b) Training must be ongoing. In military forces it never stops, so why should it stop in police forces? Stress reaction begins to occur when the individual runs out of problem-solving techniques. Better trained people don't run out of ideas as easily.
c) Training at times should include the police officer's family, e.g. "immunisation" lectures in dealing with critical incidents, coping with peer group and family pressures, moving towards promotion, and preparation for overseas postings.

Experience has shown that a supportive family environment, based on good communication, is the best buffer against work-induced stress. Once the family support buckles from factors outside of work, or is forced to buckle because of work stress, then the decline in the member's capability to withstand stress is rapid and pervasive.

Some basic information and support to families can do a lot to prevent the vicious cycle of stress.

Management

a) Management must become personnel-orientated so that personnel can feel free to concentrate on the job. In many police forces it is senior management which is job-orientated, and the line police officers have to look after themselves.
b) Superintendents and above ranks need to work regularly with line police officers to remind themselves what the "hands on" work is like, and to be seen, and receive feed back.
c) When senior management responds quickly and personally, and talks directly and supportively to line officers involved in traumatic incidents, the effect is usually dramatically favourable.
d) Psychologists, assisted by the medical officers, should be regarded as staff officers, and called in promptly by senior management to provide additional expert support.

Selection

Personnel selection may one day reach a point of such expertise that stress-resistant people alone will be picked for police duty, but there are a few things we can do now:

a) Look for a sense of humour.
b) Look for people with big healthy interests in spheres outside their police work.
c) Look for people who like to do their personal best, but don't expect help from others.
d) Look for people that don't have to "win" or be "vindicated". (We are personally suspicious of anyone daring to use the latter word).

Trauma Intervention

Some confusion has arisen at times about the terms "traumatic stress", "critical incident", "post trauma stress disorder", and "post shooting trauma".

Throughout a life-time, incidents occur that produce an actual or perceived threat of death, or an overwhelming sense of helplessness. These are termed "critical incidents". Post shooting trauma is just one specific form of a critical incident.

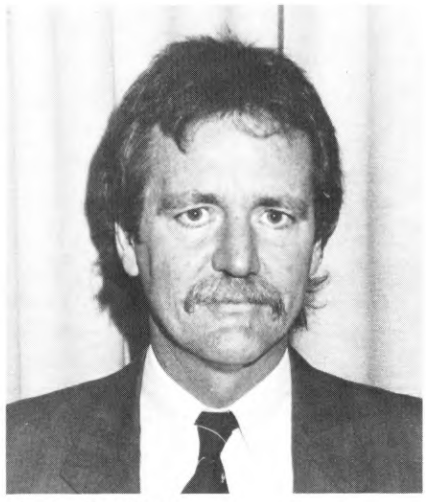
A critical incident has the capacity to produce traumatic stress and if this is not dealt with effectively at the time of the incident, it can develop into a post trauma stress disorder (PTSD).

Remember that not all people respond to the same incident in the same way. This is due to a variety of factors including past life experience, proximity to the incident and individual personality differences. The rule of thumb is that one third of the population will have a severe reaction, one third a moderate reaction, and one third little or no reaction to stressful incidents.

The AFP now has guidelines in place, outlined in Administration Circular 277, Gazette 13/88, that provide a framework for commanders, medical services and psychology services to provide support following a critical incident.

So, with police stress several key factors that promote health following a traumatic event:

a) Members should remain at work following an incident. If they can do anything and do not seriously impinge on the operational efficiency, they stay in the line.
b) It is extremely important that they not be given a label of illness. By this it should be impressed on members that the stress they are suffering is "a normal reaction to an abnormal situation".
c) It is also critical that members receive leadership and social support, both from the organisation and at home.



Mr Len Backhouse.

d) It is also appropriate to discharge the tension by reliving in words, feelings and actions, the traumatic experience in the presence of professional support, e.g. medical/psychological.

Footnote:

Dr Michael Dwyer

Michael Dwyer is the Health Services Adviser to the AFP. He graduated in Medicine from Sydney University in 1952, and combined 20 years of general practice at Gosford with service in the Australian Army Reserve until 1981, when he transferred to the Regular Army, serving as SMO Land Warfare Centre Canungra in 1981, and as Colonel Preventive Medicine, Directorate Army Health Services 1982–84. He became Director Medical Services AFP in January 1985. He served with the RAAMC in Vietnam 1968–69, and as MO to a survey squadron in Irian Jaya in 1977.

He was appointed a Member of the Order of Australia in 1978, and holds the Efficiency Decoration and the Reserve Forces Decoration.

He will retire to Sydney in April 1989, and will continue to serve the AFP as a consultant.

Mr Len Backhouse

Len Backhouse is psychologist to the AFP.

After gaining a B.A. degree in 1980, and a Grad.Dip. in Science (Psychology) in 1982, Len worked with Dr Barnardo's as a Residential Youth Worker, and then with the CES as an Occupational Psychologist for three years.

He joined the AFP three years ago and has mainly been involved in recruiting, training and providing counselling and consultative services.