Industry Review: Trauma in Australia's Security Industry

Causes, effects, prevention and a proposed Phoenix Bunker response

Report 1 • Strategic discussion draft

PHOENIX BUNKER

Trauma-informed education • Peer connection • Industry advocacy • Referral pathways

Prepared 19 October 2026 | Australia

Evidence-informed discussion document. Not legal advice, clinical assessment or a substitute for regulator guidance.

Executive overview

Security workers perform roles across guarding, hospitals, licensed venues, transport, events, corporate facilities, cash-in-transit and other settings. Depending on role and site, workers may encounter aggression, threats, assault, distressing incidents, serious injury, death, suicide-related incidents, intoxication and people experiencing acute distress.

Trauma risk is not limited to one critical incident. Repeated exposure, poor recovery, fatigue, isolation, inconsistent supervision and weak post-incident support may combine to affect wellbeing. The issue should be understood as both an individual health issue and a workplace risk-management issue.

The Australian evidence specific to private security is limited. Evidence from public safety personnel, hospital security and national workplace data is relevant but cannot be treated as a direct estimate of security-sector prevalence.

Key position: prevention, supportive response and organisational accountability must work together. Resilience training alone cannot replace risk controls.

1. Occupational trauma: sources and pathways

Potential sources include physical violence, threats, witnessing severe injury or death, suicide-related incidents, repeated exposure to distress, managing volatile incidents, and working where backup is delayed or role boundaries are unclear.

Cumulative exposure can interact with fatigue, night work, long shifts, limited breaks, client pressure, bullying, low control, poor communication and concern about employment consequences if a worker discloses distress. These are risk factors to investigate, not assumptions about every employer.

- Direct exposure to traumatic events and occupational violence.
- Repeated lower-level threats or emotionally demanding interactions.
- Fatigue and insufficient recovery between shifts.
- Insufficient preparation, equipment, staffing or escalation support.
- Stigma, weak reporting culture or poor post-incident follow-up.
- Contract and client pressures that discourage reporting or corrective action.

2. Possible effects

Potential effects include intrusive memories, sleep disruption, hypervigilance, avoidance, anxiety, depression, emotional numbing, reduced concentration, relationship strain, absence from work and reduced confidence. PTSD is a specific clinical diagnosis and should not be used as a synonym for any stressful experience.

AOD use may develop for many reasons. Some people may use alcohol or other substances to cope with sleep problems or distress, but this is not inevitable and should not be presumed. Mental health symptoms and substance-use problems can overlap and require appropriate assessment.

3. Evidence and limitations

Ferguson et al. (2011) used Australian workers' compensation data from 2000–2008 to compare police and security officer occupational violence and injury. It found occupational violence was a significant concern. It is historically important but does not describe current prevalence or all forms of psychological injury.

A small qualitative study of hospital security guards in one Australian hospital explored repeated personal threats, wellbeing, coping, safety concerns, communication, role clarity and training. It provides contextual insight, not a national estimate.

A 2025 survey of 539 Australian public safety personnel found high trauma exposure, probable PTSD and hazardous or harmful substance-use patterns. Those figures apply to that study sample, not to private security officers as a whole.

National WHS and workers' compensation data confirms psychological injury is a wider workplace concern. It cannot determine how many Australian security workers have PTSD, depression, anxiety or AOD disorders.

Evidence priority: commission security-specific, ethically governed research using clear role definitions and transparent sampling. Avoid presenting adjacent-workforce statistics as private-security prevalence.

4. Prevention and response

- Identify and control site-specific risks of violence, traumatic exposure, fatigue and other psychosocial hazards.
- Use clear incident escalation, duress arrangements, staffing, backup and post-incident welfare procedures.
- Train supervisors to recognise distress, respond non-judgementally and refer rather than diagnose.
- Provide access to professional mental health and AOD support, including pathways for co-occurring concerns.
- Avoid compulsory emotional recounting as a universal post-incident intervention; use evidence-informed clinical guidance.
- Use confidential reporting, consultation and review to improve controls.

5. Proposed Phoenix Bunker contribution

Phoenix Bunker could become an independent industry partner focused on peer connection, trauma-informed education, systems advocacy and referral navigation. It should not replace employer WHS duties or clinical treatment.

- Peer connection: trained, supervised peers, clear confidentiality limits and referral pathways.
- Education: trauma awareness, PTSD/depression/anxiety literacy, AOD stigma reduction, fatigue and recovery.
- Advocacy: de-identified feedback about recurring hazards and recommendations for safer work systems.
- Partnerships: clinicians, AOD services, GPs, EAPs, worker representatives, industry bodies and researchers.

6. Governance safeguards

- Publish service scope, privacy policy, informed-consent process and limits to confidentiality.
- Define escalation protocols for immediate safety risks and urgent clinical needs.
- Separate peer support from disciplinary investigations and routine employee surveillance, subject to lawful obligations.
- Use trained and supervised peer supporters; provide support for supporters themselves.
- Do not promise prevention or cure of PTSD, and do not offer diagnosis or treatment unless properly qualified and governed.

7. Twelve-month implementation and evaluation

Months 1–2: consultation and service mapping. Months 3–4: design and governance. Months 5–8: pilot with diverse security workplaces. Months 9–12: independent evaluation and redesign.

- Process measures: training reach, service awareness, referral wait times, welfare follow-up timeliness.
- Safety measures: hazards identified, corrective actions completed, incident trends and worker reporting confidence.
- Experience measures: trust, perceived usefulness, privacy concerns and worker voice.
- Longer-term indicators: retention, absence, claims and return-to-work outcomes where reliable and appropriately interpreted.

8. Education and prevention principles

Workforce education should explain psychosocial hazards, trauma-aware communication, early support options and practical prevention measures. Content should be evidence-informed, culturally responsive and clear about the limits of non-clinical support.

References and further reading

Links checked 19 October 2026. Confirm current legislation, approved codes and regulator guidance before operational use.

1. Safe Work Australia. Model WHS laws. https://www.safeworkaustralia.gov.au/law-and-regulation/model-whs-laws. Model laws apply in all jurisdictions except Victoria, with local variations.
2. Safe Work Australia. Model Code of Practice: Managing psychosocial hazards at work (2022). https://www.safeworkaustralia.gov.au/doc/model-code-practice-managing-psychosocial-hazards-work. Legal effect depends on local approval.

3. Safe Work Australia. Mental health—WHS duties. https://www.safeworkaustralia.gov.au/safety-topic/managing-health-and-safety/mental-health/whs-duties. Risk management and consultation.

4. Safe Work Australia. Workers' compensation for psychological injuries. https://www.safeworkaustralia.gov.au/workers-compensation/workers-compensation-psychological-injuries. National workers compensation context.

5. Safe Work Australia. Insights from the Australian Worker Exposure Survey 2026. https://data.safeworkaustralia.gov.au/reports/hazards-and-injuries/insights-australian-worker-exposure-survey-2026. National survey, not security-specific.

6. SafeWork NSW. Psychosocial hazards. https://www.safework.nsw.gov.au/hazards-a-z/psychosocial-hazards. NSW guidance; WHS Regulation 2025.

7. SafeWork NSW. Code of Practice: Managing psychosocial hazards at work. https://www.safework.nsw.gov.au/resource-library/codes-of-practice/codes-of-practice/managing-psychosocial-hazards-at-work. NSW regulator code.

8. WorkSafe Victoria. Psychological health regulations and guidance. https://www.worksafe.vic.gov.au/psychological-health-regulations-frequently-asked-questions. Victorian OHS framework; regulations commenced 1 Dec 2025.

9. Sercombe, J. et al. (2025). Trauma exposure, PTSD and alcohol and other drug use among Australian public safety personnel. Australian & New Zealand Journal of Psychiatry, 59(5), 413–422. DOI: 10.1177/00048674251324814. https://pmc.ncbi.nlm.nih.gov/articles/PMC12022364/. 539 public safety personnel; not private-security prevalence.

10. Ferguson, P., Prenzler, T., Sarre, R., & de Caires, B. (2011). Police and Security Officer Experiences of Occupational Violence and Injury in Australia. International Journal of Police Science & Management, 13(3), 223–233. DOI: 10.1350/ijps.2011.13.3.239. https://journals.sagepub.com/doi/10.1350/ijps.2011.13.3.239. Historical workers compensation data, 2000–2008.

11. Brown, J. et al. (2022). Hospital security guard's well-being and repeated exposure to personal threats: a qualitative study in an Australian hospital. International Journal of Workplace Health Management, 15(6), 728 ff. https://www.emerald.com/ijwhm/article-abstract/15/6/728/160667/Hospital-security-guard-s-well-being-and-repeated. Single-site qualitative study, small convenience sample.

12. Multi-site study (2020). Experiences of security staff responding to mental health, drug health and behavioural challenges in emergency departments. https://pubmed.ncbi.nlm.nih.gov/32356401/. Qualitative study across three NSW hospitals.

13. Leung, C. et al. (2026). Perceived Barriers and Facilitators to Help-Seeking for Alcohol and Other Drug Use Among Australian Public Safety Personnel. Drug and Alcohol Review, 45(4), e70176. DOI: 10.1111/dar.70176. https://doi.org/10.1111/dar.70176. Confidentiality and career concerns; supportive managers facilitate help-seeking.

14. Safe Work Australia. Traumatic events or materials. https://www.safeworkaustralia.gov.au/safety-topic/managing-health-and-safety/mental-health/psychosocial-hazards/traumatic-events-or-materials. Guidance on traumatic exposure.

15. WorkSafe Victoria. Compliance code: Psychological health. https://www.worksafe.vic.gov.au/compliance-code-psychological-health-part-1-introduction. Victorian OHS compliance guidance.

16. Comcare. Managing psychosocial hazards. https://www.comcare.gov.au/scheme-legislation/whs-act/regulatory-guides/managing-psychosocial-hazards. Commonwealth guidance.