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‘Swinging the lead and working the head’ – An explanation as to why mental illness stigma is prevalent in policing

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Sean Bell 

Department of Policing Organisation and Practice, The Open University, Milton Keynes, UK

Sue Palmer-Conn

Faculty of Science, Natural Sciences and Psychology, Liverpool John Moores University, Liverpool, UK

Nick Kealey

Liverpool Centre for Advanced Policing Studies, School of Justice Studies, Liverpool John Moores University, Liverpool, UK

Abstract

Policing can be injurious to the mental health of those delivering the service. The causes can be operational, organisational or a mixture of both. Mental health related stigma is prevalent within policing; thus, help seeking is avoided. Those who do seek help are often thought to be malingerers. Managers are considered to be ill equipped to identify and support those at risk. The processes and policies that are meant to support recovery do not meet the needs of the officers and staff living and working with mental ill health. Consequently, disclosing a mental health issue is seen as career destroying.

Keywords

police, culture, attitudes, mental health

Introduction

Many areas of policing are subject to increasing academic research, with police attitudes and interactions to those with mental ill health being one of them. However, despite initiatives like the *Blue Light Campaign* and *Oscar Kilo – The College of Policing*

Corresponding author:

Sean Bell, Department of Policing Organisation and Practice, The Open University, Michael Young Building, B2 Wing, Walton Hall, Milton Keynes MK7 6AA, UK.

Email: sean.bell@open.ac.uk

Wellbeing Programme (2017), research into the lived and working experiences of police officers and police staff with mental ill health is still relatively rare (Bell and Eski, 2016; Blue Light Programme, 2016; Bullock and Garland, 2017; Edwards and Kotera, 2020; Turner and Jenkins, 2018). The College of Policing (2020) identifies a range of trends that could define the police operating environment for the next 20 years. The COVID pandemic of today and a range of issues including rising inequality to climate change, workforce automation and the expanding information space all provide challenges for policing and will require an adaptable, healthy and resilient workforce.

The research gap has ramifications for policing, as mental illness is the second-largest source of burden of disease in England and is more common, long-lasting and impactful than other health conditions with nearly one in five adults aged 16–64 suffering from at least one mental health disorder (Public Health England, 2019). Emergency workers in the UK are more likely than civilian counterparts to experience mental ill health, whilst Police personnel top the scale with 90% having experienced stress or poor mental health at work (MIND, 2016).

The Police Federation of England and Wales (PFEW) reported that 39% of police officers had sought help for feelings of stress, low mood, anxiety and poor mental health and wellbeing (Houdmont and Elliot-Davies, 2016) whilst Police staff suffer a similar fate. UNISON (2014) reported that 32% of police staff were very stressed, 62% were moderately stressed and 15% of police staff were referred to their force occupational health department due to stress and anxiety, the same occupational health departments subject to streamlining because of austerity and budget cuts. Rates of PTSD in UK police forces are believed to be almost five times higher than in UK population (Brewin, et al., 2020).

Police officer suicides rates are increasing. Analysis by the Labour Party found that the yearly average has increased by almost a third from 17 between 2001 and 2009 to 23 between 2010 and 2017 (Townsend and Savage, 2019). Research on behalf of the Police Foundation (Lewis, et al., 2019) noted that police sickness related to mental ill health was worsening and nine out of ten officers who responded indicated they had significant periods of poor mental health whilst at work.

Unfortunately, mental health related stigma is widespread in UK policing, and officers and staff can find themselves ostracised personally and organisationally (Bullock and Garland, 2017; Bell and Palmer-Conn, 2019; Lane, 2019). As a result, officers and staff avoid seeking help due to a culture of invincibility, a lack of confidentiality and a fear of hampering their career progression (Bullock and Garland, 2017; Bell and Palmer-Conn, 2019; Edwards and Kotera, 2020; Fox, et al., 2012; Turner and Jenkins, 2018). Supervisors and peers often doubt the validity or genuineness of colleagues with mental ill health insinuating that reported absences are not bona fide and worse malingering (Bell and Palmer-Conn, 2019; Stuart, 2017; Turner and Jenkins, 2018), in addition to the concerns raised by Jansz and Timmers (2002) and the links to emotional labour and dissonance, that feeling of unease when someone evaluates an emotional experience as a threat to his or her identity, so they suppress their response.

This article explores the attitudes, experiences, opinions and perceptions of police officers and police staff with mental ill health and identifies the risks of emotional harm through voluntary or proscribed screening and debriefing, and the clear need for leadership and resources to enable a cultural shift in attitudes towards officers and staff with mental ill health.

Literature

Policing is widely accepted as a stressful occupation. However, due to its personal nature stress is subjective and therefore medically difficult to define. Stress is part of life but if it becomes overpowering then it can lead to mental health problems. Police stressors come in two forms: organisational stressors linked to poor management, shifts, poor communication and lack of support from senior ranks and increased workload (Brown and Campbell, 1990; Crowe and Stradling, 1993; Purba and Demou, 2019) and operational stressors in the form of traumatic incidents (Abdollahi, 2002; Brewin, et al., 2020; Hesketh and Tehrani, 2019). The latter appear to have less impact than the former (HSE, 2007; Houdmont and Elliot-Davies, 2016; MIND, 2015; Purba and Demou, 2019; UNISON, 2014).

However, that is not to underestimate the impact of traumatic events on those who deliver policing. The most common police operational stressors identified by Abdollahi (2002) are dealings with the judicial system, public scrutiny and media coverage, officer involved shootings, encountering victims of crime and fatalities, community relations and encountering violent/unpredictable situations (Abdollahi, 2002). Police staff are not immune from such stressors, they deliver a range of quasi policing roles with some operational crossover and or limited police powers exposing them to similar traumatic incidents as police officer colleagues (Alderden and Skogan, 2014; McCarty and Skogan, 2012; Regeher, et al., 2013).

Despite the prevalence of several public education campaigns in the UK (Time to Change and MIND), mental ill health related stigma and discrimination continues to impact negatively on the lives of people with mental health issues. Thornicroft et al. (2016) argues that this stigma and discrimination can have worse consequences than the conditions themselves. Research in the UK recorded 87% of respondents agreeing that people with mental illness experience stigma and discrimination (Time to Change, 2015). Unfortunately, the workplace is the second most common area (after family and friends) where mental health stigma is encountered (Wahl, 1995).

Police officers mirror wider society by holding a variety of stereotypical views about mental health (Cotton, 2004; Bell and Palmer-Conn, 2019; Lane, 2019; Pinfold et al., 2003). Research suggests that police officers tend to perceive those with a mental illness as dangerous and may doubt the integrity or reliability of people with mental ill health (Broussard et al., 2011; Lane, 2019; Watson et al., 2004). Unfortunately, mental health related stigma remains one of the biggest barriers to successful community integration of those with mental illnesses (Cotton, 2004). It is questionable whether police officers' experience and interactions with members of the public with mental health problems in the criminal justice system, or pervasive police culture, is the major influence of their perception and understanding of mental health.

It has been suggested that officers may have similar personality traits, but not all police officers are alike (Twerky-Glasner, 2005) and officers may work behind a 'cultural shield which defines a working personality' (Abdollahi, 2002: p. 64). There is a further assertion that Police recruitment processes, including application, screening, training and assimilation into the Force, provide the 'cultural shield' and police personality (Twerky-Glasner, 2005). The police personality includes traits such as pessimism, hardiness, authoritarianism, suspiciousness, solidaristic, conservative, alienated and bigoted (Abdollahi, 2002; Collins and Gibbs, 2003; Waters and Ussery, 2007). Arguably it is some of these traits that facilitates successful policing.

According to Stuart (2017, p. 18), 'The police role requires officers to exercise a high degree of control, suppress affect, and maintain a cool demeanour where talking about emotions is typically unacceptable'. This is worthy of further discussion as arguably it is the pervading police culture which prevents or suppresses dialogue about officer and staff mental ill health which allows stigma to flourish.

Corrigan (2004) suggests stigma can be viewed on a public perspective and the self, both inextricably linked and sharing the same characteristics of prejudice, discrimination and negative stereotyping. Karaffa and Tochkov (2013) suggest that police officers, like the general population, experience the same social-cognitive effects of stigma, which in policing are compounded by their perceived interactions with colleagues. They argue officers who cannot control their emotions may be viewed as unreliable when responding to critical incidents. Failure to meet the accepted norms or standards can be detrimental to an officer's position within a team and make them question their own worth (Corrigan, et al., 2001).

As a result, Police officers are reluctant to seek help for mental health issues (Bell and Palmer-Conn, 2019; Bullock and Garland, 2017; Stuart, 2017; Turner and Jenkins, 2018). Officers seeking counselling or support may be viewed as weak and lacking resilience by colleagues, increasing feelings of stigmatisation (Karaffa and Tochkov, 2013; Toch, 2002). In turn, fear about fitness to practice can result in officers/staff avoiding seeking help and support (Bell and Palmer-Conn, 2019; Bullock and Garland, 2017; Stuart, 2017; Turner and Jenkins, 2018; UNISON, 2014) potentially prolonging or intensifying the condition. Bullock and Garland (2017) refer to this as 'spoiled identity' as they are labelled as weak and unreliable and can be ostracised from the group and the force.

In contrast, it could be argued that much has been done to tackle mental health related stigma and ensure officers and staff are supported in the workplace. Wellbeing initiatives such as MIND Blue Light Campaign, Police Federation, 'Hear Man up – Think Man Down' and more recently the College of Policing Wellbeing Programme (2017) have increased the conversation about mental ill health and reduce the stigma associated with it. Forces have also introduced in-house wellbeing initiatives, employee assistance programs and have employed mental health counsellors to support existing Occupational Health provision.

However, whilst nearly 17,000 police officers and police operational staff are believed to have some form of PTSD (Brewin, et al., 2020), it is likely that research into the lived experiences of officers and staff continues to be relevant if they are not to be a marginalised community within policing.

Methodology

Officers and staff with mental ill health are a unique group within policing. It is important that the research sample is appropriate to the research question that is being addressed and is specific to the profile and uniqueness of the study group to be analysed. After securing ethical approval (Liverpool John Moores University, Research Ethics Committee), participants were contacted via gatekeepers in police forces and a national police wellbeing charity who provided participant contact details to the researchers.

From an initial pool of 48 volunteers who currently or previously experienced poor mental health, the researcher conducted 33 semi-structured interviews between January 2017 and March 2017, with 21 police officers and 12 police staff up to the rank of Chief Inspector or police staff equivalent from forces in England and Wales. This ensured a fair representation of both metropolitan and non-metropolitan forces and geographical spread. Ten of the interviewees were female, non-identified as BAME and ages ranged from mid 20s to mid-50s with the majority having between 10 to 20 years policing experience. This is not dissimilar to existing policing demographics (Home Office, 2019).

Participants provided written and verbal consent for the recording, transcribing and the use of their interviews for publication. Depending on the wishes of the respondent, interviews were conducted via telephone, Skype or in person. The semi-structured interviews were audio recorded, anonymised, transcribed and imported into NVivo 11 (a qualitative analysis software tool).

Each interview was read and analysed, labelled and coded according to the to the emergent themes. They were then grouped into hierarchical categories, concepts and frameworks (Bryman, 2016; Strauss and Corbin, 1998; Urquhart, 2013) using keywords and phrases. As can be expected in most trades and professions, the responses are full of acronyms, phrases and terminology, which add authenticity to the work. Similarly, the core themes and subsections are grounded in policing vocabulary.

‘Cop This’ examines the causes of mental ill health in the participants, whilst ‘Cop That’ examines the impact of mental ill health on their professional and personal lives. ‘Turning Blue’ explores police attitudes to mental illness, and ‘Well Officer’ assesses how officers and staff with mental ill health are managed.

The pseudonymised quotations from officers and staff provide a revealing insight into the lived experiences of those in policing who have experienced mental ill health in the workplace.

Findings and discussion

Findings are organised under four headings:

Cop this - the causes of mental ill health in the participants

‘Cop This’ examines the causes of mental ill health in participants and identifies issues such as the underreporting of mental ill health within policing and pinpoints personal and operational stressors that contribute to mental ill health.

Underreporting of mental ill health is prevalent

Participants were adamant that there is underreporting of mental ill health within policing in England and Wales. They thought it suspicious that only a handful of officers/staff disclosed mental health problems when one in four of the general population experience mental ill health (MIND, 2016). Tellingly, participants recognised the symptoms and signs of mental ill health in colleagues who had either not recognised it in themselves or had chosen not to disclose it to colleagues.

Neil: one of them turned to me and he said “don’t take this the wrong way but I’m glad this has happened to you because you’ve actually had the balls to stand up and say what’s happened. I’ve had this for years, but I haven’t had the balls to stand up”.

Officers and staff working in small teams become familiar with each other’s traits and characteristics and recognise the physical, psychological and behavioural changes, which can be signs of mental ill health (Edwards and Kotera, 2020; Link, et al., 1989).

Stressors

When asked about the causes of participants’ mental ill health it appeared that repeated exposure to operational and organisational stressors were the overriding causes. Personal and domestic issues did feature but were not the primary causes.

Operational stressors

Police officers cited the numerous traumatic incidents they dealt with which impacted on their mental health, recalling dangerous confrontations and threatening incidents where their own lives had been put at risk whilst restraining violent persons and incidents of large-scale public disorder and riots (Brown, et al., 1999; Walsh, et al., 2012).

John: When I think back, there’s loads and loads of issues I could mention but one classic is after the riots that we had, we had a fixed expectation of death that night. It was horrible. Worse than anything I’d seen in Force.

Paul: I honestly don’t think there can possibly be one police officer in this country who hasn’t dealt with something pretty unsavoury and has left them shaken, ... because you don’t realise you’re parking it up in your brain somewhere so the professionals tell me and sooner or later it will come out.

This was not confined to police officers and police staff reported having similar experiences. Crime Scene Investigators who are frequently exposed to violent crime and murder scenes for long durations reported similar issues (Mrevlje, 2016). Police staff in quasi-operational roles such as Communication Dispatch Officers spoke of overload and burnout and the nagging emotional voids as few of the operational encounters they managed were done so to fruition (Regeher, et al., 2013).

Although specific incidents were cited as having an impact on wellbeing (over half had PTSD), it was not the initial diagnosis that led to the longer-term problems, but poor organisational responses including workplace policies and the use of demeaning language by supervisors in front of other colleagues.

Organisational stressors

For the majority of participants, it was not the traumatic incident(s) that led to the long-term mental ill health but the mismanagement of the individual and the scarcity of support provided (Abdollahi, 2002; Deschenes, et al., 2017). Participants complained of the lack of formal debriefing for officers who had experienced traumatic incidents (at best it was 'tea and biscuits' with no desire to raise any potential issues). However, several participants questioned how willing officers and staff would be to engage in the process or admit to having had negative or traumatic experiences in a public arena. According to Turner and Jenkins (2018, p.6) poor or inadequate debriefing is 'a glaring omission that leaves police officers to internalise the impact of involvement in traumatic events without suitable interventions'.

Workload and austerity

Since 2010, police officer and police staff numbers have diminished. Unsurprisingly, police officers cited workload and not having enough officers to respond to policing demands (Houdmont and Elliot-Davies, 2016).

Neil: So, you've got two, three jobs, two job lines are now feeding into that officer. It is horrific. That's the thing, you don't get a let up, meal breaks. You get allotted meal break times, but you don't get the bloody meal break.

Helen: There's no cops. They're still wanting you to do the job you were doing before, there's more pressure on you for problem solving, vulnerable people and all that sort of stuff and there's just no cops.

Where individuals sought to highlight increasing workloads, managers were reportedly dismissive, and this can lead to embitterment and feelings of alienation and another source of stress (Abdullahi, 2002). Furthermore, an increased use of lone patrolling has left officers feeling vulnerable and isolated. Single-crewing policies diminish officers' contacts with their peers and opportunities for informal debriefs and sharing of stressful incidents thus 'destroying vital informal support mechanisms' (Turner and Jenkins 2018: p.8).

Colin: I mean most officers now will spend their entire ten-hour shift working alone. People are working in silos, they're not communicating.

On reflection, longer serving officers spoke of previous times when there was a greater sense of camaraderie and opportunities to socialise in and outside the workplace. Many

lamented the loss of canteens which lead to a reduction in such interactions and a subsequent demise in team spirit (Bullock and Garland, 2017; Turner and Jenkins, 2018). So called ‘canteen culture’ allowed officers a safe place to unwind and share experiences as a coping mechanism (Waddington, 1999; Loftus, 2010).

Ann: We all looked after each other. Ok it was in the days where there was a gym at the police station, there was a bar in the police station and people spent a lot of time out of work with each other ... I guess more recently I’ve noticed that that has gone.

It has become clear that operational and organisational stressors compounded by isolation reinforce the negative fears often associated with mental ill health that police organisations look to address, yet staff want to be part of the solution, even proposing some forms of regular mental health screening,

Frank: I’d have the mental health MOTs.

There are sound arguments to support screening. Tehrani (2016, p. 405) found in her research that screening of police officers revealed ‘15% have scores which are concerning, and 5% have clinically significant symptoms of PTSD’. Similarly, Brewin, et al. (2020) found close to 20% of police officers and staff in the UK have symptoms consistent with either PTSD or Complex PTSD, yet over 66% were unaware. Tehrani (2016) argues that screening does not deter operational deployment but provides an opportunity to monitor those who may potentially be more at risk and allow early support and/or intervention.

Cop that - the impact of mental ill health on their professional and personal lives

‘Cop That’ examines the impact of mental ill health on their professional and personal lives by examining how poor communication, secrecy, denial and disclosure to the family or line manager creates a serious barrier to welfare, support, professional development and promotion.

Denial, realisation and disclosure

The data suggest that police personnel generally find it difficult to accept that they have a mental health issue and are reluctant to discuss or disclose their mental illness to medical professionals, family, colleagues or managers, and prefer secrecy to disclosure (Bell and Palmer-Conn, 2019; Edwards and Kotera, 2020; McDowall, 2014; Thoits, 2011).

Participants stated they managed to conceal their condition for some time until they ‘imploded’ or ‘the Pandora’s box’ was opened which led to ‘break down’ and inevitable personal acknowledgement and subsequent enforced disclosure.

Diane: Because I just think the mentality of being a police officer, you do not want to ask for help, you do not want to admit that you are struggling.

Irrespective of rank or role, there was a generic lack of trust in supervisors, occupational and personnel support departments (Bullock and Garland, 2017; Bell and Palmer-Conn, 2019; Stuart, 2017), whilst participants doubted whether their illness would remain confidential if they sought support.

Liz: It's not a safe environment because with the Occupational Health Unit everything can go back to your supervisor.

For some, such disclosure was about limiting the number of people who knew. Keeping it confined to a small number of people was a relief, but there was a fear this information may be leaked or shared to the detriment of the participant.

There was an overriding perception that colleagues would doubt the authenticity of their illness (Bell and Palmer-Conn, 2019; Turner and Jenkins, 2018; Stuart, 2017). Terminologies like 'lead swingers' and 'head workers' were used frequently and attributed to those experiencing mental ill health.

Ged: Some were supportive, very few though, fewer than you'd imagine. Others I imagine went fuck it, he hasn't got it.

Such attitudes were also found in officers and staff with mental health issues who at times hold similar views and doubt the genuineness of a colleague with mental ill health believing them to be workshy (Turner and Jenkins, 2018).

Ann: If somebody is taking the piss, if somebody is swinging the lead, then there are other processes that can be used to deal with that individual.

Being difficult - breakdown in relationship with force

A number of participants stated they underwent behavioural changes due to their mental ill health (Toch, 2002). They became more angry or emotional, characteristics which do not sit with the regimented emotionally stable stereotypical characteristics of the police (Charman, 2017).

Eric: I think, you know, there was a failing on their side to engage properly and there was probably a failure on my side to engage but I now look back and go - well that's more to do with my illness, that was not deliberate.

Such behavioural changes in many cases led to a breakdown in relationships with supervisors and line managers and with organisational Human Resources (HR) and Occupational Health (OH) staff and functions; therefore, line managers were often not informed. Participants felt that there was a lack of engagement with their Force, which was not always one sided. In hindsight, they could have or were deemed to be awkward or difficult and this created barriers to communication with managers; however, they stressed this was not a deliberate strategy but commensurate with their illness (McDowall, 2014).

In several instances, supervisory welfare visits to participants homes were vetoed by participants and in some cases led to a cessation of all communication. Once this became a reality, this was a serious hurdle to overcome.

Away from the line manager, peer support networks were highlighted as good practice as they were seen to be safe and secure (Blue Light Programme, 2016; Karaffa and Tochkov, 2013; Miller, 1995). Unfortunately, peer support networks were not widespread.

Informing a manager

The process of informing a manager was deemed to be a lottery with the majority of participants portraying negative experiences. There was a common theme of supervisors being more concerned about managing resources and priorities over the welfare of staff.

Neil: I knew that I was not ready to go back but it's the pressure that was put on 'oh well I appreciate how you feel but you know we are very, very short at the moment, we know you do a good job, but we'd really like to get you back' so I agreed ... I knew the shift was short.

Many supervisors were considered to be dismissive of the illness or that the response was viewed purely as a 'tick box' or 'back covering exercise'. The participants perceived supervisors often had a reputation for strict adherence to attendance and sickness policies lacking flexibility and were deemed by participants to be unlikely to appreciate the need for reasonable adjustments (Randall and Buys, 2013). As such they were unlikely to be confided in or trusted to deal with an officer or staff member, thus prolonging concealment and help seeking (Stuart, 2017). As with informing peers, participants feared managers would be sceptical about the reality of their illness (Stuart, 2017; Turner and Jenkins, 2018), so their concerns accumulate, and mental ill health can and does suffer.

Career implications

There was overwhelming perception that officers and staff with mental health issues believe their peers and managers would see them as less capable in the field and that having a mental illness will impact on lateral development and promotion prospects (Bullock and Garland, 2017; Bell and Palmer-Conn, 2019; Edwards and Kotera, 2020; Fox et al., 2012; Karaffa and Tochkov, 2013; Turner and Jenkins, 2018). Officers disclosing mental health issues are routinely moved or placed on restricted duties with little or no dialogue or consultation (Bullock and Garland, 2017) and participants felt they had little or no control over their welfare (Einarsen, et al., 2003).

Redeployment or withdrawal from operational duties appears to be of great consequence within policing and often removes peer support leading to feelings of exclusion and stigmatisation (Rogers and Pilgrim, 2010), appearing to be viewed as an attack on professional competence. The unwilling redeployed feared that they were now labelled with a mental health issue in a new environment where they would have to account for themselves and in many cases, repeated recounting or disclosing of their mental health issues.

Colin: I felt that my professional abilities were being questioned so it knocked my confidence. It made me very bitter.

However, there was a recognition that if done properly with due process, OH redeployment may be a positive and an effective support mechanism. Participants saw it as essential that any moves were conducted in consultation with the officer/staff member with agreed terms and a 'meaningful role' (HSE, 2007). Unfortunately, and much to their chagrin, many were moved to undefined or what appeared to be insignificant jobs 'counting paper clips' or to units which were primarily resourced with officers and staff on recuperative duties often labelled 'as sick, lame and lazy' or 'broken biscuits units'. Staff felt worthless, therefore further isolating them.

Turning blue - police attitudes to mental health within the organisation

'Turning Blue' explores police attitudes to mental illness and the stigma associated with fear, abuse, bullying and exclusion.

Stigma

Participants stated mental health related stigma is prevalent within policing and is a deterrent to the disclosure and management of mental ill health (Karaffa and Tochkov, 2013; Bullock and Garland, 2017; Stuart, 2017; Bell and Palmer-Conn, 2019; Turner and Jenkins, 2018; Soomro and Yanos, 2019; Edwards and Kotera, 2020). Participants were routinely challenged by supervisors who posed loaded questions such as,

Diane: Do you really want the stigma of being off sick with stress on your record?

Once identified as such the label would remain, shattering previously held impeccable reputations (Stuart, 2017). Like stigma, participants feared being thought of as weak. They referred to a macho policing culture, where physical and mental strength are seen as essential traits, when being reliable at times of crisis is the key to survival (Bullock and Garland, 2017; Edwards and Kotera, 2020; Karaffa and Tochkov, 2013; Stuart, 2017; Soomro and Yanos, 2019; Turner and Jenkins, 2018).

Paul: From a cop's point of view, the shame of it, the absolute shame and feeling of weakness is just overwhelming, it's horrible.

Derogatory terminology

Participants reported that they had heard or been subject to derogatory abuse or bullying because of their mental ill health. It was not necessarily the words that were the issue, the narrative had the greater impact, implying that having a mental illness was allied to laziness or inability to cope with the job. Negative stereotyping was deemed more harmful and insulting than inappropriate terminology (Corrigan and Watson, 2002).

Kelly: I pointed out to him [the manager] that one of the members of staff appeared to be having a mental health problem and was struggling. He went up to him in the middle of the office and said [in a childish, demeaning voice] “Ah diddum’s, can’t you cope with the work you need some help?”

Some thought there was a place for humour and that deprecating language may have its place amongst close colleagues. Coping via humour is part of police culture, but by its very nature, in this context, it further isolates someone who may need help. One officer described how the light-hearted ‘banter’ deployed by his colleagues towards his condition was indicative of their support (Bullock and Garland, 2017). Notwithstanding that other people within ear shot may have found it offensive.

John: So, he stuck his head round the door and said, “Oh you’re there, you might be a raspberry (cripple) but you’re our raspberry” and gave me a big hug which I thought was just what I needed, it was just the welcome back if you like within the terms of being a cop, of acceptance if you like.

It became obvious that this reference to humour was an exception and that the narrative and culture of the organisation towards personnel with mental health issues fell far short of the standards and values of the police service.

Absence leading to exclusion

Participants reported how sickness induced absence could result in the exclusion or withdrawal of officers from their workplace community and in turn shrink their social circle.

The responsibility for the exclusion was generally lodged with the organisation (Bullock and Garland, 2017) and less so with colleagues and participants themselves withdrawing from the group. However, a small number of participants withdrew from their peers and the organisation avoiding potentially rejecting situations.

Well officer - how officers and staff with mental ill health are managed

‘Well Officer’ assesses how officers and staff with mental ill health are managed by line managers, Human Resources (HR) and Occupational Health (OH), and how attendance management policies and half pay/no pay contribute to a negative impact on wellbeing.

Leadership

Respondents placed great emphasis on the importance of senior management in recognising and having a responsibility to effect cultural changes towards mental ill health in the service (Bullock and Garland, 2017; Karaffa and Tochkov, 2013); however, many respondents thought some chief officers’ support was insincere or were ‘paying lip service’ to mental health initiatives

Gill: They’re not interested in the issues. They just don’t want the headline ***** Force Police Officer Dies.

The majority of participants sought a display of leadership from the highest level. The active participation and effective communication of chief officers was seen as fundamental to driving cultural change. Participants questioned the likelihood of a chief officer revealing their own mental ill health and championing the cause as a role model and changing the narrative about mental ill health in policing (Bullock and Garland, 2017). There were encouraging instances of staff with mental health issues becoming proactive about reducing stigma and discrimination who had sought the support of chief officers to embark on mental health awareness programmes for staff.

Paul: She's basically lit a torch for police mental health, and she's gone off on a charger.

Champions working under or alongside strategic leaders and role models can break down cultural barriers, acknowledge primary and secondary trauma and the acceptability of seeking help to the benefit of the service and public alike (Bell and Eski, 2016; Loftus, 2010; Thoits, 2011; Turner and Jenkins, 2018).

Role of supervisors

Supervisors and leaders have a duty to create a positive and professional work environment. The majority of respondents thought their direct line supervisors had most impact on their experiences and relationships with the organisation. In research conducted into post-incident management in the UK police, 44% of officers suggested good supportive supervision as one of the best methods to change culture and provide a support base to enhance help seeking (HSE, 2000). Sadly, it was suggested most managers lacked knowledge and training in dealing with staff in such cases.

Ann: I think absolutely there needs to be better training for all ranks around stress and mental health and identifying, not only within yourself but within colleagues, and I think if that was done I'd like to think that the stigma would be less.

As a result, there was evidence of supervisors getting it wrong by trying to ignore the matter hoping it might go away and that officers/staff with mental health issues are just too hard to handle. These leaders must recognise the early signs of mental ill health and support staff effectively, enabling them to address issues around personal or workplace stressors in a positive way and as part of united front, not one tainted with despair, mistrust and isolation.

Human resources and occupational health, policies and people

HR and OH departments were generally held in low regard. Respondents were reluctant to let others know they were attending OH and were wary of having OH appointment on working rosters or team calendar. What should have been seen as a confidential appointment becomes almost a public announcement. If seeking or receiving treatment for mental ill health adds to the stigma, such processes are problematic and become a barrier to help seeking (Toch, 2002; Royle, et al., 2009; Karaffa and Tochkov, 2013; Clement, et al., 2015).

For those who overcome the stigma of receiving treatment (Clement et al., 2015) and opted to attend OH they were frequently met with lengthy delays (Edwards and Kotera, 2020; Turner and Jenkins, 2018).

Freddy: All the help was offered, and I said 'yes', but then the help was delayed, then criticised for not getting worked on expeditiously.

It is possible that austerity measures have led to decreasing numbers of operational officers and subsequent increase in workload and job-related stressors and illness (Hesketh, et al., 2015). Accompanied by cuts to police staff numbers in HR and OH departments, this has created a bottle neck where demand outstrips supply. Unfortunately, the withdrawal of key support roles were accompanied by an overall hardening of attitudes towards mental ill health amongst personnel working in HR and OH functions. Similarly, amongst police officers, there were doubts as to how knowledgeable OH/HR personnel and medical staff were about the realities and vagaries of policing.

This was not an issue for police staff and is one of the few aspects where differences in attitudes to police officers and police staff appeared. Police officers saw OH/HR personnel and medical staff as outsiders who are incapable of understanding the challenges and dangers of operational policing (Alderden and Skogan, 2014). As such, there is a distrust of outsiders who were seen as ill equipped in delivering psychological services to police officers (Miller, 1995; Karaffa and Tochkov, 2013).

Delays in accessing treatment presented officers and staff with a 'double whammy' where there was pressure being exerted to return to work by managers and HR attendance policies and practices, yet help provision was seen to be delayed.

Diane: Well, a couple of days before I was due to go they rung me and said, "oh we've got to postpone it for another 4 weeks" and I just broke down on the phone, begging them to bring it forward if anything because I was so desperate for some help.

Lack of access to care heightened tensions between the participant and the organisation. It was as if the 'emotional contract' (Coyle-Shapiro and Kessler, 2000) had been broken, which had a further detrimental impact on the mental ill health of those concerned as they felt excluded, unsupported and removed from their professional relationships.

Attendance and performance policies

Process and policies were believed to be used to walk roughshod over officers/staff with mental health issues without taking account of the effect on officers/staff already suffering with mental health issues (McDowall, 2014; Turner and Jenkins, 2018).

Gill: There are strict guidelines on policy and there is no leeway either way on the policy, ... and they plough through it regardless of what the situation is. Which just adds to people's illness and mental health problems.

Unsatisfactory performance, attendance management policies and half/no pay considerations featured frequently as having a negative impact on wellbeing. Such policies which are

portrayed by forces as supportive and encourage a return to work were seen by participants as punitive and oppressive, yet their very existence was an obstruction to returning to work as lengthy or frequent absences were anticipated to be met with immediate deployment of these policies on return to the workplace. Police Regulations and guidance, and Staff Policies and guidance, suggests managers have discretion and should not rigidly apply policies (HSE, 2007). This is seldom the case. It is obvious from participants that they see the implementation of these policies as unfair and unjust taking little cognisance of the impact on their wellbeing.

Half pay, no pay

After a sickness absence of 6 months, officers and staff are subject to a cut in half their pay. After 12 months, this is reduced to no pay. There is some flexibility in the policy and depending on the circumstances which are generally either a life-threatening illness or an injury in the execution of duty, this can be delayed or disregarded. The half pay/no pay policy was seen as a threat which undermined the relationship between the individual and the organisation. It was seen as punitive and uncaring (Bullock and Garland, 2017; Turner and Jenkins, 2018).

Officers and staff at crisis point could not understand how such an additional burden was being placed upon them.

Gill: Well, he just said, “well what do you want us to do” and I said to him “look I am a person in crisis here, you backed me into a corner right ... You’re telling me that if I don’t do this I’m going back on sick which tells me I’m going on no pay”.

Respondents felt that there was little or no thought given to the delivery method or impact of being in receipt of notification of forthcoming reduction in pay; thus, the pressure of facing a reduction in pay may coerce staff back to work before they are mentally well enough to do so.

Training

The lack of suitable education and training about mental health was a constant theme through the interviews. It was generally inadequate or non-existent but is seen as the key to changing organisational attitudes and tackling stigma (Bullock and Garland, 2017; Edwards and Kotera, 2020; Randall and Buys, 2013; Turner and Jenkins, 2018).

Moreover, appropriate training would allow officers and staff to recognise the contributory factors and manifestations of stress and anxiety allowing earlier recognition in themselves, colleagues or their staff (Blue Light Programme, 2016).

Conclusion

This research has sought to give a voice to police officers and police staff who have lived with mental ill health. It has provided them with an opportunity to share their experiences and make suggestions to improve the working lives of others who may find themselves in a similar position.

Despite the rarity of similar research, there is an acceptance amongst researchers that all is not well in policing when it comes to recognising the extent and impact of mental ill health on those who deliver policing (Bell and Eski, 2016; Blue Light Programme, 2016; Bullock and Garland, 2017; Turner and Jenkins, 2018). It appears that mental health is underreported and greater than current sickness and absence rates reveal. Respondents experiences have identified several shortcomings towards supporting those with mental ill health and in addressing the stigma, lack of confidentiality and fear of exposure that prohibits disclosure and help seeking. Common to much of their concerns was the role of the line manager and their link to other parts of the organisation. Police leaders should take cognisance of these issues when addressing staff wellbeing.

Those who chose or are forced by circumstance to disclose mental ill health frequently find themselves doubted by their peers and managers and accused of malingering. Often, they are managed by supervisors with little or no training in recognising the symptoms of mental ill health and lacking the confidence to discuss the issues or potential remedies. Instead, they are sucked into a bureaucratic system which relies on 'one size fits all' policies which fail to provide options and alternatives which could otherwise individualise a response to aid recovery (Bell and Eski, 2016; Bullock and Garland, 2017; Turner and Jenkins, 2018). Furthermore, austerity has contributed 'to officers experiencing high demand and capacity pressures and are at significantly increased risk for various forms of impaired welfare' (Houdmont and Elliot-Davies, 2016: p. 12), whilst occupational health provision has been reduced, leaving participants unable to access services when most needed (Hesketh et al., 2015; Houdmont and Elliot-Davies, 2016).

Wellbeing initiatives including *The Blue Light Campaign* and more recently *College of Policing Wellbeing Programme (2017)* and *Oskar Kilo* which have made positive contributions to increase the conversation about mental ill health and reduce the stigma associated with it. However, unless wholesale investment in education and training (similar to the introduction of diversity training post-Macpherson) is provided, the required root and branch change to tackle stigma and improve attitudes towards mental ill health will not be achieved. Tools are available to forces to measure attitudes pre and post any intervention to assess their impact (Bell and Palmer-Conn, 2018).

Finally, participants pointed out the lack of formal and informal debriefing. This should be addressed with a system to identify trigger incidents and officers and staff at risk of emotional harm through voluntary or proscribed screening and debriefing (Tehrani, 2016). Efforts also need to be made to ensure officers and operational police staff are not constantly working in isolation demonstrated through single-crewing, self-briefing, staggered shift and refreshment times and increased use of technology negating time spent in police premises. There is a need to ensure that police officers/staff have opportunities for down-time together and build the informal support networks required to provide support and reassurance.

The findings highlight several areas that could benefit from further research. Police staff are overlooked in much of the police related literature, despite making up a third of the workforce and carrying out many duties previously undertaken by warranted officers (e.g. Crime Scene Investigators, Call Handlers, Despatchers and Detention Officers). Therefore, a greater emphasis on inclusion of police staff may provide a richer, more

generalisable understanding of police attitudes to mental ill health. Furthermore, there is obvious dissatisfaction with the deployment, interpretation and adherence to sickness and absence policies and their implementation by supervisors, OH and HR staff. This is worthy of further study on how they influence officer and staff wellbeing and how they aid or hinder recovery. Doing so may well provide a solution to closing the disparity between those who have a physical and mental illness in the police.

Further research should also be considered to identify the drivers and culture which allows the widespread use of derogatory terminology where colleagues and managers doubt the authenticity of those with mental ill health. The accusations are hurtful and inhibit disclosure and help seeking of officers and staff suffering from an array of mental health conditions. This has been an overriding theme throughout the findings and is inexplicably linked to the stigma and discrimination experienced by officers and staff with poor mental health.

This paper demonstrates the need for leadership and resources to enable a cultural shift in attitudes towards officers and staff with mental ill health which may well prevent unnecessary long-term absences and premature retirements. It is time that organisations, departments, policies and managers alter their focus from ‘working the head and swinging the lead’, to challenging stigma and being more supportive, compassionate and professionally led.

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ORCID iD

Sean Bell  <https://orcid.org/0000-0003-4730-9438>

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