugs amongst ADF personnel.

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<sup>215</sup> Bull, 2003, p. 1

<sup>216</sup> Bull, 2004

<sup>217</sup> *ibid.*

<sup>218</sup> Bull, 2003

The program was followed by the introduction of drug and alcohol workplace drug testing, with alcohol testing for safety-critical areas developed first. Alcohol testing commenced in 2004.<sup>219</sup> Members who test positive (above .02) can be referred for treatment, including being referred to health education from a unit peer-support provider, counselling by clinical specialists or, where needed, residential rehabilitation.

The broad tri-service approach is complemented by subordinate policy and procedures in the form of single Service or Branch directives.

Costs of alcohol treatment may be borne by the ADF when there is a reasonable expectation that the member will return to work. The member is also able to access sick leave to receive treatment.

To meet the needs of personnel with an identified or suspected alcohol or licit drug problem the ADF originally advertised for specialist alcohol and drugs case workers. However, because the positions were for limited contracts, there were few applicants. A process was undertaken to make the positions non-ongoing (2 years) public service positions. This was approved, but a subsequent freeze on public service positions within ADF meant the positions were not filled.

ADF have since outsourced counselling to the health departments in each jurisdiction (except ATODS in Queensland) on a fee-for-service basis. The decision to go with state services was based on an expectation of a certain standard of professionalism, coverage, and consistency. ADF is the principal client in this contract. This ensures that they access a minimal but necessary level of information about the individual's progress on a specified level of treatment – not unreasonable when ADF is picking up the tab, and when successful adherence to a treatment plan is a mandatory condition of continued employment.

ADF also have a good health service that includes medical and nursing staff, psychologists and social workers, and an alcohol dependency program at Richmond (NSW).

AREP is the ADF's in-patient treatment facility for alcohol-dependent members, and is a component of the ADF's comprehensive approach to dealing with problematic alcohol use. It provides commanders with the flexibility to consider treatment options away from the normal workplace, and the program has helped many ADF members.

An external review of AREP was conducted during May-December 2003. The final report contains 34 recommendations, all of which have been accepted by the Head of Defence Health Services in consultation with advisers. The evaluation report was presented to the Defence Health Services Steering Committee in April 04, where it and the implementation plan received endorsement. Major recommendations relate to:

- policy consistent with Commonwealth standards
- the need for a strengthened treatment focus and broadened continuum of care,
- the need for improved clinical governance
- improved qualifications, skills and greater experience of staff
- the need for greater follow-up care.

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<sup>219</sup> DI (G) PERS 15-4, Alcohol Testing in the ADF

Implementing the recommendations is necessary in order to redevelop AREP as a health service facility that is recognised as meeting Commonwealth standards and to secure its future in the organisation as a flagship facility. To fulfil the ADF's duty of care to members it is important that the facility is brought into line with current Commonwealth standards, that it is transparent in its practices, has recognised clinical supervision and has accredited training for workers in the facility.

In a paper presented at the Winter School in the Sun Conference in Brisbane in 2003, Donna Bull spoke of the challenges identified and overcome during the development and implementation of AREP. She said the following main topics need consideration:

- organisational culture
- territorialism
- prioritising
- political imperative and community expectation
- data
- staffing
- change management.

In reference to organisational culture, she wrote:

The ADF is a large organisation with a robust and pervasive culture, incorporating rituals, ceremony and tradition. Gaining an understanding of the power of the cultural/organisational symbols and the organisation's core values has been critical to the introduction of the program [AREP]. Within the ADF there are aspects of the organisational culture that work to maintain and increase the likelihood of ADD-related hazard/harm and other aspects that reduce the likelihood of hazard/harm.

Ms Bull also outlined the benefits of putting the program in place, including:

- organisational benefits (a consistent framework from which to manage illicit drug use, encouragement of self-reporting and peer-referral, improved health and wellbeing of members, reduced turnover, and enhanced corporate image), and
- economic benefits (reduction in costs as a result of less drug-caused or drug-exacerbated illness, reduced absenteeism, fewer accidents and incidents due to increased wellness of members, and increased productivity due to enhanced ability to perform work).

Ms Bull also identified the benefits to the members, including:

- physiological benefits (improved physical health and long-term health potential, and improved occupational health and safety environment)
- psychological benefits (improved psychological health resulting from increased wellness, and improved morale)
- social benefits (enhanced capacity for establishing and maintaining functional relationships and improved family cohesion)
- other benefits (increased awareness of the impact of illicit drug use, and improved skills for identifying and managing drug use problems).

While the above also refers to illicit drug use, the drugs most commonly used in the ADF are alcohol, tobacco, and prescription and over-the-counter medications.

The ADF is taking a multi-strategy approach to meet the needs of members with suspected or identified alcohol and other licit drug problems, including prevention, referral to treatment, and support through rehabilitation, and on return to work.

## **Canada**

### **Law-enforcement and emergency services**

#### **Vancouver**

##### **Royal Canadian Mounted Police**

While in Vancouver I visited the Royal Canadian Mounted Police (RCMP) and met with the officer in charge of Health Services, the regional psychologist, and two RCMP Health Services officers, one of whom is an alcohol and drug specialist.

The RCMP is the Canadian national police service and employs approximately 22500 members, deployed across a vast area in often remote locations.

The RCMP has a comprehensive alcohol and drug response for members suspected or identified as having a problem with alcohol or other licit drugs. Their program is codified in policy and Commissioner' Standing Orders, such as the Authority to Compel Health Assessment.

The RCMP allows for members to self-refer for alcohol or other licit drug problems, and 30-40% of all referrals in the last two years have been self-referrals. Members may be identified as part of a discipline action (such as that resulting from drink driving), referral by a manager, or through the member's assistance program (MAP). Occasionally addiction problems are identified in the context of another illness. More rarely, a member will be directed to the Health Services area by family members or the family doctor.

Addiction problems may also be identified during periodic health assessments (PHAs), which are conducted routinely every two years as a condition of transfer to certain positions, and include a psychosocial interview, CAGE questionnaire and liver-function tests. The interview entails reporting on exposure to psychologically traumatic events, experience of personal problems, questions about alcohol consumption, and perceptions of mental health. While denial and cover-up of addictions and mental health problems are common, clinicians are skilled in identifying such behaviour. The interview also provides the officer with an opportunity to request referral to a counsellor, in a supportive and confidential environment.

Initial assessment of alcohol dependency may occur in-house, as RCMP have an addiction specialist on staff. If an in-house assessment cannot be arranged, or is unsuitable, the Health Services area has good knowledge of outside services that work regularly with RCMP personnel and are familiar with a law-enforcement culture. Health Services do not function as an EAP or direct service provider. Their main function is to provide case management, including referral and monitoring, rather than primary care.

Regardless of how Health Services become aware of a member's alcohol problem, standardised responses and organisational procedures are adhered to. Once a member is suspected of having a substance-use problem they are referred to an addictions physician for an assessment, at which time a full medical history is taken, examination and lab tests performed, and a treatment plan formulated.

Treatment plans are individualised, and depend on the severity and nature of the addiction. If dependence is severe, detoxification and residential treatment may be necessary. Members are required to sign a treatment contract. Usual professional standards of confidentiality apply to members under a treatment contract, however, with the client's consent, Health Services receive full case reports to enable them to properly case manage each case.

RCMP prefer treatment programs with a 12-step component and that have the long term goal of abstinence. Treatment is usually offered locally, but a member may attend treatment in another territory/province, or even in the US, although this is less common. Residential treatment is favoured over out-patient treatment. Centres which are able to provide family programs are also favoured.

An important part of the RCMP response to workplace substance use problems is the long-term recovery program, which provides follow-up support for members on return to work. The long-term recovery program requires complete abstinence ('controlled drinking is not an option'), regular attendance at AA, and adherence to a 12-step program. The member on a recovery program will be required to undergo periodic random drug tests to ensure compliance with treatment centre recommendations; 'multiple relapses make continued employment with RCMP uncertain'.

Medical treatment entitlements ensure that the costs of counselling and treatment are met by the organisation under private health cover. There is no limit to cover for treatment, which is usually residential and always private. There is also no real limit on sick leave, although the member's recovery is closely monitored. Under Canadian legislation, if a member is unable to undertake their usual duties on return to work, the organisation is required to offer alternative duties (Duty to Accommodate).

Within RCMP three areas are able to provide support to the addicted member – the MAP, occupational health nurses (OHNs) and the Health Services officer (HSO). The HSO liaises with the outside treatment service provider, and the MAP provides direct and often practical support to the member, such as accompanying them to appointments. OHNs help monitor treatment contracts, order drug screens and support recovering members.

In reference to prescription and over-the-counter drugs, RCMP currently does not compel members to supply details of medications they may be taking, even if those medications may impair performance. However, when an invoice for payment for medical treatment is received by an external treatment provider, a report is included on which the medical practitioner has to indicate (by ticking a box) whether the member is fit or unfit for duty. If the medical officer specifies that the member is not fit for duty, they will suggest a time by which they are expected to return to duty. The invoice thus becomes the equivalent of a medical certificate. The Blue Cross health-insurance medical provider can also generate a list of medications received by a specific member. This can help identify misuse of prescription medication.

Prevention initiatives within RCMP – such as the dissemination of drug and alcohol information and resources – have in the past been minimal, and have been managed by the fitness and lifestyle health promotion area, rather than Health Services. More recently one of the Health Services officers developed and delivers a comprehensive addictions awareness presentation and training package, which includes information on addictions, assessment, treatment, and support resources.

To maintain equity, RCMP offer culture- and gender-specific services. The other concern relating to equity is distance. The remoteness of some outposts was identified as an obstacle when identifying a dependency problem, and when providing support and access to services.

The other problem that was identified during the consultations with RCMP was the difficulty in promoting a responsible drinking message to members in a broader culture of acceptance of high consumption. It was stressed that it was not enough to create a drug- and alcohol-free workplace, but that the culture of high consumption and bingeing outside work hours also needed to be dealt with.

RCMP personnel considered the following points to be crucial in providing dependency support:

- The service must provide a residential program with medically supervised detoxification if required.
- The service should have a continuous intake and be flexible (rather than being a rigid 28-day program)
- A medical practitioner and psychologist should be on staff, so clients don't need to go out for access to specialist services.
- The service should include a 12-step abstinence-based program.

In regards to whether members should have RCMP-exclusive AA groups, it was suggested that 'terminal uniqueness' was a potential problem and that an 'accountability group' may be a better option. An accountability group can be made up of similar professions, such as law enforcement, emergency services, and defence. An accountability group would usually meet about once a month and would be facilitated by a doctor or psychologist. While similar to AA in fulfilling a support function, the accountability group would also ensure compliance with treatment contracts. Several police accountability groups are in operation in different parts of the country.

When discussing barriers to implementing drug and alcohol policy, personnel suggested that the culture of the organisation was not necessarily conducive to seeking help for a substance-use problem. It was also suggested that age and length of service may sometimes work against an officer seeking assistance, which was interesting because this was not raised in other workplaces. It was thought that older officers may be more reluctant to seek assistance, even though alcohol dependency usually becomes more apparent in older officers.

Overall, health services within RCMP were considered by staff to be of a high standard and generally meet the needs of members with an identified alcohol problem.

## Vancouver Police Department

Vancouver Police (VPD) is a relatively small department of about 1100 sworn members and 150 non-sworn members.

It was pointed out that there had been a significant change in drinking patterns within police over the last ten years. This was thought to be due, in part, to a perceived shift to more responsible consumption within the community generally and changing recruitment profiles to older, better-educated recruits. It was suggested that organisationally there was also less tolerance for intoxicated behaviour in the workplace and a greater willingness to assist officers suspected of having a dependency problem.

Support for officers with a suspected or identified substance-use problem is provided by an alcohol and drug manager, who is an ex-sworn member, located within the Human Resources Section. Officers with problems come to the attention of the Human Resources Section through self-referral and through referral by managers as a result of observed behaviours or a discipline action. As in other workplaces, self-referral is not common.

Because the department is relatively small, the alcohol and drug manager also visits the various sections and stations performing outreach and training. He suggested that because he is well known 'on the ground' after 30 years as an officer and through his active outreach approach, he receives a number of 'tip-offs' about individuals, to which he is able to respond confidentially.

Officers with an alcohol-dependency problem also come to the attention of the Human Resources Section through the Periodic Health Assessment Program. Health assessments are conducted once a year for officers over 50, every three years for officers over 40, and every five years for younger officers.

When a member is suspected of having a problem, they are interviewed by the alcohol and drug manager, who then refers them onto an external alcohol and drug specialist for a comprehensive assessment. Vancouver Police Department currently refer to one particular doctor for assessments and a small group of treatment service providers who are familiar with the police workplace. The alcohol and drug manager suggested that the quality of service depended significantly on the service provider's qualifications and their experience of working with a law-enforcement client group.

Vancouver Police Department provide paid time-off and travel entitlements for treatment (administrative leave), but the actual cost of treatment is met by the individual's health insurance. While there are technically no limits on the amount of time an officer will be granted for recovery, the limiting factor may be the officer's health insurance, which usually does limit the frequency and length of treatment.

While an officer is in treatment and on department-funded leave, the alcohol and drug manager receives verbal reports from the treatment service provider on the client's progress. The VPD alcohol and drug manager does not keep written records, and reports from the treatment service provider are more along the lines of compliance reporting than case notes.

There is some debate regarding the detail about a client's progress that is needed for an organisation to make an informed judgment about whether the member is able to return to



work, and whether they should undertake safety-sensitive duties. It was suggested that a change of workplace or role may be helpful while recovering after treatment.

Although VPD do not perform routine drug testing, an officer returning to work will undergo random testing to ensure compliance with their treatment contract. Treatment contracts, which are developed by the treatment service provider, are individual to each client and are usually valid for two years.

In discussing substance use in a police workplace, the alcohol and drug manager suggested that recruiting procedures played an important role in identifying worthy applicants and in providing applicants with a clear message about unacceptable alcohol use.

The alcohol and drug manager identified lack of trust and fear of breaches of confidentiality as the most significant barriers to reaching and helping members with alcohol problems, and suggested that the most effective way of building trust was through outreach and word of mouth. He also cited active follow-up and support, not just compliance monitoring on return to work, as critical in preventing relapse.

### *Critical-incident stress management (CISM)*

To ensure that officers don't automatically turn to alcohol as a debriefing mechanism, the alcohol and drug manager includes a session on alcohol and critical-incident stress in his in-service training program.

Vancouver Police Department have a formalised approach to CISM that includes mandatory team debriefs that are a mixture of operational and psychological approaches. Peer counselling is provided by peer-support officers who have experienced similar critical incidents, and referral to professional counselling is organised through Psych Services. All officers who have been involved in a critical incident and undergo debriefing are individually followed up by the alcohol and drug manager.

The point was made that although VPD have procedures in place to deal with critical-incident stress, there are no formal responses to treat organisational stress. It was also suggested that although there was a certain degree of tolerance and understanding of operational stress, organisational stress, while more prevalent, was less understood or tolerated.

## Toronto

### **Toronto Police Service**

The Toronto Police Service (TPS) meeting was attended by the manager of the Employee and Family Assistance Program (EF AP), the manager of the Occupational Health Services, the addictions coordinator, and a staff member from Bellwood Health Services.

Toronto is the largest city in Canada, and TPS is one of the larger police services, with about 5260 sworn members and 3340 non-sworn members, spread over 35 workplaces. The EF AP has a full-time addictions coordinator and excellent links have been established with their main treatment provider, Bellwood Health Services.

Most officers and staff members come to the attention of the EAFP through the usual channels of self-referral, or referral by family, peers or their managers. The medical advisor within Occupational Health Services may also refer officers to the EFAP. The medical advisor may request a fitness-for-duty assessment and, depending on the results of the assessment, may recommend a period off duty, or on restricted duties. Such a recommendation would entail referral to the addictions coordinator at the EFAP.

Some officers come to the attention of the TPS as a result of a discipline action, such as that resulting from a drink-driving incident, or when the officer has been criminally charged with another offence. The EFAP is not automatically notified in these cases. The EFAP is located away from police headquarters and organisationally sits to the side of Health Services, which is perceived as a part of management. This allows the EFAP a measure of autonomy and reinforces the perception of confidentiality.

Officers self-referring to the EFAP initially identify as having emotional problems, marital and family problems, addictions, and critical-incident stress, although it was agreed that for officers with emotional or marital problems, alcohol was frequently a contributing factor.

Toronto Police Service does not conduct regular fitness-for-duty testing, but can refer officers with a suspected alcohol problem to Bellwood Health Services for a safety-sensitive assessment (see Bellwood Health Services, p. 137). Safety-sensitive assessments can also be organised through the Toronto EARP (see p. 134).

Bellwood Health Services run a weekly support group, HEART (Healing, Esteem, Awakening, Reality, Trust) group for police who may be suffering from stress (operational and organisational) or have addictions. The group meets at Bellwood and is conducted by a trained counsellor from Bellwood, and the EFAP addictions coordinator.

Although attendance is voluntary, attendance records are kept, and officers who are not able to attend are required to put in an apology. If non-attendance is because of relapse, the member is encouraged to make an appointment with a counsellor from Bellwood. One of the differences between the HEART Group and AA is that because attendance records are kept, the facilitator of the HEART Group is able to vouch for an officer's attendance and progress, although not in detail, and only with the officer's permission.

The HEART Group does not replace AA, although there are many similarities between the groups, such as the emphasis on sharing personal stories, group medallion, maintaining confidentiality, and the use of the 'I serenity prayer' to close the meeting. Bellwood also has an unofficial/badge courage group', which a number of police and former police attend.

The representative from Bellwood said that Emergency Services were planning an Emergency-Services-only residential treatment program, which would cover a range of addictions, including prescription-drug dependency.

Participation in the HEART Group was said to contribute to the high recovery rate among attendees. It was pointed out that police are generally slow to trust, and it was suggested that the success of this group preventing relapse was a strong argument for a police-only support group. It was also suggested that police in such a group are well placed to provide outreach to other officers in the workplace.

Another advantage of the HEART Group was that it is sometimes a catalyst for encouraging an officer into treatment. An officer who may have been attending the HEART Group for anger management or stress, for example, may come to acknowledge their problems with alcohol or other licit drugs within the supportive and semi-structured environment of the group. A similar group for non-sworn members was starting shortly.

It was pointed out that police often see things in absolutes of black and white, good versus evil, all or nothing, and that this was one the reasons police do well (better than community norms) in abstinence-based treatment programs.

Another interesting point that was made during the consultation with TPS related to a legacy of previous recruiting practices. There are a number of officers in the TPS who were recruited in the mid 70s when the hire ratio was 1:2. At that time, and in the 20 years that followed, heavy drinking was the workplace norm.

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The recruiting ratio is now closer to 1:6, and recruits are generally older at entry and are better educated. It was also stated that the workplace is less tolerant of alcohol abuse (certainly during work hours) and that these factors combine to make alcohol less of a workplace problem than before. Although alcohol abuse may not be as widespread as 20 years ago, the alcohol consumption data we do have indicates it is still a serious problem.

It is also possible that younger officers, while less likely to be abusing alcohol, may still be misusing over-the-counter or prescription medications – this area needs more research and workplace education.

Regarding workplace culture, the point was made that while there is still a bar in headquarters and a senior officer's lounge, it is not possible to promote an alcohol free workplace. This highlights the challenge of deciding on the message that police and other emergency services want to convey to their staff: harm minimisation, e.g. drink but don't drive; responsible consumption, based on NHMRC guidelines; or abstinence in the workplace.

The TPS is considering introducing workplace drug testing as a result of a review similar to the Woods Royal Commission in NSW, which was also the stimulus for introducing drug testing. The Ferguson Report on the TPS makes 56 recommendations, including the introduction of drug testing, and changes to recruitment, training and risk management.

Similar to NSW Police, TPS are endeavouring to situate their drug testing within a multi-faceted Wellness Program. It was pointed out that addiction is a progressive disease and that prevention, education and awareness provides an opportunity for early, and therefore, more effective intervention. The Wellness Program is run by Health Services in association with the EF AP, who provide a half-day session during recruit training and have input into in-service training, such as promotion or change of-role training.

As well as providing the usual support functions, the EAFP coordinates a 40-person peer-support (referral agent) program, and a critical-incident debriefing team. Referral agents are front-line personnel and are often the first contact for an officer seeking confidential support or assistance.

Some officers who were being treated for alcohol dependency also had a gambling problem.

A final point that was made during the TPS consultation related to gambling. It was suggested that police who were assessed for alcohol addiction should also be at least briefly assessed for gambling addiction. It had been noted during assessment and treatment that some officers who were being

treated for alcohol

dependency also had a gambling problem, and the two addictions need to be treated simultaneously.

The following were put forward as guiding principles in providing *support* to officers with a suspected or identified alcohol or licit drug problem:

- trust – in the person, in the services referred to, and in the process
- confidentiality
- genuine commitment
- peer involvement
- welfare rather than a discipline focus.

The following were put forward as guiding principles in providing treatment to officers with a suspected or identified alcohol or licit drug problem:

- an abstinence-based approach
- continuous intake
- follow-up.

It was suggested that the alcohol and drug support officer within a policing organisation needs a detailed knowledge of treatment services available, their particular areas of expertise and their experience in treating police.

It was also suggested that an officer's recovery may be enhanced by the EF AP working closely with family. Officers with a substance problem are often reluctant for the organisation to communicate directly with family members. Contact with family members is easier when the lines of communication between the EF AP and the family are already established through strategies such as newsletters and open days.

### *Critical-incident stress management (CISM)*

Responding to the welfare needs of police involved in a critical incident is an EF AP role. They select and train teams (two police officers and two civilians) using a modified Mitchell model. When a critical incident occurs, EF AP is immediately notified and a psychological debrief is usually undertaken – 'I attendance is mandatory, participation is voluntary'. The debrief is conducted by a mental health professional assisted by a critical-incident debrief team member.

An important part of the critical-incident debrief is giving information and an opportunity to promote the services available through the EFAP. EFAP continue to closely monitor the wellbeing of officers involved in a critical incident. EFAP staff are also aware that the incident, such as a line-of-duty death, may also have an impact on officers not directly involved. It was suggested that critical incidents had the potential to trigger relapse.

It was stressed that not all police involved in a critical incident will suffer trauma and that most of the stress the EF AP deal with is a result of organisational stress. The EF AP is proactive in managing organisational stress and informs people about the subject during presentations and updates that are part of the Wellness Program.

It was suggested that critical incidents had the potential to trigger relapse.

### **Toronto Emergency Medical Services**

The Toronto Emergency Medical Services (EMS) is the largest municipal EMS in Canada and employs a full-time clinical psychologist to manage their responses to workplace alcohol and drug problems. He is available to staff and their families around the clock and has formed and trained a team of peer counsellors to help him.

A substantial component of his role is outreach and giving information. He conducts half-day training sessions during recruit training, focusing on management of managing personal alcohol use, and he ensures recruits are provided with contact numbers if they wish to take up assistance. He also conducts in-service training of supervisors to help them recognise and manage substance-use problems in the workplace.

The current incumbent suggested that high visibility out in the stations encouraged self-referral and informal approaches by concerned peers. Five to eight per cent of referrals to his program were related to alcohol. Employees are encouraged to self-refer, and confidentiality is stressed as an important part of the program.

Rather than refer employees to one treatment facility, he uses Drug and Alcohol Referral to Treatment (DART), which operates a 1800 line to choose the most suitable service. Treatment focusing on setting goals, behaviour and controlled drinking is favoured over abstinence for most of the officers.

There is no cost to the officer for critical and short-term sessions (up to about 15), and the organisation usually pays any costs associated with treatment. Toronto EMS employees can also use at no cost an Ontario EAP, which covers police, fire and other city employees. This program is more likely to deal with substance use in the context of discipline breaches.

It was suggested that humour, which is a characteristic of EMS workplaces, is a good tool in building rapport with officers, and in creating a climate where they felt comfortable about self-reporting. Another suggestion was that EAP support staff need to be highly visible 'on the ground' and be well known (and accepted) by officers.

### *Critical-incident stress management (CISM)*

The psychologist I interviewed said that paramedics adopt protective behaviours, such as detachment. He suggested that while detachment allowed them to get the job done, it did not encourage them to "admit, accept and process their emotions. As a result they

experience burnout, compassion fatigue, post-traumatic stress disorder or exhibit dysfunctional behaviour on and off the job".<sup>220</sup>

Toronto EMS do not conduct compulsory psychological debriefings. However, the EMS psychologist conducts defusing sessions and follow-up after critical or highly emotional incidents and has developed several strategies to help paramedics cope with diverse stressors on and off the job. He is helped by trained trauma teams (Employee Assistance Teams) originally founded on the Mitchell model.

Toronto EMS has since moved away from the Mitchell model – with the 'realisation that one model does not fit all' – to a 'focus on needs not models'. Team members are trained to look for and meet the expressed needs of the personnel involved in the incident, initially focusing on the most commonly expressed needs, which are usually information (what's going on; what's going to happen; the condition of people involved), food and water. Team members are also trained in listening, maintaining confidentiality and, if necessary, referring people to treatment providers.

The staff psychologist suggested that defining a critical incident with EMS is almost impossible, as officers may attend several such incidents in a shift. To handle this difficulty, EMS has a system in place whereby an officer who may be distressed can take themselves out of service for an hour, or go home for up to two 12-hour shifts.

This system is used occasionally, but not abused. The staff psychologist did not favour a distressed officer going home if the officer was going home to an empty house, or if there was a risk of the officer binge drinking. If an officer requests to be relieved of duty, the staff psychologist endeavours to talk to the officer first to ascertain that there will be a supportive family member or friend on hand, and to warn the officer about the use of alcohol or other licit drugs.

### **Toronto Employee Assistance and Rehabilitation Program**

While in Toronto I met with the Director of the Toronto Employee Assistance and Rehabilitation Program (EARP). This program offers short-term confidential counselling, information and referral to Toronto's 35 000 employees, including police and ambulance. The EARP complements the staff support services provided in-house by police, fire and EMS, and primarily considers substance use as a workplace health and safety matter.

The Toronto substance abuse policy and program are based on prevention, and include education, assessment, referral counselling, crisis intervention and case management. There is no cost to the client for short-term services and safety-sensitive assessments, which are conducted by Bellwood Health Services. Where long-term or specialised counselling is needed, clients are referred to treatment providers and can access funded health insurance facilities.

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<sup>220</sup> 1998,p.34

Safety-sensitive assessments can be ordered if an employee is considered to be at risk to themselves, the public, or others in the workplace. Managers or superiors can recommend a safety-sensitive assessment based on reasonable suspicion of dependency or hazardous use without evidence of impaired work performance.

Managers or superiors can recommend a safety-sensitive assessment based on reasonable suspicion of dependency or hazardous use without evidence of impaired work performance.

The Director suggested that safety-sensitive assessments were more than just targeted testing and provide a more comprehensive and positive outcome. She suggested that they were an excellent early-intervention tool and provided a means whereby an employee could be confronted with the outcomes of their addiction and offered a possible solution. Although Bellwood conducts the safety-sensitive assessments, they may not necessarily provide the treatment services. This strategy overcomes the risk of over-referring.

The substance abuse policy and program stipulate the roles and responsibilities of those involved (front-line supervisors, EARP specialists, union/associations and employees), and sets out procedures for referral and follow-up. It was noted that the union had indicated a preference for outsourced EARP services, based on the perception of enhanced confidentiality, but the existing service suggested that an outsourced service could not be expected to have the same intimate and detailed knowledge of specific workplaces.

Referral to EARP is voluntary, suggested or formal. Under voluntary referral, there is no responsibility to inform the department, unless work time is used for the EARP appointment, and any communication with the department is initiated at the client's request and with their written consent. Under suggested referral the EARP will, with the client's consent, inform the department of the client's participation in treatment and any required follow-up. Under formal referral, which usually results from discipline, a signed consent form granting the EARP permission to disclose information to the department is a condition of providing services.

Clients who attend the EARP under formal referral must attend a 'Re-entry to the Workplace' meeting, where performance expectations and other matters and conditions are clarified. Clients under formal referral are monitored for the duration of the program and may undergo drug testing while in treatment.

The following were suggested as guiding principals:

- quick response – once a problem is identified the workplace should act quickly to help the individual and to alleviate a potential workplace safety threat
- holistic approach – employees with an alcohol dependency often have other problems, such as financial or family problems, that need to be looked at the same time
- sound reporting mechanisms – there needs to be a good rapport between the workplace and the treatment provider to ensure coordinated case management and rehabilitation
- quality, qualified staff at both the EARP and the treatment provider
- capacity to include family – positive family involvement can enhance recovery and complement the support being offered through the workplace; the workplace EARP can also be a positive support for the family

- mixture of approaches – rather than promoting an exclusive approach to treatment, it was suggested that the treatment facility should be flexible enough to customise the treatment, and be willing to apply either an abstinence or a controlled-drinking approach.

A workplace environment that supports or enables harmful levels of consumption and drinking practices is not conducive to self-referral or successful rehabilitation.

The following are barriers to providing support service:

- cultural – a workplace environment that supports or enables harmful levels of consumption and drinking practices is not conducive to self-referral or successful rehabilitation
  - 'too hard basket' – some organisations place alcohol problems in the too hard basket and react to situations only when they become impossible to ignore
- lack of knowledge – lack of knowledge about what constitutes good practice and how to respond to employees with dependency problems may hamper a speedy and effective response. Lack of information on the possible effects of alcohol on the workplace can result in alcohol problems not being allocated adequate staff resources or funding.

### *Critical-incident stress management (CISM)*

The Toronto EARP was in the process of reviewing their response to critical-incident management at the time of my visit. They had previously applied the Mitchell model to all critical incidents but reviewed and modified procedures after they analysed the model. Of greatest concern with the Mitchell model was that an individual's repressing an experience until they could deal with it was an effective response.

Fire, police and ambulance conduct internal situational debriefings, but the Toronto EARP will provide extra counselling if needed. Not all incidents are critical incidents and not all designated critical incidents affect everyone involved in the same way. It was suggested that organisations need to be able to customise care according to the individual and the situation. This is a managerial responsibility.

It was also acknowledged that CISM is a specialist area and that, while it was a managerial responsibility to ensure good-practice systems and responses are in place, counselling (as opposed to peer support) should be delivered by qualified and experienced counsellors with a good knowledge of the workplace culture.

## ***Treatment facilities***

### Toronto

#### **Bellwood Health Services**

Bellwood is a 60-bed private hospital that treats alcohol and drug disorders, gambling and sexual addictions, and stress-related and other problematic behaviours. They are experienced in treating armed services and law-enforcement personnel.



### *Approach*

Bellwood takes a holistic (mind, body and spirit) approach to recovery. Clients undergo a fitness, nutrition and stress assessment, as well as diagnosis of alcohol or drug dependency. It was stated that a substantial proportion of police who present for treatment for substance abuse also present mental health problems, such as depression or stress, and unresolved trauma problems. The point was made that such conditions need to be treated concurrently, and not in isolation, and that it was important to choose a facility with the capacity to treat co-morbidity.

### *Treatment*

Bellwood recommends that clients abstain from alcohol or drugs for at least 72 hours before admission, and can assist with detoxification as required. Treatment programs, which are customised, include medical intervention, therapy, educational lectures, relapse prevention and aftercare planning.

Bellwood provides assessment, intervention assistance, in-patient and out-patient medical and psychological services, family programs, relapse prevention and aftercare services. Bellwood's services range from individual counselling to intensive programs that last up to 12 weeks. The average length of stay is 32 days.

Bellwood also conducts a 21-day comprehensive (government-funded) program for clients for whom alcohol is the sole addiction. The goals of the program are:

- to interrupt the process of addiction
- to repair the related physical, emotional, family, social and spiritual problems
- to improve tolerance to stress without the use of mood-altering substances
- to develop effective coping techniques
- to create a personal recovery and aftercare plan.

The 21-day program is run as a closed cycle every four weeks.

Bellwood's programs encourage abstinence, and Bellwood conducts drug and alcohol testing to ensure compliance with treatment.

Bellwood offers a three-and-a-half day program for family members and friends to learn about the nature of addiction and recovery, and how best to support the addicted client.

### *Aftercare*

Bellwood offers aftercare services for up to a year. The services include ongoing weekly group meetings for the client, and the family aftercare group for one family member, as well as phone and email follow-up, and access to mini programs that are scheduled throughout the year. Clients are encouraged to join a 12-step program and attend meetings at least three times a week as part of their recovery after discharge. The aftercare program should be a partnership between the workplace and the treatment provider.

Bellwood counsellors pointed out the following barriers to effective treatment:

- trust – 'police often have trust issues' with the police organisation or with the treatment facility and may 'erect barriers as a defence mechanism'. Trust between client and counsellor has to be established before real progress in treatment can occur.
- engagement – counsellors suggested that it was sometimes problematic getting police to fully engage in treatment. This is a difficulty with referral mandated by the workplace, especially if it is part of discipline. It is critical that client's do not just go through the motions to fulfil employer directives.
- approach – 'police officers do not need specialised clinical treatment, but do need specialised handling'. This point was repeated by other service providers who were experienced in treating police with substance-abuse problems.
- cultural socialisation – 'police do not access their feelings well. They have been taught not to disclose, and that any expression of feelings may be seen as a weakness.' It was suggested that men have greater difficulty than women in expressing their feelings, and that 'police officers have greater problems than most.' It was also suggested that 'females are more likely to access their feelings and are also more likely to already have other female support systems in place'.
- 'police often view issues in black and white' – this trait was identified as an impediment to counselling.
- lack of police / emergency services research – because there was a lack of profession specific consumption data, it was felt that the problem of alcohol use for those professions was not fully recognised, and therefore not dealt with. Alcohol use in police and other emergency services is underestimated, under reported, and under evaluated or measured. Baseline data is either non-existent or not reliable.

Police officers do not need specialised clinical treatment, but do need specialised handling.

Alcohol use in police and other emergency services is underestimated, under-reported, and under-evaluated or measured. Baseline data is either non-existent or not reliable.

### *Concurrent substance dependency and post-traumatic stress disorder program*

Bellwood recognises the close links between substance dependencies and post-traumatic stress disorder: 'police typically turn to unhealthy coping mechanisms, such as alcohol and sleeping tablets', a view which is reflected in the research and in the experience of the counsellors at Bellwood. Bellwood conducts a specific program to treat these co-morbidities.

A specialised hazardous employment program is provided for clients from Canada's armed services, police and other emergency services, paramedics and health care professionals, news media professionals and others who are at risk of exposure to traumatic stress in the course of their work.

Assessment of post-traumatic stress disorder is based on the Significant Life Events Screening (B. Hudnall Stamm Traumatic Stress Research Group) and the Trauma Symptom Inventory (Psychological Assessments Resources Inc.), which can provide a severity rating and indicate a level of impairment. Treatment is delivered in a weekly

psycho-education-and-skills training group called the Hazardous Employment Issues Group (HEIG).

Clients from high-risk occupations are required to attend a minimum of three HEIG sessions during which they are assessed and are given a basic understanding of stress management. Those with significant symptoms are encouraged to attend the full program.

All patients at Bellwood attend three primary group therapy sessions per week during treatment, and trauma is also covered in these sessions. Additionally, patients who participate in Bellwood programs of 45 days or longer attend a three-week intensive coping skills program. The counsellor who conducts this program also has specialised training in trauma counselling.

### *Safety-sensitive assessments*

In an ideal world and in keeping with the principles of modern employee assistance programs, an employee with addiction issues would come forward to seek help voluntarily. In reality though, denial, which is such a strong component of chemical dependency, and the uncertainty of the employee about h[is] (sic) status with the company, obviously limits the numbers of employees that self-identify. The onus is therefore mainly on the company to take action.<sup>221</sup>

The following profile of safety-sensitive assessments is drawn from Dr Levinson's presentation to the 2002 Winter School in the Sun Conference in Brisbane, and the subsequent meeting I had with her at Bellwood, Toronto in May 2004.

Police, emergency services and Defence are characterised by safety-sensitive work. One of the dilemmas such organisations face is judging if an employee is fit for duty. This is necessary when a problem with alcohol is suspected (before assessment and confirmation), and after a person has undergone treatment and is in recovery.

This is not only a dilemma for the employing organisation, but is also a problem for addictions professionals who are reluctant to 'I assume the responsibility of making a judgment in such an unpredictable, yet significant matter',<sup>222</sup> especially considering such a judgment relies, at least in part, on self-report data.

In response referring organisations requesting an assessment of an employee's fitness for duty, the staff at Bellwood developed a process and reporting format which was able to meet those needs. Reports contain:

1. a clearly formulated referral question with essential background information which would be provided by the referring company
2. a statement indicating that the assessment is based, to a considerable degree, on the client's self-report
3. an outline of the components upon which the assessment is based
4. recommendations that are in essence an expert's opinion based on this material.

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<sup>221</sup> Levinson, 2002, p. 7

<sup>222</sup> Levinson, 2002, p. 5

A lawyer also developed two additional documents which further clarified the services offered:

1. a company contract that outlines the nature of the relationship between the employer requesting the safety-sensitive assessment and Bellwood
2. an employee-consent form that details the purpose and nature of the assessment and the employee's relationship with Bellwood.

The retainer agreement states expressly that the employer holds harmless the Director and their delegate, along with the staff of Bellwood, from any and all liabilities and damages, however caused, except by malpractice, negligence, or wilful misconduct. The consent and waiver of liability lists the persons to whom the information will be released.

The assessment can vary according to the circumstances of the case, but usually includes:

- a standardised format for an extensive psychosocial history
- a detailed evaluation of all mood-altering substances used by the individual (past and present)
- the substance-abuse subtle screening inventory.

Psychological testing may also be undertaken, and if considered necessary, a psychiatric consultation. Where necessary and available, and with the employee's written consent, collateral information from family may be included. A full medical examination is undertaken. The final report will indicate either:

- no evidence of an alcohol or drug problem
- evidence of some alcohol / drug abuse
- alcohol / drug dependency

The report will recommend accordingly:

- no further action needed
- education program needed
- treatment required.

If there is no evidence of a substance-use problem, the employee is cleared to return to normal duties. If preventive education has been recommended, the employee resumes safety-sensitive duties once the program has been completed, although in this case, the company is advised to monitor the employee for a set time.

Where treatment is recommended and completed, declaring someone fit for return to safety sensitive duties is a little more problematic. Based on their own follow-up data and research – which indicates that relapse occurs most frequently in the first three months, less frequently by six months, and that a year's sobriety is a significant indicator of ongoing recovery – Bellwood has taken the following position.

A client who has successfully completed the Bellwood intensive phase of treatment (21-80 days), who is regularly attending aftercare, and is actively involved in a 12-step program, may be cleared for return-to-safety-sensitive duties three months into aftercare. The client

will be required to undergo random urine testing for at least a year, and will be closely monitored in the workplace.

Where Bellwood has not conducted the initial assessment and treatment, they will not recommend a client for return-to-safety-sensitive duties until they are 12 months into aftercare, with no evidence of relapse.

Workplaces such as police and emergency services need to consider a process similar to Bellwood's to determine the conditions under which an employee is determined fit for return-to-safety-sensitive duties after treatment.

## ***United States***

### Law-enforcement and emergency services

#### **National**

#### **Federal Bureau of Investigation (FBI), Department of Justice**

During two visits to the US I consulted FBI representatives in Washington DC, Denver, New York, Chicago, Milwaukee, San Francisco and Los Angeles. I met with the unit chief and staff of the Employee Assistance Unit in Washington, the program manager of the EAP and lecturer in Addictions at the FBI Academy in Quantico, and the drug program (drug testing) administrator. In the other jurisdictions I met with EAP coordinators, specialist psychologists (some of who specialised in CISM), and in some instances, Health Services coordinators.

Initial discussions during the first round of consultations focused on the genesis of drug testing within the FBI, and the gradual development of accompanying support services. During the second round of consultations, the emphasis was on providing support services, and managing critical incidents (see p. 53 for details of FBI CISM). The following section relates to support services.

One strategy the FBI uses for the early identification of problems, including substance-use problems, is fitness-for-duty testing. Fitness-for-duty testing includes drug testing and some psychological screening. The Health Care Programs Unit usually decides if a person is a candidate for fitness-for-duty testing. If a 'mild' problem is identified, the agent is referred to the EAP, which will recommend a response and provide clearance for return to work.

The FBI currently has physical fitness testing, as opposed to fitness-for-duty testing, operated by the Health Services area. Physical fitness testing does not include psychological testing, although this is included in testing by some police departments in the US. If psychological testing were to be included, it could include screening for substance-use problems. Such tests would have to be administered and interpreted by an expert.

Physicals were previously conducted on a yearly basis, but this has more recently been stretched out to about every eighteen months, due to financial constraints. Blood and urine taken during a physical are not normally used for drug testing, but could be.

It should be noted that the EAP can also order drug testing separate to that organised through the Drug Deterrence Program. EAP-initiated drug tests are managed through an external agency.

#### ***FBI Employee Assistance Program***

Originally, the FBI provided an alcohol program, which catered for those identified as having an alcohol problem. By the time someone was identified as having a problem, it

was usually substantial, and the person would be referred to treatment, which historically has been residential treatment. The alcohol program gradually evolved into the more comprehensive EAP.

Federal Personnel Manual System Letter 792-14, (1988), sets out considerations regarding employee counselling services and programs, and includes references to authority, relationship to work performance, voluntarism, personal privacy and confidentiality, communication and training, and relationship with labour organisations. This latter inclusion is important as it stipulates the need to consult with the relevant unions.

The FBI EAP fulfils the usual support, referral and educational roles. In regards to information and training, EAP staff provide drug-education sessions on:

- types and effects of drugs
- symptoms of illegal drug use and effects on performance and conduct
- the relationship of the EAP to the drug-testing program
- confidentiality and other relevant treatment and rehabilitation.

The EAP also provides training for managers and supervisors to help them identify and manage alcohol and drug use by employees.

Of particular interest is the fact that most EAP personnel are agents who perform either full- or part-time EAP functions. Those agents receive about 32 hour's in-service training relevant to their EAP role per year, including an annual training conference at the FBI Academy. Some agents who have chosen to remain in the EAP area have opted for additional training, often at their own expense and in their own time. The role of these agents is to provide peer-based EAP services. They can interview and refer but are not meant to provide ongoing counselling. There are advantages and disadvantages to agents fulfilling this role.

It was suggested by the Los Angeles coordinator that a key role for any EAP coordinator was to inform management of emerging concerns and trends, and to lobby for optimal services. For this reason it was felt that EAP services had to be on site and have a positive, proactive and high-profile role.

The roles of the coordinator in the New York office are contribution to policy and procedures development, initial assessment and referral, short-term counselling, support, monitoring and follow-up. The coordinator also trains and informs staff, conducts an Alanon and a single-working-parents group. St Andrews (across the road) runs an AA group. The EAP coordinator maintains close links with the chaplaincy services, which also manage a bereavement group.

The New York field office covers four divisions and oversees 2000 employees, 1200 agents and 800 staff. The field office has a full-time EAP coordinator and five part-time field officers (agents with collateral duties). The coordinator of the New York office is a non-sworn member with post-graduate counselling qualifications. All part-time field officers also have counselling qualifications.

Because it is a smaller jurisdiction, the Milwaukee FBI EAP coordinator is an agent and only works part-time on collateral duties. There are also four part-time counsellors, three with psychology degrees. The coordinator explained that EAP positions in Milwaukee are

voluntary positions and are usually filled by agents with relevant qualifications and/or experience. In discussing relevant experience the coordinator gave the example of an agent who had been involved in a shooting incident, and may be called on in that capacity.

EAP personnel attend at least one week's training which includes:

- how to counsel someone who has gone through a shooting or a scare from a mass-disease threat (such as anthrax)
- active listening skills
- death notification
- drug and alcohol awareness
- grief counselling
- suicide prevention
- financial problems
- networking and referring.

It was suggested that 10% or more of the EAP caseload is related to alcohol. Most cases do not self-refer but come to the attention of the EAP through adverse situations, 95% of which are driving under the influence (DUI). Denial is a significant part of alcohol dependence and it sometimes takes a DUI or similar incident to initiate counselling or treatment.

The EAP is not advised when an agent is notified by the Office of Professional Responsibility (OPR) that they are under investigation, but OPR is required by policy to suggest the employee seek assistance from the EAP. OPR is required to provide the employee under investigation with an EAP brochure that explains how EAP may assist them, and EAP confidentiality provisions.

Also, a supervisor may refer personnel who they have identified through diminished work performance. The LA coordinator suggested that it was easier and preferable for supervisors to refer staff with a perceived problem to the EAP than to struggle with the problem themselves. Supervisors who refer an employee to the EAP are better able to maintain distance. Too close an involvement in an employee's personal life can make it difficult for the supervisor to provide proper workplace supervision and direction, and may also result in the wrong advice. It is not the supervisor's responsibility to solve an employee's problem, but rather to ensure that person receives the assistance they need. This is an important point to stress in supervisor training. Supervisor training should enhance the capacity of supervisors to recognise there is a problem, and show them how to go about enlisting help from the EAP.

Personnel with an alcohol problem may be referred to treatment (in-patient or out-patient), counselling, and attendance at Alcoholics Anonymous (AA). They may also be subject to ongoing testing and monitoring, and have a contract with the EAP that will specify their treatment and return-to-work conditions. If an employee has self-referred to the EAP, their contact with the EAP may only be disclosed with the employee's consent.

Federal regulations (*Substance Abuse Counselling, 1993*) specifies the level of confidentiality afforded to an EAP and other counselling situations. Federal regulations specify when confidentiality does not apply, such as when there is a threat to national



security, a threat to self or others, or elder or child abuse. Because some EAP staff are not fully accredited counsellors, they cannot legally guarantee full confidentiality. Most EAP staff overcome this by keeping minimal, non-identifying written records.

In regards to medical costs, the Federal Employees Health Benefit (80% paid by the employer) substantially covers FBI employees for some treatment and counselling. The range of doctors and services that employees can access is limited by the service provider they have selected, as is the number of times a person can access those services. FBI employees have the option of selecting their federal health care provider from about 40 carriers, depending on where they live. Counselling and treatment services are limited to whatever carrier they select, which means that some employees will have more extensive benefits than others. If an employee's benefits are limited, EAP will try to develop alternative referrals at negotiable rates.

In regards to preferred services, most EAP coordinators maintain their own lists of preferred suppliers. The EAP coordinator in New York works from a personally developed computer-list of services known to be experienced with law-enforcement personnel. The list includes information on which health funds it accepts, and whether that service takes emergency cases.

The EAP can consult with Health Services if an agent requires access to medical services. In some areas Health Services have a psychiatrist on retainer who is available 24 hours a day, and who can help access services, and who can provide advice on related matters, such as the effects of different medications.

To help locate suitable services, EAP has an 1800 number they can call to discuss a particular case and obtain details of services in any geographical area. The 1800 service does a follow-up call to check if a referral has been successful. There is also an associated website. The FBI pays for this service, which is confidential and available nationwide. As mentioned previously, some coordinators also keep their own file of service providers and details of a facility's health-fund limits.

Previously, anyone with an alcohol-related problem, or identified through an alcohol-related incident, would usually have been referred to a residential alcohol program. Nowadays, there are fewer referrals to in-patient treatment, other than for emergency detoxification. This is partly due to increasing medical costs, and partly in response to the more recent research that supports out-patient treatment over residential treatment. During these consultations, EAP staff hotly debated the benefits of in-patient and out-patient treatment, but agreed that it probably comes down to what is best for each individual.

Although alcohol misuse is largely seen as a health problem, particularly if use has not come to light as a result of an incident such as drunk driving, illicit drug use is seen as a discipline problem and treated accordingly. An initial positive result for an alcohol test would most likely result in a referral to EAP for an assessment, but no disciplinary action. An employee arrested for a second incident in which alcohol was a contributing factor is by policy recommended for dismissal, unless there are mitigating circumstances recommending otherwise. In regards to appeals, the Inspection Division and Discipline Review Board hear appeals against a discipline decision.

### *Barriers to support services*

- cultural – similar to most law-enforcement organisations, the FBI has a culture of exclusivity and mistrust of 'outsiders'; this is exacerbated by a reluctance to be seen as weak or asking for help; added to this is a high benchmark for 'normal' alcohol consumption and a reluctance to deal with personnel who have a perceived alcohol problem; hence it is difficult to educate agents to encourage a fellow worker to access the EAP; these problems are only partly overcome by information sessions which outline EAP services, and which stress the confidential nature of service provision
- management support for and understanding EAP – this can be boosted by information and training
- difficulties in providing support services to isolated agents – these can be partly overcome by recalling agents when necessary; a more proactive approach would be to include comprehensive screening for drug and alcohol misuse during physicals and before placement; isolated agents may need access to specialised information and support
- the reluctance of non-health professionals, that is, FBI management, to embrace new therapies was also suggested as a potential barrier to implementing cutting-edge therapies
- conflict between members over types of responses to drug and alcohol misuse could also hinder best-practice treatments. This is exemplified in the counselling area, where differing views on critical-incident debriefing and cumulative stress abound.

The EAP coordinator in Milwaukee suggested that a barrier to personnel accessing the EAP was gossip. She suggested that in smaller workplaces it was more difficult, but not impossible, to keep such information private. However, if the agent had a significant problem with substance use, it would probably already be known.

#### *Critical factors for providing support services*

- solid policy, solid procedures – comprehensive and legally exact policy and practices overcome the risk of litigation and contribute to ready acceptance of the policy among employees
- training and information – recruit training at the FBI Academy includes information on the health and other impacts of drug and alcohol misuse, and is based on real-world workplace scenarios; middle management and supervisors are trained to recognise employees at risk, and how to ensure intervention
- ensuring that the drug and alcohol policy resides with a health/support area, not ethical standards/discipline

In reference to the positioning of the policy, the balance of ownership of a drug and alcohol policy may depend on the substance. Although alcohol misuse is dealt with in the context of a disease model, and treatment and support are seen as a necessary and positive workplace function, deliberate misuse of a licit drug would be seen more from the perspective of discipline. Unless the alcohol misuse comes to light in the context of an alcohol-related incident, such as drunk driving, it is treated as a medical problem.

Even if an alcohol-related incident requires discipline, all efforts are made to involve the EAP in the offer of treatment and counselling. It is not unusual for discipline and EAP to run parallel, and in some instances, undergoing EAP-recommended treatment might be taken into account in determining discipline.

Placement of policy and programs can depend on how an organisation wants its drug and alcohol policy to be perceived. If the policy is punitive, it may be placed in the investigations/discipline area. If, however, the organisation's policy is aimed at promoting a healthy lifestyle and supportive workplace, the policy will be more likely to reside in the human resources/healthy lifestyles area. Having the policy managed by the right section of the organisation may go a long way towards the policy being accepted by employees.

The Milwaukee coordinator cited visible, active support from management as critical for drug and alcohol policy and support services. She also suggested flexibility and communication of the policy as key factors in its acceptance. Although all those who were consulted agreed that it was important to make sure all staff were aware of the policy and its ramifications, there was some debate over whether the policy should be flexible and take a case-by-case approach.

The New York coordinator suggested that the exact links between mental health problems and substance misuse have yet to be determined, but those links are often present and need to be further explored, particularly in the context of work-related stress. She suggested that mental health check-ups should be conducted alongside physical fitness tests, and that there was a particular need for the early identification of depression. It was suggested that blood samples routinely taken in the context of physicals could be used to identify high alcohol use.

Law-enforcement officers are prone to self-medicate with alcohol, rather than seek professional help.

As well as the lack of awareness at all levels of the links between mental health and substance misuse, the New York EAP coordinator suggested that the main barrier to high-quality service delivery in the EAP area was the lack of trained, experienced staff. Staff need to be available all hours of the day, and although usual caseloads may be manageable, it becomes more difficult to cope during a large crisis, such as the TWA crash and September 11. The ongoing impact of such incidents on drug and alcohol use

for those involved is not yet known. Law-enforcement officers are prone to self-medicate with alcohol, rather than seek professional help, which is one of the arguments put forward for compulsory critical-incident debriefing.

There was also some debate regarding the necessity for an exclusive in-house AA. One of the coordinators did not believe that internal AA was necessary and suggested that, if they did not wish to identify themselves as FBI at an external meeting, they did not have to.

A major point to emerge from discussions with the EAP coordinator was the duty of care that the FBI as an employer owes to its members. The organisation has a duty of care to those identified with any medical problem regardless of whether the problem was specifically due to work. Even if an employee is to be terminated for their substance misuse, they will require EAP support before termination. This should stem partly from the culture of law enforcement to look after their agents, and partly because it is proper not to release someone who is identified (especially in the media) as an (ex-) agent with unresolved and potentially dangerous problems.

The FBI policy and procedures are continually being re-examined by its own EAP service providers to improve delivery and ensure that quality is consistent with current acceptable practices offered in the private sector and sanctioned by research.

If agents had one main area of concern it was the organisation's ability to ensure high-quality services in all cases. While EAP staff were totally dedicated and professional, the sheer volume of work was sometimes felt to be overwhelming. Whatever system an organisation puts in place, they need to ensure that they are watching out for and properly resourcing personnel who are responsible for the wellbeing of all staff.

## Washington

### **Metropolitan Police Department (Washington) Employee Assistance Program**

While in Washington during the first round of consultations, I met with the Clinical Director and administrator of the Metropolitan Police Department (MPD) EAP. The program is a model for other jurisdictions and provides an excellent level and range of services. Although the program provides the usual EAP services, it differs from most EAPs in that it provides long-term services.

Services provided include individual and family therapy, group therapy, alcoholism-prevention and relapse groups, and critical-incident debriefing. There is an average of two police-involved shootings per week in this jurisdiction, and EAP staff are on call 24 hours a day. The program comprises training such as recruit training, training about stress and substance use, and training for peer counsellors and supervisors.

One of the features of the program is that it takes a joint union-management approach. The Director does not work for MPD or the City, but for the Fraternal Order of Police Labor Committee. The Director maintains that this ensures confidentiality. The program is run out of a single-purpose building that is not associated with the department and is available exclusively to police. This also increases a sense of anonymity for officers.

The program enjoys a 24% utilisation rate, which is exceptionally high when compared with government-provided services, which are said to fluctuate at around 1-3%. Seven per cent of the services used are for alcohol-related problems. The Director suggested that a significant number of those officers accessing the program for stress-related disorders (23%) would also have substance-use problems.

The Director has adopted the term *police trauma syndrome* to describe the cluster of symptoms many police officers suffer as a result of their work. One characteristic of policing is its unpredictability and potential for violence, leading to a constant state of hyperawareness. High public scrutiny, media misrepresentation, the threat of civil-law suits, administrative censure, and the use of deadly force also contribute to high levels of stress for police. Chronic, long-term and cumulative stress take their toll on police, who may resort to negative and self-destructive coping mechanisms, such as substance misuse.

The Director says the success of the program is due at least in part to the staff, who are all fully qualified, but also have extensive experience with police. She strongly advocates outsourcing EAP services.

## **New York**

### **New York Police Department**

The New York Police Department (NYPD) has approximately 55 000 employees, 40 000 sworn members and 15 000 non-sworn staff.

While in New York during first round consultations, I met with personnel from the NYPD, including the Director of Employment Relations, personnel from the Medical Division, and a representative and counsellor from the Sergeant's Benevolent Association.

#### *Employee assistance programs*

New York City Police have a range of support services they can access for members with substance-use problems, including the services of the Psychological Services Section, the Family Counselling Program, and the Membership Assistance Program (MAP). The Psychological Services Section provides candidate testing and clinical services as a free walk-in service. The New York Central Employee Assistance Program Referral Unit also provides free and confidential referrals to professional help.

#### *Membership Assistance Program (MAP)*

MAP is a union-sponsored volunteer support program that was created by the Patrolman's Benevolent Association in 1995 after 21 police suicides in just two years. MAP was designed to overcome concerns regarding confidentiality in the police-run program, and to encourage police to enter alcohol-counselling programs voluntarily. The program is not open to police who have legal or departmental action against them.

MAP is supported by the department, but is completely independent, and works strictly on a self-referral basis. MAP operates an 1800 number, 24 hours a day, 7 days a week, 365 days a year. One hundred and seventy peer-support officers, who have been screened and trained for the job, and a psychologist staff the phone service. While not a counselling program as such, the program puts officers in touch with counsellors and rehabilitation options. During 1998, after three years of operation, MAP received more than 1000 calls. Approximately 10% were related to alcohol.

#### *NYPD alcohol program*

The NYPD has been operating an alcohol program for over 30 years. The program is run off-site and is strictly confidential. Most officers enter the alcohol program after an incident has occurred, or through the intervention of a supervisor. If NYPD are called to an officer's home because of domestic violence, or an officer is found to be driving under the influence, they have to notify their supervisor, who can refer them to the alcohol program. Officers may also be referred if they arrive for their shift intoxicated, smell of alcohol, or take an unusual amount of unexplained sick leave. Officers referred in this way may be subject to mandatory treatment. Officers can also self-refer, although this is less frequent. If an officer self-refers, treatment cannot be mandated.

If detoxification is required, the case is treated as a medical emergency and the officer is immediately hospitalised, usually for three to five days. NYPD have about a dozen facilities that they can refer officers to, but usually use about five or six. The officer then attends rehabilitation for 21-28 days. Their supervisor approves sick leave, which is

virtually unlimited, although an officer is usually expected to return to work within about four months.

When an officer returns to work, they are on a signed contract to attend aftercare monitoring for 90 days. The contract enables the counselling unit to discuss the officer's case with their therapist. They may have to attend AA, usually five times a week. Officers can access a police-only AA group, and there is also a group for women only. The relapse group is a mixed sworn/non-sworn group. In theory, clients are meant to be monitored on return to work, and if necessary, can be referred again to treatment. There is a 'three strikes and you're out' policy, but this is flexible. After 90 days, the officer has to see the chief surgeon for clearance. There may be between 300 and 400 police on a rehabilitation contract at anyone time.

While the alcohol policy allows for some flexibility, there is less tolerance of illicit drug use. There is, however, some flexibility in the case of prescription-drug misuse, where the response depends on the circumstances, and the degree of deliberate misuse, such as doctor shopping.

Another feature of the NYPD policy is the pivotal role of the unions. While the unions may not have played a substantial role in the drafting (no-one I spoke to could remember their exact role), they do have to be consulted if changes to the policy are suggested. The point was made that managers and officers attend separate treatment services.

### **Suffolk County Police Department**

While visiting Suffolk County Police Department (SCPD) during first-round consultations, I met with the commanding officer of the Employee Assistance Bureau, the senior psychologist/social worker, the commanding officer of the Medical Evaluation Unit, and the executive officer of Internal Affairs.

SCPD has about 2700 sworn staff, and 1200 non-sworn staff. It is a very well resourced department. SCPD screen recruits, have random and targeted testing (based on reasonable suspicion) for alcohol and illicit drugs. Their policy applies to police, but not to non-sworn staff. Sworn and non-sworn staff have different contracts.

The role of the union in this example is interesting in that the EAP process needs union support to function effectively, and at this stage the union does not support the internally run EAP. The union instead runs its own service, supplying two psychologists. There are a number of unions with a mandate for SCPD, including the Patrol's Beneficiary Association, Superior Officer's Association, and the Association of Municipal Employees.

SCPD make an interesting distinction between work-related and non-work-related illness, which affects the level of support and access to services offered as well as conditions for returning to work. There are two categories of illness/injury – 301 and 401. Category 301 is for illness/injury that is not work related, and does not allow for access to limited duties. Category 401 is for work-related illness/injury, and can allow for return to limited duties. Alcohol and other drug problems are not normally considered work related.

SCPD does not conduct routine physicals. If a problem is identified, the employee may be referred to a psychologist. If an employee takes too many unexplained sick days they may

be referred to Internal Affairs, which will in turn refer them to Health Services for assessment.

A first-line supervisor may relieve an employee of duty if they suspect the employee to be impaired by alcohol, and will inform the Internal Affairs Bureau of their decision. The officer will then be drug tested. Any employee can be drug tested at the instigation of a superior officer, but this must be based on impaired work performance. The standard for determining fitness for duty is the same standard used to determine whether a motorist is impaired under Article 31 of the New York State Vehicle and Traffic Law.

Another subject that was discussed was the stigma attached to having to disclose certain psychotropic medications, such as Valium or serotonin drugs, before undertaking a drug test. This subject was raised as a matter of concern in a number of jurisdictions, and indicates that most workplaces do not have a good understanding of the nature and extent of prescription and over-the-counter drug use, and are not necessarily sympathetic or accommodating when an employee is undergoing treatment for conditions which require certain prescription medications.

## **Milwaukee**

In Milwaukee on the first round of consultations I met with the FBI, Milwaukee Police Department (Personnel and Internal Affairs Division), and the Waukesha Police Department.

### **Milwaukee Police Department**

In relation to alcohol, members are required to submit to an alcohol test whenever two or more supervisors observing the member have a reasonable suspicion that the member is in violation of Rule 2/090 (Rules and Procedures Manual) pertaining to on-duty consumption, and Rule 2/095 pertaining to being intoxicated on or off duty. Positive tests constitute grounds for discipline, which may include discharge. A member's refusal to submit to a test is also grounds for discipline. While second chances may apply for an alcohol-related positive test, progressive discipline applies, and repeat offences may result in dismissal.

The policy does not include a section on pharmaceutical misuse, and members are not asked to disclose medications they are currently taking.

In relation to support services, there is a Police Officers Support Team comprising sworn and non-sworn members. This peer-based support program operates 24 hours a day. However, there were two significant problems identified with this service: lack of adequate training for members, and lack of privilege (confidentiality). The department also operates an EAP, which functions in the usual manner. This is an example of a smaller policing organisation with more limited access to support services than larger policing organisations.

### **Waukesha Police Department**

During discussions with the administrative division commander, it was suggested that the Waukesha City Alcohol and Other Drug Policy, which applies to all employees, was applied on a case-by-case basis, taking into consideration the substance used. In regards to alcohol, officers with ongoing alcohol problems are referred to counselling and treatment. Health insurance, paid for by the City, usually covers the cost of treatment. Officers can

take unlimited sick leave (though usually not more than one year) at the discretion of the Chief of Police.

It is interesting to note that the relevant unions, who actively support the policy, initially negotiated the benefits covered. It is also interesting to note that the EAP that was previously funded under the City insurance scheme has been discontinued through lack of use. However, for critical-incident debriefing the City provides access to a psychologist who specialises in policing.

To ensure that all officers are familiar with the terms of the policy, the policy is discussed with police and staff, who have to sign-off that they have read and understood it, and were provided the opportunity to ask questions regarding the content and meaning. Sergeants are obliged to go over General Orders during the shift briefing whenever the policy is updated or amended. Knowledge and understanding of the policy's rationale were seen as critical for ensuring the acceptance of the policy.

No barriers were identified during my discussions on the policy, and it was suggested that the benefits of the policy were recognised, and fully supported by the unions.

## **Chicago**

While in Chicago on the first round of consultations I met with the FBI, the Chicago Police Department (CPD), and the Director and staff from St Michael's House (a law-enforcement treatment facility).

### **Chicago Police Department**

It is the policy of the department to support members experiencing personal problems which may be affecting their work performance and offer them the counselling resources currently available through the Department.<sup>223</sup>

The Chicago Police Department (CPD) has approximately 13 000 members. Their drug and alcohol policy applies to sworn and non-sworn members. If an officer is suspected of being intoxicated on duty, or if a complaint of intoxicated behaviour has been lodged, the officer must be breathalysed.

CPD does not routinely conduct physicals, but fitness-for-duty testing includes drug testing. Fitness-for-duty testing, which includes physical and psychological testing, is seen as an excellent opportunity for early intervention if a problem is detected. Psychological testing assesses for clinical depression. Seventy-five per cent of those identified as clinically depressed are pronounced fit for duty within the first two remedial sessions.

The Random Drug Testing Unit in Personnel assists in the development of drug-education and prevention programs.

### *Behavioural Intervention System (BIS) and Personal Concerns Program (PCP)*

These programs entail a systematic review of a department member's pattern of behaviour so that supervisors can be alerted to the need for possible intervention. They are not

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<sup>223</sup> General Order 97-10



discipline processes, but more early-warning systems. Behavioural- intervention indicators are a descriptive listing of events that are used to identify a member as a potential candidate for inclusion in the BIS. An individual performance plan is developed for identified officers and includes specific goals to correct the problematic behaviour or problem with performance.

### *Professional Counselling Service's Employee Assistance Program*

There is an Alcohol Assistance Unit situated within the Professional Counselling Service. Street officers who fulfil an EAP-type function work in the Unit. Members can self-refer, although this is not usual. First-time alcohol offenders are referred to the Unit. If an officer's alcohol use is assumed to be problematic, but work is not impaired, treatment cannot be mandated.

Second or subsequent referrals result in fit-for-duty testing, which becomes an administrative/discipline response as opposed to a health-driven/support response. The standard for a positive alcohol test is .08. This standard also applies off duty.

A supervisor can order referral to the EAP and can ascertain if the officer has turned up (that is, obeyed an order), but the supervisor cannot obtain details of treatment. The EAP runs a Professional Counselling Service and employs psychologists and licensed counsellors, including recovering alcoholics and ex-sworn police. Usual confidentiality safeguards as mandated by federal and state legislation apply. The EAP is located away from headquarters, in the Bureau of Staff Services. Services are provided case by case and are free of charge. Referral to treatment is not automatic. There is, however, mandated and automatic referral to counselling after a traumatic incident, such as a shooting.

Officers and their families can also access St Michael's House (see section on treatment service providers), which is union supported.

The officers to whom I spoke felt that a gradual change in culture now made it difficult to cover-up unacceptable drinking patterns that may have existed in the past. This is a comment I heard frequently: 'It's not as bad as it used to be.' During the discussion on culture change it was pointed out that older, more experienced police tended to be allocated the more desirable shifts, leaving the younger, newer police on the less desirable shifts. This meant that police of similar age and experience tended to work together, and there was less mentoring and transferring of skills and culture than in previous years.

There were no significant barriers identified for providing support services. It was suggested that officers sign-off that they have read and understood the policy, and have had the opportunity to ask any questions. It was considered important that the policy arose from the perspectives of the workplace and public safety, rather than the perspectives of detection and discipline. As mentioned previously, this is why it is so important that a department's drug and alcohol policy and programs are seen to emanate from the human services area rather than ethical standards or discipline area.

## **Los Angeles**

In Los Angeles during first-round consultations, I met with the FBI, the Los Angeles Fire Department EAP, the Los Angeles Police Department Employee Assistance Unit, and the Los Angeles County Sheriff's Department EAP. During my second round consultations I

revisited the FBI, particularly in relation to CISM (see p. 53), and the Los Angeles Fire Department. The profile of the Los Angeles Fire Department includes additional material from the second consultation round.

## **Los Angeles Police Department**

Los Angeles Police Department (LAPD) have about 9000 sworn members and 3000 non-sworn members. LAPD Employee Assistance Unit (EAU) is an internal department within the Behavioural Science Services that provides:

- chemical-dependency counselling
- assistance in arranging funerals
- family support
- management of the Peer Support Program
- Department Honour Guard
- an HIV Coordinator.

The Chemical Dependency Rehabilitation Team provides information, education, counselling, assessment, placement, and support. Members can self-refer, be referred by a family member or friend, be referred by a supervisor, or be referred as a result of a discipline action.

As City employees, LAPD members can also access counselling and treatment through the external EAP operated by the Managed Health Network Corporation.

The LAPD funds positions within the EAU, but does not provide funds for training and resources. The union financially supports the EAU on a case-by-case basis, but does not provide ongoing running costs, and the service considers itself substantially under funded.

If an alcohol-related incident such as drink driving occurs, the officer may be referred to the EAU. The department's discipline process may impose 20 days off without pay for DUI, in addition to any court-imposed penalty. Although they may reduce their penalty by voluntarily accessing EAU services, 20% will opt simply to take the days. If an officer does self-refer to EAU, they have to meet with a psychologist and the substance misuse counsellor, who will determine the most suitable referral. They may have to attend up to five AA meetings a week (three peace officer's meetings, and two other). They also have to submit to random breath testing once a month, administered by their supervisor. If treatment is deemed necessary, it will be mandatory. The officer will be on the program for one year and will report back to the EAU once a month. If they are disciplined a second time for an alcohol-related incident, the officer may be terminated.

Addiction to prescription drugs or painkillers is treated much the same as for alcohol.

The department does not place a limit on the number of times an officer can access the EAD for assistance for alcohol-related problems, but the officer may find limits imposed by their health insurer. A health insurer may only payout for 30 days treatment per year, and may only cover two episodes in a lifetime. The department provides 12 days paid sick leave per year, and an officer can accumulate up to 100 days. If an officer has no leave owing, the department will usually allow leave without pay.

Referrals to the EAD may be self-referral, incident driven, or referral by supervisor. Personnel at EAD suggested that there may be reluctance by supervisors to report alcohol-related concerns, especially if misuse is predominantly off duty. A supervisor would require strong 'reasonable cause' to place an officer on the breathalyser. (The FBI, on the other hand, may discipline a supervisor who was aware of an agent's suspected alcohol misuse and did not report it.)

LAPD used to conduct physicals every three years for officers up to 40 years of age, then every year for those over 40, but these have been suspended due to costs. Physicals previously afforded a good opportunity for early identification and remediation of an alcohol-related problem.

#### *Barriers to effective service delivery*

- lack of sustained adequate funding – this particularly affects access to physical resources, such as mobile phones and cars, and training
- difficulty in attracting and holding high-level staff – there is currently a low cut-off rank level for officers seconded to the EAD; staff mobility also hinders consistency of service delivery

These barriers are overcome at least in part by the commitment of staff.

### **Los Angeles County Sheriff's Department**

An average of one department member per month is arrested for driving under the influence of an alcoholic beverage. Drunk-in-public arrests are up, as well as alcohol-related domestic-violence incidents. In an average year there are more than 20 departmental alcohol-related incidents resulting in discharge and/or discipline.<sup>224</sup>

The Los Angeles County Sheriff's Department (LASD) employs about 14 000 staff, 10 000 sworn and 4000 non-sworn.

The LASD EAP was set up to respond to alcohol-related problems, but has since expanded to provide an Addictions Control Program that covers other addictions, such as gambling, and addiction to painkillers and prescription drugs. The EAP may refer an officer to a psychologist, or to the department's alcohol program coordinator.

Policy and support programs are promoted to recruits and supervisors during training, and the service also conducts outreach to families and retired members.

If an officer is involved in an alcohol-related incident, their captain can order a breath test. Alcohol-related incidents, such as driving under the influence, are handled by Internal Affairs. Officers who are convicted by the court may be put on 15 days leave without pay. If an officer attends the EAP, their captain may hold 10 days pay in abeyance. If an officer is convicted of felony drink driving they will be terminated. If the courts do not convict an officer, the officer may still be charged by the department with conduct unbecoming. If an employee self-reports before an incident, they are covered under the federal *American Disabilities Act* and cannot necessarily be terminated.

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<sup>224</sup> LA County Sheriff's Department, EAP brochure

EAP will assess the officer's drinking behaviour and determine if the officer is eligible for a contract. Standard contracts are for one year, although contracts for up to five years have been implemented. Not all contracts compel AA attendance. Compliance with the contract is monitored. If a contract is broken the employee can be terminated, but this is not usual. More often, the 10 days pay being held will be reinstated.

LASD also operates a Peer Support Program with 250 members coordinated and trained through the Employee Support Services Branch. Their impact on a reduction in officer's alcohol use is not known.

LASD do not conduct physicals. This is partly due to financial considerations and partly due to the influence of the unions.

No barriers to successful policy or service delivery were identified during discussions on drug and alcohol policy, other than a reluctance of supervisors or peers to identify or deal with an officer who seems to have an alcohol problem. This is one of the reasons that a well-run and promoted EAP is important; it can take the onus off the supervisors to manage the problem themselves.

Critical factors included:

- use of (qualified) sworn or ex-sworn staff to provide support services
- gender-specific services where possible, although this is not critical
- guaranteed confidentiality
- union support.

In regards to union support, there are four relevant unions for the LASD, and a memorandum of understanding between the unions and management was signed to support the EAP. There is also a Police Officers Bill of Rights in California, which promotes access to support.

## **Los Angeles Fire Department**

The Los Angeles Fire Department (LAFD) employs about 3600 members. A memorandum of understanding between management and the union, whereby a .25% pay cut was negotiated to fund the service, established its EAP. The first Director was a recovering alcoholic, and all Directors since have come from the ranks – I all badge-carrying firefighters'. This was seen to be an important factor in establishing the unit's credibility with firefighters. The current Director has over ten years' counselling experience, and Masters-level qualifications. Volunteers with the minimum qualification of Certified Alcohol Counsellor (CAC) staff the service.

Over the years, the EAP has evolved from an alcohol-focused support service to encompassing illicit and prescription-drug misuse. The EAP provides initial assessment and counselling, and then refers employees to further assessment, counselling or treatment if needed. Before an officer undergoing treatment or rehabilitation is granted return-to-work clearance, they must meet with the EAP every week. On return to work, they are subject to ongoing monitoring, compulsory attendance at recovery meetings and random testing.

The department also provides drug and alcohol information sessions to firefighters at their own stations. Combining these two roles provides an excellent opportunity for the EAP to promote its services.

It was suggested that firefighters, similar to police, may 'compare out' and did not consider high levels of alcohol use problematic. Firefighting is a predominantly male occupation where camaraderie is high. Also similar to police, firefighters are engaged in high-stress situations, with a need for 24-hour readiness.

It was stressed that it is important for those who provide medical services (counselling, treatment, ongoing monitoring) to be fully aware of the culture of the organisation. However, it was also stressed that there was a need to dispel the myth among police and firefighters that they are in some way special or unique. It was felt that police and firefighters should not be led to believe that they need separate rules, special services, or special treatment.

In line with this belief, it was noted that groups that are homogenous are only effective in the short term, and are in fact counterproductive in the longer term. For this reason, LA firefighters do not operate an exclusive AA program.

The other significant point was the importance of confidentiality. The perception of confidentiality is strongest in a union-supported or managed EAP service.

#### *Update from second round consultation*

During my second visit to LAFD, I met with the assistant to the Director of the EAP. At that time a new alcohol and drug policy was in draft form and was undergoing negotiation between management and the union. The new policy favours a medical rather than a disciplinary approach. It was pointed out, however, that alcohol- or drug-dependant individuals need an incentive to enter and complete treatment. It was suggested that the most effective incentive for employees may be the threat of losing their jobs, and dependency problems need to be treated from a medical model, the inclusion of a discipline component may make way for accessing and completing treatment. Monitoring, in the form of compliance testing during treatment and on-the-job rehabilitation, attendance at AA meetings, and weekly meetings with EAP staff, are part of the EAP response.

By the time EAP staff are made aware of a dependency problem (usually through a positive alcohol test, or a DDI), more intensive treatment is usually required. Most clients at the initial assessment believe they only need to cut back on their alcohol consumption, and EAP staff have often found it necessary to involve family or partners to obtain a more accurate and comprehensive overview of the member's consumption patterns and associated behaviours. It was suggested that involvement of family members or significant others could be written into the treatment contract if appropriate, and treatment facilities and programs with a family component were preferred.

The recommended time for treatment is usually 90 days, after which time the client can undergo an evaluation for fitness to return to duty, based on an assessment by a addictions medical specialist, demonstrated behaviour change and compliance with the treatment contract. An officer should only return to duty when shown to be in recovery. LAFD's EAP

records indicate that their clientele achieve a 90% success rate with a 90-day treatment program and ongoing compliance monitoring.

EAP staff pointed out that many firefighters carry injuries, especially back injuries, and may be on pain medication over prolonged periods of time. Treatment for addiction to prescription drugs needs to be based in a hospital, either in- or out-patient, and must include monitoring and management of pain.

EAP staff suggested that high-quality treatment services are best identified through word-of-mouth recommendations, and on-site visits. EAP staff look for:

- a 12-step abstinence based program
- qualified staff
- low staff turnover
- a significant proportion (50%) of staff in recovery
- how well clients do (reasonable success rate)
- how closely the facility is willing to work with the referring body.

The EAP staff try to refer to a small group of providers who have established good rapport with firefighters, have a demonstrated track record of success, and can help provide outreach and ongoing AA links. By referring to a relatively small group of service providers, the chances of clients mixing with their own or similar professions during treatment are increased.

EAP staff did, however, endorse a model of joint police and emergency services personnel in some sort of support infrastructure. LAFD holds a recovery breakfast every few months to ensure members have easy access to fellow members with similar problems, as well as to mainstream support services.

Another topic covered during this consultation was relapse management. Because relapse is often a part of recovery, organisations need to have a relapse management strategy in place. As mentioned above, monitoring before and on return to duty is a significant part of the EAP role, and requires the input of an addictions specialist. If relapse occurs, an assessment will need to be made of the circumstances contributing to the relapse, and the member may have to go back through the recovery steps, including treatment if needed.

Another concern to the EAP service is the high rate of co-morbidity of depression and alcohol dependency. Their advice was to treat the chemical dependency first, while mindful of the need to tackle co-morbid mental health concerns as soon as practical. As well as treating diagnosed co-morbid conditions, it was suggested that staff need to be watchful for emerging co-morbidities, and to ensure one addiction is not swapped for another during the recovery phase.

## **San Francisco**

### **San Francisco Police Department**

While in San Francisco, meetings were held with the officer in charge of the Behavioural Science Unit and a counsellor from the Police Officers Stress Unit. I was also able to attend a police-only AA meeting.

San Francisco Police Department (SFPD) have General Orders, which outline the department's policy regarding alcohol and describes the procedures for reporting and investigating violations. General Orders are also in place that require a member to inform their supervisor if they have been prescribed or are taking medication which may impair their capacity to perform their usual duties.

Support services for SFPD are provided by the Behavioural Sciences Unit, which manages a peer-based Critical Incident Response Team (CIRT), an EAP, and the Peer Support Program which has about 300 members. The Unit also works closely with the police chaplains.

The Stress Unit – Chemical Dependency, within the Behavioural Sciences Unit, manages alcohol and drug services, including access to counselling and treatment, support services, AA, outreach and education and training. Access to the Stress Unit – Chemical Dependency is voluntary, and although managers may refer an officer to the unit, attendance cannot be mandated.

When an officer initially approaches the Unit, they are usually referred to the officer in charge of the Chemical Dependency Program. The Chemical Dependency Program is run by a police officer who is a recovering alcoholic with tertiary counselling qualifications. This blend of policing and first-hand experience with addictions, along with formal qualifications in the field, was promoted as an ideal model for anyone in such a role.

After an initial interview, the officer will usually be referred to an addictions specialist. The Unit accesses the services of a number of 'cop docs' – psychologists who go through a tender and selection process to work with police, and then undergo training to become familiar with police procedures, protocols, and less formally, police culture.

Previously SFPD provided an amnesty for officers self-reporting for any substance use problem. The amnesty provided free and confidential access to whatever services were needed, including 28 days residential treatment. The amnesty has since been withdrawn, and officers referred to residential treatment need to access their own health insurance.

Support is available for officers and family members seeking counselling through the SFPD health fund, United Behavioural Health (UBH), which provides eight free visits per year for out-patient professional counselling services. Members seeking referral to private 'cop docs' pay approximately \$20 co-payment. Referral to counselling is organised through the Behavioural Sciences Unit.

The main barriers to providing high-quality support services to police were funding and ongoing support from management. It was felt that the guarantee of access to fully funded private treatment would encourage officers to self-report.

### *Police-only AA*

The following was provided by attendees at a police-only AA meeting.

Key features of law-enforcement and emergency services workplaces are camaraderie and dependence on your co-workers in dangerous and stressful situations. In a work situation where your personal safety may depend on your team mates, there is a heightened sense of group cohesiveness.

Because of the nature of the work, which can include long hours and shift work, police often socialise outside work with their work colleagues, reinforcing a sense of shared experience (see also the sections on culture on pp. 22 and 23).

The police at this meeting suggested that they felt more comfortable speaking freely in a group of their peers and ex-peers than they would in a mixed group. They also referred to a unique brand of police and emergency services humour (gallows humour) which they feared could offend' outsiders.'

It was also suggested that having a cops-only AA was effective as an outreach strategy within the SFPD, and that it was easier to encourage someone to come along to a meeting where they would be among peers, rather than members of the general public.

It was for these and other similar reasons that they favoured a cops-only AA. This group met only twice a week, and most attendees also went to other AA meetings.

### *Critical Incident Response Team (CIRT)*

SFPD have General Orders (8.04) that establish the policies and procedures for supporting members of the department who are directly or indirectly involved in critical incidents.

The Behavioural Science Unit coordinates the CIRT program, which is comprised of peer-support members of various ranks and roles who have received additional training in critical-incident responses. The CIRT consists of eight teams of five members, who are voluntarily on-call 24 hours a day, 7 days a week.

Examples of incidents where CIRT may become involved include shootings, suicides, death of a child, or serious injury accidents. Members of CIRT attend critical-incident debriefs and are available to organise additional and follow-up support where needed. They provide practical support, such as contacting family members, replacing equipment, offering transport. They do not provide counselling, but can facilitate access to counselling.

## **Fort Worth**

### **Fort Worth Police Department**

While in Fort Worth I met with the Fort Worth Police Department Peer Support Program Coordinator, who is a sworn officer, and the City of Fort Worth EAP manager.

In addition to coming under the city of Fort Worth Alcohol Misuse and Drug Abuse Policy, Fort Worth Police Department (FWPD) has its own policy and procedures, based



on a peer-support program model. Officers and staff members can receive assistance from the internal (City) EAP, the external EAP (Alliance Work Partners), and the Peer Support Program. Alliance Work Partners provide six free counselling sessions with professional staff. If additional or ongoing counselling is indicated, officers and staff can also access the mental health benefit available to them under the City employees' health insurance plan.

The FWPD Peer Support Coordinator conducts an Alcohol Education Program, based on a similar program run by the US Navy. The program includes some participation by family members. The program adheres to the Texas Law Enforcement Educational Standard and follows an educationally sound curriculum. Alcohol misuse is covered in the section on stress management, as well as in a standalone module which includes, for example, the effects of alcohol.

The coordinator identified the following as critical to providing support to officers:

- selection and training of peer-support officers – officers need to undergo a thorough selection process; FWPD require written references from superiors and peers and only officers who are well respected by their peers are selected; peer support officers undergo a stringent selection process, training and monitoring to ensure high-quality services
- return to work – structures need to be in place to support officers' reintegration into the workplace; being able to continue their career in a supportive work environment can be critical to an officer's continuing sobriety
- confidentiality – officers need to be confident about the integrity of the information shared with the Peer Support Program; General Order 431.00 provides the protection and limitations on confidentiality; the Peer Support Program is located in a facility away from the main administrative building and all records of specific employee encounters are kept with the City EAP manager

It was pointed out that not all officers who are suspected of having an alcohol problem are alcohol dependant; however, all suspected cases must be dealt with to determine the severity or otherwise of the problem and to gauge workplace risk and safety concerns. Even if treatment is not indicated, episodes such as drink driving or bingeing require a brief intervention. The point was also made that the Peer Support Program is not an alternative to discipline: 'No member of the peer team may intervene in the disciplinary process: nor should any supervisor refer an employee for support in lieu of an appropriate disciplinary action'.<sup>225</sup>

FWPD also have a peer-based team who provide support and follow-up for critical incidents. It is acknowledged that a peer support person (PSP), sworn or non-sworn, is a specifically trained colleague, not a counsellor or therapist. When a critical incident such as a shooting occurs, a PSP assists the designated mental health professional in the debriefing process.

Critical-incident stress debriefings are not operational or tactical debriefings, and usually occur within 72 hours of an incident. Only those directly involved in the incident may attend the debriefing.

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<sup>225</sup> Standard Operating Procedure, Fort Worth Police Department

### *Post-incident activities*

Post-incident activities may occur immediately following an incident (short term) or at later dates as the problems related to the incident occur or reoccur (long term). Short-term activities include educational/informational briefings about stress from the incident, evaluation of the incident, CISM response and recommendations for improvement. Long-term activities include anniversary debriefings, informal crisis intervention, support by peer-support team members, outreach services, and evaluation of the CISM services.

An important post-incident activity involving follow-up with employees involved in a critical incident is the awareness of stress when the event creates enough mental trauma to be considered a workers' compensation issue. The Risk Management Department provides specific guidelines to supervisors and managers concerning workers' compensation issues related to critical incidents. The peer support will not involve itself in determining if these issues are present.<sup>226</sup>

### **City of Fort Worth Employee Assistance Program (police, firefighters and ambulance services)**

The City employs about 55 000 people, including about 1200 sworn police officers and 700 firefighters. Fort Worth Police Department and Fire Department come under the City of Fort Worth Alcohol Misuse and Drug Abuse Policy, which outlines the city's drug testing program. City employees are subject to a 'two strike' policy for alcohol and deliberate misuse use of prescription drugs. If an employee is legitimately taking a prescription medication and is unable to perform their normal duties safely, they may be subject to temporary reassignment or be required to take leave. They may also be referred to EAP to evaluate their ability to perform safety-sensitive tasks.

Employees may self-refer or be directed to the City EAP, where they undergo initial assessment. This assessment may include a review of sick leave to see if there is link to critical-incident stress. Under the City policy, if an employee is assessed as requiring counselling, treatment or rehabilitation, they are referred to a service and placed under formal case management. Once an employee has completed the recommended treatment, they may voluntarily commit to EAP monitoring. This was referred to as the equivalent of being under the protection of an amnesty.

The City of Fort Worth provides access to a voluntary Wellness Screening Program, which generates a profile that indicates individuals who are at risk, those who are contemplating change, and those who need to access help. There are monetary rewards or a day off for participants who have met targets set the previous year.

The City EAP, in partnership with FWPD are considering starting a police-only AA, although it could also incorporate emergency services (fire and ambulance) personnel based on a Dallas Police model.

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<sup>226</sup> Standard Operating Procedure, Fort Worth Police

During consultations, the Fort Worth EAP Manager considered the following points to be critical in providing support services:

- Promote safety and welfare rather than discipline.
- Provide support for rehabilitation and re-entry into the workplace after treatment.
- Foster a culture where it is OK to admit you have a problem and you are encouraged to seek help.
- Have supportive management.
- Foster a culture of taking care of officers.
- Promote discretion and confidentiality.
- Select suitable people to fulfil support roles.
- Expose and promote the program (value of personal outreach)
- Form realistic expectations
- Stress the importance of a supportive workplace culture – for example, do not serve alcohol during work hours at functions; remove alcohol from vending machines.

## Las Vegas

### Las Vegas Police Department

In Las Vegas I met with the manager of the Employee Assistance Program/Peer Support Unit. The unit was established in 1984, originally to support officers who had been involved in a shooting incident, after it was determined that three out of five officers who had been involved in a shooting would quit within one year of the event. There was an average of about 15 officers a year involved in such events.

Police officers are trained to handle everything ... everything except their own emotions.
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Since 1984 the unit has expanded to support officers involved in the full range of critical incidents, and to direct them to professional assessment, counselling and treatment. 'Police officers are trained to handle everything ... everything except their own emotions.'<sup>227</sup>

The unit is staffed by three sworn and one non-sworn member. Staff are not qualified counsellors, but are experienced in the issues that regularly confront police, and they have extensive knowledge of the support and treatment services that are effective with police. Unit staff are available 24 hours a day, seven days a week.

The Peer Support Unit is located away from the main police headquarters building to promote the notion of separation from management, and a high level of confidentiality. An officer may request a referral to a drug and alcohol treatment facility without necessarily disclosing the nature of their problem, although this is unusual. There has been an ongoing amnesty in place since 1984 for officers who self-refer. This is the result of a negotiated agreement between the union and management.

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<sup>227</sup> www.lvmpd.com, 15 April 2004

Once an officer who has self-referred returns to work after treatment, their ongoing liaison with the EAP is voluntary. The EAP does not monitor an officer's ongoing sobriety.

The manager stated that organisational responses to drug and alcohol problems varied, but that EAP responses did not. This was an interesting comment as it flagged a problem with inconsistency in the organisation's response, particularly in matters of discipline, which was seen as a potential disincentive for officers to self-refer.

Although the police department does not directly fund treatment, they do fund a health insurance scheme, which in turn covers the cost of most assessment, counselling and treatment services. Some officers supplement the department-funded health insurance with their own private health cover.

Prevention strategies include education to staff on alcohol use, while early intervention includes training for supervisors, and a peer-support program. The EAP unit has input into recruit training and presents on personal use of alcohol, and the link between stress and alcohol use.

In addition to responding to members with a suspected or identified alcohol or licit drug problem, the unit supports officers who have been involved in a critical incident. Participation in professional counselling is mandatory for officers who are directly involved in a shooting accident, but voluntary for other incidents. The EAP follows up with all officers involved in a critical incident at least once, and continues to support officers on a case-by-case basis as required. The staff at the EAP do not provide counselling services, but will refer on where needed.

The following points were identified as difficulties in providing services:

- establishing a relationship of trust between the EAP and employees – this can only occur with time and after demonstrating that confidentiality will be maintained
- the critical role of front-line supervisors in identifying and dealing with alcohol problems in their work units
- the need for active support from management
- the need for support staff to maintain confidentiality – the unit does not keep written records and no notes are placed on an officer's file
- the need for the unit to be staffed by full-time dedicated people, not officers on collateral duties.

## Treatment facilities

### **Palm Springs**

#### **Betty Ford Center**

##### *Introduction*

Since its opening in 1982 in Rancho Mirage, Palm Springs, the Betty Ford Center has acquired a well-deserved reputation for excellence in treatment and training in the addictions field. The Betty Ford Center has alumni of over 60 000 throughout the world, and is a high-profile facility synonymous with high-quality practice in the treatment of alcohol and other drug dependencies.

Former First Lady Betty Ford and Leonard Firestone established the Betty Ford Centre after Mrs Ford underwent treatment for chemical dependency at the US Navel Hospital in Long Beach. Mrs Ford recognised that the special needs of women were not always catered for in mainstream, predominantly male treatment facilities.

The centre provides gender-specific treatment along with five-day family programs and programs for children aged 7 to 12 who are living with chemically dependent family members. The centre had 1025 admissions in 2003, and the average length of stay was 27 days.

##### *Treatment*

The Betty Ford Center takes a holistic abstinence-based approach with an emphasis on the spiritual dimension of healing. The centre has been described as a 'Healing Circle where men and women can come together and rediscover their journey to wholeness'.<sup>228</sup>

Patients who are admitted to the Betty Ford Center undergo a medically supervised detoxification and are evaluated by an interdisciplinary assessment team. Although there may be other diagnoses, such as depression or anxiety, the primary diagnosis must be substance use and abuse.

An individualised treatment plan is developed and patients commence treatment as soon as possible. Patients at the centre usually begin with a period of in-patient care and complete their treatment in either out-patient or residential day treatment. The length of stay depends on individual patient needs.

**Inpatient treatment** is the most structured form of care. Patients attend lectures on the bio-psycho-spiritual nature of addiction, and how to manage the triggers associated with relapse. Treatment includes individual and group therapy, spiritual care, lectures and specialised groups for matters such as domestic violence, anger management, trauma/and daily physical exercise.

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<sup>228</sup> Ford, 2003, p. 9

**Residential day treatment** is a less-structured form of care that is offered five days a week in an off-campus setting. Patients live in a cluster of homes located near the main campus and can attend 12-step meetings off site. Patients are required to commit to 30-90 days of treatment to be considered for acceptance into the residential day treatment program.

**Outpatient treatment** – patients live at home or in local housing and participate in treatment five evenings a week. Patients are able to continue employment while using the 12-step program, and can access peer and clinical staff support.

**Specialised treatment for professionals** – a focused treatment (particularly residential day treatment), for licensed professionals (such as doctors, lawyers, pilots), designed to meet the particular needs of these groups. Patients attend special groups and lectures and live in with a therapeutic community with other licensed professionals.

#### *Meeting the needs of women with dependence problems*

One of the features of the approach the Betty Ford Center takes to recovery is the acknowledgement of the differences between the needs of men and women in the context of treatment. The centre provides gender-specific treatment and accommodation in recognition of these differences.

#### *Continuing care/recovery enhancement*

The Betty Ford Center takes a continuum of care approach, and believes that a patient's long-term recovery includes participation in a 12-step program. The patient's Continuing Care Counsellor designs a structured program of ongoing support so the patient can return home. An alumni from the Betty Ford Center, and who lives in the patient's area, is allocated as a contact for the 12-step program, and the centre provides regular scheduled telephone contact for the first year after discharge to help the patient through early recovery, and to minimise the risk of relapse.

The centre conducts Alumni Renewal Weekends three times a year, which include lectures and small group work, and run a variety of targeted workshops, including Couples Enrichment, Individual Enrichment, Discovering Balance, and Recovery Enrichment.

#### *Professional education*

The centre's professional education programs are based on an experiential model designed to enhance awareness, understanding, skills and knowledge of the addictions area. The professional education program includes a Professionals in Residence program, a Summer Institute for Medical Students, public lectures and a Distance Learning Centre for Addiction Studies.

The Professionals in Residence program allows professionals from a variety of occupations – such as counsellors, law enforcement, educators and social workers – to participate in either a five-day Inpatient Program, or a five-day Family Program.

Professionals in the Inpatient Program participate in the primary residential treatment units and gain an understanding of the treatment process and planning through extended involvement with patients and staff. Similarly, participants in the Family Program participate with family members and friends of patients to gain a deeper understanding of the impact of the addiction on others. Professionals in the Family Program attend lectures, group therapy, and activities, and spend time with staff in case planning and review sessions.

### **Michael's House**

Michael's House is a 22-bed inpatient centre in Palm Springs for chemically dependent and dual-diagnosed men aged 18 and over. Programs usually range from six weeks to four months. The average length of stay is 52 days.

#### *Approach*

Michael's House takes a holistic approach to care and provides a structured but individual program for each patient. Family therapy is available at no extra charge, and families are encouraged to participate in family sessions and attend support groups. Residents perform daily duties, maintaining their living quarters and preparing their meals, to encourage personal accountability and assist them cope with everyday problems. Michael's House takes a gender-specific approach to treatment and caters exclusively for men:

Loneliness, isolation, patterns of failed relationships, and unhealthy sexual functioning are confronted directly in a safe, all male environment. Men are helped to get out from under the demands of the stereotypical male role. The staff believes that men need time to learn the process of recovery without the distraction and role delineation that co-educational programs sometimes demand.<sup>229</sup>

#### *Treatment*

Patients are initially assessed and an individual treatment program is developed that focuses on life skills developed through individual, group and family therapy, nutritional and vocational guidance, recreational programs, and lectures on addictions, and for example, relapse.

Michael's House recognises that many of those who present with addiction problems also have emotional problems, such as depression or anxiety, or anger problems. Michael's House has a dual diagnosis program to deal with these problems, and runs an anger management group. During 2003 40% of their clients were receiving some form of psychiatric medication other than for detoxification.

Treatment is supported by participation in the 12-step program.

#### *Aftercare*

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<sup>229</sup> www.michaelshouse.com, 2005

During treatment staff maintain contact with each resident's primary referral source to assure continuity of care once treatment is completed. Follow-up care is facilitated by this contact and is supported by referrals to support in the resident's own community.

## **Las Vegas**

### **Las Vegas Recovery Center**

The Las Vegas Recovery Center (LVRC) is a private facility that provides medically managed detoxification, in-patient and out-patient treatment, a family program, dual diagnosis treatment and aftercare. This facility is used by Las Vegas Police as their preferred treatment service provider.

#### *Treatment*

Treatment at the LVRC is individually tailored, and encompasses individual and group sessions, lectures, relapse prevention, recreational activities, and integration into 12-step meetings.

#### *Detoxification*

Clients requiring detoxification receive a thorough medical assessment by the centre's attending physician and a detoxification plan is developed and put in place. Co-existing medical problems are determined at this time.

The LVRC is licensed by the state of Nevada Bureau of Alcohol and Drug Abuse to perform level IV-D detoxification, the state's most acute level, and can perform detoxification from acute prescription-drug misuse.

#### *Residential and out-patient treatment*

On admission, clients undergo assessment, and have a breath and urine toxicology test. A clinician conducts the psychosocial assessment and initiates contact with significant others, employer EAP, and other treating professionals. An initial treatment plan is developed and implemented to stabilise acute symptoms and prepare the client for ongoing care.

The treatment program at LVRC is designed to promote awareness and understanding of addiction and includes individual and group sessions with certified and licensed alcohol and drug counsellors, relapse prevention, recreational activities and participation in a 12-step program. Intensive outpatient treatment is offered as an alternative to residential treatment if it meets the client's needs, or as a step down from residential treatment. Clients in the outpatient program attend from 6-9 pm, four evenings a week, as well as attending individual counselling and family sessions.

#### *Dual diagnosis*

While the primary focus of the LVRC is on substance abuse, the centre recognises the frequency with which substance misuse is accompanied and exacerbated by co-existing disorders. The psychiatric staff at the centre consult and treat non-acute psychiatric diagnosis.



### *Aftercare*

The Alumni group at the LVRC is a weekly group that meets for two years after completing treatment. The group has 24-hour access to staff, continued relapse-prevention education, a multi-disciplinary team approach and family involvement. The aftercare group is seen as an important component of ongoing recovery.

While clients at the LVRC are not required to quit smoking during their stay, staff will help clients who want to quit as part of their treatment plan.

### **Texas**

#### **Summer Sky**

Summer Sky is located in Stephenville, Texas (out of Fort Worth) and offers acute and primary care, partial hospitalisation, and adolescent and adult residential and intensive out-patient services. Summer Sky is a preferred assessment and treatment centre for Fort Worth Police Department and City of Fort Worth employees. Summer Sky was recommended by the Fort Worth Police Department, and is experienced in meeting the special needs of police, Defence, and emergency services personnel.

They have a former Dallas police officer on their counselling staff, and because of their experience with police, they are familiar with the nature of police work and police culture.

Summer Sky offers assessment services, a family program, relapse-prevention education, group and individual counselling, interventions, a dual-diagnosis program, and aftercare program. Summer Sky also offers free statewide transportation to the facility for patients.

#### *Treatment*

Summer Sky provides a staged treatment process that includes a fully supervised medical detoxification, assessment, treatment, recovery and aftercare. All patients are assessed on admittance, and a physical examination, drug test, and medical history are taken. Assessment includes a primary counsellor interview, psychosocial history, activity therapist assessment, psychological testing, and the development of a preliminary treatment plan.

Once detoxification is completed, the patients personalised treatment program begins. Treatment is managed by the patient's primary counsellor and case manager, but involves a treatment team who conduct weekly reviews. Treatment is based on abstinence, and patients attend local 12-step meetings.

During recovery, patients attend individual therapy, group therapy, stress management, anger management, grief-loss therapy, relapse prevention, relationships group, alcohol and drug education, family therapy and recreational activities.

The patient's aftercare plan is developed during recovery and includes staged reintegration back into the community, continual monitoring of progress and further rehabilitation as needed. Each week of the 18-week program has a theme, but focuses on relapse prevention and support systems.

## Chicago

### St Michael's House

St Michael's House is a non-profit organisation, whose mission is to provide a range of support services for police. St Michael's operates independently of the Chicago Police Department, and provides a Police Chaplains Ministry, the Police Assistance Center, and Rush Behavioural Health. Current services include:

- individual, marital and family counselling
- substance-misuse treatment services
- traumatic-incident debriefing
- fitness-for-duty evaluations
- emergency-response services
- a family-life-enrichment program.

St Michael's operates out of a building that federal authorities seized from a convicted drug dealer. St Michael's caters for police with alcohol and other problems, particularly for those police who are at risk of suicide. Alcohol and suicide often go hand in hand. For every police officer killed in the line of duty, approximately two take their own lives.

St Michael's is the only independent social service agency in the US that operates exclusively for police. This is based on the premise that police officers and their families are a special population with their own culture. This is a premise that is debated by some other service providers who maintain that the myth that police are special and have special treatment needs should be dispelled, as it is counterproductive to their rehabilitation and integration into the wider community. The critics of police-exclusive services maintain that the perception of being special, with different rules, and separate from the community, can be a contributing factor to their addiction.

Random drug testing within the Chicago Police Department was seen to work well as a deterrent. This was supported by anecdotal comments from police, and from an analysis of the statistics after its introduction. It was also noted that random testing should prioritise testing for alcohol, as this was the substance most likely to be misused.

EAP services worked best off site, and when staffed by a combination of professionally trained ex-police officers and professionals. Alcoholics Anonymous (AA) is a significant part of most police rehabilitation programs. Unlike some jurisdictions, St Michael's, while supporting AA, does not mandate attendance. In regards to AA, it was noted that while sworn and non-sworn staff and mixed gender groups work well, groups incorporating extremes in ranks could be problematic.

## **Section 3 – Appendices**

### ***Appendix A***

Definitions

### ***Appendix B***

Abbreviations

### ***Appendix C***

Recommendations (in relation to CISM)

Recommendations (in relation to support services and treatment)

### ***Appendix D***

Questions for police and emergency services departments

Questions for treatment and other service providers to police and emergency services departments

### ***Appendix E***

Select bibliography

Note on the material included in the bibliography

Part A – Alcohol and the workplace

Part B – Critical incident stress/debriefing and substance abuse

## Appendix A

### Definitions

#### *Blood-alcohol concentration (BAC)*

the quantity of alcohol contained in a given volume of blood, expressed in grams of alcohol per 100 millilitres of blood

#### *Blood test*

a blood test measures the amount of alcohol or other drugs in the blood at the time of the test. Unlike a urine test, the results tell whether the person was under the influence at the time of the test

#### *Breath test*

a breath test is currently the most common method of testing for alcohol; the results tell whether the person was under the influence of alcohol at the time of the test

#### *Dependence*

a phenomenon with biological, psychological and social elements, whereby use of a particular drug (e.g. alcohol) is given priority over other behaviours that were once much more important to the person; dependence can be thought of as points along a continuum, and has been described as the degree of difficulty in giving up a behaviour

#### *Drug*

a substance producing a psychoactive effect

#### *Harmful drug use*

a pattern of drug use that has adverse social, physical, legal or other consequences

#### *Illicit drug*

a drug whose production, sale or possession is prohibited by law; 'illegal drug' is an alternative term

#### *Impairment*

a person is said to be impaired when that person is affected by alcohol or other drugs to such an extent that such use has the capacity to:

- adversely affect the ability to conduct official duties or perform certain tasks
- result in unsatisfactory work performance, or
- affect the safety of any person

### *Intoxication*

elevated blood-alcohol concentration such that a person cannot function within their normal range of physical / cognitive abilities; in Australia, the level for intoxication for driving, for example, is set at .05; however, intoxication is more a subjective perception of impact on mood, cognition and psycho-motor functioning

### *Licit drug*

licit drugs include alcohol, tobacco, prescribed and over-the-counter medications, kava and inhalants

### *Meta-analysis*

the use of statistical methods to combine and summarise the results of several studies

### *Patterns of drinking*

refers to aspects of drinking behaviour other than the level of drinking, and includes when and where drinking takes place, the number and characteristics of heavy drinking occasions, activities associated with drinking, personal characteristics of the drinker and drinking companions, the types of drinks consumed, and the drinking norms and behaviours that comprise a drinking culture

### *Pharmaceuticals*

includes any legally prescribed and over-the-counter medical substance

### *Poly drug use*

the use of more than one psychoactive drug, simultaneously or at different times

### *Prescribed medication*

is any substance obtained in accordance with a medical / dental prescription

Controlled and restricted drugs, poisons and other substances referred to in the Health (Drugs and Poisons) Regulation 1996 other than those obtained legitimately.

## **Risk**

### *High risk*

defines a level of drinking at which there is a substantial risk of serious harm, and above which risk continues to increase rapidly

### *Long-term risk*

the level of long-term risk associated with regular daily patterns of drinking, defined by the total amount of alcohol typically consumed per week

*Low risk*

defines the level of drinking at which there is only a minimal risk of harm

*Risky*

defines a level of drinking at which risk of harm is significantly increased beyond any possible benefits

*Short-term risk*

the risk of harm (particularly injury or death) in the short-term, that is associated with given levels of drinking on a single day; these levels assume that overall drinking patterns remain within the levels set for long-term risk, and that these heavier drinking days occur a maximum of three times per week; outside these limits, risk is further increased

**Stress**

self-perceived negative impact (felt stress)

*Ascribed stress*

external and more objective assessment of adverse consequences suffered by a person

*Distress*

the experience of specific outcomes such as physical or psychological symptoms or problems

*Perceived stress*

relates to that which is subjectively experienced by an individual

*Stressors*

environmental circumstances which may directly or indirectly affect an individual, or potential external sources of adverse reactions

*Tolerance*

when a person has been exposed to a drug, such as alcohol, higher quantities of that drug are required to produce a given response; with alcohol, people who drink regularly at a given level gradually show less immediate and apparent effects of alcohol at this level of drinking

*Withdrawal*

symptoms that occur when a person stops or reduces substance use after using the substance for a long period, or at high doses

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Australian Alcohol Guidelines: Health Risks and Benefits, National Health and Medical Research Council, 2001.

## Appendix B

### **Abbreviations**

AA – Alcoholics Anonymous

ABS – Australian Bureau of Statistics AC – Assistant Commissioner

ADA Unit – Alcohol and Drug Awareness Unit, located in the Health Services Branch, Human Resources Division, Queensland Police Service. The unit manages the QPS drug testing program, provides education, and assists employees who seek assistance with their substance use.

ADF – Australian Defence Forces

ADFATODS – Australian Defence Forces Alcohol, Tobacco and Other Drugs Service

ADPC – Alcohol and Drug Program coordinator

ADFMHS – Australian Defence Forces Mental Health Strategy

ADTA – Alcohol and Drug Team advisor

AERF – Alcohol Education and Rehabilitation Foundation

AFP – Australian Federal Police

AOD – alcohol and other drug

AMC – Absence Management Committee

AREP – Alcohol Rehabilitation and Education Program

ASD – acute stress disorder

BAC – blood-alcohol content

BIS – Behavioural Intervention System

CAC – certified alcohol counsellor

CID – critical incident debrief

CIRT – Critical-incident Response Team

CISD – critical-incident stress debrief

CISM – critical-incident stress management

CEO – chief executive officer

CF A – Country Fire Authority

CPD – Chicago Police Department

CPIP – Crisis Preparation and Intervention Program (FBI)

D&A – drugs and alcohol

DART – Drug and Alcohol Referral to Treatment

DHHS – Department of Health and Human Services



DO – district officer  
DOT – Department of Transport  
DUI – driving under the influence  
EAP – Employee assistance program  
EARP – Employee Assistance and Rehabilitation Program  
EAU – Employee Assistance Unit  
EF AP – Employee and Family Assistance Program  
EMS – Emergency Medical Services  
FBI – Federal Bureau of Investigation  
FFDE – fitness-for-duty evaluation  
FESA – Fire and Emergency Services Authority  
FWPD – Fort Worth Police Department  
HEART Group – Healing, Esteem, Awakening, Reality, Trust Group  
HEIG – Hazardous Employment Issues Group  
HSO – human services officer  
ICISF – International Critical Incident Stress Foundation  
IGCD – Intergovernmental Committee on Drugs  
LAFD – Los Angeles Fire Department  
LAPD – Los Angeles Police Department  
LASD – Los Angeles County Sheriff's Department  
LVRC – Las Vegas Recovery Centre  
MAP – Membership Assistance Program  
MFESB – Metropolitan Fire and Emergency Services Board  
MPD – Metropolitan Police Department  
MPEAP – Metropolitan Police Employee Assistance Program (Washington)  
MRO – medical research officer  
NHMRC – National Health and Medical Research Council  
NIDA – National Institute of Drug Abuse (USA)  
NOV A – National Organisation of Victim Assistance  
NT – Northern Territory  
NYPD – New York Police Department  
NZ – New Zealand  
OHN – occupational health nurse  
OHS – occupational health and safety  
OIC – officer in charge

OPR – Office of Professional Responsibility  
PCP – Personal Concerns Program  
PSO – peer-support officer  
PSP – peer-support person  
PTSD – post-traumatic stress disorder  
QPS – Queensland Police Service  
RAN – Royal Australian Navy  
RCMP – Royal Canadian Mounted Police  
RTW – return to work  
SFPD – San Francisco Police Department  
SAPOL – South Australia Police  
SCPD – Suffolk County Police Department  
SSA – safety-sensitive assessment  
TPS – Toronto Police Service  
TWA – Trans World Airlines  
UBH – United Behavioural Health  
V ACCU – Victorian Ambulance Crisis Counselling Unit  
VPD – Vancouver Police Department  
US – United States

## Appendix C

### ***Recommendations***

In relation to CISM it is recommended that:

#### **Recommendation 1**

Research (longitudinal) be undertaken to determine the frequency and severity of critical-incident stress in police and other emergency services personnel over their career to map ongoing support needs.

#### **Recommendation 2**

The efficacy of various CISM models be evaluated by randomised, controlled studies rather than one-off cross-sectional studies, or studies based on pre-post test designs. Police and emergency services agencies adopt practices based on research findings.

#### **Recommendation 3**

Positive coping styles and characteristics of resilient officers be identified to improve recruitment and training procedures.

#### **Recommendation 4**

Research be undertaken to identify workplace characteristics that exacerbate or ameliorate organisational and occupational stress, and impact on the efficacy of support interventions.

In relation to the provision of support services and treatment, it is recommended that:

#### **Recommendation 1**

Research which identifies levels and patterns of alcohol and other licit drug use in police and emergency services workplaces, be undertaken.

#### **Recommendation 2**

Police and emergency services agencies instigate periodic health assessments, which allow for the early identification and treatment of alcohol and other licit drug problems.

#### **Recommendation 3**

Police and emergency services agencies consider processes for assessing an employee's fitness to resume safety-sensitive duties during and after completing treatment for alcohol or licit drug dependency.

#### **Recommendation 4**

Examples of quality practice from evidence-based research be identified and used to guide the provision of support and treatment services.

#### **Recommendation 5**

Police and emergency services agencies consider establishing an in-house AA (or similar) group, and facilitate attendance at such a group where practical.

#### **Recommendation 6**

Confiscated assets from drug-related crime be accessed to fund employee assistance programs and associated support services for police and emergency services personnel with alcohol and other licit drug problems.

## Appendix D

### Questions for police and emergency services departments

#### Policy and Procedures

1. What policy and written procedures does your organisation have in relation to the provision of support services and referral to treatment for members with a suspected or identified problem with alcohol or other licit (prescription or over-the-counter) drugs? (*Obtain copies of policies where available.*)
2. How do personnel with dependency or other licit drug issues most commonly come to the attention of your organisation?
  - self-referral
  - result of a positive alcohol/drug test
  - referral by supervisor/manager (e.g. result of a diminished work performance appraisal)
  - other
3. Do responses to alcohol and other licit drug use vary according to how the organisation becomes aware of the problem?
4. What amnesty provisions do you provide for members who self-refer?
5. What prevention initiatives do you have in place? For example:
  - education, training and the provision of information
  - EAP / peer support
  - healthy lifestyles programs
6. What early identification systems does your organisation have in place? For example:
  - performance-management system
  - human resources/health services mass screening
  - fit-for-duty testing
  - amnesty/self-referral options
7. What is the usual course of action when you become aware of a problem?
  - initial assessment (who conducts?)
  - referral for more detailed assessment (who to?)
  - what are the conditions if an officer/member is stood down? (e.g. hand-over of gun/motor vehicle; with or without pay; access to workplace?)

## 8. Record keeping

- What identifying records do you keep and who has access to them?
- How do you deal with confidentiality issues?
- What are the limits on confidentiality?
- Do personnel have to disclose what medication they are on? (To whom and under what circumstances?)

## Service provision

1. Counselling/EAP – in-house or outsourced? – Availability for family?
  - Are there limits or conditions on the number of times someone can access support or treatment services?
2. How are your service providers selected? (tenders? minimum qualifications? experience with police/emergency services?)
3. How are support services and treatment funded?
4. To what extent are services dictated by funding?
5. Have any evaluations been conducted on the services you provide in-house, or on the services you refer out to?
6. Have you identified examples of high-quality service provision? What are the features of those services?

## Case management – rehabilitation and return to work

1. What are the conditions for an officer's return to work (after a short break and longer absence)?
2. Do your members sign treatment or rehabilitation contracts? What are the usual conditions set out in such a contract?
3. How is compliance monitored? For how long?

## General

1. Have you identified any legal issues related to the provision of services for members with an alcohol or other licit drug problem?
2. Have you identified any equity issues? (For example, do you provide special services for women? Do you provide any rank-based services? How do you provide services for officers/staff in remote areas?)
3. While most organisations seem to have strategies in place to deal with members with significant problems, fewer organisations have strategies in place to deal with the statistically greater number who drink at hazardous and harmful levels. Can you suggest any strategies that might be successful in reaching this group?

4. What do you consider to be the critical success factors for providing services to your members with alcohol dependency issues?
5. What barriers have you identified in providing services (either in-house or outsourced)? How have those barriers been overcome?
6. What are the key lessons learnt in addressing the needs of police and emergency services personnel with a suspected or identified alcohol or other licit drug problem?
7. Can you refer me to anyone else who I should be contacting about treatment or other services for police or emergency services personnel? (*Please provide contact details, e.g. email.*)

### Questions for treatment and other service providers to police and emergency services agencies

1. Do you think police and emergency services personnel should be given any special considerations during their treatment for licit substance abuse? (Why/why not?)
2. What aspects of their work environment/role do you take into account when treating police and emergency services personnel?
3. What do you consider are the critical success factors for treating police and emergency services personnel?
4. What are the most significant barriers to treating police and emergency services personnel? How do you overcome those barriers?
5. Are there any recommendations you would make to specifically address the needs of female officers?
6. While most organisations seem to have strategies in place to deal with members with significant problems, fewer organisations have strategies in place to deal with the statistically greater number who drink at hazardous and harmful levels. Can you suggest any strategies that might be successful in reaching this group?

### Stress

1. How frequently do clients presenting with stress (organisational and critical incident) also exhibit alcohol and other licit drug misuse (and vice versa)?
2. What can police and other emergency services departments do to proactively address organisational and critical-incident (one off and cumulative) stress?
3. What is current thinking on best practice in responding to critical incidents for police and emergency services personnel?
4. Can you make any recommendations regarding return to work for police or emergency services personnel who have suffered stress and licit substance misuse?
5. Can you refer me to anyone else I should contact regarding these issues? (*Please provide contact details, e.g. email*)

## Appendix E

### *Select bibliography*

#### Note on the material included in the bibliography

The first section of the bibliography deals with general alcohol and other licit drug references, particularly in the context of the workplace and, to a lesser extent, treatment options.

Part B of this bibliography includes references on critical incident stress and post traumatic stress disorder. The focus of this section is on the incidence of post-traumatic stress among professionals, particularly on Defence, police and other emergency services workers. References that debate the best way to respond to critical incidents in both the short and long term have been included. This section also covers the problems of workplace stress and self-medicating with alcohol.

This new section has been added because of the increasing awareness of the correlation between critical incident stress and unhealthy alcohol consumption patterns.

In some cases only the more recent literature of the more prolific authors has been included. In most cases, only literature post-1990 has been included. The main exception to this has been literature specifically related to the law enforcement and emergency services area, which was more difficult to access than the literature of a more general nature, and which was still deemed to be relevant to this study.

Although there is a plethora of information on alcohol and other licit drug misuse generally, there is less material specific to use and responses in policing and emergency services environments.

The material cited in the bibliography varies in quality and academic rigour. Much of the material in support of critical-incident stress debriefing, for example, is taken from trade publications and non-peer reviewed journals.

The compiler has not sighted all the references included here and it should not be assumed that inclusion signifies endorsement of content.



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## **Notes**