Industry Review: Mental Health and AOD Issues in Australia’s Security Industry

Special focus on PTSD, depression, anxiety and substance-use disorders

Report 2 • Strategic discussion draft

PHOENIX BUNKER

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

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

Executive summary

Security workers may experience violence, threats, traumatic incidents, distressing human situations, fatigue, shift work and organisational stressors. Potential consequences include PTSD, depression, anxiety, sleep disruption, harmful alcohol or other drug use, relationship strain and reduced work functioning. These conditions are not inevitable and cannot be diagnosed from workplace behaviour alone.

Australian research specific to private security remains limited. The strongest position is to combine sector-specific qualitative findings, historical injury data and adjacent public safety research while clearly distinguishing what is known from what requires investigation.

The recommended response integrates prevention, clinical access, AOD support, peer connection, supervisor capability and accountability for psychosocial hazards. Phoenix Bunker could support education, peer connection, advocacy and referral navigation under a clear governance model.

Core principle: workers should be able to seek help without stigma, while employers continue to manage impairment, fitness for duty and safety-critical responsibilities fairly and lawfully.

1. PTSD

PTSD can develop after exposure to actual or threatened death, serious injury or sexual violence. In security settings, relevant exposure may include serious assaults, fatalities, suicide-related incidents or repeated exposure to traumatic events. Not every distressing experience meets diagnostic criteria.

Symptoms may include intrusive memories or nightmares, avoidance, heightened alertness, irritability, sleep disruption, emotional detachment and concentration difficulties. Workers may continue to attend shifts while experiencing substantial distress.

Recommended response: safe reporting, prompt practical support, follow-up, appropriate clinical assessment and workplace controls that reduce repeat exposure. Supervisors should not diagnose PTSD.

2. Depression

Depression can involve persistent low mood, loss of interest, fatigue, hopelessness, changes in sleep or appetite and impaired concentration. Possible workplace contributors include cumulative distress, poor recovery, isolation, conflict, bullying and perceived lack of support, although causation is individual and multifactorial.

Do not automatically interpret changes in performance as laziness or disengagement. Address safety and performance concerns while providing fair access to support and assessment.

3. Anxiety disorders

Anxiety disorders can involve persistent worry, fear, panic symptoms, physical tension, irritability and sleep difficulties. Occupational contributors may include threats, unpredictable incidents, inadequate staffing, unclear procedures and fear of blame after incidents.

The aim is not to eliminate every operational stressor. It is to reduce avoidable hazards, improve preparedness, clarify escalation and provide suitable support.

4. Alcohol and other drug issues

AOD issues range from risky use to substance-use disorders. A disorder is a clinical condition; it should not be inferred solely from alcohol consumption or a past disclosure. Some people use substances in an attempt to manage sleep or distress; others experience problems unrelated to work.

AOD use can worsen sleep, mood, anxiety and functioning. Intoxication or impairment can create immediate safety risks in security work. A balanced model combines clear fitness-for-duty rules and fair procedures with confidential access to professional support and proportionate accountability.

5. Co-occurrence and help-seeking

PTSD, depression, anxiety and AOD problems may occur independently or together. An integrated response is important because treating only one issue may leave other needs unmet.

Australian public safety research identifies confidentiality concerns and fear of career consequences as barriers to AOD help-seeking; supportive workplaces and managers can facilitate help-seeking. These findings are relevant to service design but should not be assumed to describe every private-security workplace.

6. Evidence review

Sercombe et al. (2025) surveyed 539 public safety personnel from three Australian agencies. The study reported workplace trauma exposure, probable PTSD and hazardous or harmful alcohol/drug use in this sample, with probable PTSD associated with greater odds of hazardous or harmful alcohol use. These numbers are not estimates for the private security workforce.

A qualitative study of eight hospital security guards at one Australian hospital explored repeated threats, wellbeing, coping, physical safety, compassion fatigue, communication, roles, training and equipment. Its small convenience sample limits generalisability.

A multi-site NSW emergency department study examined security staff experiences responding to mental health, drug-health and behavioural challenges. It highlights the distinctive demands of this environment, not prevalence of diagnoses.

Ferguson et al. (2011) compared police and security officer injury and occupational violence claims using data from 2000–2008. It supports concern about occupational violence but is historical and does not quantify current psychological conditions.

7. Recommended remedies

- Use site-specific psychosocial risk assessments and violence prevention controls.
- Review staffing, backup, duress systems, incident communication and role clarity.
- Develop post-incident welfare follow-up without forcing traumatic recounting.
- Train supervisors in supportive conversations, referral and non-diagnostic responses.
- Provide clinical and AOD referral pathways, including co-occurring-condition support.
- Offer voluntary, supervised peer support with explicit privacy limits.
- Adopt fair fitness-for-duty processes that distinguish support needs from immediate impairment risk.
- Evaluate outcomes and share de-identified learnings with the industry.

8. Phoenix Bunker service model

Proposed positioning: an independent security-industry wellbeing and advocacy initiative, initially delivering education, peer connection, referral navigation and aggregated systems advocacy.

- Peer connection: trained peers, supervision, documented boundaries and referral.
- Education: trauma literacy, mental health, AOD, sleep/recovery, help-seeking and supervisor capability.
- Advocacy: de-identified analysis of hazards, support barriers and recurring operational themes.
- Partnerships: clinical services, AOD providers, GPs, EAPs, regulators, industry bodies, worker representatives and researchers.
- Safeguards: informed consent, data minimisation, clear escalation, no diagnosis by peers, and independent evaluation.

9. Pilot and measures

Run a 12-month pilot: months 1–2 consultation; months 3–4 design; months 5–8 implementation; months 9–12 independent evaluation.

- Reach and awareness of support; worker trust and confidence to report.
- Timeliness of post-incident follow-up and referral.
- Uptake and perceived usefulness of appropriate support.
- Workplace hazards identified and proportion of corrective actions completed.
- Privacy or safety incidents and user feedback.
- Longer-term absence, retention and claims indicators where valid; do not infer causation from simple before/after changes.

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.
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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.
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9. Australian Government. Work Health and Safety Act 2011 (Cth). https://www.legislation.gov.au/C2011A00137/latest/text. Check latest compilation.
10. Safe Work Australia. WHS regulators and workers' compensation authorities. https://www.safeworkaustralia.gov.au/law-and-regulation/whs-regulators-and-workers-compensation-authorities-contact-information. Official regulator directory.
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13. 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.
14. 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.
15. 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.
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