Trauma, Mental Health and AOD in Australia’s Security Industry

Comprehensive industry review, jurisdictional WHS analysis and Phoenix Bunker implementation proposal

Integrated report • Evidence and implementation edition

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 summary and recommendations

This report integrates the two companion reviews: (1) trauma in Australia's security industry and (2) mental health and alcohol and other drug issues, with particular attention to PTSD, depression, anxiety and substance-use disorders. It adds a literature review, jurisdiction-specific WHS analysis, defined Phoenix Bunker service model, and a referenced implementation and evaluation plan.

Security work can involve occupational violence, threats, traumatic incidents, emotionally demanding interactions, fatigue and other psychosocial hazards. Potential outcomes include trauma-related symptoms, PTSD, depression, anxiety, harmful AOD use, reduced work functioning and retention challenges. Outcomes vary and must not be assumed or diagnosed from observed behaviour.

The evidence base for private security in Australia is comparatively thin. Available literature supports taking occupational violence and repeated threats seriously, but does not establish robust national prevalence estimates for PTSD, depression, anxiety or AOD disorders in the private security workforce.

The recommended industry response combines primary prevention, early support, clinical referral, fair AOD and fitness-for-duty procedures, peer connection and measurable organisational accountability.

- Treat psychological health as part of WHS risk management—not merely individual resilience.
- Reduce exposure to violence and trauma where reasonably practicable; strengthen staffing, backup, reporting and recovery systems.
- Create credible routes to professional mental health and AOD care.
- Pilot Phoenix Bunker as an independent education, peer-support, referral-navigation and advocacy service.
- Evaluate reach, trust, safety, referral pathways and actual risk-control improvements.
- Commission sector-specific research before making prevalence claims or broad policy assertions.

Evidence boundary: statistics from public safety personnel, hospital security samples or national workforce datasets are not direct prevalence estimates for all private security officers.

1. Scope, terminology and approach

The review covers security officers and related operational roles across guarding, hospitals, licensed venues, transport, events, corporate sites, cash-in-transit and other environments. Exposure profiles differ substantially by work setting, client, role and level of backup.

PTSD is a specific clinical diagnosis; trauma exposure does not automatically produce PTSD. Depression and anxiety are distinct conditions with multiple possible causes. AOD use ranges from low-risk use to harmful use and substance-use disorders. AOD problems should not be inferred from past use, stigma or a single incident.

This is an evidence-informed industry review, not a systematic review with a registered protocol, a legal opinion or clinical advice. It prioritises Australian sources and distinguishes direct private-security evidence from adjacent populations and national context.

2. Detailed literature review

2.1 Direct security-sector evidence. Ferguson et al. (2011) used Australian workers' compensation data from 2000–2008 to compare police and security officer occupational violence and injury. The study found occupational violence was a significant concern and called for further research into circumstances and effective prevention. It is historically important but predates current working conditions and does not measure current PTSD or AOD prevalence.

2.2 Hospital security. Brown et al. (2022) explored repeated personal threats among hospital security guards at a single Australian hospital. Interviews with eight guards generated themes concerning wellbeing and coping, physical safety, compassion fatigue, communication, role clarity, training and equipment. This qualitative design helps explain mechanisms but cannot establish prevalence or be generalised across all security roles.

2.3 Security staff in emergency departments. A multi-site NSW study explored security staff experiences responding to mental health, drug-health and behavioural challenges in emergency departments. It gives context to complex interactions where security staff may work alongside clinical teams and encounter distressed or intoxicated people. It is not a national survey of security workforce health.

2.4 Adjacent public safety evidence. Sercombe et al. (2025) surveyed 539 public safety personnel from three Australian agencies. In that sample, 86.8% reported at least one type of workplace traumatic event, 39.4% met the study threshold for probable PTSD, 33.1% reported hazardous or harmful alcohol use and 13.3% harmful drug use. Probable PTSD was associated with higher odds of hazardous or harmful alcohol use. These results cannot be represented as private security prevalence; sampling, agency mix and self-report matter.

2.5 Help-seeking. Leung et al. (2026) studied perceived barriers and facilitators to AOD help-seeking among Australian public safety personnel. Confidentiality concerns and fear of career consequences were important barriers, while supportive workplaces and managers were facilitators. This supports a service design that is credible, independent and clear about data boundaries, but extrapolation to private security should be tested.

2.6 National workplace context. Safe Work Australia's psychosocial hazard guidance and workers' compensation reporting show that psychological injury is a wider Australian workplace issue. The Australian Worker Exposure Survey 2026 adds contemporary self-reported context on psychosocial exposures. These national sources support prevention but do not quantify security-specific diagnoses.

2.7 Evidence synthesis. Across the available sources, recurring themes include exposure to violence or threats, communication and role clarity, training and equipment, help-seeking barriers, and the need for stronger prevention research. The evidence is sufficient to justify risk assessment and a pilot; it is not sufficient to claim a definitive national prevalence rate for private security.

Research priorities: representative workforce surveys; disaggregation by sector, role, gender, tenure and geography; longitudinal follow-up; evaluation of peer-support models; and analysis of what prevention controls reduce occupational violence and psychological harm.

3. Conditions of concern: symptoms and appropriate response

PTSD: possible intrusive memories, nightmares, avoidance, hyperarousal, emotional detachment and sleep or concentration problems after qualifying trauma exposure. Response: safe reporting, follow-up, referral and reduction of repeat exposure.

Depression: possible persistent low mood, loss of interest, hopelessness, fatigue, sleep/appetite changes and concentration difficulties. Response: supportive conversation, access to assessment, fair work adjustments where appropriate and attention to workplace hazards.

Anxiety disorders: possible persistent worry, panic symptoms, tension, irritability, avoidance and sleep disruption. Response: assess work conditions, clarify procedures, reduce avoidable uncertainty and offer clinical referral.

AOD issues: risky or harmful alcohol/drug use, or a substance-use disorder, can affect sleep, mood, judgement and fitness for duty. Response: fair impairment rules, non-stigmatising access to support and treatment pathways. Do not diagnose or presume causation.

Co-occurrence: conditions may overlap, so referral pathways should support assessment of the whole person. Peer support can help someone navigate services but is not clinical treatment.

4. Causes and psychosocial hazards to assess

- Direct exposure to assault, threats, fatalities, serious injury, suicide-related incidents and repeated distressing events.
- High emotional demands, role ambiguity, low support, bullying, poor organisational change, low control or inadequate recognition.
- Fatigue from night work, rotating rosters, extended shifts, unpredictable overtime and insufficient recovery.
- Insufficient staffing, backup, equipment, duress systems, communication or de-escalation preparation.
- Poor post-incident follow-up, lack of supervisor capability or pressure not to report incidents.
- Contract and client arrangements that blur responsibility or discourage time for recovery and reporting.

5. Effects and organisational consequences

Potential effects include reduced wellbeing, physical symptoms, impaired sleep, relationship strain, withdrawal, absence, turnover, reduced confidence and unsafe performance where a worker's functioning is affected. Employers may experience replacement and training costs, claims, disruption and reduced trust.

These effects are possible rather than inevitable. Data should be interpreted carefully: increased reporting can indicate better trust, and a simple change in absence or claims does not prove a programme caused the change.

6. Jurisdiction-specific WHS analysis

Australia does not have one identical WHS statute that applies in every workplace. Most jurisdictions use harmonised model WHS laws with local variations; Victoria operates under its Occupational Health and Safety Act 2004 and associated regulations. Codes of practice have legal effect only as approved or adopted in the relevant jurisdiction. Employers and service providers should confirm the applicable law, regulator guidance and current amendments for each site.

General duty principle: the relevant duty holder must, so far as reasonably practicable, ensure worker health and safety. This includes psychological health and risks arising from work design, management and environment. Consult workers and health and safety representatives where required; identify hazards; assess risks when needed; implement controls; and review effectiveness. Security clients and contractors may both hold duties depending on their role and control.

Jurisdiction	Framework / regulator	Practical implications for security work
NSW	WHS Act 2011 (NSW); WHS Regulation 2025; SafeWork NSW. Local psychosocial code and current regulations.	Check current 2025 regulations; assess violence, trauma, fatigue, bullying, role clarity and support. Consult workers and document controls, follow-up and review.
Victoria	OHS Act 2004 (Vic); OHS Regulations including Psychological Health Regulations 2025; WorkSafe Victoria.	Do not assume model WHS Act wording applies. Psychological Health Regulations commenced 1 Dec 2025; use Victorian compliance code and guidance.
Queensland	WHS Act 2011 (Qld) and WHS Regulation; WorkSafe Queensland.	Apply local Act, regulation and codes. Document psychosocial hazard assessment, worker consultation, controls and incident response.
Western Australia	WHS Act 2020 (WA) and WHS (General) Regulations 2022; WorkSafe WA / relevant sector regulator.	Confirm regulator and sector coverage, including specialist regimes. Implement psychosocial risk management and worker consultation.
South Australia	WHS Act 2012 (SA) and WHS Regulations; SafeWork SA.	Use SA legislation and approved codes; coordinate controls between security contractors and host clients.
Tasmania	WHS Act 2012 (Tas) and WHS Regulations 2022; WorkSafe Tasmania.	Use local regulations and guidance; manage psychosocial hazards alongside physical violence risks and consultation.
ACT	WHS Act 2011 (ACT) and Regulations; WorkSafe ACT.	Apply ACT versions and regulator guidance; include psychological hazards in risk management and incident reviews.
Northern Territory	WHS (National Uniform Legislation) Act 2011 (NT) and Regulations; NT WorkSafe.	Apply NT legislation; assess isolated work, backup delays, fatigue and traumatic exposure where relevant.
Commonwealth	WHS Act 2011 (Cth) and Regulations; Comcare. Applies to covered Commonwealth workplaces and entities, not automatically every private employer.	Confirm jurisdictional coverage. Use Commonwealth regulations and Comcare guidance where applicable.

This is a high-level orientation, not a complete legal audit. Legislation changes, codes may be approved differently, and industry/site-specific duties can apply. Obtain jurisdiction-specific legal/WHS review before relying on it for compliance decisions.

7. Applying WHS duties to security contracts and sites

- Map duty holders: security provider, host/client, labour hire provider and other PCBUs where relevant. Identify who controls site, staffing, equipment, incident response, roster and post-incident support.
- Consult frontline officers and health and safety representatives about actual work, not only written policies.
- Assess likelihood and severity with attention to frequency, duration and intensity of exposure; isolated work; worker experience; backup; and cumulative exposure.
- Prioritise system controls: safer work design, adequate staffing, duress and communications, clear escalation, role clarity, suitable equipment and coordinated client procedures.

- Use administrative controls and training as part of a control package, not as a replacement for practicable higher-level controls.
- Record serious incidents, follow-up and corrective actions; review controls after incidents, changes in work or evidence of controls not working.
- Ensure peer support and EAP arrangements do not substitute for hazard control, and protect sensitive personal information.

8. Defined Phoenix Bunker service model

Proposed mission: improve the wellbeing and psychological safety of the Australian security workforce by providing accessible education, trusted peer connection, referral navigation and independent systems advocacy.

Proposed initial scope: an industry service—not a clinical provider—operating a small pilot with clear service boundaries. Clinical treatment could be offered only through separate qualified providers and suitable governance.

Service component	Core activities	Boundaries and safeguards
1. Peer connection	Voluntary listening and practical support; signposting; check-ins after incidents; facilitated peer networks.	No diagnosis or therapy; trained and supervised peers; informed consent; privacy limits; urgent-risk escalation; referral when needs exceed role.
2. Education and capability	Training on trauma, PTSD, depression, anxiety, AOD, sleep/recovery, help-seeking and supportive conversations.	Evidence-informed materials; clinical review; no promises of prevention or cure; tailored to role and jurisdiction.
3. Referral navigation	Verified pathways to GPs, psychologists, psychiatrists, AOD services, EAPs, crisis services and return-to-work supports.	Collect minimal personal data; disclose limits; no unqualified clinical triage beyond defined protocol.
4. Systems advocacy	Voluntary de-identified feedback; recurring hazards; recommendations; employer action planning.	Suppress small cells; obtain consent; no identifiable stories without explicit permission; no disciplinary intelligence.
5. Employer/client advisory	Support consultation, post-incident pathways, training design and evaluation of controls.	Does not certify legal compliance; independent legal/WHS review remains necessary; manage conflicts of interest.

9. Governance and operating requirements

- Governance: steering group with security-worker representation, clinical/AOD expertise, WHS expertise, privacy capability and independent oversight.
- Clinical boundaries: define what peers can do, when referral is required, and who provides clinical supervision. No diagnosis or treatment unless appropriately qualified and structured.
- Privacy: collect minimal information, use access controls, set retention/deletion schedules, explain disclosure exceptions and separate support records from employment records wherever practicable and lawful.
- Safety: protocols for imminent risk, threats to others, medical emergencies, child safety or other obligations as applicable. Train peers to follow protocols.
- Workforce: selection, training, supervision, periodic competency review and support for peer supporters.
- Independence: publish how funding, employer contracts and referrals are managed; protect users from pressure to disclose.
- Referral directory: verify eligibility, geography, cost, wait times and crisis pathways; review regularly.
- Complaints and evaluation: accessible complaints process, incident reporting, independent review and transparent reporting.

10. Twelve-month implementation plan

The pilot should start with discovery and governance, not broad promotion before referral capacity and safety protocols exist.

Phase	Timing	Activities and outputs	Gate to proceed
1. Discovery	Months 1–2	Consult workers, employers, clients, representatives, clinicians, AOD providers and regulators where appropriate. Map services and risks; establish baseline and steering group.	Agreed scope, risk register, referral map and sponsor.
2. Design	Months 3–4	Co-design service blueprint, privacy policy, peer boundaries, urgent-risk protocol, training, referral agreements and evaluation protocol.	Clinical/WHS/privacy review; peers trained; pathways verified.
3. Pilot	Months 5–8	Deliver limited education and peer connection across varied workplaces; gather confidential feedback; monitor safety and referral functioning.	Monthly safety reviews; corrective actions; no unresolved critical governance issues.
4. Evaluate	Months 9–12	Independent evaluation of reach, trust, safety, usefulness, referrals, hazards addressed and cost; report limitations.	Decision to adapt, extend, pause or stop.

11. Evaluation framework

Use a logic model: resources and partnerships → education, peer support and referrals → improved awareness and access → stronger reporting and corrective action → potential longer-term improvements in workforce health and retention. The pilot may not be powered to establish changes in PTSD prevalence or causation.

Domain	Indicators	Method / timing	Cautions
Reach	Workers reached; sector/role/geography; training completion; service awareness.	Quarterly service data; anonymous pulse checks.	Reach is not health impact; assess who is missing.
Trust and access	Confidence in confidentiality; willingness to seek help; usefulness; referral uptake and delay.	Anonymous surveys/interviews at baseline, midpoint and end.	Minimise personal data; non-response bias likely.
Post-incident support	Time to welfare contact; proportion offered support; referral completion where consented.	De-identified incident process audits.	Prompt offer is not clinical effectiveness.
WHS controls	Hazards identified; controls completed; repeat incidents; consultation; actions closed.	Risk registers, incident records and feedback.	Account for reporting intensity and exposure hours.
Governance	Privacy breaches; complaints; escalation quality; peer supervision; adverse events.	Continuous monitoring; quarterly governance review.	Critical event may require pause and independent review.
Longer-term	Retention, absence, claims and return-to-work trends.	Aggregate baseline and 12-month data; longer follow-up if feasible.	Confounding and time lags prevent simple causal claims.

12. Data, ethics and evaluation quality

- Make participation voluntary and explain what data are collected and why.
- Avoid collecting diagnosis, medication or detailed trauma narratives unless essential and lawfully governed.
- Use aggregate reporting and suppress small groups where identification is possible.
- Set baseline measures before delivery and pre-specify success criteria.
- Use independent evaluation to reduce sponsor bias and increase trust.
- Report negative or mixed findings, adverse events and programme limitations.
- Use trauma-informed interview practice and provide support information to participants.

13. Risks and mitigations

- Confidentiality concerns → independent governance, data minimisation and clear disclosure limits.
- Peer supporters exceeding their role → training, supervision, referral criteria and competency review.
- Employers substituting support for prevention → written terms preserving employer WHS duties and review of actual risk controls.
- Low trust or uptake → co-design, transparent independence and routes outside management chains.
- Clinical needs exceed capacity → verified referral network, escalation protocol and phased launch.

- Overclaiming impact → pre-specified evaluation, external review and distinction between outputs and outcomes.
- AOD stigma or punitive response → fair fitness-for-duty procedures, non-stigmatising referral and separation of support from discipline.

14. Communication and education approach

Phoenix Bunker proposes accessible, trauma-informed education on workplace risks, worker rights, support pathways and organisational prevention. Materials should use respectful recovery-oriented language, reflect current evidence and clearly distinguish peer information from professional clinical care.

15. Conclusion

The Australian security industry has credible reasons to treat trauma, mental health and AOD as connected workforce safety and support priorities. Existing evidence supports action on occupational violence, repeated threats, fatigue, role clarity, help-seeking barriers and organisational support, while highlighting a major gap in representative private-security research.

Phoenix Bunker can add value if it remains clear about its scope: peer connection, education, referral navigation and systems advocacy, under robust privacy, clinical-boundary and safety governance. A 12-month pilot with independent evaluation is a proportionate way to test demand, trust, operational feasibility and measurable workplace improvements before wider expansion.

Recommended decision: approve a discovery and co-design phase, establish governance and clinical/WHS partnerships, and proceed to a limited pilot only after referral, privacy and urgent-risk protocols are verified.

References and further reading

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

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