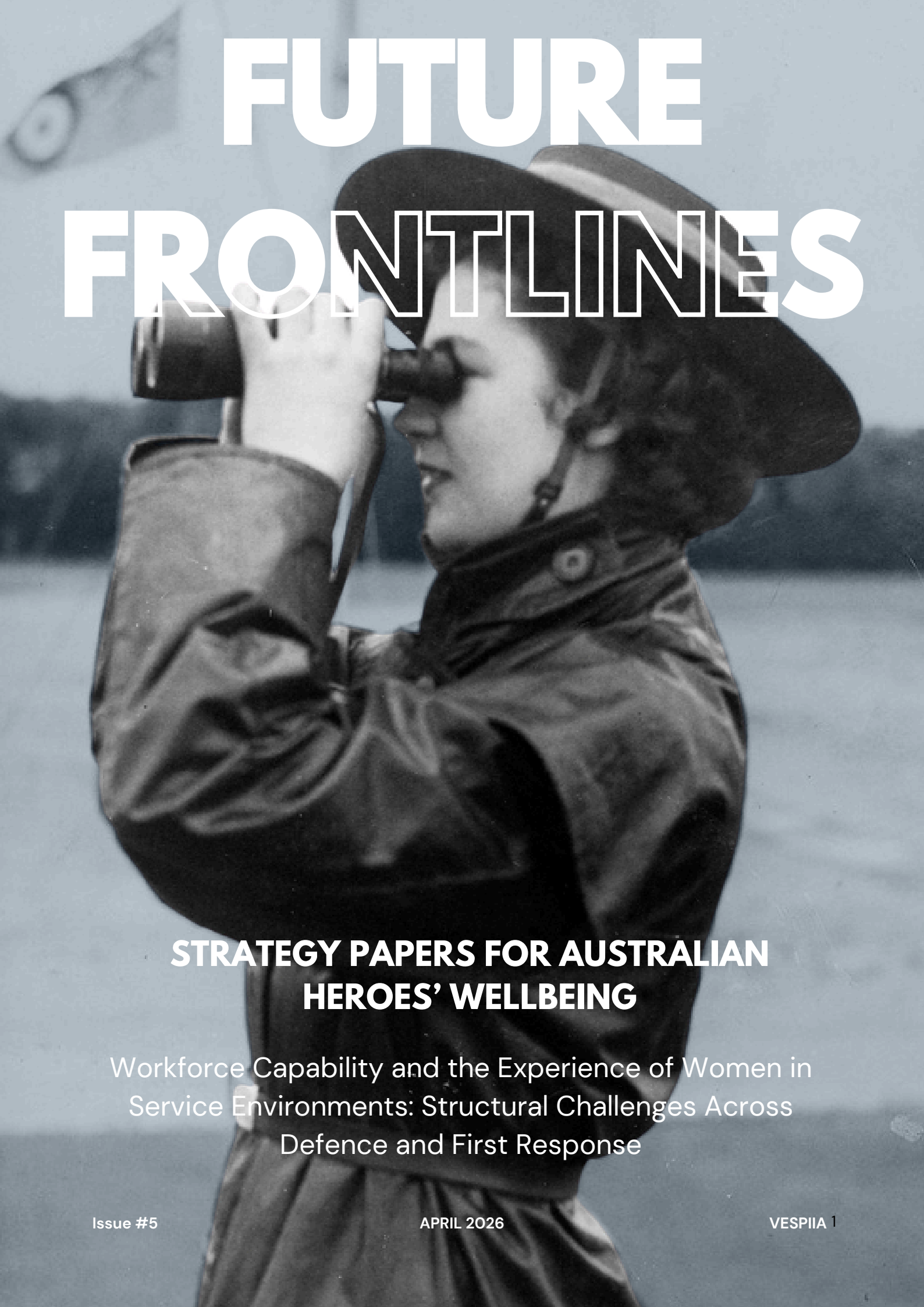
FUTURE FRONTLINES



STRATEGY PAPERS FOR AUSTRALIAN HEROES' WELLBEING

Workforce Capability and the Experience of Women in Service Environments: Structural Challenges Across Defence and First Response

Future Frontlines: Strategy Papers for Australian Heroes' Wellbeing #5

The Veterans, Emergency Services, and Police Industry Institute Australia (VESPIIA) works to create a collaborative position on public policy issues, formed alongside our members, experts and other stakeholders; the views represented do not necessarily reflect the views of VESPIIA staff, its board, or any related external funding body, including State and Federal Governments.

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The Defence and Security Institute (DSI) is an initiative by The University of Western Australia (UWA). Hosted at UWA, the DSI unifies and focuses UWA's expertise in defence and security research, engagement, and education. Defence and security provide the foundation of our nation's sovereignty. In an era of rapidly evolving geopolitics, this critical area of national policy sits at the forefront of government and public debates. The DSI plays a central role in helping to develop Australia's sovereign defence capabilities in WA by working with local, state, and federal governments, industry and business, research institutions and the community to help generate solutions towards a peaceful, prosperous and secure Australia and Indo-Pacific region.

ABOUT VESPIIA

The Veterans, Emergency Services and Police Industry Institute of Australia (VESPIIA) is the national professional body for the organisations, staff, and volunteers who support Australia's veterans, emergency services, police, and their families.

VESPIIA works across professional development, research, policy engagement, and advocacy to strengthen the sector that supports these communities. Our membership spans ex-service organisations, first responder agencies, community charities, allied health professionals, academics, and frontline volunteers nationwide. Our focus is not on delivering direct services, but on ensuring the organisations and people who do have the professional standards, evidence base, and policy frameworks to carry out that work effectively.

ABOUT THE FUTURE FRONTLINES PAPERS

Future Frontlines is VESPIIA's research and policy paper series examining workforce, capability, and wellbeing issues across Australia's veteran, emergency services, and policing sectors. Each paper draws on evidence gathered through sector consultation, research, and direct engagement with practitioners and organisations working in these environments. The series is designed to inform policy development, support sector advocacy, and contribute to the evidence base that effective reform requires.

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CONTENT NOTICE

This paper contains accounts of sexual harassment, sexual assault, workplace trauma, and experiences of suicidal distress. Some accounts are described in direct terms by the people who experienced them.

If any of this content affects you, support is available:
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1800RESPECT — 1800 737 732 (sexual assault and family violence support)
Open Arms — 1800 011 046 (veterans and families mental health support)
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EXECUTIVE SUMMARY

Australia's Defence and first response organisations depend on the experience, capability, and leadership of their people. Recruiting and developing skilled operational personnel is expensive and time-consuming. Retaining them is where that investment either pays off or is lost.

Women now serve across operational, technical, and leadership roles throughout Defence, policing, fire and rescue, ambulance, and corrections. Their participation is not incidental to the workforce capacity of these organisations. In many jurisdictions, future workforce growth will depend on the ability to recruit and retain women in service roles. Without that, many organisations will struggle to meet the demands placed on them.

This paper examines the experiences of women working across those environments and asks a direct question: are the systems that shape service careers actually working for the people who depend on them?

The answer, based on the evidence gathered, is that in too many cases they are not.

About this research
This paper draws on two phases of research conducted by VESPIIA during 2025 and 2026.

The first phase involved roundtable discussions convened in Perth and Adelaide in 2025, bringing together practitioners, researchers, and sector organisations from across Defence, policing, fire and rescue, ambulance, corrections, and academia. These discussions identified consistent themes across service environments and informed the design of a national survey.

The second phase was a national survey examining the experiences of women working across Defence and first response environments. The survey was distributed through VESPIIA networks, partner organisations, and social media channels, and was conducted anonymously using Typeform. Responses were received from 34 participants across multiple sectors, employment types, and jurisdictions. The survey collected both quantitative ratings and qualitative testimony.

The findings presented in this paper reflect responses collected between 18 February and 31 March 2026.

The sample is not statistically representative of the broader service workforce. Findings should be understood as capturing the experiences of women who were aware of the research and chose to participate. The consistency of the patterns identified across sectors, employment types, and locations, however, suggests they reflect structural features of service environments rather than isolated individual experiences.

What the survey found
The survey examined nine thematic areas: workplace culture and psychological safety; operational equipment and PPE; workforce health systems; menopause and gynaecological health; mental health and suicidality; workplace safety and sexual harm; career progression and leadership; policy implementation; and workforce consultation.

Across all nine areas, the findings point to the same underlying dynamic: systems designed for an earlier, less diverse workforce that have not adequately adapted to the people now serving within them.

The most significant findings are summarised below.

Psychological safety and speaking up
Only 32% of respondents felt comfortable speaking up about issues at work. Only 22% said women's concerns are taken seriously when raised. Nearly half, 44%, had hesitated to raise an issue because of concerns about the consequences of doing so.

When asked how women are perceived when they raise concerns, 22 of 31 respondents said "not resilient enough" and 21 said "too emotional." Only 19% agreed that when issues are raised, leadership follows through with action.

Equipment and PPE
Fifty-eight per cent of respondents said their uniforms and PPE do not fit properly. Fifty-nine per cent said poor fit has affected their comfort at work. Respondents described equipment designed around male body proportions, inadequate supply systems in regional and volunteer environments, and the inability of uniform systems to accommodate personnel following serious illness, including breast cancer treatment.

Health systems
Only 21% of respondents felt comfortable raising reproductive health or fertility-related needs at work. Fifty-three per cent believed women in their workplace are disadvantaged in their careers due to pregnancy or parenting. One respondent described being told their training had been cancelled after disclosing a pregnancy because they were no longer "worth investing in."

Twelve of 31 respondents reported living with endometriosis, PCOS, adenomyosis, or peri-menopause and menopause. Only 13% said their managers had sufficient understanding of these conditions. Half said symptoms had affected their work. Only 21% felt safe disclosing menopause or gynaecological health conditions at their workplace.

Mental health and suicidality
Fifty-two per cent of respondents had experienced ongoing mental distress that affected their wellbeing during service. Nine of 31 respondents, 29%, had experienced thoughts of self-harm or suicide during their service. Thirteen of 30 respondents, 43%, had been directly affected by suicidal distress, attempted suicide or a workplace suicide in their professional community.

Fear of career impact was the most cited barrier to seeking mental health support, identified by 19 of 34 respondents. Only 28% trusted that mental health disclosures would be handled with care and confidentiality.

Survey responses also identified menopause-related suicidality as a specific and largely undiscussed issue in service environments, with one respondent describing being told to "work through it" after disclosing suicidal thoughts.

Workplace safety and sexual harm
Seventy-six per cent of respondents agreed that poor handling of sexual harassment and assault contributes to women leaving service. No respondent disagreed. This is the strongest single finding in the survey.

Forty-seven per cent did not trust that reports of sexual harassment or assault would be handled appropriately. Fifty-six per cent had seen or experienced organisational responses that discouraged reporting. Several respondents described incidents of assault and attempted assault, and the compounding harm of organisational responses that prioritised administrative process over the wellbeing of those affected.

Survey responses, and VESPIIA's own submission to the Senate inquiry into the Defence Amendment (Sexual Assault Prevention, Intervention and Response Commission) Bill 2025, demonstrate that existing reporting systems across both Defence and first response environments have failed to deliver consistent, safe, or accountable outcomes. No equivalent legislative reform to that proposed for Defence has been initiated for any first response agency.

Career progression
Sixty per cent of respondents said women are not adequately represented in leadership in their organisation. Only 18% said career pathways allow for flexibility without penalty. Seventy per cent said leaders do not understand how health and wellbeing issues affect career progression. Only 34% could see a clear and sustainable long-term career for women in their service.

Policy implementation
Eighty per cent of respondents said policy application depends on individual managers rather than consistent organisational standards. Only 7% felt confident that policies designed to support women actually protect them in practice. Only 29% said policies work as intended.

Workforce consultation
Only 15% of respondents believed women's feedback is taken seriously by decision-makers. Forty-six per cent did not trust that honest feedback would be safe to provide. Seventy-four per cent said that when change does not occur following consultation, no explanation is given.

Despite this, 97% of respondents said data collection on women's experiences is necessary to improve service design and outcomes, and 55% still believe research like this can lead to meaningful change.

What the paper recommends
The findings of this paper point to nine recommendations directed at government at a state and federal level, agency and organisational leadership, and those responsible for workforce system design across Defence and first response environments.

These recommendations are specific, measurable, and grounded in what the evidence shows is failing. They address: equipment and PPE standards; career interruption protections; workforce health frameworks; mental health help-seeking barriers; sexual harm reporting systems; leadership accountability; policy oversight mechanisms; workforce consultation integrity; and investment in independent cross-sector research.

The full recommendations, including specific actions against which progress can be measured, are set out in the Recommendations section of this paper.

Why this matters
The issues documented in this paper are not new. Many have been identified in previous reviews and inquiries. What this survey makes plain is that they persist, that they extend across sectors and jurisdictions, and that they are not being adequately addressed.

They also have a direct cost. When trained personnel leave service earlier than planned because the environment has failed them, when safety concerns go unreported because reporting is more dangerous than silence, when mental health needs are managed privately because disclosure carries career risk, service organisations absorb those consequences in reduced capability, narrowed leadership pipelines, and recruitment challenges they cannot easily resolve.

The women who participated in this survey described environments that have not yet adapted to the realities of the workforce they rely on. Ninety-seven per cent of them said research like this is necessary. More than half still believe it can lead to change.

The organisations and governments responsible for those environments now have the evidence. What happens next is a matter of whether they choose to act on it.

INTRODUCTION

Women have served Australia in uniformed and emergency service roles for more than a century. From the women's units established during the First World War to the growing presence of women across Defence, policing, fire, ambulance, and corrections today, women have been part of Australia's service workforce for as long as those services have existed in their modern form.

What has changed in recent decades is not the fact of women's participation, but its scale, its breadth, and the expectations that now surround it. Women serve across operational, technical, and leadership roles that were historically closed to them. In many jurisdictions, future workforce growth will depend in part on the ability of service organisations to recruit and retain women. Without that participation, many organisations will struggle to meet the demands placed on them.

Workforce capability in service environments is not determined solely by how many people are recruited. It is determined by whether trained personnel can continue to operate effectively within the system over time. Recruiting and developing skilled operational personnel is expensive and time-consuming. Retaining them is where the investment either pays off or is lost.

Despite the long history and growing presence of women in service environments, many of the organisational systems that shape those careers were designed around a predominantly male workforce. Equipment procurement standards, training pipelines, promotion frameworks, workplace health policies, and reporting mechanisms reflect, in many cases, assumptions about who serves and what they need that are no longer accurate. In some areas, those systems have adapted. In many, they have not.

Evidence from reviews, academic research, and organisational inquiries has consistently identified a range of challenges affecting women across service environments. These include workplace safety concerns, structural barriers within career pathways, gaps in health policy, and inconsistencies in how policies are applied in practice. One of the most comprehensive examinations of these issues was the Royal Commission into Defence and Veteran Suicide, which documented experiences of sexual harassment and assault, barriers to reporting, retaliation, and the long-term mental health and career consequences of institutional failures to respond adequately.

The Royal Commission's findings were significant. They were also predominantly focused on the Defence environment. First response organisations, including policing, fire and rescue, ambulance, and corrections, have been subject to less systematic examination, despite evidence that similar patterns exist across those sectors.
This paper seeks to contribute to that broader understanding.

In 2025, VESPIIA convened roundtable discussions in Perth and Adelaide, bringing together practitioners, researchers, and sector organisations to explore common workforce challenges affecting women across service environments. Participants represented Defence, policing, fire and rescue, ambulance, corrections, academia, and community organisations. Across both sessions, consistent themes emerged: equipment not designed for female bodies, reproductive and menopause health poorly supported by workplace systems, mental health help-seeking deterred by career risk, sexual harm

mishandled and underreported, career progression shaped by structural barriers that compound over time, and consultation processes that collect feedback without acting on it.

These discussions indicated that the issues affecting women in service environments are not confined to any single organisation, sector, or jurisdiction. They reflect structural patterns across the broader service ecosystem. That observation informed the development of a national survey designed to examine how those patterns are experienced across Defence and first response environments.

This paper presents the findings of that survey. It draws on both quantitative responses and qualitative testimony from women working across Defence, policing, fire and rescue, ambulance, corrections, and related service environments. Its purpose is not to document individual incidents in isolation or to assign responsibility to any specific organisation. It is to identify the structural patterns that shape how women enter, experience, and remain in service careers, and to provide an evidence base that can inform policy, organisational reform, and further research.

This paper frames these issues as a workforce capability problem. That framing is deliberate. Service organisations depend on the experience, leadership, and commitment of their personnel. When structural barriers cause trained personnel to leave service earlier than planned, when safety systems deter reporting of risks, when health needs are managed in silence, and when the leadership pipeline narrows because the pathway to leadership has been systematically harder for women to navigate, the consequences are operational. They affect the organisations responsible for some of Australia's most critical public safety functions.

The purpose of this framing is not to diminish the human cost of the experiences described in this paper. That cost is real and significant. It is to ensure that the evidence presented here reaches the audiences best positioned to act on it, and that it does so in terms those audiences cannot set aside as someone else's problem.

This paper forms part of VESPIIA's Future Frontlines series, examining emerging workforce policy, and capability issues affecting the veterans, emergency services, and policing sectors. The methodology underpinning the research is described in the About the Research section. The survey findings are presented in Sections 5 through 8, followed by recommendations, areas for further research, and a conclusion.

About the Research

Purpose

This paper draws on evidence gathered through sector roundtable consultations and a national survey examining the experiences of women working across Defence and first response service environments in Australia.

The research was conducted by VESPIIA as part of its Future Frontlines series, which examines workforce, policy, and capability issues affecting the veterans, emergency services, and policing sectors. It is framed as sector consultation research undertaken by a national professional body, rather than formal academic research requiring institutional ethics approval.

The purpose of the research is to capture operational perspectives from women working across service environments, identify systemic patterns affecting workforce participation and retention, and provide an evidence base to inform policy development and further research.

Phase One: Roundtable Consultations

Initial consultations were convened by VESPIIA in Perth and Adelaide during 2025. These roundtables brought together practitioners, researchers, and sector organisations to discuss workforce challenges affecting women across Defence, policing, fire and rescue, ambulance services, academia, and community organisations working within the service ecosystem.

Participants were invited to speak candidly about workplace culture, operational conditions, health considerations, and organisational processes affecting their ability to enter, remain in, and progress within service roles. Sessions were conducted under Chatham House principles: views could be shared and attributed to the group, but not to individual participants.

Across both sessions, participants described recurring themes including challenges relating to

operational equipment design, workplace culture and psychological safety, reproductive and menopause health, mental health stigma, workplace safety, and organisational responses to harmful behaviour.

A consistent observation across both sessions was that many of these issues were not unique to a single organisation or jurisdiction. Similar experiences were described across multiple service environments, suggesting that some challenges may arise from structural features common to service systems rather than isolated organisational circumstances.
These consultations informed the design of the national survey.

Phase Two: National Survey
Design
The survey was developed by VESPIIA following the roundtable consultations. It was designed to capture a broader cross-section of workforce experiences across Defence and first response sectors and to quantify patterns identified through the initial consultation process.

The survey examined the following areas:

- Workplace culture and psychological safety
- Operational equipment and personal protective equipment
- Workforce health systems, including reproductive health and lifecycle support
- Menopause and chronic gynaecological health
- Mental health, suicide, and help-seeking barriers
- Workplace safety, harassment, and sexual harm
- Career progression and leadership pathways
- Organisational reporting systems and policy implementation
- Workforce consultation and trust in organisational feedback processes

Instrument
The survey was administered using Typeform, an online survey platform. Questions used a combination of five-point Likert scale ratings, multiple-choice responses, and open-ended qualitative fields allowing participants to describe their experiences in their own words.

The survey was conducted anonymously. Participants were not required to provide identifying information. Demographic data collected included age group, gender, sector, role type, employment status, tenure, state or territory, and location type (metropolitan, regional, or mixed).

Distribution
The survey was distributed through the following channels:

- VESPIIA member networks and mailing list
- Organic and shared social media distribution, including LinkedIn and Facebook
- Partner and affiliated organisations who circulated the survey to their own networks
- Direct invitation to participants from the Perth and Adelaide roundtable consultations

Distribution relied on a purposive and network-based sampling approach. As such, the sample is not random and findings are not statistically representative of the broader workforce population. The survey is best understood as capturing the experiences of women who were aware of the research and chose to participate.

Sample
Data presented in this paper reflects responses collected between 18 February and 31 March 2026. The survey received 34 responses in total.

Respondents represented a range of sectors, employment types, locations, and career stages:

Respondents reported service tenure ranging from one to 42 years, with a median of 9 years. The majority (58%) reported more than five years of service, with a significant proportion (42%) having served between 11 and 42 years. This indicates a predominantly experienced cohort rather than early-career respondents.

The majority of respondents were based in metropolitan locations (21), with nine in regional areas and three in mixed or multiple locations. Approximately 50% of respondents reported caring responsibilities outside work, primarily for children.

Qualitative Responses
The survey included open-ended fields at the end of each thematic section, allowing participants to describe their experiences in their own words.

These responses provide important contextual detail about how organisational systems operate in practice.

Qualitative responses have been de-identified. In some cases, quotes have been lightly edited to remove details that could identify the respondent, their organisation, or others mentioned in their account. The substance of all quotes included in this report has been preserved.

Qualitative comments are used throughout this paper to illustrate themes emerging across responses. They are not presented as representative of all respondents or all organisations, but as examples of experiences described across the dataset.

Limitations

This research has a number of limitations that should be considered when interpreting the findings.

The sample size is small. The survey received 34 responses. While the findings are consistent with patterns identified through the roundtable consultations and existing research, they should not be treated as statistically representative of the broader workforce.

The sample is not random. Distribution through professional networks and social media means that respondents self-selected into the survey. Participants are likely to have had a prior awareness of or interest in workforce issues affecting women in service environments, which may influence the nature of responses received.
Sector representation is uneven. Fire and rescue and Defence are the most represented sectors, with policing, corrections, and SES significantly underrepresented relative to their workforce size. Findings for underrepresented sectors should be interpreted with particular caution.

Geographic distribution is concentrated. The majority of responses were received from South Australia and Western Australia, reflecting the location of VESPIIA's roundtable consultations and the reach of its networks at the time of distribution. Other states and territories are underrepresented.

These limitations do not diminish the value of the findings. The patterns identified through the survey are consistent across respondents and align with evidence from existing research and organisational reviews. However, they do highlight the need for further research at greater scale and with more systematic sampling across sectors and jurisdictions.

Use of Survey Data

Aggregated survey data will be made available in the appendix of this report to support transparency and further research. No identifying information is included in the published dataset.

VESPIIA is committed to making this data available to researchers and policy developers working in this area. Organisations or institutions wishing to access the dataset for further research purposes are invited to contact VESPIIA directly.

VESPIIA CEO Shannon Hennessy, Senator Linda Reynolds CSC, VESPIIA IWD 2025 Round Table WA.

SURVEY FINDINGS

Workplace Culture and Psychological Safety

Psychological safety, meaning the degree to which personnel feel able to raise concerns, seek support, or report problems without fear of professional consequences, is a foundational component of organisational effectiveness. In operational environments where teams depend on trust and open communication, its absence is not simply a cultural problem. It is an operational risk.

Survey responses indicate that experiences of psychological safety vary considerably across service environments. Some respondents described supportive leadership and strong team cultures. A significant proportion described the opposite: environments where raising concerns was perceived as professionally dangerous, and where silence was the rational response to that risk.

Among respondents, only 32% felt comfortable speaking up about issues at work. Only 22% agreed that when women raise concerns, they are taken seriously. Forty-four per cent of respondents had hesitated to raise an issue because they were concerned about the consequences.

The most telling finding is what respondents believed would happen if they did speak up. When asked how women are perceived when raising concerns in their workplace, respondents identified the following:

- Not resilient enough, cited by 23 of 34 respondents
- Too emotional, cited by 23 of 34 respondents
- Unreliable, cited by 18 of 34 respondents
- A risk to operational capability, cited by 17 of 34 respondents
- A career liability, cited by 14 of 34 respondents

These perceptions do not describe individual attitudes. They describe a cultural environment in which raising a concern is understood to carry a professional cost, and in which women have learned, often through direct experience, to weigh that cost before speaking.

One respondent summarised this directly:

"If we speak up we are considered difficult and just playing the gender card. Most things are considered just not much of a big deal by the men. It is also hard to prove cultural things like not being listened to or heard in meetings or operationally."

This response captures two distinct but related problems. The first is the label: the risk of being seen as difficult, oversensitive, or agenda-driven. The second is the evidentiary problem: cultural exclusion is often invisible to those doing it, which makes it both harder to formally report and easier to dismiss.

Roundtable discussions convened by VESPIIA reinforced this dynamic. Participants described a broadly understood rule in service environments: as a woman in service, you don't complain. Not because complaints aren't warranted, but because the personal and professional cost of being known as someone who complains is understood to be high. The phrase "there she goes again" was offered as a shorthand for how persistent concern-raising is received, not as evidence of a systemic problem, but as evidence of a difficult personality.

This dynamic is compounded when the decision-making structures around women do not include women. One respondent described this directly:

"When it is a matter that the male leadership do not recognise or agree with, it is dismissed, as is the person raising it. All final decisions are made with only male voices. This has significantly impacted women in the agency's perspective of how their voices are valued."

The consequence of this environment is not simply that concerns go unaddressed. It is that women calculate, correctly, that speaking up is likely to cost them more than staying silent. Several respondents described observing colleagues being "managed out" as a direct result of raising workplace issues, creating a visible precedent that others absorb.

"I have observed that many who speak up about genuine workplace issues have been 'managed out'

as a result of being vocal. When I have raised or supported concerns about poor workplace treatment, the outcome has been performance management — for me and for others."

When the visible outcome of speaking up is performance management or professional isolation, the rational response, particularly for women already navigating environments where they are in the minority, is silence. That silence is not passivity. It is a learned adaptation to an environment that has made the cost of speaking clear.

This dynamic was particularly pronounced in regional and smaller operational environments, where personnel work in close proximity to the same colleagues and supervisors over extended periods, and where informal social consequences can compound formal professional ones.

One respondent working in a regional fire service described the resulting uncertainty:

"It is hard to know whether my experiences reflect the service overall or just my immediate environment. The distance from the broader organisation makes it difficult to gauge."

That uncertainty is itself significant. Personnel who cannot distinguish between a systemic problem and a local one are less likely to formally raise concerns, because they cannot be confident their experience will be recognised as legitimate rather than attributed to their own perception, or to the particular dynamics of their team.

Only 35% of respondents trusted that leadership genuinely wanted to hear concerns raised by women. Only 19% agreed that when issues are raised, leadership follows through with action.

Roundtable discussions raised a further dimension that survey responses reflect: some women are not simply deterred from speaking up, they are never aware that a formal opportunity to do so exists at all. Where consultation processes are not actively and visibly communicated, and where the outcomes of previous consultations are not demonstrated, the implicit message is that feedback is neither sought nor consequential. Women who have watched previous concerns go unaddressed describe consultation as something done to them rather than with them, a process that produces the appearance of engagement without any of its substance.

When personnel do not trust that raising a concern will lead to anything, and have evidence direct or observed that it may actively work against them, silence becomes the only rational option. That silence has consequences not just for the individual and their immediate team, but for the organisation's ability to see and respond to the risks accumulating within it.

Equipment, PPE, and Operational Safety

Operational equipment and personal protective equipment (PPE) are not administrative considerations. In service environments where personnel face physical risk, equipment that does not fit correctly is a safety issue. It is also, as this section demonstrates, a systemic one.

Fifty-eight per cent of survey respondents said their uniforms and PPE do not fit properly. Fifty-nine per cent said poor fit has affected their comfort at work. The gap between those two figures matters: it suggests a significant number of women are absorbing poor fit as a condition of the job rather than identifying it as a safety or performance problem. In environments where stoicism is culturally expected, discomfort tends to be underreported, not absent.

The underlying cause identified consistently across survey responses and roundtable discussions is that operational equipment across many service environments was designed around male body proportions and has not been systematically redesigned to account for the diversity of the current workforce. The issue is not simply sizing. Anatomical differences in torso length, hip structure, shoulder width, and chest shape mean that scaling down equipment designed for male bodies does not produce equipment that fits or protects female bodies adequately. It produces a smaller version of the wrong design.

One respondent in a fire and rescue role described the practical reality of this after nearly two decades of service:

"My turnout coat is far too long to efficiently move in and makes performing my role very difficult. A specific female turnout coat is unavailable to try on. After many years in service I have only now been advised that female-specific turnout uniform is available to order — but not available to try on before committing."

Another put it with less patience:

"Women have hips. Figure it out."

These responses reflect a frustration that is both long-standing and reasonable. The problem is not new, and in many cases neither is awareness of it. What is consistently absent is resolution.

Roundtable discussions highlighted a framing problem that helps explain why resolution is slow: women's equipment needs are frequently categorised as a "women's issue" rather than an operational safety issue. When reframed as the latter, the calculus changes. The question, as one roundtable participant put it, is not what it costs to address the problem, but what it costs not to.

This reframing is not merely rhetorical. It has practical implications for how equipment issues are prioritised, funded, and resolved within procurement systems. Body armour, for example, is not an optional piece of kit. As participants noted, it is not "an easy bit to drop." Where body armour does not fit correctly, the operational risk is direct and immediate. Yet survey respondents continue to report that body armour is not fit for purpose.

One respondent was unambiguous:

"Body armour is NOT fit for purpose."

The safety risk extends beyond general fit. One Defence respondent described a specific and largely unacknowledged hazard:

protective equipment for women when firing weapons. The required firing position involves holding the weapon close to the chest to achieve correct trajectory and stability. For female bodies, this places breast tissue directly in the impact and blast zone. There is very little clear guidance or reporting on the effects of repeated blast force and recoil on breast tissue, and standard issue uniforms and protective gear have not historically been designed with this in mind. The absence of a properly engineered protective garment for women creates an unnecessary risk of injury."

This account illustrates a category of risk that exists precisely because equipment systems were not designed with female anatomy in mind, and because no mechanism has required that gap to be identified or addressed.

Regional and volunteer environments face compounding difficulties. In many first response organisations, regional and volunteer personnel rely on centrally managed PPE allocations with infrequent replacement cycles. Where female-specific equipment exists at all, access is often constrained by these cycles, meaning women may wait extended periods for equipment that fits even when suitable options are nominally available.

One respondent described this directly:

"We are given a limited allocation of PPE. I have been allocated whatever is available, sometimes ill-fitting, and it is difficult to have it replaced before the annual allocation refreshes. If a women's-specific variant becomes available I would expect to have to wait until my allocation refreshes to access it."

The procurement and supply systems that govern equipment access were not designed to be discriminatory. But where they operate on fixed cycles and limited stock, the women least likely to have access to appropriate equipment are often those in the roles and locations where equipment fit matters most operationally.

Consultation processes around equipment have also produced mixed results. Some respondents described recent positive steps, including being included in communications about female-specific PPE trials. Others described a longer pattern in which consultation has not translated into change.

One respondent noted a further complication: where women within a service hold divergent views about whether equipment is adequate, a unified voice for change does not emerge, and the result is inaction.

"Lots of consultation that has led to no meaningful change. Often it is in disagreement with women in

the service who have 'standard' bodies and so do not have issues with the uniforms or PPE, so there is not a combined voice."

This observation is important. It does not undermine the case for change. It identifies why change has been slow, and why consultation processes that rely on consensus among affected personnel, rather than on objective safety and operational standards, will continue to produce inconsistent outcomes. Equipment standards should not depend on whether enough women agree that the problem is serious enough to warrant action. They should be determined by whether the equipment is fit for purpose across the full diversity of the workforce.

Equipment systems must also respond to changes in personnel needs over time, not just at the point of procurement. Survey responses identified a failure point that receives little attention: the inability of uniform and equipment systems to adapt when a personnel member's body changes following serious illness.

One respondent described still waiting for a uniform replacement following breast cancer treatment:

"I needed my uniform changed following breast cancer. I still don't have it back."

Breast cancer treatment can involve surgery and physical changes that affect how uniforms fit. Where supply systems cannot respond to these circumstances, personnel are effectively left without appropriate operational clothing for an indeterminate period through no fault of their own.

There are examples within Australian service organisations of more responsive approaches. Roundtable participants noted that some state police services measure women individually for uniforms rather than applying standard size allocations, and that some Defence commands have begun building measurement-based fit assessments into uniform maintenance processes. These practices exist. They are not yet standard.

From a workforce capability perspective, equipment that does not fit is not a minor inconvenience to be managed individually. It is a system design failure with direct implications for operational safety, workforce confidence, and the signal it sends about whose participation is genuinely valued. Where women are expected to perform the same roles and accept the same risks as their colleagues, they should be able to do so in equipment that was designed for their bodies.

Health Systems

Service organisations make significant investment in the health and fitness of their personnel. For that investment to deliver sustainable workforce capacity, health systems need to account for the full range of health experiences present across the workforce. Survey responses indicate that for many women, they currently do not.

The barriers described in this section are not confined to a single health condition or sector. They appear across reproductive health, pregnancy, menopause, and recovery from serious illness. What connects them is a common pattern: health needs that are specific to women are poorly understood, inadequately supported, and in many cases treated as private matters that personnel are expected to manage without organisational accommodation.

Only 21% of respondents felt comfortable raising reproductive health or fertility-related needs at work. Fifty-two per cent felt uncomfortable doing so. That figure reflects something that roundtable participants described directly: reproductive health in service environments is treated as "secret women's business", something to be managed quietly rather than acknowledged as a legitimate workplace health consideration.

The health disclosure quote that opened the psychological safety section is worth revisiting here in its fuller context. One respondent described choosing not to disclose a medical diagnosis to station leadership "through fear that my personal details will be discussed in a negative way and disclosed to others in the station who do not need to know." In environments where medical information is likely to circulate informally, the rational response is non-disclosure. Non-disclosure, in turn, means no support, no workplace adjustments, and the individual absorbing health burden alone.

Reproductive health conditions

Reproductive health conditions including endometriosis, polycystic ovarian syndrome

(PCOS), and adenomyosis affect a significant proportion of the workforce. Among survey respondents, 13 of 31 reported living with at least one of these conditions. These are not minor or occasional health issues. Endometriosis, for example, can involve chronic pain, significant fatigue, and unpredictable symptom flares. In operational environments built around shift work, physical demand, and a requirement for consistent availability, these symptoms present real and ongoing challenges.

Survey responses suggest awareness of these conditions among supervisors and managers remains limited. Only 13% of respondents said their managers had sufficient understanding of menopause and chronic gynaecological health. Where conditions are poorly understood, personnel face the additional burden of having to explain and justify their health needs before they can access even basic workplace adjustments.

One respondent working in a retained firefighting role described the calculation this creates:

"Flare-ups can be managed by going offline when not feeling 100%. Going offline somewhat regularly due to not feeling well does put you in the spotlight for not being strong enough. I have previously had comments directed at me that I'm not mentally tough enough. I believe there is still a huge focus on whether you are big and strong, and if not, you are not a good firefighter."

This response illustrates how the cultural environment around strength and operational readiness intersects with women's health. A personnel member managing a chronic health condition through reasonable, self-directed adjustments is perceived not as demonstrating good judgement but as evidence of inadequacy.

Menopause

Menopause is among the most consistently under addressed health issues in service environments, despite the fact that the workforce is ageing and a growing proportion of experienced operational women are at or approaching that stage of life.

Only 13% of respondents said their managers had sufficient understanding of menopause. Only 21% felt safe disclosing menopause or gynaecological health conditions at work. Seventy-nine per cent disagreed.

The psychological dimension of menopause is particularly poorly served. One respondent described the specific isolation this creates:

"The anxiety and lack of confidence that has resulted from menopause has been overwhelming, and I feel that there is nowhere at work that this can be discussed or addressed. The culture makes it impossible to raise this with my immediate team. I have discussed it with other women, but their solutions related to the physical symptoms only, not the psychological symptoms."

Roundtable discussions noted that early menopause is an additional and under-discussed dimension of this issue, and that symptoms intersecting with performance assessment or medical review processes can create serious career risk. One participant noted that being prescribed antidepressants for menopause-related symptoms can itself become a barrier to medical clearance or ongoing operational employment, compounding the health burden with a career consequence for seeking treatment.
Survey responses also identified a structural inequity in how menopause-related adjustments are applied.

One respondent noted that reasonable adjustments for menopause are available to office staff but not extended to frontline personnel, with operational requirements cited as justification. The effect is that the women most likely to be physically affected by menopause symptoms in demanding working conditions are the least likely to receive accommodation.

"Frontline services are not given reasonable adjustments because of 'operational requirements'. Women are seen as unfit for duty. Menopause-friendly adjustments only apply to office staff."

Pregnancy and workforce participation

Fifty-six per cent of respondents believed women in their workplace are disadvantaged in their careers due to pregnancy or parenting. The survey data and qualitative responses together suggest this disadvantage is not incidental. In several cases it is deliberate, or at minimum, predictable and unaddressed.

One respondent described the clearest possible version of this:

"I told my work I was pregnant. They cancelled all my training as 'I wasn't worth investing in'."

This experience, in which pregnancy disclosure triggers an immediate withdrawal of professional development, reflects a broader pattern. In structured training and promotion systems where qualification windows are fixed, missing a course or development opportunity during pregnancy can delay promotion eligibility, limit access to specialist roles, and place women years behind their peers in competitive career pathways. The interruption is temporary. The career consequences are not.

Roundtable discussions raised the specific operational complexity around pregnancy in first response roles. Participants described inconsistency in how safe duties are defined and applied, with some women being pushed off-road during pregnancy and others facing pressure to remain on-road beyond the point where it was appropriate. The absence of clear, consistent policy means outcomes are manager-dependent, and women navigate the same system very differently depending on who they report to.

Chemical exposure during pregnancy was also raised as an area of specific concern. Some first response environments involve exposure to substances with known or potential risks to fetal development. Roundtable participants noted a lack of clear guidance for pregnant personnel about these risks, and a broader absence of policy addressing how operational exposure profiles interact with pregnancy planning. This is an area that requires dedicated research and clear organisational guidance.

Pregnancy loss also featured in survey responses in a way that is rarely acknowledged in organisational policy discussions. One respondent described experiencing a miscarriage that was disclosed beyond those who needed to know:

"Reproductive health and pregnancy loss had a profound impact on my experience in service. What should have remained a private and confidential medical matter was instead shared within the workplace without my consent. I was subjected to inappropriate and cruel comments. This not only compounded my grief but exposed a serious absence of trauma-informed awareness, empathy, and appropriate support in the workplace."

Pregnancy loss is not a policy edge case. It is a health event that a significant proportion of women in service will experience during their careers. Where organisations have no framework for handling it, the harm is compounded by institutional indifference.

Gynaecological health and access to appropriate care

Beyond conditions managed in the workplace, survey responses also identified failures in access to appropriate medical care within service health systems. One respondent described being referred to a gynaecologist for a serious condition on only the third occasion it was raised:

"I should have been referred to a gynaecologist on multiple occasions and was not. By the time I finally received a referral, my surgery had been delayed by months and my illness had significantly worsened. That delay severely affected my capability for an extended period that was entirely preventable."

This account is significant not only for the personal impact described, but for how it frames the capability argument. Three additional months of reduced operational capacity, resulting from a referral that should have been made earlier, is a direct and quantifiable cost to the organisation, not just to the individual.

Illness, recovery, and return to service

The equipment section of this paper noted one respondent still waiting for a uniform replacement following breast cancer treatment. The health dimension of that experience extends beyond equipment. Return-to-work processes following serious illness were described by respondents as inconsistently applied and, in some cases, inadequately structured to support a gradual return to full operational duties.

Where return-to-work frameworks function well, personnel can contribute their experience and skills through modified or adjusted duties while recovering. Where frameworks are unclear or manager-dependent, personnel face the prospect of either returning before they are ready or being absent until they can return fully. The latter

effectively penalises personnel for the duration of their illness, particularly in environments with limited light or modified duty options.

From a workforce capability perspective, the ability to retain experienced personnel through periods of serious illness is not a welfare consideration separate from operational priorities.

It is a retention mechanism. Losing trained personnel, at mid-career or senior stages, due to inadequate return-to-work support represents a loss of investment, experience, and institutional knowledge that is difficult and expensive to rebuild.

Mental Health and Suicidality

Mental health in service environments has received increasing public and policy attention in recent years. The Royal Commission into Defence and Veteran Suicide brought significant focus to the psychological toll of service careers, and many organisations have invested in expanding mental health support, reducing stigma, and creating pathways to care. That work matters. The survey responses in this section indicate that for women in service environments, it is not yet reaching them consistently or equitably, and that the conditions producing psychological distress in women are not yet fully understood or acknowledged by the systems meant to address it.

The baseline findings are serious. Fifty-two per cent of respondents reported experiencing ongoing mental distress that affected their wellbeing during their time in service. Nine of 31 respondents, 29%, reported having experienced thoughts of self-harm or suicide during their service. Thirteen of 30 respondents, 43%, had been directly affected by suicidal distress, attempted suicide, or a workplace suicide within their professional community.

These findings are consistent with what existing research tells us about the mental health profile of women in service environments, particularly for veterans. The 2019 Productivity Commission report on veteran support found that female members of the ADF population had higher rates of any suicidality than the general female population, at 5% compared to 3%, with the gap between female veterans and non-veteran women greater in proportional terms than the equivalent gap for men. United States research has found that female veterans are over three times more likely to die by suicide than non-veteran women in the general population, with those aged 18 to 34 carrying the highest risk (McFarland, Kaplan and Huguet, 2010; Kang et al., 2015). The Australian evidence base on female veteran and first responder suicidality remains limited, which is itself a finding of concern. The data that does exist consistently points in the same direction.

The weight women carry before they arrive at crisis

Understanding why women in service environments reach crisis points at the rates the data suggests requires looking beyond formal mental health support access and into the cumulative load women carry before they ask for help, or decide not to.

Women in service environments frequently carry primary caring responsibilities alongside operational or professional roles. Forty-five per cent of survey respondents reported caring responsibilities outside work, primarily for children. In service environments structured around shift work, overtime availability, and unpredictable operational demand, these responsibilities are not incidental. They shape almost every aspect of a service woman's working life: which shifts are possible, whether overtime is accessible, whether training schedules can be met, and whether there is time or energy left to manage personal health.

One respondent working as a single parent in an emergency services role described this directly:

> "As a single parent there is just a lack of understanding about caring responsibilities and shift work. When your shift starts at the same time as childcare opens, there is no margin. There is no access to overtime. Most male officers would earn considerably more than me simply because I have childcare responsibilities."

This account describes not just logistical difficulty but a structural earnings and progression gap that accumulates over time. Personnel without caring responsibilities can access overtime, take on additional shifts, and participate in development opportunities in ways that personnel managing

childcare constraints cannot. The career consequences compound year on year.

Roundtable discussions added a further dimension to this. Participants described women in service as carrying not just the practical load of caring responsibilities but the cognitive and emotional load that accompanies them: the mental tracking of school schedules, medical appointments, shift rosters, and family logistics that sits in the background of every working day. This load is largely invisible within organisational systems that assess and reward operational performance, and largely unacknowledged in workplace cultures that treat it as a private domestic matter rather than a workforce design issue.

Participants also noted that women who work in high-demand service environments and carry significant caring responsibilities are rarely, in the language of one roundtable participant, "the cared for." They are the carers, at work and at home, and the expectation that they will continue on regardless is so embedded in both domains that reaching a point of genuine distress can happen quietly and without the warning signs organisations are trained to look for.

The assumption that women are already talking

One reason women's mental health needs may be structurally underserved in service environments is a specific and consequential assumption: that women are more likely than men to talk about their mental health and are therefore less in need of active outreach or support.

Fifty-five per cent of respondents said this assumption exists in their workplace. The effect, in practice, is that women's silence is misread as wellness, and their actual experience goes unaddressed. It also creates a situation where the cultural shift toward normalising help-seeking, which is genuine and important, is not being applied equally across genders.

One respondent described the asymmetry directly:

"There is change happening around being open about seeking support. It is seen as brave leadership when men seek support. For women it is still a risk of being considered a liability."

This is a precise description of a double bind. Men who seek mental health support are increasingly framed as demonstrating strength. Women who do the same risk confirming a pre-existing assumption about their emotional fragility or unsuitability for operational work. Only 17% of respondents felt that suicide prevention efforts in their workplace reflected the experiences and risks faced by women. The most common framings of suicide in service workplaces, cited in equal measure, were either as a gender-neutral issue or as something that is rarely discussed at all. Four respondents described it as primarily a men's issue. One respondent summarised the result plainly:

"It's never discussed specifically for women."

Fear of career consequences

Fear of career impact was the most cited barrier to seeking mental health support, identified by 19 of 34 respondents. Concern about confidentiality was next, at 15 respondents, followed by fear of being stood down or removed from role at 13. Eleven respondents cited an internalised belief that they should cope on their own.

These barriers are not irrational. They reflect real patterns in how mental health disclosures have been handled in service environments, and real uncertainty about the consequences. For personnel in roles with security clearance requirements, that uncertainty is particularly acute.

"The impact on security clearances is a factor that impacts on disclosure and seeking help."

Whether or not disclosure formally affects a security clearance outcome, the perception that it might is sufficient to deter help-seeking. Where personnel cannot find clear, accessible information about how mental health treatment interacts with their clearance or operational status, the safest career option is to say nothing.

The result is personnel managing significant psychological distress privately, often for extended periods, because the risk of asking for help appears greater than the risk of continuing without it. Where this calculation is being made by a substantial proportion of the workforce, as the barrier data suggests it is, organisations are operating with a fundamentally incomplete

picture of the mental health burden their people are carrying.

Menopause and suicidality

One area that receives almost no attention in existing mental health frameworks for service personnel is the relationship between menopause and mental health, including suicidality. Roundtable participants noted that the intersection of menopause with mood, anxiety, and cognition is under-researched and under-discussed in service environments, and that treatment for menopause-related mental health symptoms, including antidepressant medication, can itself become a barrier to medical clearance or continued operational employment. Women facing this situation are in the position of seeking appropriate treatment for a health condition that then creates a career consequence. That is a system failure, not a personal failing.

One respondent described both the personal experience and the organisational silence around it in terms that warrant direct inclusion:

"I have been suicidal, and the response I received was that it was my own issue and that I needed to 'work through it'. Menopause-related suicidal ideation is not discussed. Women tend to shut down and say 'I'm fine' rather than share, even with the closest colleagues."

This response sits at the intersection of several themes running throughout this paper: the absence of menopause awareness in service environments, the expectation that women manage health challenges privately, the inadequacy of organisational responses when distress is disclosed, and the silence that results from all of the above. That silence is not evidence that the problem does not exist. It is evidence that the environment has made disclosure feel unsafe, futile, or both.

The cost of unaddressed distress

Where mental health distress goes unaddressed, it compounds. Delayed access to support increases the risk of burnout, disengagement, and early exit from service. It also increases the risk that distress escalates to crisis point.

The survey found that 29% of respondents had experienced thoughts of self-harm or suicide during their service, and nearly half had been directly affected by a workplace suicide or suicidal crisis in their professional community. These figures sit against an organisational backdrop in which only 28% of respondents trusted that mental health disclosures would be handled with care and confidentiality, and only 27% said mental health support in their workplace was accessible and appropriate for women.

The gap between need and access is not principally a resources problem. It is a trust problem, a culture problem, and in several cases a structural problem created by the career consequences attached to seeking help. Service organisations cannot address workforce mental health by making support nominally available while simultaneously creating conditions that make using it professionally dangerous.

The expectation that women in service environments will continue on, manage their professional and caring responsibilities without complaint, and seek help only when they can do so without any career risk, is not a neutral cultural feature. It is an active contributor to the mental health burden this section documents. Addressing that burden requires acknowledging its sources, not simply adding more support pathways to a system that is already conditioning people not to use them.

Workplace Safety, Sexual Harm and Organisational Accountability

Of all the findings in this survey, those relating to workplace safety and sexual harm are the most serious. The experiences described in this section are not edge cases or historical grievances. They are current, they are cross-sector, and they are being actively managed, in most cases, by the people who experienced them alone.

Seventy-six per cent of respondents agreed that poor handling of sexual harassment and assault contributes to women leaving service. No respondent disagreed. That is the clearest finding in the entire survey, and it is the appropriate place to begin, because it frames everything that follows: the problem is not only what happens to women in these environments. It is what happens when they try to do something about it.

What respondents described

Survey responses included accounts of harassment, intimidation, sexual assault, and attempted assault across Defence and first response environments. These accounts were not confined to a single agency, sector, or period of service.

One respondent described an attempted sexual assault while working as a on road, and the organisational response that followed:

"A patient attempted to rape me at work. I documented what happened in detail as required and as per instructions. A complaint was subsequently made about the language used in that documentation. I was performance managed as a result. No one ever asked if I was okay."

This account does not describe a system that failed to respond. It describes a system that responded, actively and swiftly, to the wrong thing. The welfare of the person who experienced the assault was not the priority. Administrative compliance was. The consequence was that a personnel member who had just survived an attempted rape was disciplined for documenting it accurately.

One respondent described intimidation while working at an ADF base:

"A group of members surrounded me and wouldn't let me leave. I had to push my way through. I reported to the manager and was told nothing happened. I was rostered back to the same environment the following week and called in sick. The incident was never talked about again. Nobody was concerned for my welfare or how scared I was to go to work."

Another respondent described a pattern of systemic protection within their organisation:

"Senior figures responsible for conduct clearly protect those in their social networks who are responsible for sexual-related workplace issues."

And one respondent described the institutional logic that allows perpetrators to remain:

"The ADF refuses to take sexual harassment and assault as seriously as it should. It does not treat perpetrators as liabilities that should be charged, sacked, or imprisoned. Instead, units minimise the behaviour, make excuses for it, and cover it up. They retain the perpetrator because they consider them an asset, due to the amount of time and money they have invested in training them."

This last account names something that sits at the centre of the accountability failure: in organisations that have invested heavily in training and developing personnel, perpetrators are sometimes retained because removing them is understood to represent a capability cost. The capability cost of losing the personnel they harmed, or of the deterrent effect on recruitment and retention across the broader workforce, is not calculated in the same way.

The reporting problem

Fifty-five per cent of respondents had seen or experienced organisational responses that discouraged reporting. Forty-seven per cent did not trust that reports would be handled appropriately. Forty-three per cent said people who report sexual harm are not supported by the organisation. Only 37% said they would feel safe reporting sexual harassment or assault if it occurred.

These figures do not describe reporting systems that are working but imperfect. They describe systems that a majority of respondents have learned, through observation or direct experience, not to trust.

One respondent described the calculation this creates with precision:

"I am not comfortable reporting anything through station leadership or command levels due to it not being handled correctly. Doing this would result in myself being portrayed as the problem due to the station and leadership having 'good reputations'. There have been multiple times I could or should have reported safety issues and harassment but in fear of losing my position, I have not reported anything."

Another described what happens to reports that are made:

"When sexual harassment has been reported, it seems to go up the chain and get stopped and never dealt with. The person is never spoken to nor serious consequences taken."

One respondent described supporting multiple women through formal reporting processes and watching the same pattern repeat:

"I have supported women through the process of reporting sexual harassment and it was an awful journey every time, with no outcomes or repercussions. Matters were pushed around from person to person until it seemed to disappear and was hoped to be forgotten about. The person who was inappropriate was never pulled in line."

This respondent also described the cultural environment that normalises the behaviour being reported in the first place:

"I hear the phrase 'can't say that in front of women' too much. If you can't say it in front of a certain group, you should not say it at all. Sexist jokes and locker room talk occur regularly. Sexual innuendos are made frequently around women in situations where it cannot be taken as friendly banter. Women speak up and get shut down for being too sensitive."

The culture of silence extends beyond victims

One of the most significant findings in this section is that the failures described are not limited to how organisations treat women who report harm. They extend to anyone who challenges the culture, regardless of gender.

One respondent described witnessing a male soldier report a sexual assault in which the perpetrators held positions of high authority:

"Rather than being protected, the person who came forward faced serious retaliation including career consequences. It highlighted that when people speak up, they can be silenced, pushed aside, or punished rather than supported. I do not believe this is an isolated case, and it highlights the urgent need for independent reporting pathways and genuine protection from reprisals."

This account is important for what it reveals about the nature of the failure. It is not that reporting systems fail women specifically. It is that reporting systems fail anyone whose account threatens institutional reputation or challenges those with authority and protection within the organisation. Where that is the case, the problem cannot be addressed by improving how women are supported through reporting. It requires independent reporting mechanisms that sit outside the chain of command entirely.

A further observation from respondents is worth noting. Several commented that some male colleagues remain focused on the risk of false allegations rather than engaging with the reality and scale of the harm being described.

One respondent put it plainly:

"Men appear overly focused on 'false allegations' and do not understand the reality or statistics."

This is not an incidental cultural observation. It describes an environment in which the starting assumption, when a report is made, may be scepticism rather than support. That starting assumption shapes every subsequent step in the reporting process.

The need for independent reporting mechanisms that sit outside the chain of command is not merely a recommendation emerging from this survey. It is now the subject of active legislative debate in the Australian Parliament.

In 2025, a private member's Bill was introduced to the Senate proposing the establishment of a Sexual Assault Prevention, Intervention and Response Commission, or SAPIR Commission, within the Defence Act 1903. Introduced by Senator Lambie, the Bill would create a statutory independent commissioner with authority over prevention, education, reporting, investigation, and victim-survivor support, operating outside the chain of command and not subject to direction by any person in the performance of its functions.

The Bill's stated objective is an Australian Defence Force with zero incidence of sexual assault, to be achieved through a culture of zero tolerance, defined response capability, and meaningful accountability for leaders and perpetrators alike. The Bill also explicitly prohibits retaliation against those who report and establishes that personnel convicted of sexual offences must be separated from the ADF rather than retained.

VESPIIA made a formal submission to the Senate inquiry into the SAPIR Bill in February 2026, supporting its establishment in principle while identifying areas requiring strengthening, including safeguards against future erosion of the Commission's independence, clearer accountability mechanisms extending beyond criminal conviction outcomes, and protections for civilian victims and Defence family members. VESPIIA's submission noted that previous Defence-led reform mechanisms, including the Defence Abuse Response Taskforce, were

ultimately time-limited, reshaped, or discontinued without assurance that the systemic causes of failure had been addressed, and argued that structural independence must be protected by legislation rather than left to administrative goodwill.

That such legislation has been necessary, and that it has reached the Senate, is itself an acknowledgement by Parliament that existing systems have not functioned as required.

Critically, no equivalent legislative reform has been proposed for any Australian first response agency. The experiences described by policing, fire, and ambulance respondents in this survey, including patterns of underreporting, career-based deterrence, and institutional protection of perpetrators, suggest that the accountability gap is not confined to Defence. For first responder agencies, there is currently no equivalent push for independent oversight, no equivalent mechanism to receive and investigate reports outside the chain of command, and no equivalent legislative floor below which accountability cannot fall.

That absence is not a neutral finding. It is a policy gap with real consequences for the women who serve in those environments.

The Defence respondent context

One respondent described a Defence environment in terms that warrant inclusion in full, because they describe not just individual incidents but an institutionalised culture:

"I observed a culture where aggression, dominance, and intimidation were sometimes normalised or even rewarded, and where harmful behaviour could be minimised rather than confronted. I became aware of what amounted to a system in which sexual assaults were referenced and bragged about using coded identifiers. The existence of something so brazen spoke volumes about the culture of silence and the way perpetrators sought validation from each other. Being one of the only women who recognised what was happening placed a target on my back. Speaking up did not feel like it led to accountability. It often felt like it led to isolation."

This account describes behaviour that, if the Royal Commission findings are any guide, is not unprecedented. What it also describes is the specific position of women who are few in number within their environment, who recognise what is happening, and who are then isolated for that recognition. The problem is not that they were alone in experiencing a hostile environment. The problem is that they were alone in being unable to ignore it.

The connection to mental health and workforce exit

Sixty-eight per cent of respondents agreed that how organisations handle sexual harm influences whether women seek help for mental health concerns. Sixty-three per cent said career impact concerns discourage women from reporting in the first place.

These two figures, read together, describe a reinforcing cycle. Where reporting is perceived as dangerous, incidents go unreported. Where incidents go unreported, the behaviour continues. Where the behaviour continues, psychological harm accumulates. Where psychological harm accumulates, the barriers to seeking mental health support, already described in Section 5.4, become even harder to overcome. And where help is not sought, the eventual outcome is frequently exit from service.

Seventy-six per cent of respondents agreed that poor handling of sexual harm contributes to women leaving service. That figure has no counterweight. Not one respondent disagreed.

The organisational response to sexual harm is therefore not a discrete human resources or legal compliance issue. It is directly connected to workforce retention, mental health outcomes, and the ability of service organisations to sustain experienced personnel. Treating it as anything less is not just a moral failure. It is a capability failure with a measurable cost.

Career Progression and Leadership

Leadership capability in service organisations is built over long career timelines. Operational leaders develop their expertise through years of frontline experience, progressive responsibility, and access to training and development opportunities at the right points in their career. When those opportunities are unevenly distributed, or when structural barriers interrupt

the path to leadership, the consequences extend beyond individual careers. They narrow the pool from which future leaders are drawn.

Survey responses indicate that for many women in service environments, career progression is shaped less by formal policy than by the practical realities of where they work, who their manager is, and what personal circumstances they are navigating at any given point in time.

Sixty per cent of respondents said women are not adequately represented in leadership roles in their workplace or service. Only 25% could identify clear examples of women progressing into senior or influential roles. Only 34% described promotion processes as transparent and fair. Taken together, these figures suggest that formal promotion frameworks exist, but that access to the experiences and opportunities required to succeed within them is far from evenly distributed.

The regional and retained divide

One of the clearest patterns in the career progression data is the gap between full-time metropolitan personnel and those in regional, retained, or volunteer roles. Sixty per cent of respondents were based in metropolitan locations, but the qualitative responses suggest that career development opportunities are significantly less accessible for those outside those environments.

One respondent working in a retained fire service described this with precision:

"I definitely see career progression and support for women in a full-time capacity but I do not feel that it extends to regional and retained. Women at the retained station I am part of are constantly overlooked for additional things. Weaknesses are regularly pointed out but no support or training is geared to improvement. Things are manipulated by leadership to exclude women by making it seem there are other reasons."

This account describes not just uneven access to opportunity, but active exclusion dressed as objective assessment. Where leadership has discretion over who receives development support and who does not, bias, whether conscious or not, can operate without accountability.

Another respondent in a regional fire role noted that limited opportunities and inconsistent training access affects both men and women in their environment, while acknowledging the particular impact on women. This cross-gender observation is worth noting: structural disadvantage in regional and volunteer environments is not always gender-specific in its origin, but it compounds the barriers women already face from the factors described elsewhere in this paper.

Mentoring: self-sourced and structurally absent

Access to mentoring and development support is one of the recognised pathways through which career progression can be supported, particularly for personnel navigating environments where formal networks are thin or where informal sponsorship is limited.

Only 25% of respondents said mentoring or development opportunities had supported their career progression. The picture that emerges from qualitative responses is not simply that mentoring is unavailable, but that where it exists, it operates informally and at the initiative of individuals rather than through any organisational structure.

One respondent described this dynamic in terms that capture both the effort involved and the institutional failure it reflects:

"Mentoring I have accessed has been done by me, not supported or provided by my agency. I have supported other operational women to access mentors, and this has been supported by their managers, but our agency has no process for doing this. I have been informally requested to mentor several staff, but when a mentor is required for someone I am never considered by senior management or asked."

This account describes a system in which the work of building and sustaining mentoring relationships falls entirely on individuals, most of whom are already carrying the structural disadvantages described throughout this paper. The same person who is not being considered by senior leadership as a formal mentor is likely also the person who is being overlooked for development opportunities and working without organisational support for their own progression.

Roundtable discussions noted that the value of mentoring in service environments lies in sharing operational experience and navigating institutional

culture, not in training new graduates. Where mentoring systems are absent or depend entirely on individual initiative, that accumulated knowledge does not transfer systematically through the organisation.

The structural bias in who progresses

Career progression in service environments does not always operate on formally stated criteria alone. Survey responses and roundtable discussions identified several structural features that shape outcomes in ways that are rarely named explicitly.

Roundtable participants described how women in some services face a choice between career progression and family planning, particularly in specialisations where training windows are narrow and timing is rigid. Defence was specifically noted as not having job sharing options, meaning that the career is either full commitment or it is not. Physical infrastructure tells the same story: barracks have historically lacked lactation rooms, and while some first response depots have begun adding them, access remains inconsistent and often metropolitan-focused. The observation from participants was direct: the system assumes an outdated household and workforce model.

Leave systems compound this. Participants noted that women exhaust leave faster than male colleagues, because sick leave, personal leave, and carers' leave are drawn on for a wider range of circumstances. Male colleagues who are not carrying primary caring responsibilities can preserve their leave for study, development activities, or additional shifts that build career capital. The result, over time, is a structural earnings and progression gap that accumulates without any single discriminatory act.

Only 18% of respondents said career pathways in their workplace allow for flexibility without penalty. Seventy per cent said leaders do not understand how health and wellbeing issues affect career progression. Only 19% said leadership decisions about progression balance operational needs with long-term workforce sustainability.

That last figure deserves particular attention. It suggests that where progression decisions are made, short-term operational availability is weighted heavily against the long-term development of the workforce. Personnel who are most available in the immediate term are disproportionately rewarded. Personnel navigating health issues, caring responsibilities, or regional postings are structurally disadvantaged in a system that does not account for those realities.

One respondent in an ambulance service described reaching a ceiling that has nothing to do with capability:

"Once reaching paramedic, career progression stalls. There is no opportunity available for women to pursue additional training or roles. Recruitment lacks transparency and manager positions tend to go to men who are more sociable."

The "more sociable" observation is not incidental. Roundtable participants described how informal social networks within service organisations influence sponsorship, visibility, and ultimately who is considered for leadership roles. Where those networks are predominantly male, and where acceptance into them requires a degree of social conformity that many women navigate differently, women are competing on an uneven surface even when the formal criteria are equal.

One respondent described the specific form this takes in terms of how women are characterised:

"Unconscious bias and negative views about women who do not conform with a male's view on how they should act, being demure or sweet, has a negative impact. Women are characterised negatively, such as being called aggressive rather than assertive."

This is the same dynamic described in Section 5.1 in the context of speaking up. It appears again here in the context of career progression: the characteristics that are rewarded in men are reframed as liabilities in women. Confidence becomes aggression. Assertiveness becomes difficulty. The result is that women must navigate not only the formal requirements of progression but a second, unwritten set of expectations about how they should present themselves while doing it.

The leadership pipeline consequence

Seventy per cent of respondents said leaders do not understand how health and wellbeing issues affect career progression. Only 34% saw a clear and sustainable long-term career for women in their service.

These two figures together describe an organisation that is not adequately preparing for the workforce it already has. Where leaders do not understand how health, caring responsibilities, and lifecycle factors interact with career progression, they cannot make decisions that support sustainable participation. And where women cannot see a long-term career in their service, the retention signals are already embedded in that perception.

Roundtable discussions noted that a generational shift is underway, with older male leaders retiring, but that policies have not kept pace with that shift. The women who have been navigating inadequate systems for years are not yet represented at the leadership levels where those systems are designed and maintained. Until they are, the gap between formal policy and operational reality is likely to persist.

From a workforce capability perspective, the combined effect of these barriers is a progressive narrowing of the leadership pipeline. The loss is not only felt by the individuals whose careers are constrained. It is felt by the organisations that fail to develop the depth and diversity of leadership required to sustain operational effectiveness over time.

Policy Implementation

The findings presented in the preceding sections describe a workforce navigating health systems, safety risks, career barriers, and cultural pressures that are, in many cases, well understood by those experiencing them and inadequately addressed by the organisations responsible for them. This section examines why that gap persists, and why the mechanisms most commonly used to close it, policy frameworks and workforce consultation processes, are not functioning as intended.

Policy implementation

Service organisations across Defence and first response sectors have developed policy frameworks addressing workplace safety, workforce participation, health support, flexible work, and reporting processes. The existence of these policies is not, in itself, disputed. What the survey data makes clear is that the existence of policy and the experience of policy are two different things.

Eighty per cent of respondents said how policies are applied depends on individual managers or local leadership rather than consistent organisational standards. Only 24% said policies are applied consistently across roles, locations, and teams. Only 29% said policies work as intended in practice. Only 7% felt confident that policies designed to support women actually protect them.

That final figure, 7%, is not a measurement of policy content. It is a measurement of trust in the system that is supposed to deliver it.

One respondent described the operational reality plainly:

"No one follows a process. They like to ignore or play in the grey."

Another identified a structural driver of this failure:

"Policy is unequally applied and written by people disconnected from the reality of on-road life. Meeting business KPIs is usually the end game."

This observation names something that runs through many of the policy failures described in this paper. Policies are often designed at a distance from the environments in which they must operate. Where the people writing policy do not share the operational realities of those it is meant to protect, the resulting frameworks can be technically compliant but practically inadequate. And where the accountability metric is organisational performance, not workforce safety or wellbeing, the incentive to apply policies consistently and rigorously is limited.

One respondent noted simply that their agency has no policies directly supporting women in the workplace at all. That absence is itself a policy choice.

Roundtable discussions framed this problem with clarity: the issue is not that service organisations lack reform intent. It is that making change stick in large, hierarchical organisations with high leadership turnover and posting cycles that shift decision-makers before they are held accountable for outcomes is genuinely difficult. As participants noted, the onus for navigating inadequate systems frequently falls back on individual women, who are left to manage the gap between what policy promises and what their specific manager or station is prepared to deliver.

One respondent described a command culture that captures this dynamic in a single sentence:

"Most commanders demand 100% capability from their troops but offer only 10% support."

Where that imbalance persists, policies designed to support workforce participation will continue to underperform regardless of their content.

The role of manager discretion

The 80% figure on manager-dependent policy application is the most consistent finding across the survey. It appears not as a fringe concern raised by a handful of respondents, but as a near-universal description of how service environments actually function.

In operational organisations where decision-making authority is distributed across stations, units, and commands, some degree of local discretion is both inevitable and appropriate. The problem arises when that discretion operates in the absence of meaningful accountability, when the gap between formal policy standards and local practice is wide enough to produce entirely different experiences for personnel in the same organisation, and when personnel have no reliable way to know which version of policy they will encounter until they need it.

Several respondents described having witnessed policies applied differently not just across stations, but by the same leader depending on who was asking.

One respondent described the consequence of this for their own decision-making:

"Some supervisors and managers ignore policies and do what they want."

Where personnel have learned, through direct observation or experience, that policy application is discretionary, the rational response is not to rely on policy. That calculation, made individually by many women across many service environments, is precisely what the 7% confidence figure reflects.

Workforce consultation: the cycle of disengagement

If policy implementation is the delivery problem, workforce consultation is the intelligence problem. Where organisations cannot accurately capture what their workforce is experiencing, the data that informs policy design and reform is incomplete. The survey findings suggest that many service organisations are operating with significantly distorted pictures of their own workforce realities. Only 15% of respondents believed women's feedback is taken seriously by decision-makers. Forty-six per cent said they did not trust that honest feedback would not negatively affect them. Forty-six per cent said they had not seen clear outcomes from consultation or surveys. Seventy-four per cent said that when change does not occur following consultation, no explanation is given.

That last figure is significant. It describes a consultation process that collects feedback, does not act on it, and does not explain why. From a participant's perspective, this is indistinguishable from a consultation process that was never intended to produce change. Over time, that perception drives disengagement, and 46% of respondents said past consultation experiences affect their willingness to participate in future surveys or research.

Roundtable discussions described this cycle with a phrase that recurred across sessions: "We'll consider it." Consultation is experienced not as a mechanism for change but as a performance of engagement, designed to demonstrate that voices were heard without any commitment to act on what was said. As participants noted, consultation without implementation is not consultation. It is data collection for its own sake.

One respondent described the feedback process at their organisation in terms that illustrate how the cycle is maintained:

"There is a disconnect between executive management and frontline. The feedback we give is edited and altered to meet the preference of the managers presenting it. Explanations as to why this information is unclear or incorrect go unaddressed."

Another described the problem of anonymity in small teams:

"Anonymous feedback becomes identified if it is too negative."

Where personnel believe their identity can be inferred from their feedback, particularly in smaller stations or specialised units, the rational response

is self-censorship. The organisation receives moderated data. Policy is designed on the basis of that moderated data. And the gap between what leadership believes is happening and what is actually happening grows wider.

One respondent, who has worked in their service for 20 years, described what that gap looks like in practice:

"The leaders in our workplace have no idea what it's like to be a woman in our service. If we tell them, we are seen to be exaggerating or complaining about minor things. An email went to all staff recently and it started with 'gentlemen' and ended with 'thanks chaps'. After many years in service, and with women making up a small fraction of the workforce, we are still invisible."

The consultation problem described here is not simply about process design. It reflects a leadership environment in which women's experiences are not taken as credible starting points for organisational learning. Where that is the case, no consultation mechanism, however well designed, will produce the data it is intended to generate.

Another respondent offered a direct challenge to that dynamic:

"Just because we are a minority group doesn't mean we don't have valid points to make or legitimate concerns to raise. Listening to our ideas and implementing appropriate change could be incredibly beneficial for women who so often suffer in silence, so as not to be seen as difficult or troublemakers."

The volunteer cohort

One dimension of the consultation and policy implementation problem that has not yet been addressed directly in this paper is the experience of volunteer personnel. In many first response agencies, volunteers form a substantial proportion of the operational workforce, particularly in regional areas.

One respondent in a volunteer firefighting role described what policy implementation and consultation look like from that position:

"Being a volunteer firefighter and a woman, you are already behind the eight ball and face casual sexism on every fireground. There is a lack of support and progression, and if you're pregnant, well let's not go there."

Volunteer personnel typically have less formal access to workplace protections, less visibility within organisational consultation processes, and fewer pathways to raise concerns. Where policies exist primarily for paid employees, volunteers may fall outside their scope entirely. This is an area where the survey data is thinner than the problem warrants, and where further research is needed.

The paradox of participation

The survey closes with a finding that sits in deliberate tension with everything described above. Ninety-seven per cent of respondents said they believe collecting data on women's experiences is necessary to improve service design and outcomes. Fifty-three per cent believe research like this can lead to meaningful change.

These figures deserve to be read carefully. They are not naive optimism from a cohort that has not experienced the consultation failures described in this section. They come from respondents who have watched feedback disappear, seen recommendations go unimplemented, and calculated that honest disclosure carries personal risk. Despite all of that, the overwhelming majority believe the work is worth doing.

That is not a small thing. It represents a residual trust in the possibility of change that the organisations and governments reading this paper have not yet fully earned. Whether that trust is honoured or squandered will determine not just the outcome of this particular research, but the willingness of women in service environments to participate in the next round of consultation when it comes.

SYSTEM CONSEQUENCES AND WORKFORCE CAPABILITY

The findings presented throughout this paper are not parallel problems sitting alongside each other. They are interconnected. A woman who cannot speak up about a health condition cannot get the workplace adjustment that would allow her to remain operational. A woman who reports harassment and is performance managed for doing so will not report the next incident, or seek mental health support, or trust the consultation process asking for her feedback on workplace culture. A woman in a regional retained role who cannot access training will not progress into the leadership position where she might eventually change the system for the women who come after her.

The survey findings do not describe a set of discrete workforce issues that can be addressed through targeted policy fixes. They describe a system operating in a way that progressively reduces women's ability to participate, advance, and remain in service careers. Understanding that interconnection is essential to understanding why incremental reform, applied to one area at a time, has repeatedly failed to shift the overall picture.
This section draws together the key system-level consequences emerging from the survey findings.

Attrition of trained personnel
Service organisations invest years and significant resources in developing operational personnel. Recruitment, initial training, field experience, specialist qualifications, and leadership development all represent accumulated investment that cannot be quickly or cheaply replaced. When trained personnel leave service earlier than planned due to preventable system failures, that investment is lost.

Survey responses indicate that decisions to leave service, withdraw from operational roles, or disengage from the organisation are not typically made in response to a single incident. They are the product of accumulated experiences, each of which has been weighed against the personal and professional cost of staying. The respondent who has managed a health condition in silence for years, reported harassment and been performance managed for it, watched feedback disappear through internal consultation processes, and been passed over for development opportunities is not making a single decision to leave. They are making a long series of smaller decisions that add up to the same outcome.

One respondent described where that trajectory had taken them:

"Numerous experiences of abuse of various types have severely damaged my career. I will seek support to rebuild my career."

That sentence contains a significant amount of organisational failure in very few words. It describes a personnel member whose capability has been degraded not by anything inherent to them, but by repeated system failures. The organisation that developed that person is not getting the return on its investment. The individual is carrying the cost.

The survey data puts quantitative weight behind this picture. Seventy-six per cent of respondents agreed that poor handling of sexual harm contributes to women leaving service. Only 34%

can see a clear and sustainable long-term career for women in their service. Only 18% said career pathways allow for flexibility without penalty.

These are not retention statistics in the abstract. They are leading indicators of attrition, already embedded in how the current workforce views its future.

Leadership pipeline loss

The consequences of attrition are not confined to the individuals who leave. They shape the composition of leadership over time.

Leadership in service environments is built from the inside. Operational leaders develop through years of frontline experience, progressive responsibility, and access to training and development at the right career stages. Where structural barriers interrupt that pathway, the consequences extend beyond individual careers.

Sixty per cent of respondents said women are not adequately represented in leadership in their organisation. Only 25% could see clear examples of women progressing into senior or influential roles. These figures do not simply describe an underrepresentation problem. They describe a compounding problem: where women cannot see examples of others who have navigated the system and progressed, the signal about whether the system is navigable at all is clearly negative.

Roundtable discussions highlighted what this means in practice. As older male leaders retire and a generational shift creates space for change, the women who should be stepping into those roles are the same women who have been navigating inadequate systems for the duration of their careers. The leadership pipeline is narrow precisely because the barriers that restrict progression have been operating for long enough to shape who is available to step up.

From a capability perspective, organisations that do not actively address the structural barriers to women's leadership progression are not simply failing on representation. They are narrowing the diversity and depth of the leadership pool at the same time as operational complexity and workforce demand are increasing. That is a capability risk, not a cultural aspiration.

Operational safety risks

Several findings in this survey have direct implications for operational safety, not just workforce participation.

Equipment that does not fit correctly increases physical risk in operational environments. The respondent who described firing a weapon without protective equipment designed for female anatomy described an ongoing and unaddressed injury risk. The respondent who described receiving whatever PPE is available at a regional station, regardless of fit, described operating in conditions that do not meet the safety standards the organisation nominally applies.

Where personnel cannot trust reporting systems, safety concerns are not reported. The respondent who described multiple unreported safety incidents and harassment due to fear of losing their position was describing an organisation operating without accurate safety information. Where that information does not reach those responsible for managing risk, the risks do not disappear. They remain in the operational environment, unaddressed and invisible to leadership.

The pattern of non-disclosure that runs through this paper, from health conditions to harassment to general workplace safety concerns, means that service organisations are consistently making decisions based on incomplete pictures of what is actually happening in their operational environments. That is not just a workforce problem. It is an operational safety problem.

Recruitment reputation and the cost of replacement

The capability consequences of attrition extend beyond the individuals who leave. They affect the organisation's ability to attract and retain the next generation of personnel.

Seventy-six per cent of respondents agreed that poor handling of sexual harm contributes to women leaving service. No respondent disagreed. That finding does not remain internal to the organisation. It is communicated through professional networks, community connections, and the visible experiences of women already in service. Potential recruits form views about whether service careers are viable for them partly

based on what they observe in the experiences of those already serving.

Where organisations are known to mishandle sexual harm, to have inadequate equipment, to penalise pregnancy, or to offer no realistic long-term career for women, recruitment of women into those environments becomes harder. The costs of replacement, both financial and in terms of operational experience, are significant. The Australian Institute of Health and Welfare estimates the cost of replacing a trained employee at between 50 and 200 per cent of their annual salary, depending on role seniority and specialisation. For service organisations replacing operational personnel, those costs sit toward the higher end.

Addressing the conditions that drive attrition is therefore not only a workforce participation issue. It is a financial and operational priority.

Institutional trust and the data problem

Underlying all of these consequences is a trust deficit that affects the organisation's ability to understand and respond to its own workforce.

Only 15% of respondents believed women's feedback is taken seriously by decision-makers. Forty-six per cent did not trust that honest feedback would be safe. Seventy-four per cent said that when change does not occur following consultation, no explanation is given.

Where trust in reporting, consultation, and feedback systems is this limited, organisations are not receiving accurate information about what is happening within them. Policy is designed on the basis of incomplete data. Safety risks go unreported. Mental health needs are managed privately. Career barriers are absorbed rather than challenged. The organisation believes the picture is better than it is, because the systems that would reveal how bad it actually is are the same systems that personnel have learned not to trust.

This is the most difficult consequence to address because it is self-reinforcing. Distrust reduces data quality. Poor data quality reduces the likelihood of meaningful reform. The absence of meaningful reform deepens distrust. Breaking that cycle requires more than better policy. It requires organisations to demonstrate, through visible and consistent action, that feedback leads to outcomes and that raising concerns does not lead to professional consequences.

That demonstration has not yet been made convincingly in most of the environments described by this survey's respondents. The 97% who said data collection is necessary, and the 55% who still believe research like this can lead to meaningful change, are extending a conditional trust. The conditions are simple: act on what has been found, report back on what changed, and do not ask for the same feedback again while nothing has moved.

RECOMMENDATIONS

The following recommendations are grounded in the findings presented throughout this paper and are directed at government, agency leadership, and those responsible for workforce system design across Defence and first response environments.

Recommendation 1: Establish fit-for-purpose equipment and PPE standards across service organisations

Service organisations and procurement agencies should ensure that uniforms, PPE, and operational gear meet fit and safety standards for the full diversity of the workforce. To achieve this, they should:

(a) establish female body proportion standards as a baseline requirement in all equipment and uniform procurement specifications, not as an optional variant
(b) conduct structured consultation with operational personnel, including women in regional, retained, and volunteer roles, as a mandatory step in equipment procurement and review cycles
(c) develop responsive supply processes that allow personnel to access suitable equipment during pregnancy, illness, and recovery from medical treatment without waiting for standard replacement cycles.
(d) commission an independent cost and risk analysis examining the relationship between PPE fit, workplace injury and illness rates, and workers' compensation claim costs, with findings reported to agency leadership and used to inform future procurement decisions.

Recommendation 2: Remove career penalties for workforce interruptions

Agencies should audit and redesign training and promotion frameworks to ensure that career interruptions do not result in permanent disadvantage. To achieve this, agencies should:

(a) identify and map all qualification windows and promotion pathways where an interruption creates a structural disadvantage, and establish re-entry mechanisms for each
(b) remove any policy or practice that allows pregnancy or parental status to be used as a basis for withdrawing access to professional development or training opportunities
(c) report annually on the career progression outcomes of personnel who have taken pregnancy, parental, or illness-related leave, to identify and address systemic disadvantage.

Recommendation 3: Modernise workforce health frameworks to reflect the full career lifecycle

Service organisations should review and update health policies and support systems to reflect the health realities of a diverse workforce. Reviews should:

(a) explicitly incorporate reproductive health conditions including endometriosis, PCOS, and adenomyosis into workplace adjustment and support frameworks
(b) establish menopause as a recognised workforce health consideration with clear guidance for supervisors and access to workplace adjustments
(c) deliver mandatory awareness training to supervisors on reproductive health, menopause, and lifecycle health needs
(d) ensure return-to-work pathways following illness or medical treatment are clearly documented, consistently applied, and not contingent on individual manager discretion.

Recommendation 4: Address the conditions that prevent women from seeking mental health support

Governments and agencies should treat the barriers to mental health help-seeking as a workforce safety issue requiring structural intervention, not individual management. To achieve this, they should:

(a) review and clarify the formal and operational impact of mental health disclosure on security clearances, operational eligibility, and career progression, and communicate those findings transparently to the workforce
(b) develop gender-informed mental health support options that recognise the specific barriers faced by women in service environments, including the disproportionate career risk

associated with disclosure
(c) establish confidential reporting and support pathways that are structurally separated from chain-of-command processes and performance management systems.

Recommendation 5: Conduct independent reviews of sexual harm reporting systems
Agencies should commission independent reviews of sexual harm reporting frameworks with a focus on reporter safety, retaliation risk, and accountability outcomes. Reviews should assess:

(a) whether current reporting pathways are accessible, trusted, and free from conflict of interest
(b) the outcomes of reports made over the past five years, including rates of substantiation, disciplinary outcomes, and subsequent career impacts on those who reported
(c) whether independent or external reporting mechanisms are required where internal systems have demonstrably failed to retain the confidence of the workforce
(d) how organisational responses to sexual harm are communicated to the workforce, including outcomes and accountability actions taken.

Recommendation 6: Incorporate workplace culture and safety outcomes into leadership performance frameworks
Service organisations should embed accountability for workplace culture and safety into how leadership performance is defined, measured, and evaluated. To achieve this, organisations should:

(a) develop specific, measurable performance indicators for commanding officers, managers, and supervisors relating to workplace safety, reporting culture, and workforce participation outcomes
(b) ensure that these indicators form part of formal performance review and promotion assessment processes at all levels of command
(c) establish that a station, unit, or command's reputation does not shield it from scrutiny under these frameworks.

Recommendation 7: Introduce oversight mechanisms to ensure consistent policy implementation
Governments and agencies should introduce audit and oversight processes that can identify and address inconsistent policy application across operational units. To achieve this, they should:

(a) establish regular, independent audit processes examining how workplace policies, including those relating to safety, health, and workforce participation, are being applied across stations, units, and commands
(b) require agencies to report publicly on the outcomes of these audits, including identified inconsistencies and corrective actions taken
(c) ensure oversight mechanisms have the authority to require remedial action where inconsistent or inadequate implementation is identified.

Recommendation 8: Reform workforce consultation processes to ensure feedback reaches decision-makers accurately
Organisations should redesign consultation mechanisms to ensure that workforce feedback is collected, reported, and acted on transparently. To achieve this, organisations should:

(a) implement independent or third-party verification of workforce consultation data before it is reported to senior leadership
(b) guarantee the anonymity of feedback through structurally robust processes that cannot be overridden at a local or management level
(c) commit to communicating outcomes of consultation back to participants, including what changed, what did not, and why, within a defined timeframe.

Recommendation 9: Fund independent, cross-sector research into women's workforce participation and retention
Governments should commit to funding research that builds the evidence base required for structural reform across Defence and first response environments. Priority research areas should include:

(a) longitudinal studies examining long-term retention patterns, career progression outcomes, and the specific points at which women exit service careers
(b) the health and lifecycle impacts of shift work, environmental exposure, and operational stress on women across the career lifecycle, including fertility and pregnancy planning

(c) the experiences of women in regional, retained, and volunteer roles, where access to support and development opportunities is typically more limited
(d) the mental health, wellbeing, and secondary trauma burden carried by families and partners of service members, as a standalone research priority and not a footnote to research focused on service members themselves,
(e) the effectiveness of existing policy interventions, with a view to identifying what is working and scaling those approaches across sectors and jurisdictions.
(f) commission independent efficacy research examining the relationship between correctly fitted PPE and operational performance, including task completion rates, physical strain, injury incidence, and confidence in equipment across matched cohorts of personnel. This research should include regional and volunteer environments and be conducted independently of the agencies whose procurement practices are under examination

Organisations such as VESPIIA, working alongside research institutions and service agencies, are well placed to support and coordinate this work.

AREAS FOR FURTHER RESEARCH

This paper provides an initial cross-sector examination of women's experiences across Defence and first response service environments. The survey findings identify consistent patterns across multiple themes, and the qualitative testimony provides important context for understanding how those patterns operate in practice. However, the scope of this research also highlights areas where the current evidence base is insufficient to drive the scale of reform the findings suggest is needed.

The following research priorities emerge directly from the gaps identified through this survey. They are not presented as aspirational topics for future consideration. They are areas where specific, methodologically rigorous research is required before organisations and governments can design and implement effective responses.

LONG-TERM RETENTION AND CAREER ATTRITION PATTERNS

This survey captures a cross-sectional snapshot of current and recent service experiences. It cannot tell us at what point in service careers women are most likely to exit, which barriers are most predictive of attrition, or whether attrition rates differ significantly across sectors, employment types, or geographic locations.

Longitudinal research tracking women's career trajectories across Defence and first response environments would provide a clearer picture of where attrition occurs and what organisational factors contribute to those outcomes. Identifying the critical points in career pathways where targeted intervention could support retention would significantly strengthen the evidence base for workforce policy reform.

This research should examine both voluntary and involuntary separation, including medical discharge, to capture the full range of exit pathways and their relationship to the structural factors identified in this paper.

HEALTH, LIFECYCLE, AND OPERATIONAL PARTICIPATION

Survey responses identified reproductive health conditions, menopause, pregnancy, and illness recovery as significant factors affecting workforce participation. The data in this paper provides a foundation for understanding the scale of those impacts, but several important dimensions remain under-examined.

Research is needed into how operational demands, shift work patterns, and environmental exposures interact with women's health across the full career lifecycle. This includes the health implications of extended shift work on reproductive health, the relationship between menopausal symptoms and operational performance in physically demanding roles, and the adequacy of existing return-to-work frameworks for personnel recovering from serious illness.

Pregnancy planning and fertility represent a specific gap that this survey did not examine in detail. Service conditions, including chemical exposure profiles, shift work, operational stress, and the career penalties associated with taking leave, may influence decisions about if and when to have children. Understanding how service careers shape those decisions is important for

workforce planning and for designing policies that support sustainable long-term participation. This is an area that warrants dedicated research, not a footnote in broader workforce studies.

MENTAL HEALTH, SUICIDALITY, AND GENDER-SPECIFIC RISK

The Royal Commission into Defence and Veteran Suicide brought significant attention to suicide risk among serving and ex-serving Defence personnel. However, the gender-specific dimensions of that risk remain inadequately understood and largely absent from mainstream mental health frameworks in service environments.

This survey found that 29% of respondents had experienced thoughts of self-harm or suicide during their service, and 48% had been directly affected by suicidal distress, attempted suicide, or a workplace suicide in their professional community. These figures are drawn from a small sample and cannot be treated as statistically representative, but they are consistent with existing research suggesting elevated suicidality among female veterans compared to non-veteran women.

Research is needed that specifically examines the mental health risk profile of women across Defence and first response environments, including the relationship between workplace safety experiences, sexual harm, and psychological distress; the role of career-related fear in deterring help-seeking; and the intersection of menopause with mental health and suicidality, which this survey identified as a significant but largely undiscussed issue. Gender-informed mental health frameworks and support pathways that account for these specific risk factors should be developed and evaluated as part of this research agenda.

WORKPLACE SAFETY, REPORTING SYSTEMS, AND ORGANISATIONAL ACCOUNTABILITY

This survey documents a widespread failure of trust in sexual harm reporting systems across Defence and first response environments. However, the survey was not designed to evaluate the design or operation of specific reporting mechanisms, and the data cannot tell us which elements of reporting systems are most associated with reporting behaviour or with long-term workforce retention outcomes.

Research examining how reporting frameworks function in practice across different service environments would provide valuable insight into where system redesign is most needed. Priority areas include the relationship between reporting system design and reporting rates, barriers to disclosure across different service types and employment models, the long-term career impacts on those who do report, and the effectiveness of organisational accountability mechanisms in deterring repeat behaviour.

This research should include first response agencies specifically. The legislative reform debate currently underway for Defence, including the proposed SAPIR Commission, has no equivalent in policing, fire, or ambulance contexts. Comparative research examining how accountability frameworks differ across sectors, and what the workforce participation implications of those differences are, would significantly strengthen the case for cross-sector reform.

FAMILIES, PARTNERS, AND SECONDARY TRAUMA

The experiences of families and partners of women in service represent a research gap that this paper has noted but cannot adequately address. Women in service environments carry primary caring responsibilities at significantly higher rates than their male colleagues, and the mental health and wellbeing of those families is both a workforce participation factor and a significant policy issue in its own right.

Roundtable discussions identified secondary trauma among partners of first responders as an area with some research but significant gaps, particularly in relation to postvention care following workplace suicide, the specific experiences of dual-service families, and the burden carried by families of women who have experienced workplace sexual harm.

This is not a peripheral issue. The sustainability of service careers for women is directly linked to whether the systems around them, including the support available to their families, are adequate. Research in this area should be treated as a standalone priority, not appended to studies focused on service members themselves.

INTERSECTIONAL AND SECTOR-SPECIFIC EXPERIENCES

This survey achieved meaningful representation across several sectors and employment types, but the sample size limits conclusions about specific cohorts. In particular, policing, corrections, and state emergency services are significantly underrepresented relative to their workforce size, and the experiences of women in those environments may differ in important ways from the Defence and fire and rescue respondents who make up the majority of this dataset.

Further research with adequate sector-specific sampling would allow for more precise identification of which barriers are common across service environments and which are sector-specific. This distinction matters for policy design: cross-sector problems require cross-sector solutions, but sector-specific problems require responses tailored to the operational realities of each environment.

Research should also examine the experiences of women in regional, retained, and volunteer roles more systematically. This survey consistently identified this cohort as facing compounding disadvantage, with less access to equipment, training, development opportunities, and policy protection than their metropolitan and full-time counterparts. That finding warrants dedicated investigation rather than treatment as a sub-theme within broader workforce studies.

This survey also did not examine the experiences of LGBTIQA+ women and gender-diverse personnel in service environments. This is a meaningful gap. The intersections between gender identity, sexual orientation, and the structural barriers documented in this paper, including harassment and reporting systems, family planning and parental leave frameworks, mental health support, and workplace culture, are areas where specific research is warranted. LGBTIQA+ personnel may face compounding barriers not captured in a survey focused primarily on women's experiences as a broad cohort, and their experiences should not be subsumed into general workforce diversity research. Dedicated inquiry into how service environments support, or fail to support, LGBTIQA+ women and gender-diverse personnel is needed as part of any comprehensive reform agenda.

CONCLUSION

The findings presented in this paper are not new in every respect. Many of the themes documented here, including equipment that does not fit, career penalties for pregnancy, sexual harm that goes unreported, and policies that exist on paper but not in practice, have appeared in reviews, inquiries, and organisational reports across Defence and first response environments for years. The Royal Commission into Defence and Veteran Suicide documented many of them in detail. Internal organisational surveys have identified them repeatedly. They have been raised in roundtables, in submissions, and in the direct testimony of women who have served.

What this paper adds is evidence that these issues are not confined to any single organisation, sector, or jurisdiction. The patterns identified through VESPIIA's national survey are consistent across Defence, policing, fire and rescue, ambulance, and corrections. They appear in metropolitan services and regional ones, in full-time roles and volunteer ones, at the beginning of careers and at mid-career and senior levels. The consistency of that pattern is itself a finding. It means the problem is not one of isolated organisational failure. It is structural.

Service organisations depend on the experience, capability, and leadership of their people. Recruiting and developing skilled operational personnel is expensive, time-consuming, and increasingly difficult in a tight labour market. When trained personnel leave service earlier than planned because the environments they work in have failed them, organisations absorb that cost. When the leadership pipeline narrows because structural barriers have shaped who progresses and who does not, organisations absorb that cost too. When safety concerns go unreported because personnel have learned that reporting is more dangerous than silence, organisations operate with blind spots they may not even know exist.

These are not welfare problems. They are operational problems with measurable consequences for the workforce capability that service organisations depend on to function.

The survey findings presented in this paper also document something that should not be overlooked: the women who participated did so in full awareness of the risks and frustrations of speaking up. They described environments where feedback disappears, where consultation produces no change, where raising a concern can cost a career. They participated anyway. Ninety-seven per cent of them said data collection on women's experiences is necessary. Fifty-three per cent still believe research like this can lead to meaningful change.

That is not a small act of trust, given what they have described. It places an obligation on everyone who reads this paper to take the findings seriously and to act on them in ways that justify the participation.

VESPIIA produced this paper because the evidence that prompted it, gathered through roundtable discussions in Perth and Adelaide and a national survey, pointed to patterns that no single organisation could see from within its own systems. As a national body working across the veterans, emergency services, and policing sectors, VESPIIA is positioned to hold that cross-sector view and to ensure findings from one environment inform practice in others.

The work does not stop here. VESPIIA is committed to continuing the roundtable and research program that produced this paper, to making the survey dataset available to researchers seeking to build on these findings, and to working alongside service organisations, government, and academic institutions to develop the evidence base that effective reform requires. The research priorities identified in this paper represent a genuine agenda for collaborative work, not a list of aspirations.

The women who shared their experiences through this survey described environments that have not yet fully adapted to the realities of the workforce they rely on. They also described, in most cases, a continued commitment to the work they do and to the communities they serve. The organisations and governments responsible for those environments owe them systems that are worthy of that commitment.

Appendix A:

Full Survey Data

1. This appendix presents complete quantitative data from the Future Frontlines: Women in Service national survey.

2. Distributions are verified against the official Typeform aggregate export (exported 31 March 2026, Australia/Perth time).

3. 81 Likert-scale questions (1–5) are displayed with full response distributions, agree/disagree percentages, and response counts.

4. Multi-select and single-select question results are displayed as counts and percentages.

5. Scale: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree.

6. Agree = responses of 4 or 5. Disagree = responses of 1 or 2. Percentages rounded to nearest whole number.

7. Note: Some questions have lower n due to conditional routing (asked only of respondents meeting prior criteria, e.g. pregnancy, health conditions).

8. Open-text qualitative responses are not included in this appendix. De-identified qualitative data available on application to VESPIIA.

n = 34 | February – March 2026 | National | VESPIIA

All distributions verified against the official Typeform aggregate export (exported 31 March 2026).

How to Read This Appendix

Likert Scale — Response Key

1 — Strongly Disagree	2 — Disagree	3 — Neutral	4 — Agree	5 — Strongly Agree

Sample row:

Question text	1 — Strongly Disagree	2 — Disagree	3 — Neutral	4 — Agree	5 — Strongly Agree	Agree %	Disagree %	n
Stacked bar (numbers = raw count per response)	2	6	8	12	6	53% Agree	24% Disagree	n=34

Sections are colour-coded by theme:

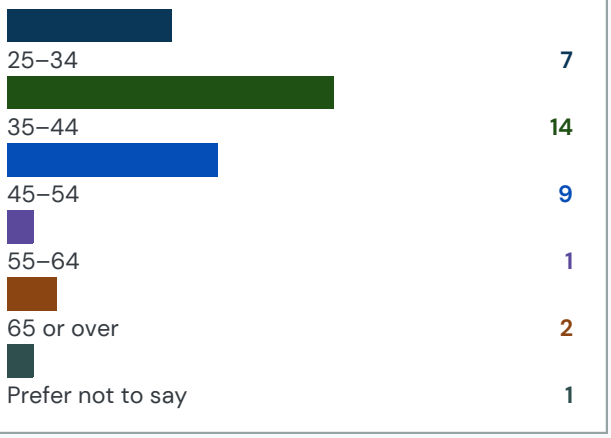
- Psychological Safety / Menopause / Career Progression
- Equipment & PPE / Mental Health / Policy Implementation
- Reproductive Health / Sexual Harm / Consultation

Note on conditional routing: Questions in the Reproductive Health and Menopause sections were shown only to respondents who met specific criteria (e.g. had been pregnant in service, or had selected a relevant health condition in Q5a). These questions have lower n values than the full sample of 34. The n value is shown for each question.

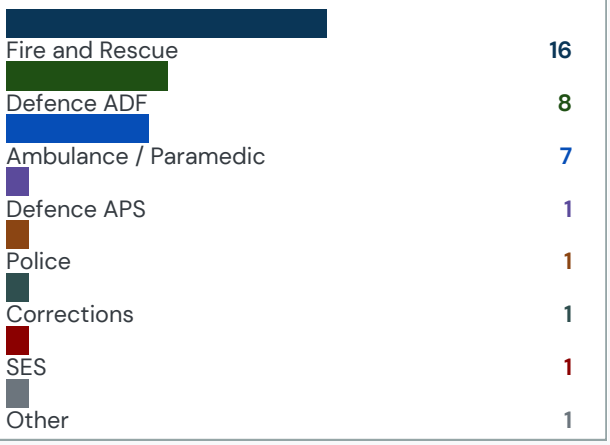
Gender: All identified as women (n=28 specified, 6 not stated)

Participant Demographics — n = 34 | February – March 2026

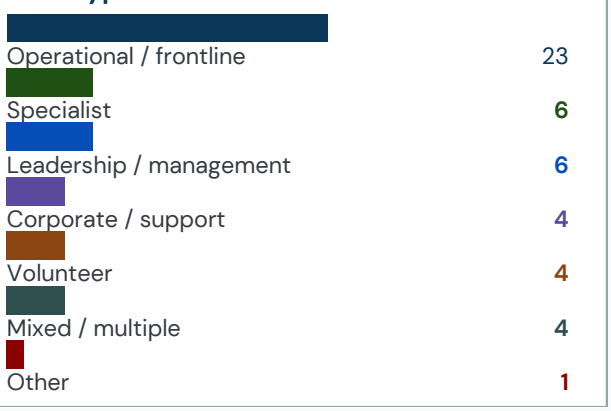
Age Group



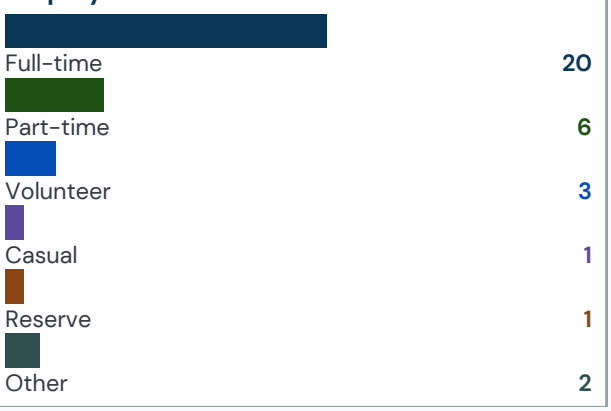
Sector



Role Type



Employment Status



Participant Demographics — n = 34 | February – March 2026

State / Territory

South Australia	19
Western Australia	9
Queensland	3
New South Wales	2
Regional or remote	3
ACT	1
Northern Territory	1
Victoria	1

Location Type

Metropolitan	21
Regional	9
Mixed locations	3
Other	1

Caring Responsibilities

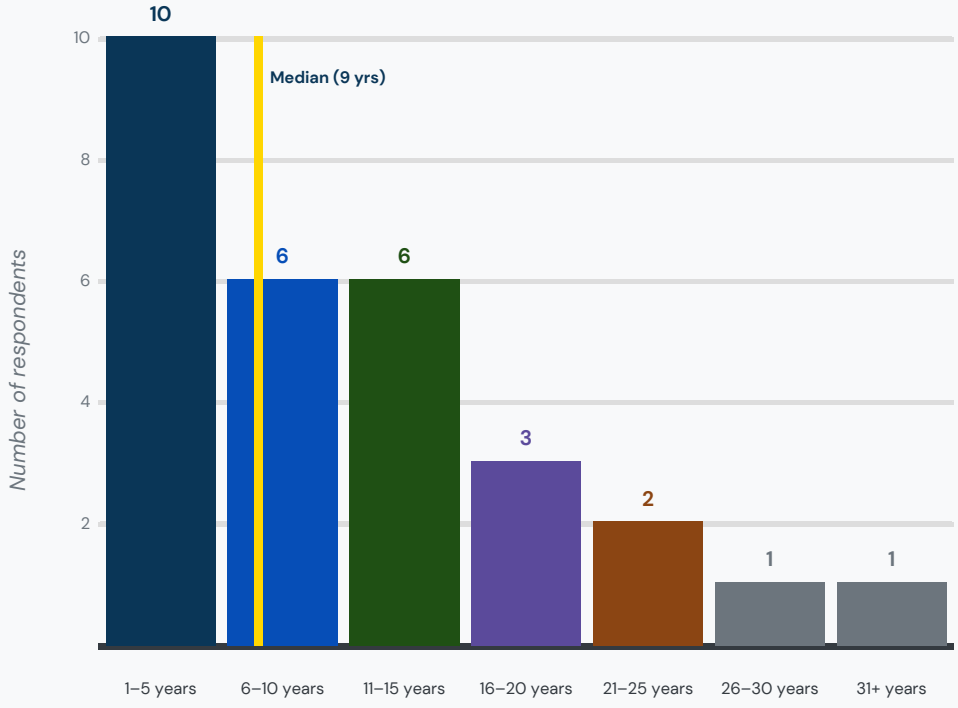
n = 31 (3 not stated)

Yes — children	14	45%
No	13	42%
Yes — both (children & other dependants)	2	6%
Yes — other dependants		3%
Prefer not to say		3%

~50% of respondents reported caring responsibilities outside work

Length of Service

n = 29 (5 not stated) | Median 9 yrs · Mean 10.9 yrs · Range 1–42 yrs · SD 9.62



66% of respondents have served 10 years or less · 3 respondents have served 20+ years

Psychological Safety

Question	Response distribution (raw counts, 1–5)	Agree	Disagree	n
I feel comfortable speaking up about issues that affect me at work.	3 | 8 | 12 | 5 | 6	32%	32%	n=34
When women raise concerns in my workplace, they are taken seriously.	3 | 8 | 12 | 6 |	23%	37%	n=30
I feel that my perspective is valued in workplace discussions.	2 | 8 | 8 | 10 | 5	45%	30%	n=33
I have hesitated to raise an issue because I was concerned about potential negative consequences.	5 | 5 | 8 | 9 | 5	44%	31%	n=32
I feel pressure to appear 'resilient' or 'tough' rather than acknowledge difficulties.	4 | 3 | 6 | 6 | 14	61%	21%	n=33
In my workplace, women are expected to 'just cope' or adapt to existing systems.	2 | 5 | 3 | 11 | 13	71%	21%	n=34
I have felt that raising women-specific issues risks being seen as complaining or difficult.	5 | 6 | 9 | 13	65%	18%	n=34
I trust that leadership in my organisation genuinely wants to hear concerns raised by women.	6 | 10 | 7 | 9 | 2	32%	47%	n=34
When issues are raised, leadership follows through with action.	4 | 9 | 15 | 5 |	18%	38%	n=34

Equipment & PPE

Question	Response distribution (raw counts, 1–5)	Agree	Disagree	n
The uniforms and PPE provided to me fit properly.	3 | 17 | 7 | 5 | 2	21%	59%	n=34
Poor fit or design of uniforms or PPE has affected my comfort at work.	3 | 4 | 5 | 15 | 5	63%	22%	n=32
Poor fit or design of uniforms or PPE has affected my ability to perform my role safely or effectively.	6 | 14 | 6 | 5 | 2	21%	61%	n=33
I feel physically safe in the equipment provided to me.	2 | 11 | 11 | 9	61%	6%	n=33
When feedback is provided about uniforms or PPE, it leads to meaningful changes.	7 | 9 | 14 | 3	12%	47%	n=34
I have access to uniform or PPE options that are appropriate for my body and role.	3 | 7 | 16 | 4 | 3	21%	30%	n=33
Appropriate uniform or PPE options are available during pregnancy or other significant body changes.	6 | 5 | 6 | 4 | 3	29%	46%	n=24
I feel comfortable requesting adjustments to uniforms or PPE when needed.	5 | 7 | 10 | 6 | 5	33%	36%	n=33

Reproductive Health & Pregnancy

Question	Response distribution (raw counts, 1–5)	Agree	Disagree	n
I feel comfortable raising reproductive health or fertility-related needs at work.	10 4 8 5	21%	50%	n=28
Reproductive health needs are treated as legitimate health concerns in my workplace.	5 4 7 10 3	45%	31%	n=29
I felt supported by my workplace during pregnancy.	3 2 5 2	17%	42%	n=12
During pregnancy, decisions about my role or duties prioritised safety rather than convenience.	1 1 5 5	42%	17%	n=12
I was given clear and consistent information about my options during pregnancy.	5 6 1	8%	92%	n=12
I felt supported when returning to work after pregnancy or parental leave.	3 5 1 2	18%	73%	n=11
Parenting responsibilities are reasonably accommodated in my workplace.	7 13 6 5	35%	23%	n=31
Pregnancy or parenting has negatively affected my career progression.	1 3 2 4 3	54%	31%	n=13
I believe women in my workplace are disadvantaged in their careers due to pregnancy or parenting.	8 6 7 9	53%	27%	n=30
Appropriate facilities are available for pregnancy and parenting needs.	7 6 7	0%	65%	n=20

Menopause & Gynaecological Health

Question	Response distribution (raw counts, 1–5)	Agree	Disagree	n
I feel safe disclosing menopause or chronic gynaecological health issues at work.	11 | 8 | 4 |	21%	79%	n=24
Symptoms related to menopause or chronic gynaecological health have affected my work.	2 | 2 | 8 | 8	80%	10%	n=20
These symptoms have affected my ability to work safely or effectively.	1 | 2 | 5 | 11 | 1	60%	15%	n=20
I have been able to access appropriate workplace adjustments when needed.	10 | 3 | 2 | 2 | 3	25%	65%	n=20
Managers or supervisors in my workplace have sufficient understanding of menopause and chronic gynaecological health.	14 | 5 | | | 3	17%	79%	n=24
I have worried that disclosing these health issues could negatively affect my role or career.	3 | 3 | 1 | 4 | 9	65%	30%	n=20
Menopause or chronic gynaecological health has influenced my decisions about staying in service.	2 | 2 | 4 | 4 | 4	50%	25%	n=16
Where policies exist, they are applied consistently and in a supportive way.	5 | 8 | 3	0%	81%	n=16

Mental Health & Suicidality

Question	Response distribution (raw counts, 1–5)	Agree	Disagree	n
Suicide prevention efforts in my workplace reflect the experiences and risks faced by women.	8 4 15 3 2	16%	38%	n=32
There is an assumption in my workplace that women are more likely to talk about their mental health than men.	3 11 12 5	53%	13%	n=32
I believe this assumption makes it harder for women's mental health concerns to be taken seriously.	3 7 7 12 3	47%	31%	n=32
I have experienced ongoing mental distress that has affected my general wellbeing during my time in service.	3 7 5 10 6	52%	32%	n=31
If I experienced suicidal distress, I would feel confident seeking help through workplace or service-linked supports.	6 5 12 4 5	28%	34%	n=32
I trust that mental health disclosures would be handled with care, confidentiality, and fairness in my workplace.	6 5 12 4 5	28%	34%	n=32
Mental health support in my workplace is accessible and appropriate for women.	4 5 15 4 5	27%	27%	n=33

Workplace Safety & Sexual Harm

Question	Response distribution (raw counts, 1–5)	Agree	Disagree	n
I believe my workplace takes sexual harassment and assault seriously.	7 | 3 | 11 | 4 | 8	36%	30%	n=33
In my workplace, it is clear what behaviour is unacceptable.	5 | 6 | 6 | 11 | 5	48%	33%	n=33
I would feel safe reporting sexual harassment or assault if it occurred.	8 | 4 | 9 | 8 | 4	36%	36%	n=33
People who report sexual harassment or assault are supported by the organisation.	5 | 9 | 10 | 7 | 2	27%	42%	n=33
I trust that reports of sexual harassment or assault would be handled appropriately.	7 | 9 | 9 | 6 | 2	24%	48%	n=33
I have seen or experienced organisational responses that discouraged reporting.	6 | 6 | 3 | 10 | 9	56%	35%	n=34
Concerns about career impact or workplace treatment discourage women from reporting sexual harm.	2 | 3 | 8 | 12 | 8	61%	15%	n=33
Experiences of sexual harassment or assault can affect women's mental health in my workplace.	3 | 3 | 8 | 18	81%	9%	n=32
Organisational handling of sexual harm influences whether women seek help for mental health concerns.	3 | 7 | 5 | 16	68%	10%	n=31
I believe poor handling of sexual harassment or assault contributes to women leaving service roles.	8 | 5 | 20	76%	0%	n=33

Career Progression & Leadership

Question	Response distribution (raw counts, 1–5)	Agree	Disagree	n
I have had fair access to career progression opportunities.	5 6 5 10 6	50%	34%	n=32
Career progression processes in my workplace are transparent and fair.	5 9 7 8 3	34%	44%	n=32
Women are adequately represented in leadership roles in my workplace or service.	13 7 5 2 6	24%	61%	n=33
I can see clear examples of women progressing into senior or influential roles.	5 10 8 5 3	26%	48%	n=31
I have access to mentoring or career development support.	7 5 10 7 4	33%	36%	n=33
Mentoring or development opportunities have supported my career progression.	8 5 8 3 3	22%	48%	n=27
Career pathways in my workplace allow for flexibility without penalty.	10 7 9 3 2	16%	55%	n=31
Interruptions to service (for example, leave or modified duties) negatively affect women's career progression.	3 7 10 11	68%	10%	n=31
Leaders in my workplace understand how wellbeing and health issues can affect career progression.	8 13 3 4 2	20%	70%	n=30
Leadership decisions about progression balance operational needs with long-term workforce sustainability.	5 7 12 3 2	17%	41%	n=29
I see a clear and sustainable long-term career for women in my service.	2 10 9 7 4	34%	38%	n=32

Policy Implementation

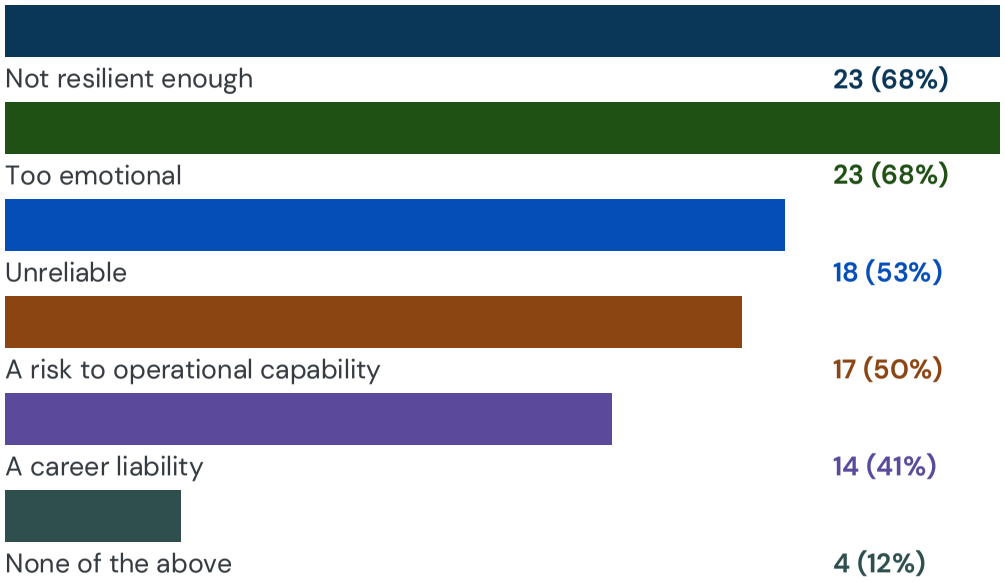
Question	Response distribution (raw counts, 1–5)	Agree	Disagree	n
I am aware of the workplace policies relevant to my role.	2 · 10 · 14 · 7	64%	6%	n=33
Policies are communicated clearly and in a way that is easy to understand.	4 · 7 · 13 · 6 · 2	25%	34%	n=32
Workplace policies are applied consistently across roles, locations, and teams.	7 · 7 · 10 · 5 · 3	25%	44%	n=32
How policies are applied often depends on individual managers or local leadership.	6 · 12 · 14	79%	3%	n=33
In my experience, policies work as intended in practice.	5 · 8 · 10 · 7	26%	42%	n=31
I feel confident that policies designed to support women actually protect women in practice.	5 · 7 · 16	7%	40%	n=30
I trust workplace systems to treat me fairly if I rely on policy-based processes.	5 · 6 · 12 · 7	26%	35%	n=31
Previous experiences (my own or others') affect my willingness to use workplace policies.	2 · 11 · 10 · 6	53%	10%	n=30
Lack of trust in policy implementation affects women's willingness to stay in service roles.	2 · 2 · 13 · 9 · 5	45%	13%	n=31

Workforce Consultation

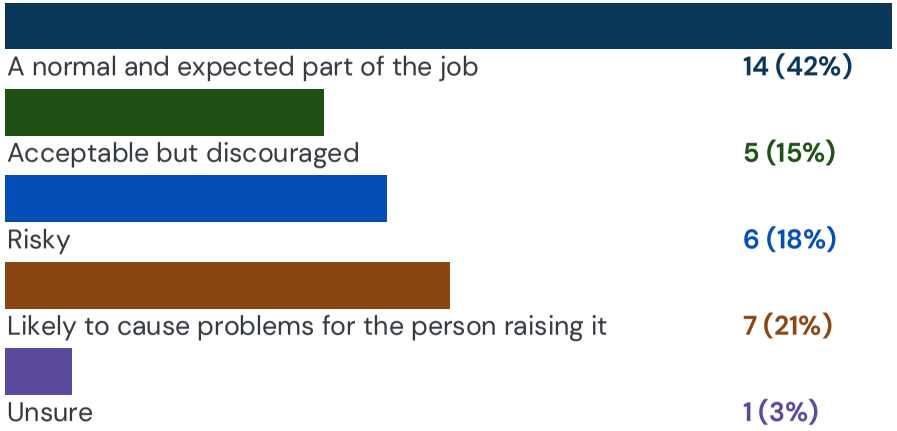
Question	Response distribution (raw counts, 1–5)	Agree	Disagree	n
I have been asked to provide feedback or participate in consultation processes in my service.	2 5 6 11 10	62%	21%	n=34
Consultation processes in my service are inclusive of women's experiences.	5 4 11 8 3	35%	29%	n=31
Feedback provided by women is taken seriously by decision-makers.	4 7 14 3 2	17%	37%	n=30
I have seen clear outcomes or changes resulting from consultation or surveys.	7 9 7 6 2	26%	52%	n=31
Outcomes of consultation or data collection are communicated back to participants.	3 10 9 5 3	27%	43%	n=30
When change does not occur, reasons are explained clearly.	10 13 6 2	6%	74%	n=31
I trust that providing honest feedback will not negatively affect me.	7 8 8 6 2	26%	48%	n=31
Past consultation experiences affect my willingness to participate in future surveys or research.	4 5 7 8 5	45%	31%	n=29
I believe collecting data on women's experiences is necessary to improve service design and outcomes.	9 23	97%	0%	n=33
I believe research like this can lead to meaningful change.	4 10 6 12	55%	15%	n=33

Categorical & Multi-Select Questions — Part 1

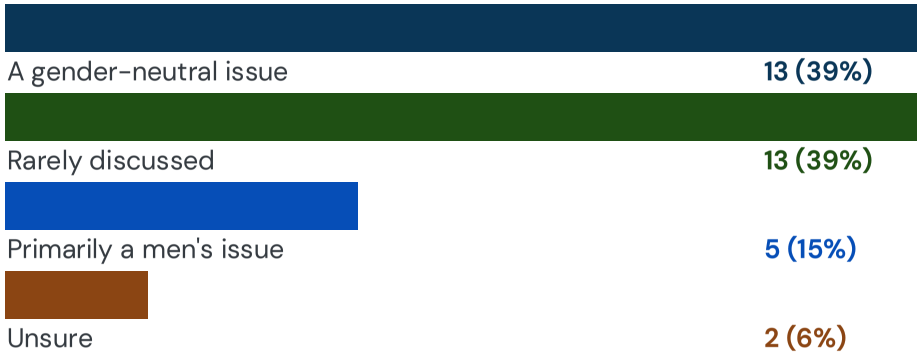
How women are perceived when raising concerns (select all that apply, n=34)



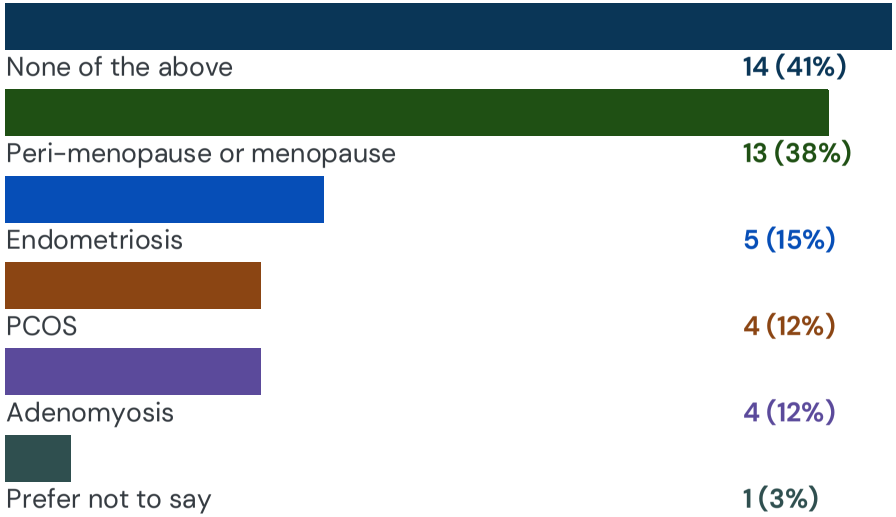
How raising concerns is seen in the workplace — single select (n=33)



Suicide most often discussed in workplace as (single select, n=33)



Health conditions reported (select all that apply, n=34)

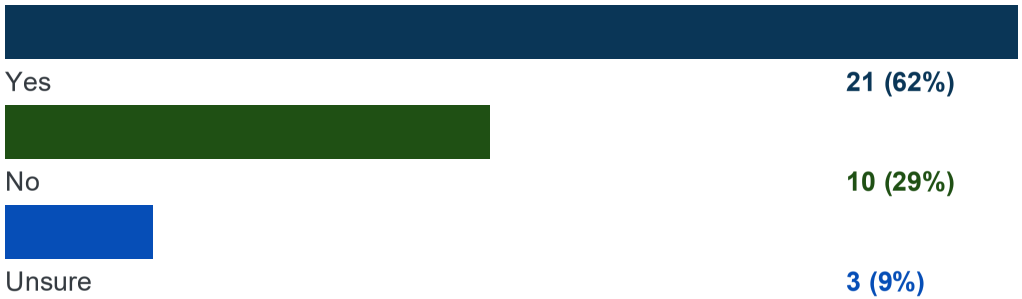


Categorical & Multi-Select Questions — Part 2

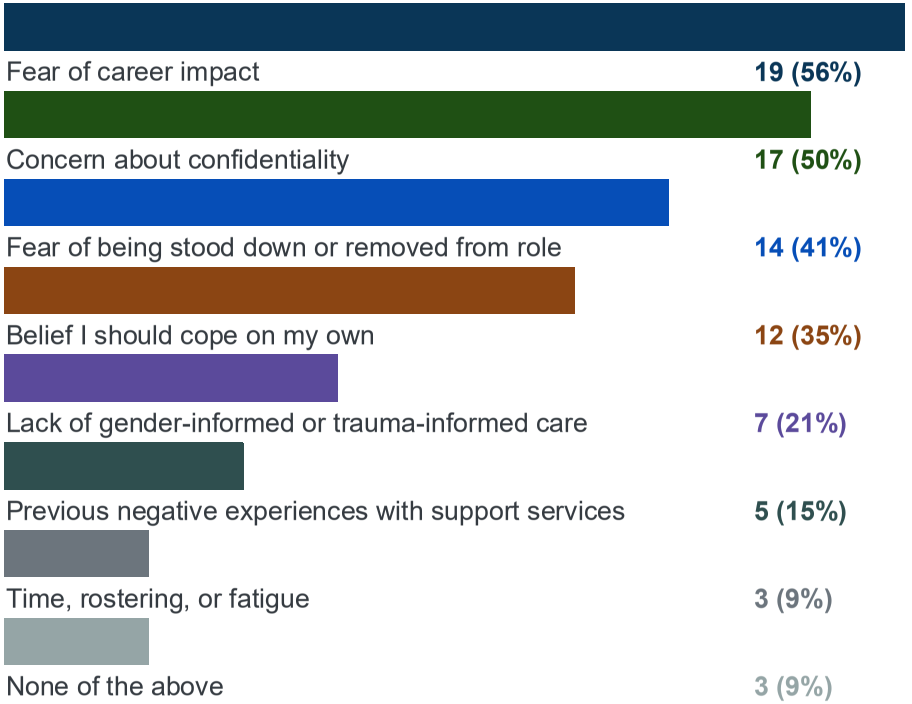
Self-harm or suicide thoughts during service (single select, n=31)

Affected by suicidal distress, attempt, or workplace suicide (single select, n=30)

Consultation — I have been asked to provide feedback (single select, n=34)



Barriers to seeking mental health support (select all that apply, n=34)



DATA NOTES & ACCESS

Verification	All Likert distributions verified against the official Typeform aggregate export, exported 31 March 2026, Australia/Perth time. Questions not appearing in the aggregate export (due to Typeform formatting) were verified against the raw individual response CSV.
Survey platform	Typeform. Survey conducted anonymously. No identifying information collected or published.
Sample	n=34. Not statistically representative. Purposive, network-based sampling via VESPIIA channels, partner organisations, and social media.
Survey period	18 February – 31 March 2026.
Conditional routing	Some questions were shown only to respondents meeting specific prior criteria (e.g. pregnancy questions shown only to those who confirmed pregnancy in service; menopause/gynaecological questions shown only to those who selected a relevant condition in Q5a). These questions have n values lower than 34.
Scale	1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree. Agree = 4 or 5. Disagree = 1 or 2. Percentages rounded to nearest whole number.
Qualitative data	Open-text responses not included in this appendix. All qualitative material de-identified. Available on application.
Data access	The aggregated dataset is available to researchers on application to VESPIIA: hello@vespiia.org
Citation	VESPIIA (2026). Future Frontlines: Women in Service. Survey data, February–March 2026. Veterans, Emergency Services and Police Industry Institute of Australia, Subiaco WA.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