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Leadership for Wellness: A Strategy for Developing Police and Public Safety Leaders

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Table of Contents

Executive Summary

Working in the police profession is associated with higher rates of post-traumatic stress disorder, depression, anxiety and poor health outcomes (Carleton, Afifi, Taillieu, Turner, Mason et al., 2020). Individuals who are employed by police agencies have undergone psychological testing at the time of their recruitment, meaning that individuals entering the academy are more psychologically healthy compared to the general community. The job of policing is impacting on people who represent some of the most psychologically healthy in our population but results in many becoming the most psychologically *unhealthy* individuals within employed cohorts (Carleton et al., 2020; Chowdhury, Shah & Payal, 2017; Drew & Carroll, 2022; Regehr et al., 2019). In response, police agencies have embarked on the development of a range of organisational initiatives to address wellbeing (Polkinghorne & Drew, 2021). Unfortunately, despite these efforts we are yet to see any substantive signs of decline in adverse psychological outcomes.

In this paper we contend that one reason that we have not achieved greater success is due to a predominate focus on trauma as the leading cause of harm. While trauma has a role to play in understanding wellbeing outcomes, the focus on trauma has had the unintended consequence of diverting attention from the substantial adverse impacts we now know are being caused by workplace stressors (Carleton et al., 2020; Drew & Carroll, 2022). Organisational and operational stressors form a hidden 'black box' of potential harms that has not been adequately acknowledged or addressed. For this reason, we call attention to *leaders and leadership*. Our aim is to draw focus to the fact that the continued and persistent rate of psychological ill-health in our police and public safety agencies is fundamentally a *people issue*; it must go beyond simply providing support to staff who are negatively impacted by the workplace. Leaders create, or at least influence, many of the workplace factors that are associated with wellbeing. Leaders have a pivotal role to play and need to be effectively supported in their role to create and maintain the critical factors that sustain healthy workplaces.

We focus on the role of leaders and leadership. Our aim is to draw attention to the pivotal role of leaders in creating and maintaining healthy workplaces.

The Role of Leaders and Leadership

As highlighted, recent research has shed light on the significant harm caused by organisational and operational stressors, particularly for police, beyond the impact of traumatic events and critical incidents (Carleton et al., 2020; Drew & Carroll, 2022). These include factors such as management of employee workload, bullying and harassment, (un)supportive leadership, feelings of being undervalued by the organisation, and balancing workload demands to promote physical and psychological health (Carleton et al., 2020; Drew & Carroll, 2022). After accounting for the impact of trauma, organisational and operational stressors remain highly associated with negative psychological and health outcomes for police (Carleton et al., 2020; Drew & Carroll, 2022). This means that we can no longer contend that direct experiences of trauma provide a comprehensive explanation of the high rates of psychological distress and poor wellbeing we see in police cohorts.

Police agencies have devoted considerable effort to the management of, and response to, negative health outcomes amongst staff. Policies, procedures, strategies, human resource processes and injury management are all vital mitigation efforts. However, they focus on organisational systems and are typically designed to wait for harm to occur and then intervene, rather than prevent harm. Further, while organisational systems and processes have an important role to play in mitigating poor health outcomes for employees, organisations are not living, breathing entities. Organisational systems are created, managed and maintained by the people and leaders who work within them. It is leaders inside organisations who can play a pivotal role in the application of organisational mitigations; operationalising them into individual interactions with staff, and ultimately understanding and modifying the workplace factors that may create significant harms. We must have a clear and distinct focus on how we can support leaders, who through their decisions and actions, have an enormous impact on staff wellbeing.

> *Organisations are not living, breathing entities; they are created, managed and maintained by the people and leaders who work within them.*

The role for leadership is of course different at varying levels of the organisation. Senior leaders can address factors and systems at an enterprise level to create healthy police workplaces. Leaders at supervisory and middle management levels have the closest proximity to, and influence over, the day-to-day workplace experiences of staff. Through these day-to-day interactions they create and manipulate the broad organisational environment (Gayed et al., 2018).

Leaders who role model healthy workplace behaviours, including the importance of self-care, can inspire staff to follow their example (Franke, Felfe & Pundt, 2014). They can also generate a sense of shared responsibility with staff, to collaboratively create safe and productive work environments. In short, the health of the workplace and employee wellness, are reliant on the behaviours, skills and attitudes of their leaders, who can "make or break" the experience of work.

In developing the Leadership for Wellness Strategy, we leverage a framework for understanding workplace health developed by Franke et al. (2014) to create a holistic leadership development approach.

Based on a review of wellness interventions being implemented by Australian and New Zealand (ANZ) police agencies, Polkinghorne and Drew (2021) concluded that despite the pivotal role for leaders and leadership in employee wellbeing, none were adequately equipping leaders to undertake this role. This is not an ANZ phenomenon. Evidence provided in this paper, based on a comprehensive review of global literature, also found no published empirical evaluations of police leadership programs that had sufficient focus on leadership for wellness. On this basis, it is proposed that a way to address this identified gap is through the development of a *Leadership for Wellness Strategy.* This *Strategy* is focused on the education and development requirements for leaders, who will lead for wellness. Implementation of the *Strategy* will enable leaders to better support organisational efforts focused on the wellbeing of their staff.

A 'Leadership for Wellness' Strategy

In developing the *Leadership for Wellness Strategy,* we leverage a framework for understanding workplace health developed by Franke et al. (2014) to create a holistic leadership development approach. We believe the Health Oriented Leadership model (HoL) is a useful foundation on which to develop a comprehensive, health-supportive, leadership development approach for police and public safety agencies. The HoL articulates the complex interplay between how health is 'valued' by leaders and followers. It considers how aware leaders and followers are of the impact of their organisational context on their health and, the behaviours in which leaders and followers engage that either support or undermine their wellbeing. As a result, the model provides a frame through which leaders can better understand their role and how they can influence workplace factors to promote their own, and the health of their staff. It is model that equally weighs the importance of improving the health of leaders themselves, with the role and responsibilities of leaders to influence the staff health. Rather than blame leaders for poor outcomes, HoL points to the multidimensional relationship between leaders, wellbeing, and health, while recognising the role leaders play in creating and modifying workplace factors that cause harm (Franke et al., 2014).

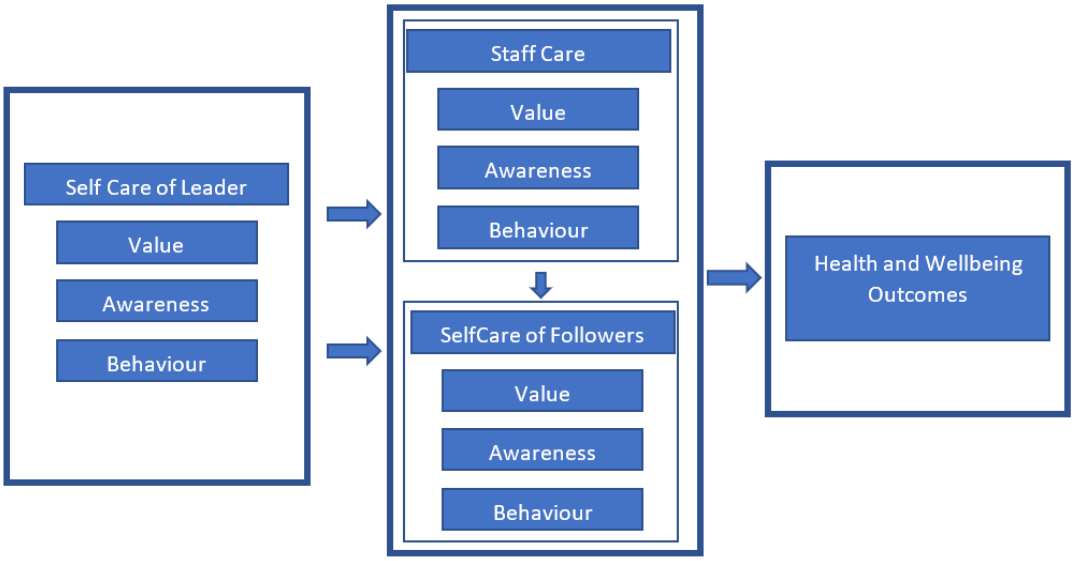

Figure 1. The Health Oriented Leadership Model (Adapted from Franke et al. 2014).

This health-supportive approach can be regarded as 'primary prevention'. It seeks to uplift leaders' knowledge, skills and behaviours to create and sustain healthy workplaces, and

prevent workplace generated health harms. This addresses the critical gap that has been identified with current approaches most often used by police agencies (Polkinghorne & Drew, 2021), there is a need to create initiatives, programs and interventions that prevent harms rather than waiting for harm to occur and then respond to it.

We adopted a systems perspective to create an evidence-based *Leadership for Wellness Strategy* for police and public safety. This has produced a *Strategy* that we contend is the first of its kind in the world. The *Strategy* complements the parallel work of police and public safety organisations, by equipping leaders to better support the many organisational efforts to create workplaces the influence, support and maintain healthier outcomes. Our *Strategy* comprises work across three key domains:

- An AIPM-Griffith Criminology Institute *'Leadership for Wellness'* pilot program; a leadership development program developed to explicitly focus on activating the knowledge, skills and behaviours required by leaders who will *lead for wellness*[1].
- Extension of existing programs to integrate a health-oriented leadership knowledge across general leadership development activities carried out by AIPM[2].
- Stimulation of a global conversation, utilising digital mediums, between police and public safety leaders; involving the dissemination of content that supports leaders in recognising their unique role in contributing to organisational wellness initiatives.

Structure of this Document

This paper is structured in two parts:

First, we provide an evidence-informed review that led us to conclude that police and public safety agencies have taken a predominate focus on the impact of trauma on poor health outcomes amongst staff. This has, in large part, obscured the role of workplace stressors on those same outcomes. We explore the prevalence and types of stressors that are most connected to poor wellbeing and argue, that the role for leaders in mitigating these harms and risks, has to date been largely overlooked. We must ensure that leaders have the knowledge, skills, and behavioural repertoire to enable them to support broader organisational intentions to protect and enhance staff health and wellbeing.

[1] An evaluation process (discussed later in the report) will be undertaken to monitor understanding, impact, and effectiveness of the pilot program.
[2] An evaluation process (discussed later in the report) will be undertaken to monitor understanding, impact, and effectiveness of the integration of *Leadership for Wellness* principles into existing AIPM programs.

Second, we suggest a *Strategy* that focuses on the development of leaders to better understand their role, both in creating a workplace that enhances positive staff health and wellbeing outcomes and a workplace that mitigates risks. We articulate our proposal as a *Leadership for Wellness Strategy* that is founded in a health-oriented leadership framework. The health-oriented framework is one which is supported by a growing body of evidence for its efficacy. Our *Strategy* is designed to equip leaders with the tools to enable them to mitigate workplace harms before they negatively impact staff, a true primary prevention approach. This second part of the paper will elaborate on each of the three domains identified earlier that encapsulate the *Strategy*. These include the AIPM-Griffith Criminology Institute *'Leadership for Wellness'* pilot program; integration of leadership for wellness content across AIPM's leadership development suite; and, stimulating the global conversation among organisational police and public safety leaders.

We conclude the paper with an invitation to join us in developing a language and set of leadership practices for policing and public safety that supports better health and wellbeing outcomes for all staff across the profession.

Part 1: Understanding the Leadership-Wellness Nexus

Police and public safety agencies have long acknowledged their responsibilities around physical health. Recent workplace health and safety legislation now requires agencies across Australia to eliminate, or at least reduce, *psychosocial hazards*[3] that stem from organisational and operational factors (SafeWork Australia, 2022). Workplace health and safety legislation stipulates that the goal of agencies must be *prevention rather than cure*. Meaning that organisations and leaders are now legislatively bound to proactively identify the presence of harms (assess risk) and once recognised mitigate these risks a priori in the future (control hazards and risks; and, review control measures). In this part of the paper, we explore the nature of workplace harms stemming from organisational and operational stressors, the reactive and preventative mechanisms that are at the disposal of agencies, and the role of leadership. We then explore the existing literature to review how leadership has been incorporated into corporate wellness agendas. Finally, we identify a useful theoretical model that can be used to support the translation of the leadership practices into tangible wellness outcomes.

Understanding the Nature of Harms

When considering the mitigation of psychosocial risks, particularly those that stem from organisational and operational stressors in policing, most agencies have focused on the impact of trauma and critical incidents; and mechanisms for responding after hazards have been experienced by staff. This is understandable. Exposure to traumatic events is part of the policing and public safety role and frontline staff experience a very high prevalence of traumatic incidents over the course of their career (Rose, Bisson, Churchill & Wessely, 2002; Wagner, White, Fyfe, Matthews, Randall et al., 2020). Consequently, wellness strategies and interventions have tended to be responsive in nature. These post-hoc interventions are classified as either secondary or tertiary level. Secondary interventions are reactive, they detect and respond to wellbeing problems once they have occurred and seek to minimise the progression of poor health. They do this through modifying individuals' appraisal and responses to stress, for example, through such interventions as mediation or relaxation

[3] "A psychosocial hazard is anything that could cause psychological harm (e.g. harm someone's mental health). Common psychosocial hazards at work include: job demands, low job control, poor support. Psychosocial hazards can create stress. This can cause psychological or physical harm." (SafeWork Australia, 2023 - https://www.safeworkaustralia.gov.au/safety-topic/managing-health-and-safety/mental-health/psychosocial-hazards)

programs (LaMontagne, Ostry & Shaw, 2016). Tertiary interventions focus on treatment or management of health problems and include return to work programs and rehabilitation (LaMontagne et al., 2016).

While secondary and tertiary interventions will also be needed as it is impossible to eliminate all psychosocial hazards and risks, the goal of a wellbeing agenda should always be to invest and engage in primary prevention. Primary intervention approaches seek to address wellbeing through a reduction in job stressors, for example, implementing job design or changes to the organisational environment initiatives (LaMontagne, Martin, Page, Reavley, Noblet et al., 2014). Currently, very few police wellbeing strategies are engaging primary interventions, interventions or initiatives that seek to prevent work-related psychological harm in the first place (Polkinghorne & Drew, 2021).

Research has started to confirm what many in policing and public safety agencies intuitively knew: that trauma is only one of the drivers of harm. Significant impacts are also caused by organisational and operational stressors. Carleton et al. (2020) conducted research with Canadian public safety personnel (including police) and found that staff shortages and bureaucratic 'red tape' were the key drivers of harm. Operational stressors, including fatigue associated with shift work and working alone at night, were also strongly related to negative wellness outcomes. These findings were echoed in research with United States law enforcement officers, which found that staff shortages and fatigue were the most highly rated sources of stress (Drew and Martin, 2022a). These types of findings are important when we consider what is the viability of primary preventions approaches to wellness in policing and public safety. Trauma is inevitable and will most often demands secondary and tertiary interventions; organisational and operational stress much more within the control and mandate of actionable modifications of agencies. Harms stemming from organisational and operational stress can be targeted by primary prevention approaches.

To fully understand what can be achieved, if we address the relationship between organisational and operational stress on poor wellbeing, we must calculate the proportionality of impact that trauma, organisational and operational stress has on staff. Carleton et al. (2020) research with Canadian public safety personnel found organisational and operational stressors were two times more strongly related with negative psychological outcomes compared to the impact of trauma (Carleton et al., 2020). In a study, which for the first time assessed the proportional harm caused by trauma, organisational and operational stress for an Australian

police cohort, trauma was not found to have a significant or direct predictive relationship with exhaustion (burnout) when considering the impacts of organisational and operational stressors. Trauma was only connected to exhaustion in the presence of organisational and operational stress. While trauma was found to be significantly and directly related to psychological distress, organisational stressors had a three times stronger relationship and operational stressors had an almost 2.5 times stronger relationship with psychological distress compared to trauma (Drew & Carroll, 2022).

This research, coupled with the legislative imperative to identify and prevent workplace harms, provides the evidence and in turn, the impetus for agencies to address the organisational and operational artefacts associated with the day-to-day nature of job. If the artefacts of the bureaucratic, hierarchical structure of police and public safety agencies is a significant cause of harm, there is a pivotal and mandated role for leaders.

Australian research indicates that compared to the relationship between trauma and psychological distress, organisational stressors are 3 times and operational stressors are 2.5 times more strongly related with distress outcomes (Drew & Carroll, 2022).

The Role of Leaders in Creating Healthy Workplaces

Middle managers and front-line supervisors are directly involved in managing staff and controlling aspects of day-to-day work. They have an essential role in shaping workplace attitudes, and as such the experiences of individual staff. Given the numbers of middle managers in our agencies and the high overall proportion of organisational staff with which they engage, this middle tranche of leaders and managers represent a vital lever in securing organisational wellbeing.

We must acknowledge that the role of a leader in mitigating operational and organisational harms varies, it will not always be within the span of control for middle managers to influence workplace factors connected to wellbeing outcomes. Some factors, such as the structure of shift work, or whole-of-agency bureaucratic systems, necessitate larger scale reforms. Leaders at the highest levels of an agency could address these by engaging in organisation-wide structural and policy changes, or lobbying government and partners for reimagined support.

Fortunately, many of the organisational and workplace factors influencing wellbeing that can be created, supported, and enacted by leaders can occur at the front-line and middle management level. They do not always necessitate financial or human resources that are more characteristic of the types of reforms demanded of senior leaders. As an example, one critical factor that has no financial impost and is arguably one of the most important ways of influencing wellbeing is the enactment of organisational justice by supervisors and leaders. Research has found that middle managers who create supportive, organisationally just, cultures (i.e., an environment perceived by staff to be a fair place to work) can reduce staff cynicism and embitterment and increase wellbeing (Drew & Martin, 2022b; Nero, Campbell, Doyle & Meagher, 2022; Richardsen, Burke & Martinussen, 2006; Trinkner, Tyler & Goff, 2016).

Australian and New Zealand Police: Strategic Plans for Wellness

In Australia and New Zealand police agencies, and consistent with the narrative set out above, early waves of wellness initiatives in agencies centred on interventions such as critical incident stress debriefing and training to address the experience of trauma, are rooted in the belief that elevated stress in policing is most closely associated with exposures to these types of events (Rose et al., 2002; Wagner et al., 2020). This has resulted in interventions that are mostly at the secondary or tertiary level, supporting staff after an event has occurred. It has also led to the creation of many interventions that are centred on the individual. Popular interventions, such as induvial resiliency training, prepare staff to experience or cope with the inevitability of traumatic harms.

While these interventions remain essential in policing and should be a part of a suite of offerings, they are insufficient to meet new legislative imperatives and perhaps, even more importantly, research has shown that they are unlikely to create the meaningful behavioural change required to support wellbeing most effectively (Wild, El-Salahi, Degli Esposti & Thew, 2020). Yet these sorts of initiatives persist. A recent analysis of all mental health and wellbeing strategic plans produced by Australian and New Zealand police agencies found that agencies acknowledge the importance of leadership in achieving wellness objectives (Polkinghorne & Drew, 2021). They had plans to ‘train’ leaders on mental health principles, but typically focused on improvements to knowledge, such as improving mental health literacy or psychoeducation or providing support to those who had already been identified as having poor wellbeing. Only three agencies indicated that mental health training would be

specifically tailored to leadership cohorts. The researchers concluded that these strategic plans reinforced the predominance of secondary and tertiary level interventions, that primary prevention was largely focused on the individual (rather than organisational or leadership reforms) and there continued to be an enduring emphasis on trauma rather than organisational and operational stressors (Polkinghorne & Drew, 2021).

What seems missing from these strategic plans is the linkage between organisational and operational factors - which are under the control of agencies and their leaders – and mechanisms to support leaders to effectively recognise harms and make necessary changes. Instead plans inadvertently reinforce the notion that individuals are responsible for their own wellbeing, and the best the organisation can hope to do is to encourage resilience and 'pick up the pieces' afterwards. It has been acknowledged that such interventions are important, particularly in the context of trauma and critical incidents, however we must move our agenda to better incorporate the many drivers of harm that lie in the organisation itself. Leaders, with the right guidance and support, represent a promising mechanism to mitigate operational and organisational harms.

While agencies across Australia and New Zealand have made some progress in recognising the role of leaders in achieving organisational wellness outcomes, they have thus far struggled to articulate the 'how'. We would contend that leaders are an underutilised resource in improving police wellbeing. In the following section we provide an evidence-based review of the international literature to provide a comprehensive understanding of the approaches being taken by police agencies across the world to developing leaders to *lead for wellness*.

Police Leadership Development for Wellness Across the World

We sought to identify any rigorously evaluated leadership development programs from across the world that were designed to support police leaders to achieve organisational wellness outcomes. We focused explicitly on police leadership development programs. The purpose of the review was to determine whether there were existing leadership development programs that might be adapted for use in Australia and New Zealand. We undertook a comprehensive systematic review of the literature (academic and grey literature) using the Global Policing Database (GPD) (Higginson, Eggins, Mazerolle & Stanko, 2015) for the period 2009 to 2019. We identified literature that involved an empirical evaluation of a police-specific leadership training or development program and which included measurements of wellbeing outcomes

such as work-related stress, psychological distress, mental health diagnoses or burnout. We found only three articles that met the inclusion criteria[4].

1. Biggs, Brough & Barbour (2014) undertook an evaluation of a leadership development program in a large Australian state police agency. The study measured changes in perceptions of work-related characteristics, attitudes, and wellbeing among subordinates whose direct supervisor had undertaken the leadership program. When questioned seven months after the program, subordinates reported increased levels of work-culture[5] support, work engagement, job satisfaction and strategic alignment.[6] No changes were found in the levels of supportive leadership, psychological strain, turnover intentions, or job demands experienced by followers, suggesting the benefits of the program were experienced at the team, rather than the organisational level.
2. The second empirical study[7] was a randomised control trial (RCT) which included a 'leading for wellbeing' program and coaching for station-level leaders, sergeants, and senior sergeants. Station leaders also completed one-day of mental health literacy training. This research was undertaken with the Victoria Police, Australia. The aim of the program was to improve the supportive leadership capabilities of leaders and this was, in turn, predicted to improve psychosocial working conditions ((LaMontagne, Martin, Page, Reavley et al., 2017)[8]. The intervention was designed to operate at primary, secondary and tertiary levels; seeking to improve psychosocial factors, create a supportive workplace, and improve both help-seeking and help-offering. The research found no significant improvement on any of the outcome measures, although the authors strongly noted this was most likely due to a range of implementation challenges.

[4] Two articles were identified via the GPD and one additional article was located based on the first author's knowledge of relevant research. The additional article was not identified in the GPD as it did not indicate in either the title or abstract that the population under study included police.
[5] 'extent to which the organization's culture is viewed as supportive of staff in response to both chronic and acute stressors' (Biggs et al., 2014, p.53)
[6] 'employees' perceived awareness and importance of the organization's strategic priorities' (Biggs et al., 2014, p.53)
[7] This paper was originally identified as a published protocol for a cluster RCT undertaken with the Victoria Police, Australia (LaMontagne, Milner, Allisey, Page, Reavley et al., 2016). Contact with authors of the article lead to the identification of a research report, written in 2017 that was based on the same study. This report was included in our review (LaMontagne, Martin, Page, Reavley et al., 2017).
[8] For staff, this was predicted to be the improvement of supervisor support. For leaders it was predicted to be improvements in people management skills, which would lead to lower job demands.

3. The third study involved officers employed by the Hong Kong Police Force (Au, Wong, Leung & Chiu, 2019) and examined the effectiveness of Emotional Fitness Training. It focused on improving resilience, emotional well-being, positive emotions and cognitive flexibility. Leaders were engaged in the training, but largely in a 'train the trainer' capacity, making it difficult to assess the full impact of the program on their own leadership approach. The program was less effective for leaders in the agency, compared to its impact on general staff. The authors suggested this could be attributed to the lack of out-of-class practice in which leaders engaged.

There are three substantive conclusions that can be drawn from the systematic review:

- First, is the lack of methodologically rigorous evaluation research that has been undertaken on police leadership development programs that has included measurement of wellbeing outcomes. Very few police leadership development programs are seeking to understand the impact of leadership training on either leader or staff wellbeing. The finding that only three relevant studies could be located that examined the relationship between leadership and wellness was initially surprising. However, reflecting on the review work of others (Neyroud, 2011), robust evaluations of leadership development interventions in policing, even beyond a focus on wellness, appear to be a rare undertaking.
- Second, only one study (LaMontagne et al. 2017) fully embraced the notion of a leadership development program that was specifically designed to impact psychological health. The other two studies identified in the systematic literature reviews having wellbeing outcomes measures (and hence, meeting the criteria for inclusion in the review) they did not provide an explanation of the program that led us to believe that they were created or designed specifically to achieve wellness outcomes. Rather they were more generic leadership programs and the researchers sought to determine the programs' effectiveness in improving general workplace attitudes, one of which happened to be outcome measures associated with wellness.
- Third, it should be acknowledged that the work by La Montagne et al., (2017) was innovative for police leadership programs, being designed at primary, secondary and tertiary levels. It sought to improve psychosocial factors, create a supportive workplace, and improve both help-seeking and help-offering. This program addressed the critique of police agencies identified earlier, concluding that (particularly in the leadership development space) the use of primary prevention approaches is

uncommon. Unfortunately, the work of La Montagne et al., (2017) was the only program of its type found across the systematic search undertaken and failed to thrive due to significant implementation issues.

The lack of focus on leadership programs for wellness is concerning. Biggs et al (2014) based on their research with police, called for leadership programs which are designed specifically for wellbeing outcomes to do more than develop generic, 'good' leadership skills in the hope that it will lead to the reduction of ill-health. This leads us to ask, what are the specific leadership skills required to support wellness outcomes? Are there distinct health-related behaviours and skill sets that can be differentiated from the general notions of leading organisations? We believe that there are. The following section provides a discussion around leading for wellness outcomes that requires conscious engagement with health and wellbeing.

Leading, Specifically, for Wellness

The Australian Institute of Management (AIPM) has been educating public safety leaders since the 1960s. Program content and curricula have been responsive to the challenges faced by the profession, and as such it is fair to question whether specific leadership for wellness development programs are required. Leadership development at AIPM, at its core, is fundamentally about creating powerful observers. The rationale being that powerful observers can assess, reflect on, and operate within a complex operating environment, and that this in turn means they are equipped to achieve the best for their staff, their organisation, and their community. Surely *leadership for wellness* is just an extension of 'good leadership'? Our systematic review has suggested that this may not be the case, with one of the identified studies suggesting that generic leadership programs were insufficient to advance wellness themes in policing (Biggs et al., 2014). In this section we consider the evidence base for why *leadership for wellness* is not simply, *good leadership*.

Until recently, studies examining leadership in the context of health, have centred on the relationship between traditional theories of leadership and wellness outcomes. Typically, research has focused on transformational leadership and leader-member exchange (LMX) theories. Harms, Crede, Tynan, Leon & Jeung (2017) and Kaluza, Boer, Buengeler & van Dick, (2020) found that leadership is influenced by the wellbeing of leader, and that their leadership style in turn impacts on subordinates' wellbeing. Transformational leadership has been associated with lower levels of subordinate stress and burnout, and higher levels of wellbeing (Harms et al., 2017; Skakon, Nielsen, Borg & Guzman, 2010; Weberg, 2010).

Others have found that the quality of the relationship between leader and their followers (as captured through LMX theory) to be associated with positive psychological-related outcomes (Sparr & Sonnentag, 2008).

Research with police populations has provided evidence for the association between transformational leadership and lower levels of staff burnout (Russell, 2014). Supervisor support (captured by LMX) can moderate the relationship between emotional exhaustion and job performance (McCarthy, Trougakos & Cheng, 2016). These findings suggest that because police supervisors act as gatekeepers they can offset the experience of exhaustion through the provision of tangible organisational resources.

We acknowledge based on the research discussed that there is some value in applying general leadership theories to understanding *leading for wellness*. However, two questions still stand. Whether these theories are *sufficient* for a comprehensive understanding of the connection between leadership and wellbeing and whether they provide the most effective approach to uplifting leaders who can *lead for wellness*? Consequently, researchers have started investing in health leadership models, seeking to understand whether models capturing health-specific leadership have incremental predictive validity in explaining wellbeing, over and beyond more established leadership models, theories and constructs (Rudolph, Murphy & Zacher, 2020). There is a growing body of evidence to support health leadership models. One such model that has established empirical support, and specifically with police cohorts, is the Health Oriented Leadership (HoL) model (Franke et al. 2014).

Health Oriented Leadership

HoL is a model of leadership that recognises the complex interplay between the health of leaders and staff, and the impact this has on wellness outcomes (Franke et al., 2014). It captures the connection between the leader, workplace, and wellness. Specifically:

a) the impact and influence of a health-specific orientation of leaders on followers (this includes leader self-care *and* how they manage the workplace factors that impact on the health of staff), and
b) the health-related behaviours of followers themselves.

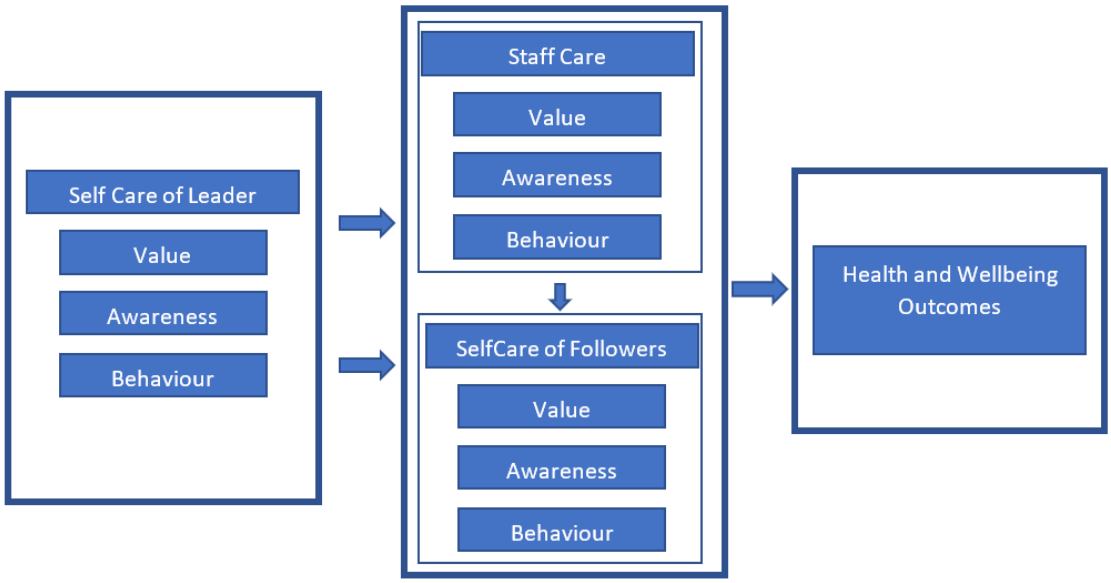

Figure 2. The Health Oriented Leadership Model (Adapted from Franke et al. 2014).

The model articulates the role of leader self-care, staff-care, and follower self-care. Reflecting many traditional models of leadership, staff-care sits at the centre of the model. Staff-care is an external process or resource that is provided by leaders to their staff. Leaders who actively engage in staff-care seek to foster health promoting working conditions that support, protect, and promote good health. Staff-care activities include health-promoting job design, health-specific communication, and health-related support provided by leaders. Leaders who enact staff-care directly impact the workplace factors causing health harms, and are more likely to identify, recognise the impact and address negative organisational and operational workplace factors (Franke et al, 2014).

Staff-care refers to leader-self-care and follower-self-care. Self-care is an internal process or resource that individuals use to promote or protect their own health (Franke et al, 2014). Self-care involves awareness of workplace risks to one's own health, recognising and paying attention to one's health, and actively engaging in behaviours that support healthy outcomes. It encompasses concern for self, and how one manages the demands and resources of work, while taking care of one's own wellbeing (Franke et al, 2014).

The theory indicates that from a leader perspective, leaders who role model good self-care are not only improving their own health, but also, are positively influence the self-care of staff. Staff who have a leader that actively engages in self-care will perceive that such behaviours

are valued. Staff will in turn, be more likely to engage in caring for their own health (Franke et al, 2014). The self-care demonstrated by the leader essentially builds the foundation of a health orientation for both themselves as the leader and their staff (Franke et al, 2014).

Each of the components that we have discussed, including staff-care and self-care of followers and leaders, are further understood through exploring: awareness, value and behaviours. To understand staff-care and self-care we must consider the (perceived) *value* of health, *awareness* of health, and health *behaviours*. Table 1 provides examples of how each of these elements are defined.

Table 1. Health-Oriented Awareness, Value and Behaviours.

	Self-care **Leader and Follower**	**Staff-care**
Health Awareness	Attention, recognition and reflection on health, stress, strain and the conditions that are creating or perpetuating this.	A leader accurately evaluates stress experienced by staff, and is able to recognise signs of strain.
Value of Health	The importance that an individual attaches to their health and their interest in maintaining their health.	A leader's concern for the health of staff and their sense of responsibility for staff health; responsibility should be associated with accurate perceptions of risk and the need for action.
Health Behaviour	Personal engagement in health-relevant activities, actions and behaviours.	Actions of the leader in providing working conditions that are associated with positive wellbeing.

Source: Adapted from Franke et al. (2014).

The health behaviour element, from both a leader and follower perspective, refers to the behaviours in which leaders and followers might engage to support and promote their own health and wellbeing. From a staff-care perspective, health behaviour are those behaviours and actions that are taken by a leader to identify, modify and manage the working conditions that can detract from staff wellbeing.

Behaviours are important but this approach to health-oriented leadership also tells us that it is not enough to simply have the 'actions' associated with self-care and staff-care. Research has found that it is essential that staff perceive that their leaders are actively identifying when they are under stress or strain (awareness). Further, leaders must feel some responsibility for the health of their staff (value) to be most effective (Franke et al., 2014). As such, it is not just the actions of leaders that matter; staff need to feel genuine interest and concern from their leaders and they must feel that the leader is committed to understanding how workplace factors are impacting them. There must be an acknowledgement that addressing workplace health is a collaboration between a leader and their staff (Franke et al., 2014).

To be most effective, it is essential that staff perceive that their leaders are actively identifying when they are under stress or strain (awareness) and leaders must feel some responsibility for the health of their staff (value) (Franke et al., 2014).

HoL is a promising model to help police and public safety organisations organise leadership interventions that better support wellness. Rather than blame leaders for poor outcomes, HoL points to the multidimensional relationship between leaders, wellbeing, and health. It recognises the role leaders play in creating and modifying workplace factors that cause harm *and* contends that healthy workplaces are not just about healthy staff but also, healthy leaders. This approach in indicative of a primary prevention intervention.

The HoL model would complement the existing suite of wellness initiatives, such as those already created by police and other public safety agencies, that focus on secondary and tertiary levels. It further provides a framework that explicitly addresses the role of leaders in modifying and creating workplaces that not only seek to support staff who experience trauma-related stress but proactively addresses what we know is causing some of the most

significant harms, organisational and operational stressors. Stressors that are potentially much more modifiable by leaders. The HoL provides a way to frame a comprehensive role for *leadership in wellness*.

Importantly, the HoL is culturally relevant for police. It draws on an appreciation of the distributed team dynamic that is prevalent across decentralised organisations like police and public safety. It has already been tested with police (although not broader public safety) populations. Studies conducted with German police found that health-oriented leadership behaviours are associated with less depression, burnout and physical complaints (Santa Maria, Wolter, Gusy, Kleiber & Renneberg, 2018). Specifically, it appears that leaders who score higher on HoL characteristics buffer the impact of work effort on burnout for their staff (Santa Maria, Wolter, Gusy, Kleiber & Renneberg, 2021).

In summary, we take the position that police and public safety agencies that are striving to make a more positive impact on wellness outcomes for their employees should engage in leadership (and associated leadership development programs) that place wellness – rather than generic concepts of leadership effectiveness - at its core. In Part Two of this paper, we use the HoL model of leadership to underpin a *Leadership for Wellness Strategy*.

Leading for wellness outcomes requires conscious engagement in health and wellbeing.

Part 2: A Leadership for Wellness Strategy

There is an urgent need for leaders to better understand their role in creating supportive and protective workplace environments and to look after their own health. Healthy leaders are best placed to positively influence their own wellbeing, the workplace that they lead and their staff. An opportunity exists to build from the HoL model an approach that addresses persistent rates of poor wellbeing outcomes across police and public safety organisations and the legislative requirement for these agencies to look beyond traumatic events and engage in primary prevention initiatives. In this section of the paper, we articulate a *Leadership for Wellness Strategy* which rests on equipping leaders with the knowledge, skills, and behaviours to adopt a health-conscious leadership approach. We believe this *Strategy* complements, rather than competes, with existing organisational wellness interventions. Secondary and tertiary level interventions remain necessary, as are those interventions designed to address adverse outcomes resulting from the traumatic nature of policing and public safety. However, they are insufficient for organisations to achieve their wellness aims. Leaders, and especially front-line supervisors and middle managers, are particularly well placed to impact a high proportion of staff, and we would contend are a yet untapped resource that can supported and uplifted to enact meaningful change.

The *Leadership for Wellness Strategy* aims to contribute to the growth of a profession-wide culture that acknowledges the role of leaders in creating wellness outcomes. This is offered *in addition to* existing leadership development initiatives that seek broader organisational effectiveness as their key metric of success. Each lens is not mutually exclusive, but the absence of a health-oriented perspective has obscured the pivotal role that leaders play in wellness outcomes. This *Strategy* rebalances that, by placing wellness at the core of the development intent.

The *Leadership for Wellness Strategy* elevates the importance of primary prevention. Cognizant of legislative requirements and a growing appreciation of the organisational and operational workplace factors that impact wellness, leaders need to be equipped with the skills and sense of agency to create positive and healthy workplace environments. This requires increasing the capacity of leaders to build healthier workplaces by influencing the broader organisational context, by managing up and down the system.

Even with this *Strategy*, wellness will remain a concern in police and public safety organisations. It is the nature of the job that staff will be exposed to traumatic events, and that

despite efforts to mitigate the impact of these, individuals will continue to experience negative wellness outcomes. However, this makes it even more important for agencies and their leaders to eliminate those factors that are within their control. By adopting a health-oriented leadership lens, and developing leaders' ability to *lead for wellness*, organisations will be doing all they can to prevent and mitigate causes of workplace harms. They can do so with the knowledge that secondary and tertiary interventions remain an important pillar for preparing for and addressing the consequences of unavoidable risks when prevention is either unattainable or fails.

A Leadership Development Plan

We propose a three-pillar leadership development approach:

1. An AIPM-Griffith Criminology Institute "*Leadership for Wellness*" pilot program designed to uplift middle managers in the knowledge, skills, and behavioural repertoire required to lead, specifically for wellness outcomes.
2. Extension of ongoing programs to integrate health-oriented leadership concepts into existing programs, through the systematic audit and review of AIPM's suite of programs (as appropriate).
3. Stimulation of a global conversation about leadership for wellness, by utilising digital channels to disseminate information and stimulate debate among police and public safety organisations around the world.

Pillar 1: A Leadership for Wellness Pilot Program

AIPM has a long history of crafting impactful issue-specific leadership development strategies. AIPM's Balance Program for women in leadership was designed to support profession-wide efforts to support gender equity and female participation in leadership. AIPM's ANZ Police Leadership Strategy was similarly impactful in creating networks of senior leaders who did not require a formal graduate qualification. We propose that the *Leadership for Wellness* Program could similarly lead to a self-sustaining network of wellness-oriented leaders across the Australian and New Zealand public safety landscape. The program would:

- Be nested in health-oriented leadership tenets that have proven promising in the policing and public safety context.

- Offer a real-world learning environment to advance, test, and evaluate the arguments for wellness-specific leadership development.
- Involve a partnership between the AIPM and Griffith Criminology Institute, bringing together world-renowned experts in leadership (AIPM), police and public safety, and mental health (Griffith Criminology Institute, Griffith University)[9].
- Be conducted in a privileged and trusted location at AIPM, utilising expertise in the police and public safety leadership pedagogy, that has developed at AIPM across 60 years of operations.
- Combine academic knowledge with the AIPM's adaptive, human-centred approach to learning and its facilitative style, that is perfectly aligned with the health-oriented leadership philosophy at the centre of the program.

Program Curriculum

The program rests on the two key pillars of the health-oriented leadership model: self-care (leader and follower) and staff-care. Both these improve health outcomes through:

- enhanced awareness about health-related factors
- enhanced value placed on health in the workplace, and
- behaviours that support health

Using these interlocking concepts as a foundation, we have created a draft curriculum (see Figure 3), which activates the following learning outcomes:

- **Awareness**: Develop your ability to observe yourself and others, to assess the system (seen and unseen), and understand the factors that contribute to the wellbeing of yourself and your staff.

[9] Griffith University has an international reputation in police mental health, established from the work of Associate Professor Jacqueline Drew. Associate Professor Drew at the Griffith Criminology Institute is a recognised leader in police wellbeing collaborating with law enforcement across Australia and the United States. Associate Professor Drew (and Professor Janet Ransley and Queensland Police Commissioner Katarina Carroll) are currently leading a world-first research program (funded through an Australian Research Council Linkage Grant) that will develop an early warning system for police workplace health and performance. Further, Associate Professor Drew co-leads with the National Director of Wellness (US Fraternal Order of Police), a biennial national survey of over 360,000 US law enforcement officers on issues related to mental health, wellbeing and burnout. This expertise in police wellbeing will provide the academic rigour underpinning the design and delivery of the *Leadership for Wellness* program content, including assurance that the program content is contemporary, best-practice and evidence-informed.

- **Value:** Develop your ability to communicate the importance of self-care and role modelling and articulate the value of investment in wellness to staff and superiors; value the role you as a leader play in controlling workplace factors that promote health and mitigate harms.
- **Behaviour**: Through skilful intervention and resourceful action execute compassionate leadership; leadership actions that create, facilitate and monitor the workplace to promote health outcomes and mitigate the risks of harm; and in turn, encourage and support health behaviours of you as a leader and your staff.

Leadership for Wellness Mock Timetable

Time	Day 1 – Sunday	Day 2 - Monday	Day 3 - Tuesday	Day 4 - Wednesday	Day 5 - Thursday
Theme	Introduce	Self-Care Leader and follower	Self-Care Leader and follower	Staff-Care	Staff-Care
8.30 am		Reflection on Day 1	Reflection on Day 2	Reflection on Day 3 • Debrief Keynote Forum	Reflection on Day 4
9.00 am- 10.30 am		**Session 1:** Sense-making. • Introduction to HoL • Prevention	**Session 5:** Resourceful action (Behaviour) Application of the HoL Self Inventory	**Session 10:** Working with difference - Democratic leadership	**Session 14:** Resourceful action (Behaviour) • Early warning tools
Morning Tea		10.30 – 11.00	10.30 – 11.00	10.30 – 11.00	
11.00 am – 12.30 pm		**Session 2:** Sense-making: Exploring the evidence base • Embitterment • Leadership impacts	**Session 6:** Resourceful action (Behaviour) Wellness Master Class	**Session 11:** Working with difference - Democratic leadership	**Session 15:** Resourceful action (Behaviour) • Commitment to action
12.30 – 1.15 pm	Lunch				
1.15 pm – 3.00 pm	AIPM check in from 2pm.	**Session 3:** Meaning-making (Awareness and Value) • HoL Self Inventory survey • Knowing self • Second order learning	Staff-care **Session 7:** Sense-making (Awareness) • Assessing the system • Observation and interpretation	**Session 12:** Skilful intervention (Behaviour) • Bystander Effect • Ontological coaching practices	Travel
3.00 – 3.30 pm	Afternoon Tea				
3.30 pm – 5.00 pm	4pm – Meet & catch up.	**Session 4:** Meaning-making (Awareness and Value) • HoL Self Inventory survey • Knowing self • Second order learning	**Session 8:** Working with difference – Democratic leadership	**Session 13:** Skilful intervention (Behaviour) • Bystander Effect • Ontological coaching practices	
Dinner	6.30pm	6.30 pm	6.30 pm		
After Dinner	Evening Activity e.g. Program mentor Graeme Ashton	Free evening	**Session 9:** Keynote Forum	Free evening	

Figure 3. Draft Leadership for Wellness Program Curriculum.

Figure 3 represents an indicative timetable for the curriculum. Work is ongoing to craft an exact schedule, available dates, and to engage with jurisdictions and stakeholders to determine participant availability and selection processes. In addition to the above-delivered content, participants will also have access to alumni extension events to support ongoing learning and cross-cohort networking. This could include regular alumni reconnection events,

and peer-mentoring groups. Participants will have access to - and will lead - the global conversations about leadership for wellness proposed under Pillar 3 of the *Strategy*.

Target Audience and Selection

The *Leadership for Wellness* program is targeted at middle managers. This is due to their relatively high numbers in police and public safety organisations and the high proportion of the workforce that they directly supervise. Middle managers are already visible role models and under the HoL model, equipping this group with the understanding and skills they need to create healthy workplaces can impact the behaviour of a large percentage of the workforce. They are also the senior executives of tomorrow and represent the future of organisational policy and practice.

AIPM's experience has shown that participants achieve learning outcomes, and issue-related strategies succeed, when organisations select appropriate participants. Participants need to link outcomes of the program to their own challenges; and organisations will need to embrace a shared commitment to developing a leadership culture that prioritises wellbeing. This is facilitated by an acceleration and on-boarding approach that sees participants engage in activities prior to the core learning event. In the case of the AIPM-Griffith Criminology Institute pilot program, such activities would extend to:

- On boarding conversations that set participants' readiness to learn.
- Creation of a holding environment by establishing trust and confidence (psychological safety).
- Initial multi-media content, including short readings, videos and podcasts, to help participants understand the debates and evidence base around leading for wellness.
- Completion of the HoL Self-Report Inventory, to provide insight into the leaders HoL style.
- The creation of peer-learning groups and learning support mechanisms such as syndicate leads, who will act as key learning partners throughout the program and beyond.

Program Evaluation

The pilot program will be evaluated in the first instance by an internal evaluation process, to determine its impact on participants knowledge, attitudes, and behaviour. On completion of

the pilot evaluation period, and if there is intent to extend the program further, AIPM and Griffith Criminology Institute will seek a formal evaluation of the program to help agencies assess its return on investment.

Pillar 2: Weaving Wellness Concepts Across AIPM's Suite

At the time of writing, AIPM had engaged in three separate 'experiments' to introduce leadership for wellness concepts (specifically the interplay between self-care (leader), staff-care, and self-care (follower)) during residential sessions of the executive development suite of programs. On each occasion the content was well received, indicating an appetite among leaders for a wellness lens across programs. This is unsurprising. We know that wellness is not an issue that authority or directive action on its own can resolve, and as such it is in the pantheon of adaptive leadership problems that leaders undertaking AIPM programs are already primed to consider. There is real value in complementing the development of a *Leading for Wellness* pilot program with the broader integration of aspects of health-oriented leadership concepts across existing AIPM programs. First, the strategy begins to have greater reach and access to police and public safety leaders. Second, it accelerates the conversation across the profession which helps influence the broader organisational context. Third, it sense-checks the underlying assumption that leading for wellness is best learnt through a stand-alone wellness-centric program.

Process for Integration

In the 2023/2024 financial year, AIPM will embark on an 'Audit and Review' of AIPM programs to determine existing inclusion of *Leading for Wellness* content, and to assess where this may be enhanced. This timeline ties in with the existing review of the AIPM's graduate programs in preparation for re-registration and re-registration with the Tertiary Education Qualifications Standards Agency (TEQSA), and the periodic review of the Executive Development Suite. The Audit and Review will be led by the Executive Director, in consultation with Faculty leads, and program amendments will be documented as per AIPM's existing review cycle.

Assessment of the viability of integrating *Leading for Wellness* will be determined through a review and evaluation using several mechanisms. Including:

- learning outcomes
- assessment items (where relevant)
- lesson plans, and
- co-curricula activities such as evening speakers and fireside chats

Pillar 3: A Global Conversation

The third pillar of the *Leadership for Wellness Strategy* has the widest breadth. Leveraging digital platforms, we will stimulate a global conversation about *leading for wellness* through dissemination of research, policy development, expert commentaries and leadership provocations discussion. This will enable leadership conversations at scale.

Moreover, global connectivity works two ways. As well as pushing out content, a digital presence enables engagement across global experts from policing, wellness and academic contexts, bringing leading edge global thinking to Australian and New Zealand leaders. We see initial steps to advance this global conversation being threefold:

1. Leverage the power of AIPM's specialist library and the Australian Libraries in Emergency Services (ALIES) network to develop a repository of leadership for wellness content, which can be disseminated across AIPM's existing global network of leaders (numbering more than 6000 middle managers across almost 20 countries) with targeted efforts to increase engagement rate.
2. Explore collaboration with global research partners, connecting with Australian academic experts in police wellbeing, beginning with but not limited to: Associate Professor Drew's program of police wellbeing research at Griffith Criminology Institute and her international work on police mental health with United States law enforcement; the German architects of the Health-Oriented Leadership framework (Franke and colleagues). This will begin to create a centre of gravity for global discussions to understand leadership for wellness in police and public health organisations.
3. Create multi-media content, and connection opportunities, to stimulate discussion and debate about leadership for wellness. Content could include, but is not limited to, podcasts, webinars, vlogs and blogs, sourcing and creating "TED" style talks, creation of a searchable repository for resources, websites and social media.

Wellness is an issue that affects all police and public safety organisations around the world. There is much to be learnt from our global partner organisations across police and public safety. Digital technologies and post-covid has led to shifts in leaders' attitudes toward and practice of online engagement. This presents a significant opportunity to scale the reach of this *Strategy* beyond Australian and New Zealand shores.

Concluding Thoughts

Throughout this paper we have presented and critically assessed research that has identified a gap in the understanding and utilisation of the role of leadership when addressing issues of wellness, particularly for police but also, more broadly, public safety agencies. We have argued that existing policy and practice approaches to wellness largely rely on secondary and tertiary interventions. It is our contention that leaders have a pivotal role to play in preventing workplace harms. They represent one of the most significant ways to engage in primary prevention, addressing workplace factors before they have the opportunity to contribute to the rising rates of poor wellbeing amongst police and public safety personnel. Beyond the compelling research evidence that has been presented, there is a legislative imperative to address workplace factors that pose a risk to wellbeing and mitigate workplace factors that cause harm. To this end, we have proposed a comprehensive *Leadership for Wellness Strategy*. It involves a multi-channel approach, include a *Leadership for Wellness* pilot program for leaders; the integration of leadership for wellness content across the AIPM program suite and the stimulation of a global conversation about leadership for wellness utilising digital channels. In conclusion, we invite you to join us in developing a language and set of leadership practices that support better health and wellbeing outcomes for all of our staff across the profession.

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