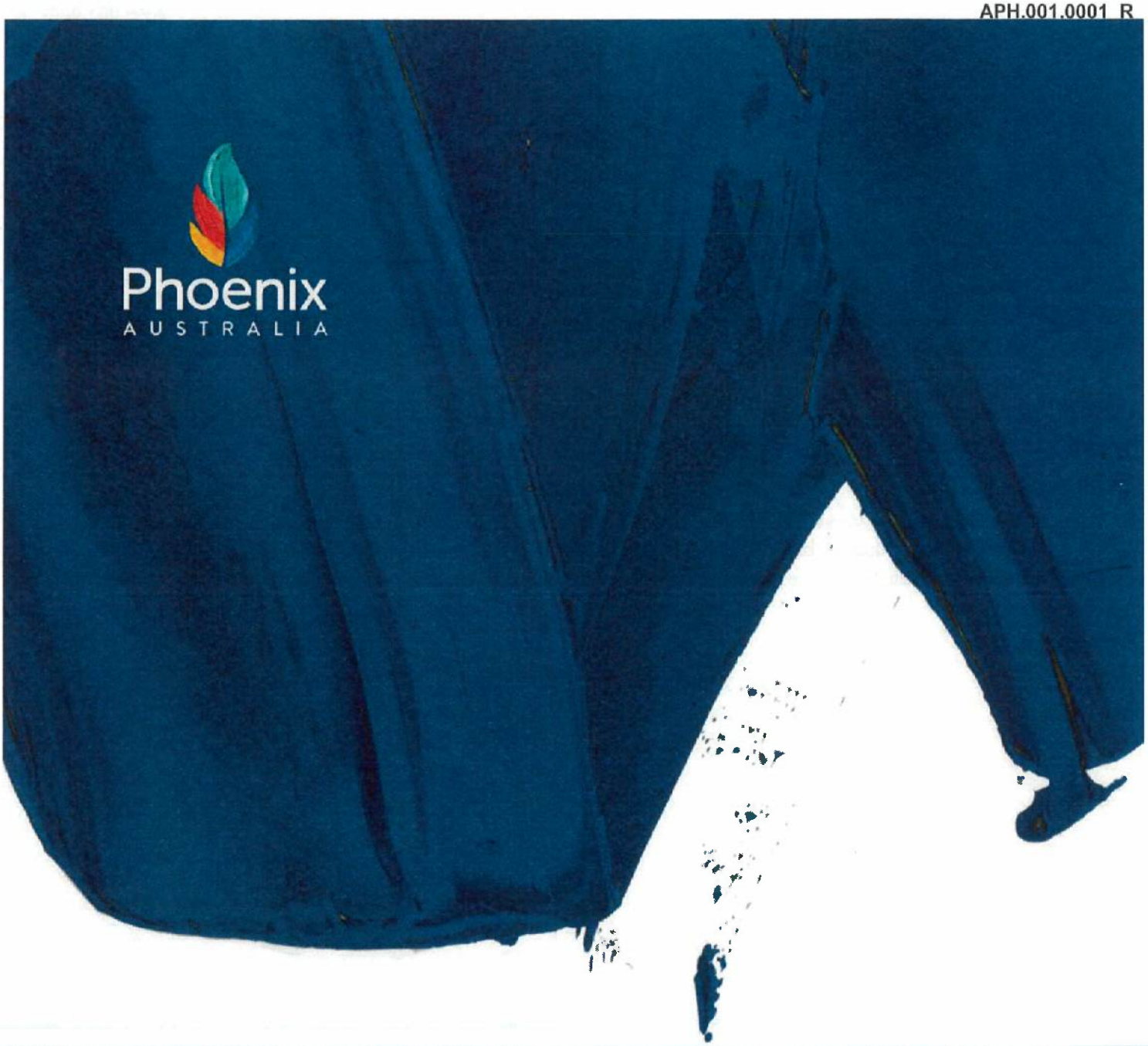

Phoenix Australia Expert Report

For the Commission of Inquiry into Queensland Police Service responses to domestic and family violence

26 July 2022

MELBOURNE

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1) What is compassion fatigue? What is burnout?

Compassion fatigue and burnout are two terms that are used to describe the potentially negative consequences of long-term involvement in emotionally demanding situations (Bride et al., 2007). The concept of compassion fatigue is specifically related to the demands placed on those in helping professions, with regards to their compassion. Compassion can be described as a sympathetic consciousness of others' distress together with a desire to alleviate it (Merriam-Webster Online Dictionary, 2022). Compassion fatigue is understood to develop as a result of prolonged exposure to people who are distressed, feelings of obligation or desire to help, and overwhelming emotional involvement through empathy. The term has been described simply as the helping professional being emotionally "too tired to care" (Collins & Long, 2003), and many writers use the term simply to describe a reduced capacity for, or interest in, bearing the suffering of others. Compassion fatigue has been examined extensively in professions such as mental health professionals, medical professionals, child protection workers, and chaplains and clergy.

Investigations of compassion fatigue in police officers has provided some mixed findings. A meta-analysis of secondary trauma, which included compassion fatigue found low levels of secondary trauma amongst on-site first responders (e.g. police, firefighters, paramedics), with rates ranging from 4% to 13% (Greinacher et al., 2019). Similarly, a study of compassion fatigue amongst 113 police officers found that, contrary to expectation, only very low levels of compassion fatigue were present, at lower levels than are observed in the general community (Grant et al., 2019). In contrast, a study involving a larger sample of police officers (N = 1,351) found that 23% reported high or extreme compassion fatigue (Andersen et al., 2018). In the research where low levels of compassion fatigue have been observed for first responders and/or police officers, it has been suggested that there may be a reluctance to honestly endorse symptoms of psychological burden, due to the organisational culture and a concern of being perceived as incapable of doing their job (Greinacher et al., 2019).

Burnout is another well recognised impact of working in high-risk occupations (i.e. those where there is a high risk of exposure to trauma), which can often overlap with compassion fatigue and secondary traumatic stress. While there is no consistent definition of burnout in the literature, the International Classification of Diseases 11 (ICD-11; World Health Organization, 2018) defines burnout as a syndrome arising from chronic workplace stress that has not been successfully managed, which is characterized by: feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy. Prior to this, Maslach, Jackson, and Leiter (1996) conceptualised burnout as comprising the three dimensions of emotional exhaustion (i.e. feeling worn out, loss of energy, depletion and fatigue), depersonalization (later known as cynicism; a negative or inappropriate attitude towards clients), and feelings of incompetence or reduced personal accomplishment and this remains the cornerstone of most contemporary definitions. A recent meta-analysis of more than 100

studies, examining the rate of burnout in police officers found that 11% of police experienced burnout (Queirós et al., 2020).

The unique, accumulative adverse psychological impact of working with traumatized clients, is known as vicarious trauma (McCann & Pearlman, 1990). Vicarious trauma is conceptualized as encompassing changes in the helping professionals' views about themselves, the world, changes to their interpersonal relationships, and changes to their imagery system (i.e. the helper may internalize the clients' vivid account of a trauma, as a memory, and reexperience it as an intrusive image) (Pearlman & Saakvitne, 2013).

It is also very important to also consider the policing context. Police officers face a range of operational stressors such as anticipatory stress (i.e., stress endured prior to arrival at a potentially traumatic event), motor vehicle accidents, exposure to serious communicable diseases, the death or serious injury of a child, threats to the safety of themselves and their colleagues, as well as many other potentially traumatic events (Colwell et al., 2011). For those working with victims of domestic or family violence, there is also emotional demands of being exposed to the victims' distress, and not having the capability to manage this distress, and the stress of having an awareness of the level of risk that the victim is facing. In addition, police officers also face a range of organisational stressors, which are defined as strains associated with working for one's organization, include conflicting task demands, court appearances, high administrative load, shiftwork and other unremitting stressful conditions (Mayhew, 2001). Our recent study of a large sample of police officers (N = 2,440) found that police officers rated a number of organisational stressors as stressful, with staff shortages, inconsistent leadership style, lack of resources and feeling that different rules apply to different people amongst the most stressful (Varker et al., 2022). Organisational and operational stressors have both been associated with police officers reduced psychosocial well-being and increased mental health (Garbarino et al., 2013; Houdmont & Randall, 2016; Purba & Demou, 2019).

2) What causes compassion fatigue and burnout (trauma/vicarious trauma)?

Compassion fatigue is considered to arise from the demands that are placed upon the helper, in regards to their compassion, to help those who are suffering. Early models of compassion fatigue have focused on the helper's engagement with the experience and needs of the person they are helping, their sense of responsibility over time and how this intersects with their own experiences and capacity to help (Figley (2002). More recently, the link between exposure to others' distress and trauma and burnout has been taken into consideration. One notable model of compassion fatigue suggests that burnout is one component of compassion fatigue and secondary traumatic stress is the other component (Adams et al., 2006; Stamm, 2010). According to this model the secondary traumatic stress component is related to exposure to

secondary exposure to trauma material (such as the client's account of their experience). The burnout component focuses primarily on emotional exhaustion. Burnout is considered to result from the cumulative effect of emotionally demanding situations that push personal stress levels beyond the capacity of the individual's coping resources (Kohan & Mazmanian, 2003; Maslach & Leiter, 2016). A meta-analysis which focused on examining the relationship between burnout and secondary traumatic stress (which was conceptualized to include both compassion fatigue and vicarious trauma), showed that there is a strong link between the two (Cieslak et al., 2014). This association has also been demonstrated in police, with a study of 1,351 police officers finding that compassion fatigue was positively correlated to burnout (i.e. those with higher levels of compassion fatigue had higher levels of burnout) and was also positively correlated to authoritarian attitudes (Andersen et al., 2018).

The risks for compassion fatigue and burnout can be considered to fall into three categories: exposure to other's distress and trauma; individual factors such as past experiences and training; and organisational factors such as leadership style. Further information related to each of these three categories of risk is provided below.

Exposure

Exposure to another's person suffering and disclosure of potentially traumatic events is multifaceted: this includes seeing someone's distress, knowing or suspecting the level of risk they are exposed to, and being exposed to descriptions of traumatic incidents that have occurred. Exposure to distress can be complex as it can include displays of aggression, where the lines between victim and perpetrator are blurred, thus making the experience for police officers more difficult.

Cumulative direct and indirect exposure to trauma or traumatic materials on the job can also impact on a responder's mental health and wellbeing as well as their experience of disclosure of violent incidents by victims. Known high-risk work areas for police, in terms of contributing to the development of compassion fatigue, burnout or other mental health disorder, include family violence, rape, child exploitation, child protection, police death, and homicide (Brady, 2017; Conrad & Kellar-Guenther, 2006; Ermasova et al., 2020; MacEachern et al., 2019; Maple & Kebbell, 2021; Roach et al., 2018; Seigfried-Spellar, 2018; Turgoose et al., 2017)

Individual factors

Professional self-efficacy which incorporates beliefs such as "I do my job well", "I make a difference", and "I am making an effective contribution to what this organisation does" can be a protective factor (Perez et al., 2010).

Working in isolation for those in high-risk occupations such as policing or being unmarried in other helping professions (such as therapists) has been linked to the development of compassion fatigue and burnout (Boscarino et al., 2004; Hensel et al., 2015; Killian, 2008).

Professional experience has been investigated, with mixed findings observed across professions. For mental health professionals, being younger or less experienced placed the individual at greater risk for burnout or compassion fatigue (Devilly et al., 2009). In a recent study of policing personnel, length of service was related to less organisational stress, with it hypothesised that longer service may result in increased stress tolerance over time (Varker et al., 2022). In contrast, however, police officers working the longest with rape victims were more likely to experience compassion fatigue and burnout but the researchers noted that this may indicate high levels of exposure rather than years in police (Turgoose et al., 2017).

Organisational factors

Research examining organisational causes of burnout have identified six key domains: workload, lack of control, insufficient recognition and reward, community (i.e. support from colleagues), perceived fairness of decisions and values (i.e. the ideals and motivations of the individual) (Maslach & Leiter, 2016). Using structural equation modelling, Bakker and Heuven (Bakker & Heuven, 2006) showed that for police officers, emotionally demanding work interactions lead to burnout and impaired performance. Similarly, recent research has shown that there is a direct association between negative perceptions of organisational culture, and burnout (Zeng et al., 2020).

Examination of risk factors for compassion fatigue for mental health workers, has found that those with, high case load demands, lack of a supportive work environment and working in isolation (Boscarino et al., 2004; Hensel et al., 2015; Killian, 2008). Similar risk factors for burnout in mental health workers have been identified, with older age, workload, poor relationships at work increasing the likelihood of burnout while role clarity, a sense of being treated fairly, professional autonomy and access to regular clinical supervision appearing to be protective (O'Connor et al., 2018).

3) How can compassion fatigue / burnout be identified?

There are several self-report psychological measures that have been developed to identify those who are experiencing compassion fatigue or burnout. Identifying people who are at higher risk for mental health issues can assist in facilitating treatment and support for the individual worker, and can also assist agencies in achieving greater operational efficiencies. The primary measures that is used to assess compassion fatigue is the Professional Quality of Life Scale (ProQOL; Stamm, 2010), which includes three subscales measuring compassion fatigue, compassion satisfaction and burnout. Participants are asked to answer items in relation to the last 30 days. The ProQOL is a revised, updated version of the Compassion Fatigue Self Test (Figley, 1995),

One of the most commonly used and widely validated measures of burnout is the Maslach Burnout Inventory (Maslach et al., 1997), which measures emotional exhaustion, depersonalization, and personal accomplishment. Other measures of burnout include the Copenhagen Burnout Inventory, (Kristensen et al., 2005), the Bergen Burnout Inventory (Maarit et al., 2013), the Oldenburg Burnout Inventory (Halbesleben & Demerouti, 2005) and the Shirom-Melamed Burnout Measure (Shirom & Melamed, 2006).

There are a few measures that are specifically developed for police officers, to assess constructs such as burnout, compassion fatigue, or stress. The Police Stress Questionnaire has two versions- the Operational Police Stress Questionnaire (PSQ-Op), and the Organisational Police Stress Questionnaire (PSQ-Org), (McCreary & Thompson, 2006), which are designed to measure the levels of stress associated with operational stressors and organisational stressors. These measures may present an alternate means of identifying police at risk of developing psychological problems, given that occupational stress and burnout are closely related (Queirós et al., 2020).

Alternatively, those in caring professions can be encouraged to self-screen, to identify and become aware of their own symptoms. One such self-screening instrument has been developed by Pfifferling & Gilley (2000). Although it has not been empirically validated, it can be a valuable tool. Respondents answer "yes" or "no" to a series of statements such as "my patient's stress affects me deeply" and "I feel vulnerable all the time". A general measure of psychological wellbeing can also be useful tool for individuals to screen themselves with, to check on their own psychological wellbeing. The Kessler Psychological Distress Scale (K10; Kessler et al., 2003) is a well validated, widely available tool that can be used to indicate if further assessment or support is needed.

It is also important for organisations to undertake risk assessments of certain roles, such as roles in domestic or family violence units, to ensure that those working in such high-risk roles, where they will be exposed to trauma, vicarious trauma, awareness of a victim facing ongoing danger from a perpetrator, or extended exposure to the suffering of other, are monitored and routinely offered support.

4) How does compassion fatigue / burnout usually affect an individual?

Figley (2002) noted that compassion fatigue can lead to the helper becoming tense, preoccupied, anxious, and avoidant. Other impacts may include reduced ability to feel empathy towards clients, fatigue, absenteeism, anger and irritability, sleep disturbance, impaired clinical decision making, and avoidance (Lombardo & Eyre, 2011; Sinclair et al., 2017).

Typical symptoms of burnout have been described as physical and emotional exhaustion, decreased self-esteem, feelings of helplessness and hopelessness, depression, reduced insight, and reduced capacity for decision making. These symptoms impair the individual's social and occupational functioning and may lead to absenteeism from work. Amongst medical professionals, burnout has been found to be associated with major medical errors (Shanafelt et al., 2010). In addition, burnout has been found to be related to mental health problems, including depression (Bianchi et al., 2015) and problematic alcohol use (Oreskovich et al., 2012).

For police specifically, the impact of occupational stress that is not properly managed has been reported to include absenteeism, decreased ability to concentrate, poorer quality of life and the development of mental health problems (Garbarino et al., 2013; Mustafa et al., 2015).

Investigation of the relationship between burnout and PTSD symptoms among police officers has shown that burnout can lead to PTSD for those who tend to ruminate about traumatic experiences (Ogińska-Bulik & Juczyński, 2021). Furthermore, hopelessness (characterised by negative expectations for the future) has been associated with burnout, depression and suicidality, and an investigation of police found that hopelessness was significantly associated with depression and burnout (Civilotti et al., 2022). Hopelessness is a particularly important indicator, with earlier research showing that it is 1.3 more times likely to explain suicidal ideation, than depression (Beck et al., 1993). Therefore it is important that those with burnout, chronic stress, or compassion fatigue are identified and appropriately supported to prevent the development of mental health disorder.

5) How do compassion fatigue and burnout affect an organisation's ability to perform its duties?

When workers are experiencing burnout, research has shown that they are more likely to be absent, they have greater intention to leave, there is greater chance of turnover, they are less effective and have poorer job performance (Maslach et al., 2001; Mor Barak et al., 2001; Wright & Bonett, 1997). Amongst medical professionals, burnout has been linked to suboptimal patient care, and lower patient satisfaction ratings (Williams et al., 2007). For police organisations, it has been suggested that the negative long-term effects of burnout may impair the functioning of the organization by increasing rates of absenteeism, decreasing the quality of work, and increasing intention to leave (Noblet et al., 2009). Furthermore, police organisational stressors such as red tape, role ambiguity, administrative hassles, and office politics have been shown to cause exhaustion in the long term, and less engagement with the work (Lockey et al., 2022).
As noted previously, burnout can also lead to increased cynicism and this may be particularly of concern when dealing with vulnerable victims such as survivors of family and domestic violence, which may require

more time and empathy to lead to effective interventions (e.g. links between empathy and disclosure in policing(Greeson et al., 2014).

6) What is the current best practice for preventing compassion fatigue and burnout in organisations like QPS

Primary Prevention

There are a number of steps that can be taken at the primary prevention level to mitigate against the risk for the development of compassion fatigue and burnout. Known risk factors, identified in the literature, such as inexperience, excessive workload, working in isolation, lack of support or supervision, and unclear role definition should be addressed where possible (Phelps et al., 2009).

Protective factors such as establishing and maintaining emotional boundaries, clear role definitions, camaraderie, and clear role definitions should be fostered, and strategies to maximise these should be developed. Further risk and protective factors specific to the organization should be identified through consultation with staff.

There is considerable interest in the promise of pre-incident/exposure training in building resilience, and mitigating the effects of exposure to trauma. A resilience intervention trial with new recruit Victoria Police officers showed that those with higher resilience had less burnout (Devilly & Varker, 2013). Recent reviews of resilience training and interventions for first responders indicated that while there is currently a lack of evidence for specific resilience interventions for first responders, several studies in this area underway, such as work being conducted with new recruit UK paramedics who are receiving an internet-delivered resilience training program that directly targets and aims to modify cognitive processes that are known to be linked to the development of PTSD and depression following exposure to a critical incident (Janssens et al., 2021; Wild et al., 2020; Wild et al., 2016). Given the limits of the scientific evidence at the current time however, modifying organisational and operational risks, as described above, training operational and line managers are the most promising opportunities for primary prevention.

Secondary Prevention

Secondary prevention is also essential in detecting worker at high risk of developing compassion fatigue and burnout, as well as those with early signs of these problems. This can be undertaken through risk assessment of roles, or by early identification of those with symptoms, as described in Question 3.

It is particularly important that there is a risk assessment of roles where police officers likely to interact with people who have been exposed to a high level of trauma. An assessment of a role as being high risk should

trigger increased attention to providing support to the worker (Phelps et al., 2009). Police in particularly high risks roles, where exposure to direct and indirect trauma is high, such as child exploitation, homicide and family and domestic violence should, in particular, be provided with sound prevention strategies and monitoring of mental health and wellbeing impacts of exposure. The organisation should manage the exposure loads of those working in high-risk areas, in terms of exposure to trauma, vicarious trauma, prolonged exposure to caring for, or the distress of victims. Mechanisms should also be put in place for early identification of wellbeing issues, through both formal mental health screening by the organization, and informal screening, by encouraging workers to self-screen. An example of a self-screen tool is provided in our response to Question 3.

Encouraging self-care is also a well-recognised means for mitigating against the development of compassion fatigue and burnout. Recent research has shown that police officers who engage in self-care behaviours are less likely to experience burnout, compassion fatigue and vicarious trauma (Burnett et al., 2020). The way in which an individual looks after their well-being (i.e. self-care), will vary between individuals, but should include strategies such as: healthy eating; limiting alcohol intake; getting sufficient sleep; limiting the number of hours worked; taking regular rests from work, including regular breaks during the day, and occasional holidays; and avoiding overwork. It may also include strategies for coping with specific trauma material, such as using support networks or peer support; reducing other sources of stress; and engaging in other enjoyable activities (Phelps et al., 2009).

However, as indicated in our response so far, encouraging self-care and mental health awareness alone is not going to be sufficient if organisational factors that increase the risk of burnout are not addressed. For example, it is important to ensure that recruitment and induction foster role clarity and a sense of competency, particularly in those units or groups that are most at risk because of secondary trauma exposure through dealing with vulnerable victims. The role of both executive and line managers in ensuring that workloads are manageable, that there is a supportive culture, free of bullying and where workers feel treated fairly is also important.

7) How can compassion fatigue and burnout be managed/treated?

Although burnout and compassion fatigue should be managed and treated at both the individual level and the organisational level, the focus of research efforts has been on interventions for the individual. These interventions tend to be general in nature, seeking to either increase the workers' awareness of signals of stress, through self-monitoring for symptoms of distress or stress, self-assessment of their level of burnout or stress, or provision of information on the signs and symptoms of stress. This is often accompanied by practical information on relaxation strategies, healthy habits (i.e. diet, sleep, reduced alcohol intake,

exercise), and cognitive behavioural techniques such as stress inoculation training, cognitive restructuring, and behavior rehearsal. (e.g. Freedy & Hobfoll, 1994; Gardner et al., 2005). There is, however, a concern that these interventions do little to change the environmental stressors.

Modifiable variables within the policing context that appear to be significantly related to mental health include leadership style, provision of social support by supervisors and colleagues, organisational engagement and stigma (Carleton et al., 2020; Padyab et al., 2016). In other words, a culture that encourages police officers to report problems early and support from immediate supervisors and colleagues are important elements of recovery.

8) Whether there are any other systemic issues (specific to your area of expertise) that affect the function of the QPS / equivalent organisations?

As we have touched on briefly in some of our earlier responses, it is important to recognise the role of trauma in terms of its' impact on the mental health of police officers. Police officers, by virtue of their occupation, are exposed to high rates of occupational trauma. The recent "Answering the Call" study indicated that amongst Australian police officers, 10.6% are experiencing current probable PTSD (Kyron et al., 2022). Other mental health disorders are also elevated for police officers, with a meta-analysis showing that 14.6% were experiencing current depression or depression symptoms and 9.6% had generalised anxiety disorder (Syed et al., 2020). The data from Answering the Call showed even higher rates, with 16.1% having probable current depression and 16.3% with probably anxiety, and 60.6% of police screening positive for alcohol use disorder (Kyron et al., 2022). In addition the data from this study showed that there was a strong association between mental health issues and length of service – rates of psychological distress doubled among with over 10 years of service. These findings are consistent with the theory that cumulative trauma is a risk factor for mental health disorder (Karam et al., 2014). Police officers who are experiencing mental health disorders such as PTSD, depression, anxiety or alcohol use disorder are likely to be less effective and have suboptimal job performance.

In recent times, moral injury has been investigated in a number of occupational groups. Moral injury refers to events in high-stakes situations where someone perpetrates, fails to prevent or witnesses actions that "transgress deeply held moral beliefs and expectations" (Litz et al., 2009, p.1). Due to moral risks experienced by police officers, they experience potentially morally injurious events (PMIEs) and are vulnerable to the development of morally injurious outcomes. A recent study of moral injury in police officers operationalised moral injury of the respondent's exposure to "perceived offenses" and/or exposure to others' "perceived betrayals" (e.g. "I am troubled by having acted in ways that violated my own morals or values". "I

feel betrayed from fellow service members who I once trusted") (Papazoglou et al., 2020). It was found that moral injury predicted PTSD, and it was also found that compassion fatigue predicted PTSD. As such, there is potential that some QPS police may also suffer from moral injury, which could also impact their mental health and job performance.

9) What measures are necessary to ensure that training and practice supervision assists to assure continued good culture in an organisation like the QPS?

It is important that a trauma informed culture is created, as police officers regularly encounter community members with mental health issues or trauma exposure, particularly when working in high-risk areas (Lorey & Fegert, 2022). In addition, as previously discussed, at any given time a number of fellow police officers will be dealing with mental health issues, and exposure to potentially traumatic events. A trauma informed culture would involve police officers being educated about the types of trauma responses that they may encounter, when dealing with traumatized individuals, and why such responses can occur.

Leadership training will also assist to ensure that there is a health culture, with training focused on fostering leaders who promote team cohesion and are trained in ethics. Leaders who build strong cohesion and morale create teams that exhibit less behavioural health problems (Wilk et al., 2013).

In addition, peer support programs can provide a useful way of increasing support options for police and assist in addressing barriers to standard care such as stigma, lack of time, poor access to providers and lack of trust. Peer programs should be established and maintained in line with best practice principles, as described in the "Guidelines for Peer Support in High-Risk Organizations" (Creamer et al., 2012).

10) Can you provide examples of models used by other agencies that may be able to be implemented by QPS?

There are a range a models that can be referred to when looking at improving prevention and response to compassion fatigue and burnout. Examples of these models are provided on the following page.

Sound overarching wellbeing strategies- the Victoria Police strategy (https://www.police.vic.gov.au/mental-health-strategy) highlights actions to support role preparedness, leadership support for mental health awareness and reporting and access to quality support services. These are all important aspects to prevent and respond effectively to compassion fatigue and burnout. It takes a lifecycle approach where members' mental health is considered from recruitment to transition out of the service.

Embedded, centralised support services: SHIELD- AFP's health hubs that brings health, operational readiness and mental health together, therefore increasing accessibility, coordination and has potential to decrease stigma for presenting for mental health (https://www.afp.gov.au/news-media/platypus/shield-leading-way-health-and-wellbeing).

Best practice guidelines for high risk industries – The Beyond Blue Good Practice Framework for Mental Health and Wellbeing in First Responder Organisations provides guidance for police and emergency services agencies on how to create and maintain a healthy workforce (https://www.beyondblue.org.au/docs/default-source/resources/bl2042_goodpracticeframework_a4.pdf). Internationally, the Police Specific Wellbeing Guidelines have been developed to help police services benchmark their practice in supporting the health and wellbeing of their personnel, and these also include an online self-assessment tool (https://www.college.police.uk/support-forces/health-safety-welfare/wellbeing).

Prevention, response and support with regards to high stress and traumatic stress - Phoenix has developed a framework, first based on its work with the AFP (Phelps et al., 2018) that aims to describe evidence-based strategies that organisations can use to promote employee wellbeing, protect them from the impact of exposure to traumatic events and offer effective and timely support to employees that develop mental health difficulties following exposure. The framework provides a series of principles and recommended actions to address both organisational stressors such as lack of clarity of role and operational stressors such as shift work and cumulative exposure that are likely to make coping with secondary and direct trauma more difficult. This includes recommendations around areas such as role preparedness, leadership support and monitoring.

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