Suspicious minds:
A mixed methods study of police officer and police staff attitudes to mental ill health in England and Wales

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Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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S.BELL 12/12/2019

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Abstract

Policing and mental ill health are inextricably entwined. Operationally the police respond to distressed persons and depending on the circumstances act as pseudo mental health practitioners or law enforcement officers. Likewise, due to operational and organisational stressors policing can be detrimental to the mental health of those delivering the service. Due to the prevalence of mental ill health in society, it is inevitable that police officers and police staff will either experience, work alongside and/or manage colleagues with a mental illness. Therefore, it is vital that the attitudes of police officers and police staff to mental ill health are established. The research employs a mixed methods approach to quantifiably measure police attitudes to mental ill health and benchmark them against the public alongside qualitative data gleaned from survey responses and interviews. The results indicate that police officers/staff share with the public similar attitudinal scores to the public. However, police officers and staff display social distancing whilst being less supportive of community-based interventions. The police qualitative data portrays an organisation where mental health related stigma and discrimination is evident, where disclosure and help seeking is avoided, officers and staff feel isolated and having a mental health issue seen as career destroying. Previous studies into UK police attitudes to mental ill health have been confined to single forces. This national study has established a measure and explanation for police attitudes to mental ill health across England and Wales.

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List of acronyms

ACPO	Association of Chief Police Officers
APMS	Adult Psychiatric Morbidity Survey
AMI	Attitudes to Mental Illness
ANOVA	Analysis of Variance
CAMI	Community Attitudes to Mental Illness
CMD	Common Mental Disorders
CMHI	Community Mental Health Ideology Subscale
CoP	Colege of Policing
CSI	Crime Scene Investigator
EAP	Employee Assistance Programme
GT	Grounded Theory
HR	Human Resources
HSCIC	Health & Social Care Information Centre
HSE	Health & Safety Executive
ICAL	Interactive Computer Aided Learning
ICD	International Classification of Disease Codes
MAKS	Mental Health Knowledge Schedule
NIMBY	Not in my back yard
OHU	Occupational Health Unit
OMI	Opinions of Mental Illness
PC	Police Constable
PCSO	Police Community Support Officer
PFED	Police Federation of England and Wales
PTSD	Post-Traumatic Stress Disorder
PTED	Post-Traumatic Embitterment Disorder
TRiM	Trauma Risk Management

CHAPTER 1

Background to the research and literature review

1 Background to the research

This chapter introduces the background to my PhD journey including its origins in my policing career. It will explain how my tenure as a 'Fed Rep' (Police Federation Representative) exposed me to the stigma and discrimination experienced by colleagues with mental ill health and a desire to understand why this was prevalent in modern policing. It then examines the relevant theoretical frameworks and available academic literature on mental ill health in policing. It will identify the causes and prevalence of mental ill health in policing and police culture and its relationship towards those with mental ill health. It also identifies the 'gaps in knowledge' which provided me with the opportunity to explore an under researched area of policing.

Mike

Spring 2013 a conversation at Merseyside Police Federation:

> *Me, Police Inspector, Federation Deputy Secretary Representative & Advocate: "So Mike what can I do for you?"*
>
> *Mike, Police Constable, and Federation Member: "I can't take it anymore, I'll end up assaulting someone and get sacked."*
>
> *Me: "Doesn't sound like you, you are a good bobby, with a good reputation."*
>
> *Mike: "I've been suffering with PTSD for years I'm at the end of my tether, it's just I can't tell anyone. They will think I am a basket case."*
>
> *Me: "I've known you for years. Worked with you and supervised you, how could I not know?"*
>
> *Mike: "You just don't admit these things, it's not what being a cop is about. You say nowt"*

Unfortunately, as a Police Federation Representative, this was not the only conversation I had like this. Such exchanges took place on many occasions as I supported officers who were managing their mental ill health. What struck me most, is that in several instances, I knew the officers well but I had no inclination they were concealing their poor health from their colleagues and/or the organisation. They only chose to reveal this information when circumstances forced them to do so. Regardless of my years working alongside and supervising police officers, I was surprised by the number of times such conversations were repeated.

I had not always been a Federation Representative. I undertook this voluntary role on promotion to sergeant with 18 years' service. A role I continued with on promotion to inspector, two years later. The statutory role of a 'Fed Rep' is to support the 'welfare and

efficiency of the force' (Police Act, 1919). Although a voluntary role, extensive training is provided which enables 'the reps' to support and advise their colleagues on misconduct, performance, attendance, sickness and other welfare related matters. For the last three years of my service, I was the Merseyside Police Federation Deputy Secretary whose main role was to act as an advocate for officers who were seeking, undergoing or undergone early medical retirement or injury awards. Despite having been a 'Fed Rep' for nearly half my service, I was struck by the high proportion of officers who were experiencing mental ill health. More so, it was the hesitant and guarded way that officers would commence any enquiry or dialogue about mental ill health, as if trust or confidentiality was an issue, which was not evident in dealing with even the most intimate physical illnesses.

Police Regulations govern medical retirements and injury awards and as such are a bureaucratic process, which requires the collection, analysis, and submission of copious amounts of medical evidence, and police personal records. Therefore, I had access to confidential and private information about the lives of those I was supporting. When coupled with the conversations about their work and personal lives I was party to some of their innermost thoughts and experiences. This provided me with a rare insight into the lived world of police officers with mental ill health.

A world where they were worried about being seen as weak, unreliable and unable to cope. Worse still, to be labelled as malingerers or 'lead swingers'. Officers who in many cases had a successful career working alongside colleagues protecting and serving the public found themselves isolated with little or no contact from teammates or supervisors alike. Perhaps I was naive but this is not what I expected in policing in 2013. Since The Macpherson Report (1999) the police had worked hard to improve equality and diversity but here was a community within policing who appeared not to be heard and possibly even spurned.

I, like some colleagues, was guilty of thinking of some of these officers as being difficult, failing to see how their illness and the culture of the organisation was making them appear so. In many cases, they were in conflict with 'the job' that they had loved and could not fathom how, as they perceived it, be cast aside. Officers like Mike made a significant impact on me. I found myself wanting to better understand why these officers were often side-lined and more importantly for me what could be done to improve their circumstances and that of colleagues who may succumb to mental ill health.

So began my curiosity about attitudes to mental ill health within policing. I began to explore the subject area in order to enhance my knowledge and better placed to support my

colleagues. To my surprise, I found research about attitudes to mental ill health within the police service was scarce. There was limited and mostly historical research about the causes of poor mental health amongst police officers. Similarly limited, and mostly dated research regarding police attitudes to members of the public with poor mental health. What appeared to be lacking was contemporary research examining police officer attitudes to poor mental health within the service. Thus, my response was to undertake a Master's in Research to develop my understanding of the subject and to try to establish what current attitudes may be and the impact such attitudes may have on the lived experiences of police officers coping with poor mental health.

This lead to reading the work of Goffman (1963) on stigmatisation. Corrigan's (2000) and Link & Phelan's (2001) work on discrimination experienced by those with poor mental health and their reluctance to seek support. Police focused research from Cotton (2004) and Clayfield et al. (2011) and Karaffa & Tochkov (2013) examining police attitudes to members of the public with mental health issues. Researchers like Violanti (1995) and Toch (2002) also identified the threats and injustices faced by police officers who dared to reveal incidents of mental ill health. Yet questions remain around what is the benchmark? How or against who are police attitudes regarding mental ill health benchmarked? Cotton (2004) in her research attempted to so, measuring police attitude scores against those from a public survey. She concluded that police officers and members of the public shared similar attitudes to mental ill health. However, there were limitations to the research as there was a significant time lag between the public survey data and the researcher's police data.

Master's studies

My master's studies fared well and provided a stepping-stone to the current research. Within the masters research I adopted a mixed methods approach. This was challenging as I had to embark on appropriate training (encompassed in MRes) and develop both quantitative and qualitative skill sets (Creswell & Plano Clark, 2011). However, the reward as suggested by Hurmerinta-Peltomaki & Nummela (2006) is that mixed methods increases validity in findings, improves knowledge creation and a deeper, broader understanding than a single approach.

The MRes study employed selected items from the 'Attitudes to Mental Illness Questionnaire' (Time to Change, 2012) survey benchmarked against police officers' responses and semi-structured interviews with serving officers with mental health issues. The results (unpublished) found that the majority of survey respondents were more likely

to be accepting and supportive towards mental illness than the public. However, the qualitative data went on to paint a picture of a force where officers were very reluctant to reveal a mental health problem to colleagues or the organisation because it was viewed as career destroying.

Due to Governmental austerity measures, police, unions and staff associations began monitoring and exploring the impact of increasing demands on a diminishing workforce on their membership. Both Unison (UNISON, 2014) and the Police Federation of England and Wales (Houdmont & Elliot-Davies, 2016) undertook research into stress and wellbeing in policing. At the same time MIND introduced the *Blue Light Programme* to assess the extent of mental ill health in the emergency services, challenge associated stigma and develop supporting mechanisms.

Interestingly this research encapsulated and painted a glum picture of increasing stress, negative stereotypes and discrimination towards those with mental ill health in policing. However, it did not complete the whole picture. It did not provide a benchmark. One could not say whether this was a unique policing experience or if the police shared similar attitudes to the wider public, they serve. This is an important question because if it can be established that policing is in or out of kilter with society then responses can be designed to guide senior managers in delivering generic or developing tailor-made responses.

As I ventured into this new field of research and academia, I attempted to build my personal network. In doing so, I was encouraged to write a discussion paper for publication. This resulted in '"Break a Leg – It's all in the mind": Police officers' attitudes towards colleagues with mental health issues (Bell & Eski, 2015). The peer reviewed paper recommended that research be undertaken to establish, what are police officers' attitudes towards those with mental ill health; how do they compare to that of the general public and what are lived experiences of officers who have lived with mental ill health?

I was now a 'pracademic' with one foot in policing and one foot in academia. My operational policing and Police Federation background gave me credibility with peers and senior officers whilst my research gave me a confidence to discuss and challenge force systems and culture. This enabled me to challenge and champion a change in attitudes towards mental ill health in my force. In doing so I was exposed to what on one hand was widespread support and what on the other hand was a pervasive suspicion that amongst those reporting a mental illness were 'headworkers playing the system'. A belief that was evident amongst all ranks up to chief officer level and within the local Police Federation

Branch Board. This acted as a further driver for me to improve my understanding how such attitudes help or hamper those with mental ill health in policing.

Since the publication of 'Break A Leg' a number of authors have published research addressing some aspects of these themes (see, Hesketh, et. al., 2015; Houdmont & Elliot-Davies , 2016, Bullock & Garland, 2017; Stuart, 2017; Soomro & Yanos, 2018; Turner & Jenkins, 2018). These researchers found that negative attitudes and stereotypes prevail. However, benchmarking such attitudes against other organisations, professions or the public are rare. Significantly (with the exception of Houdmont & Elliot-Davies, 2016) the majority of these studies were conducted using a small number of participants and generally based in a single force area. Furthermore, participants consisted solely of police officers. Police staff who account for approximately one third of police personnel (in England and Wales) were excluded from the studies. In response, this research has endeavoured to establish police attitudes towards mental ill health and to what extent do police attitudes to mental ill health impact on the lived experiences of police officers and police staff experiencing mental ill health.

1.1 Previous work and literature

> "one of the central paradoxes of this book is that while up to three-quarters of adults know someone directly who has been affected by mental illness, we act as if nobody knows anything" (Thornicroft, 2006, p. 266)

1.1.1 Introduction

This section identifies relevant theoretical frameworks and available academic literature on mental health and police related mental ill health including the stressors, which may lead to mental ill health. It examines stigma and discrimination theories and their interaction with police culture and the impacts it can have on the profession towards help seeking and the management of those who experience poor mental health. It also identifies the 'gaps in knowledge', which provides the opportunity to research an often overlooked but critical aspect of policing.

1.1.2 Prevalence of mental illness in UK

> "Stress is nothing more than a socially acceptable form of mental illness" (Carlson, 2016, p. 161)

One of the challenges surrounding discussions about mental ill health is its broad scope and what can be construed as mental ill health. The World Health Organisation takes a wide stance, "Mental health is an integral and essential component of health. Health is a state of complete physical, mental and social well-being and not merely the absence of disease

or infirmity. An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities. Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community." (World Health Organization, 2013, p.7). A person's mental health is determined by several social, psychological, and biological factors at any given time. Poor mental health is associated with stressful work conditions, discrimination, social exclusion, exposure to danger and poor physical health. There are also biological, psychological and personality factors that make people vulnerable to mental disorders (World Health Organization, 2013).

Within the UK the Health & Social Care Information Centre (HSCIC) on behalf of the English Department of Health, commission the Adult Psychiatric Morbidity Survey (APMS). This has taken place every seven years since 1993. The last APMS survey was undertaken in 2014 with the report published in September 2016. The report details the everyday stresses, strains and joys affecting the health of people living in England. It is the primary source of information on the prevalence of both treated and untreated psychiatric disorders and their associations in the home and work place (McManus et al., 2016). This includes Common mental disorders (CMD) and Post-traumatic stress disorder (PTSD) which are prevalent in the general population. CMD is broken down into different types of anxiety and depression, which can cause emotional distress and can interfere with daily living, but do not tend to affect insight or cognition.

McManus et al., (2016) found that in the 16 to 64 age group 17% of respondents had at least one CMD. Gender and age appears to have a bearing on CMD. Overall women were more likely than men to have a CMD (19% and 12% respectively), males peaked in the age group 25-54 years (15%) and females 45-54 years (25%). As a predominantly male dominated occupation with a relatively low retirement age ceiling and relatively young workforce, this can have implications for policing. As female recruitment has increased steadily from the 2000s (Brown & Woolfenden, 2011) there has been an increase of the proportion of female police officers in the 43 forces in recent years from 22.3% in 2006 to 30% in 2018 (Home Office, 2018). Statistically it is likely the incidence of CMD found within policing can be expected to increase in line with the higher proportion of female recruits. A similar situation occurs with police staff where female staff outnumber their male counterparts with 61 % being female (Home Office, 2018). Of those reporting with CMD in the general population, 39% were receiving medical interventions.

The APMS (McManus et al., 2016) identifies several risk factors associated with CMD, which include: being female, work stress, social isolation, poor housing, negative life events, poor physical health, a family history of depression, poor interpersonal and family relationships, a partner in poor health, and problems with alcohol.

CMDs can be detrimental to physical wellbeing and social functioning, and are a significant source of distress to both the sufferer and friends and family. Frequently anxiety and depression are often undiagnosed with individuals failing or reluctant to seek treatment. If left untreated, they can lead to long-term disability and premature mortality (Cassano & Fava, 2002). Furthermore, CMDs are considered, relapsing conditions that can recur many years after an earlier episode. Therefore having a CMD can have long-term implications (Thornicroft & Sartorius, 1993; Weich et al., 2007)

PTSD, is related to a traumatic event where an individual experiences, witnesses or is confronted with life endangerment, death or serious injury or threat to self or close others. The International Classification of Diseases for Mortality and Morbidity Statistics Reference Guide (World Health Organisation, 2019) describes a traumatic stressor as 'a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone' (World Health Organisation, 2019). The majority experiencing such trauma will encounter distressing symptoms, but only a minority are thought to develop PTSD (Benjet et al., 2016). Such traumatic events are generally more severe than stressful life events associated with CMD and is a disabling condition with sufferers experiencing flashbacks, nightmares, avoidance and hyper-vigilance. McManus et al. (2016) informs us that overall, 3.0% of adults were currently deemed to be suffering from PTSD. Men are more likely to have experienced a trauma than women (35.2% and 31.5% respectively). Interestingly, gender does not significantly affect rates of PTSD (2.6% of men and 3.3% of women) and according to their figures, there is a 'conditional probability' of 8.9% of adults experiencing PTSD in their adult life time (McManus et al., 2016). Unfortunately, 17% of police officers reported having experienced PTSD (Blue Light Programme, 2016). Symptoms may not appear immediately, but onset is usually within six months. However, as with CMD, sufferers may chose not to disclose their symptoms or seek help. In line with CMD those who reported with PTSD, 28% were in receipt of medical treatment (McManus et al., 2016).

Suicidal thoughts, attempts and self-harm are reported on as they can be used in predicting who is most likely to commit suicide (Skegg, 2006). Such thoughts and behaviours are

associated with high levels of distress, both for the individual and friends and family. Overall 16.7% have thought about committing suicide at some point in their life, 5.6% having attempted to do so (Skegg, 2006). Women (19.2%) were more likely than men (14%) to have suicidal thoughts (McManus et al., 2016). However, men are more likely than women to commit suicide. The Office for National Statistics data (Office for National Statistics, 2017) indicates that 5,821 suicides of people over the age of 15 were registered in 2017, a UK suicide rate of 10.1 deaths per 100,000 people. Of those 75% were male, having risen from 63% in 1981. The proportion of male to female deaths by suicide has increased steadily since 1981 with 2013 being the first year men aged 45 to 59 recorded the highest suicide rate (Office for National Statistics, 2015). However, it should be noted that the majority of people who have a diagnosable psychiatric condition, such as major depressive episodes, schizophrenia, post-traumatic stress disorder and anxiety do not commit suicide, as other factors such as social factors and physical illness as well as mental disorder can impact on suicidal behaviour (Harris & Barraclough, 1997; Beautrais, 2000; Hawgood & De Leo, 2008)

As stated above PTSD focuses on a stressful event or events, which can result in poor mental health. However, it does not necessarily take account of the impact of events such as unemployment, divorce, conflict at work (or in the police environment investigations into misconduct, imposition of restricted duties and premature retirement) which can destroy an individual's core values and shatter their basic beliefs. As a result, people can feel wronged and humiliated in that some injustice has fallen on them (Linden, et al., 2009). This can result in embitterment, which can lead to a long lasting mixture of depression, helplessness, hopelessness, intrusive thoughts and memories long after the triggering event. This challenge to one's core values resulting in intense emotional embitterment has been termed Post-Traumatic Embitterment Disorder (Linden et al., 2009). Linden et al. (2009) suggest that 2-3 % of the population experience PTED and will suffer similar symptoms to PTSD. Furthermore, the authors suggest sufferers of PTED rarely seek psychological help. Sufferers do not have the feeling that they must change, but rather have the idea that the world or situation should change or the oppressor should change, and are therefore reluctant to seek treatment.

There are of course a myriad of other mental health issues and definitions including Psychosis; Antisocial and borderline personality disorders; Attention deficit hyperactivity disorder; Eating disorder; Alcohol misuse and dependency; Drug use and dependency; Problem gambling; Psychiatric comorbidity, much of which is beyond the remit of this

paper. However, it is pertinent to point out the police related literature examined focused on CMD, PTSD and Suicidal thoughts which are more common and regularly appear in policing studies and literature (Bonifacio, 1991; Violanti, 1995; Collins & Gibbs, 2003; Violanti et al., 2006; HSE, 2007)

1.1.3 Stigmatisation and discrimination

The World Health Organisation defines stigma as 'a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society' (WHO, 2001, p. 1)

Goffman (1963, p. 3) defines stigmatisation as 'an attribute that is deeply discrediting within a particular social interaction'. It is the shame that a person may feel when he or she fails to meet other people's standards (of which that person expects they are important), and the fear of being discredited. This often causes the individual not to reveal his or her condition or shortcomings (Goffman, 1963). According to Link and Phelan (2001), stigma stems from the identification and labelling of differences among people, which results in discrimination, loss of status, or loss of opportunities.

Stigma is composed of stereotypes, prejudice, and discrimination. Stereotypes are defined as knowledge structures that are learned by members of society. Negative stereotyping can lead to prejudice, where individuals engage in these knowledge structures and generally hold a negative view of a sub population or out-group. Discrimination is the behavioural reaction of prejudice (Corrigan & Watson, 2002).

Othering

Stigmatisation', is closely linked to the theory of 'othering' (Said, 1978) which is the process by which people are made to seem like an outgroup—'them'—who are different from 'us' (Vinkenburg, 2014, p. 382). Tajfel (1981) describes the hierarchy of the insiders and outsiders and that the outside group often see themselves as inferior. Othering has also been placed in a feminist or gender bias, where masculinity is seen as the dominant culture and women are seen from the male perspective of society with its masculine hierarchical power structures with women being the 'the other' (De Beauvoir, 1997).

Foucault (1981) suggests 'Othering' is strongly connected with power and knowledge and more importantly that 'knowledge' changes according to what those in power deem to be knowledge. The powerful group reinforces their position and knowledge whilst illuminating the perceived weakness of the 'others'. Thus deeming the 'others' inept and serving to

keep power where it already lies. It is on this basis, whilst commenting on the isolation of the mentally ill, that Foucault suggested they were segregated into an 'other' world and that it is the powerful who create the labels of sanity and insanity. The terms sanity/insanity are a long way off from modern parlance but the roots of the labelling and 'othering' of people with mental health issues can be found in the attitudes of those delivering and receiving psychiatric services today (MacCallum, 2002).

Othering can also be seen as any action by which an individual or group becomes mentally classified as "not one of us". Failing to see that every individual is a complex collection of emotions, ideas, motivations, reflexes, priorities, and many other subtle aspects. In its worse sense othering allows the dominant culture or person to dismiss 'others' as being in some way less human, and less worthy of respect and dignity than themselves whether on an individualistic, group or community basis. This can manifests itself as dislike or suspicion of people who are different where potentially officers/staff experiencing mental health problems are not seen to be or feel to be part of the norm.

Labelling

According to Link and Phelan (2013) a 'label can be described as a definition that identifies what type of person he or she is. Labels can be "official" when they are formally applied in a sanctioned official process or "informal" when they are used in day-to-day interactions but not officially processed and recorded.' (Link & Phelan, 2013, p. 525)

Labelling theory has its roots in the study of crime and deviancy. Becker (1963) was at the forefront setting out a form of labelling that examines so-called deviant acts and how some behaviours are labelled deviant, and what subsequently happens when persons are labelled as deviant. Becker (1963) suggests that the establishment creates rules and laws and applies them to 'outsiders'. Therefore, an act or person only becomes deviant when labelled by others as deviant. Thus, the establishment defines behaviour that is acceptable or unacceptable.

Becker (1963) suggests, the stigma that comes with such a label, is more a product of society than it is of the individual committing the deviant act. Social norms vary amongst cultures and time. What is considered deviant in one society, or at one point in time, may not be considered deviant in another. Arguably, deviancy is not a measure of the act or behaviour a person displays, but the consequence of the application by others of rules and sanctions to an offender.

Labelling theorists speak of primary and secondary deviance (Lemert, 1951) . The former are deviant acts not publicly labelled, the latter results in social labelling as an offender who will be treated as such by society and conform to the label resulting in further acts of deviancy.

Scheff (1966) adopted some of the tenants of Becker (1963) and Lemert (1951) theories and argued that mental illness is manifested solely as a result of societal influence. Scheff (1966) argued that society views certain actions as deviant and, in order to come to terms with and understand these actions, frequently labels those displaying them as 'mentally ill'. As a result, people see themselves as 'mentally ill' and can conform to the expected behaviours and stereotypes.

Gove (1975) argued in the opposite direction implying that it is the behaviours displayed by people with mental illness that cause people to be identified as such and labelled accordingly. Not all researchers are so extreme in their views. Link (1982) developed a 'modified labelling theory' regarding mental health. This recognised the fact that the process of socialisation influences people's concept of mental illness. If these perceptions are related to negative connotations then an individual who develops mental ill health is likely to relate them to themselves. If the individuals then see themselves in a similar light, it can be to their detriment.

Stigma

Stigma is a form of social distancing which occurs when people are unwilling to associate or choose to avoid people with a mental illness due to the perceived stereotypes or prejudices associated with mental illness. Arguably, people who live with mental illnesses are among the most stigmatised groups in society (Stuart, 2008). Several health conditions are stigmatised, with mental health problems being second only to HIV/AIDS. This potentially affecting 'many aspects of the person's life it has the greatest impact on work […] and is experienced across all aspects of the employment process' (Lelliott et al., 2008, p. 7).

Clement et al. (2015) in their review of the associated literature identify several types of stigma. These included:

> 'anticipated stigma (anticipation of personally being perceived or treated unfairly); experienced stigma (the personal experience of being perceived or treated unfairly); internalized stigma (holding stigmatizing views about oneself); perceived stigma (participants views about the extent to which people in general

> have stigmatizing attitudes/behaviour towards people with mental illness); stigma endorsement (participants ' own stigmatizing attitudes/behaviour towards other people with mental illness); and treatment stigma (the stigma associated with seeking or receiving treatment for mental ill health).' (Clement et al., 2015, p. 11)

Thornicroft et al., (2007) suggests the term stigma can be seen as an overarching term that contains three elements: 'problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behaviour (discrimination).' (Thornicroft et al., 2007, p. 192)

In order to better, understand the impact of stigma. Link and Phelan (2001) developed and conceptualised their modified labelling theory. This theory examines perceptions of being labelled with a mental illness and the subsequent interaction with society. That society constantly demeans and rejects those with a mental illness often in a variety of subtle ways, which when combined, undermines self-belief and confidence. Those who are labelled or fear being labelled as such can withdraw from society and maybe rejected by society (Link & Phelan, 2001).

Further Link and Phelan (2001) suggest,

> 'Stigma exists when the following interrelated components converge. In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link labelled persons to undesirable characteristics – to negative stereotypes. In the third, labelled persons are placed in distinct categories so as to accomplish some degree of separation of "us" from "them." In the fourth, labelled persons experience status loss and discrimination that lead to unequal outcomes. Stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labelled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination. Thus, we apply the term stigma when elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows them to unfold. ' (Link & Phelan, 2001, p. 367)

Distinguishing and Labelling: People by their very nature are different physically and emotionally, each with a variety of characteristics. However, some such as race, gender and sexuality are due to socialisation and are deemed to be significant and attributed labels. In the area of mental health, classifications such as International Classification of Disease Codes (ICD) allow medical professionals to attribute labels to people's emotions or behaviours (Link & Phelan, 2013). The impact of such labelling can have negative consequences for the labelled. On a more basic level, Putman (2008) points out that derogatory terms regarding ethnicity are rare whereas those related to mental illness are

still common and rarely challenged even amongst health care workers. Despite the efforts to marginalise discrimination and embrace diversity Bullock & Garland (2017) and Turner & Jenkins (2018) reported similar issues in policing.

Differences and negative attributes: As can be seen above people may stereotype those with a mental illness. Unfortunately, without first-hand knowledge, people's opinions of mental illness can be based on ignorance and negative reporting in media and popular culture (Wahl, 1995; Corrigan et al., 2001; NIMHE, 2005). As a result, those with a mental illness regardless of the condition can be thought of as unpredictable, potentially dangerous and prone to violence (Phelan & Link, 1998). Research suggest police officers share similar thoughts (Pinfold et al., 2003; Cotton, 2004; Lane, 2019).

Separation: Link and Phelan (2013) also adopt the theory of othering when attempting to understand stigmatisation. They note mental illness knows no boundaries as far as race, class and other sociological labels are concerned. They suggest that the prevailing labels and associated bonds which result in people adopting an 'us and them' perception may protect those who develop a mental illness as they continue to be part of the 'us' fold. However, they argue that a new label in the case of more severe mental illness can override the existing ties and becomes the overriding label and status as 'us or them' separating the individual from their network. Perry (2011) suggests that the degree of separation will be less amongst those in the core network (family) and more so amongst the wider networks. Family ties are closer and less fickle or transient than friends and colleagues. This may be problematic in policing where there is a churn of personnel who routinely move to and from specialist departments and on promotion loosening bonds and friendships.

Emotional responses: The modified labelling theory recognises that both the stigmatising person and the stigmatised person are susceptible to a range of emotions. The former anger, irritation, anxiety, pity and fear and the latter embarrassment, shame, fear, alienation and anger (Link & Phelan, 2013). Such emotions are conveyed to others and people will respond accordingly to the detriment of the person experiencing mental ill health. These emotional responses can hinder communication, prevent disclosure and marginalise officers and staff with mental health issues (Karaffa & Tochkov, 2013; Bullock & Garland, 2017; Turner & Jenkins, 2018)

Status, power and discrimination: As with othering above, power is central to stigmatising. Link and Phelan (2013) argue that many groups will stigmatise others or each other. However, the status and power of those committing the act will have a more detrimental

and longer lasting effect than any reciprocated behaviour. The group with the social, cultural, economic and political power will prevail resulting in the stigmatised loosing status and diminished power. The hierarchical nature of policing can widen the gap further resulting in a loss of self-esteem and worthlessness (Bullock & Garland, 2017).

Building on this concept Phelan et al. (2014) embraces status characteristics theory (Berger et al., 1977) which 'relates characteristics of an individual to that person's rank in a status hierarchy based on the esteem in which the person is held by self and others. The theory proposes that members of a group form expectations about each other's competence to contribute to group goals based on their status characteristics. Individuals expected to make greater contributions are more highly valued by the group' (Phelan et al., 2014, p. 16). Thus, people make assumptions about others attributes and ability based on perceived status and will place themselves and others in a hierarchy, which affords and even expects those with higher status greater influence and power. A concept which bearing in mind the hierarchical nature of policing with its own culture and sub cultures (Loftus, 2009) with formal and informal stratification is likely to be relevant to mental health related stigma in policing. A group member's performance expectancy determines their positioning, in, what is termed, the power and place in the hierarch of the group (Berger et al., 1977).

Self-stigma

Corrigan (2004) and Thornicroft (2006) identifies stigma on the public level and the self, arguing that they are inextricably linked and share the same characteristics of prejudice, discrimination and negative stereotyping. 'This perspective represents self-stigma as a hierarchical relationship; a person with mental illness must first be aware of corresponding stereotypes before agreeing with them and applying self-stigma to one's self' (Corrigan et al., 2009, p.75). Arguably, people with mental illness, living in a society that widely sanctions stigmatising ideas and stereotypes, will internalise these ideas and believe that they are less valued because of their psychiatric disorder to the detriment of their self-esteem, loss of confidence in their future and self-imposed barriers to support and treatment (Corrigan, 1998; Link & Phelan, 2001). This is also manifested in the work place. 'Self-stigma's effect in the work world, for example, leads to decreases in self-esteem (''I am not worthy to work in such a good place'') and diminutions in self-efficacy (''I am unable to carry out such jobs'')' (Thornicroft et al., 2007, p. 260). Corrgian's framework of public and self is broken down further into three core features: stereotypes (cognitive knowledge structures), prejudice (cognitive and emotional consequence of stereotypes) and discrimination (behavioural consequence of prejudice) (Corrigan, 2000). Within policing

Turner & Jenkins (2018) came to similar conclusions whilst Bullock & Garland (2017, p2) referred to a 'spoiled identity' as officers with mental ill health no longer identify with group norms.

Notably much of what has been written about self-stigma is concerned with severe mental illness. However, there is developing literature concerning the wider sphere of mental ill health encompassing depression (Conner & McKinnon, 2015), college students with mental health concerns (Denenny et al., 2015) and ADHD/depression (McKeague et al., 2015) to name but a few.

Corrigan and Watson (2002) acknowledge the negative impact of the concept of self-stigma. However, they speak of the paradox of self-stigma, which introduces both positive and neutral attributes to the concept. Those with a concealable stigma have to choose if and to whom they will disclose personal information whilst considering any possible consequence. 'The ambiguity of social situations combined with the threat of potential discovery makes possessing a concealable stigma a difficult predicament for many individuals' (Pachankis, 2007, p. 328). Corrigan et al. (2010) adopt terminology and concepts from the Gay Rights Movement the 'Benefits of being out'. In doing so they argue, people with a mental illnesses are not obvious to others unless they declare it. Seeing positive aspects of self-stigma Chamberlin (1978) and Deegan (1990) speak of righteous anger, which empowers those who experience stigma to become advocates and activists in order to improve service delivery in mental health care. People who are empowered are less likely to display low self-stigma and that people who are 'out' report less stress and other benefits (Rosario et al., 2001). Corrigan et al. (2010) research once again centred on those with serious mental health issues. However, they found 'coming out can serve the goals of people with various mental illnesses and diminish the deleterious effects of self-stigma on quality of life' (Corrigan et al., 2010, p. 270).

Social Network Theory

The above models are based on power and the impact this power has on people's status and thus relationship with others. Social scientist have used adapted forms of social network theory to explain these relationships. According to Kadushin (2004) a network is a set of relationships, which comprise of egocentric (centred on an individual connections and relationships with others); socio-centric, (networks contained within a fixed body or organisation with clear boundaries) and open-system networks, where boundaries are not clear and harder to define.

The ego centric or personal network can also be explained as ones community ties, which consists of friends, and relations who provide mutual social support (Kadushin, 1981). Researchers suggest that personal networks can be described broadly as core and peripheral. As the names suggest those relationships that are small and stable based on immediate family and spouses/partners not usually exceeding six people are core with remaining associations such as work colleagues, neighbours, and extended family which are likely to be relatively short standing and more transient with weaker ties being peripheral (Wellman & Wortley, 1990). Carpentier & Ducharme (2003) suggest that a core of close friends and family provide support when people become ill unlike peripheral personal relationships where people are less committed and are likely to disengage. Recent research suggest that staff with a mental illness in the emergency services are reliant on close family for support (Blue Light Programme, 2016) but as far as police officers are concerned they are less like to receive support from colleagues and workmates (Bullock & Garland, 2017; Turner & Jenkins, 2018).

In the case of mental health, there is evidence to suggest that personal contact with people with mental illnesses reduces stigmatising attitudes and desire for social distance (Link et al., 1989; Broussard et al., 2011). Perry (2011) suggests the concept of contact is reflected in social network theory anticipated less discrimination amongst those in core and close personal relationships. However, her research suggests there is a paradox in labelling theory regarding mental illness. She acknowledges that labelling processes for people with serious mental illness can lead to stigma and discrimination from peripheral relationships but they can also invoke strong positive supportive responses from those within the core relationships. However, this is not always the case for those with less serious issues such as depression and more common disorders, which are becoming more acceptable and may fail to register a response within the core or peripheral networks.

Stigma coping

Monat and Lazurus (1991, p.5) define coping as “an individual's efforts to master demands (conditions of harm, threat or challenge) that are appraised (or perceived) as exceeding or taxing his or her resources”. Researchers (see: Lemert 1967; Lazarus & Folkman, 1984; Link and Phelan, 2013) have agreed for some time that people who are stigmatised actively respond to their situation which has been a key element of theories surrounding stigma. For example Lemert (1967, p. 17), suggested that responses to labelling included “defence, attack, or adaptation” to overt or covert discrimination. Link and Phelan, (2013) draw upon their modified labelling theory and suggest that coping strategies include that ‘of “secrecy” (concealing labelling information), “education” (providing information to counter stereotypes), and “withdrawal” (avoiding potentially rejecting situations) (Link et al., 1989, Link et al., 1991) followed by the addition of “challenging” and “distancing” (Link & Phelan, 2013, p. 25) . However, they suggested individual coping strategies are unlikely to be effective as they fail to deal with the underlying and fundamental problems of society. Instead, they suggest that collective responses are required at societal level and amongst people with mental illness.

However, this is not to detract from the fact that people can and do implement coping strategies. These can take the form of problem focussed coping, altering the relationship between the stigmatized person and their environment to better manage or alter the source of stress and emotion focused coping, which seek to regulate negative emotions and protect self-esteem (Lazarus & Folkman, 1984). Problem-focused coping strategies can target the self, the situation, or others, and include strategies such as selective disclosure, disengagement and in the opposing direction activism. With effective action, the problem diminishes and potentially impacts positively on the health of the individual. Arguably, problem-focused coping is considered a more effective coping strategy than emotion-focused coping.

However, when the problem is not addressed or it is beyond the remit or capability of the individual, problem-focused coping strategies may fail or even be counterproductive. On such occasions, emotion-focused coping efforts would be a better strategy (Lazurus, 1993). Emotion-focused strategies include downward social comparison (evaluating one’s self against less fortunate others), attribution models of emotion (attributing negative outcomes due to the stigmatizing behaviour of others such as ignorance or prejudice), denying or minimising their situation and personally detaching or disengaging from a group or situation where stigmatisation may occur (Miller & Major, 2003).

Some forms of coping are more proactive. Thoits (2011) developed Link and Phelan's modified labelling theory (Link & Phelan, 2001) and introduced the concept of resistance as a coping mechanism. Thoits (2011, p.11) suggests that ' there are definite hints in the empirical literature that some individuals reject others' damaging remarks and behaviours or refuse to see themselves in the ways that the public or acquaintances do' . This resistance takes the form of deflecting, refusing to accept the label and challenging other people's perceptions of themselves or the stigma. In order to do so they must first acknowledge the label and accept its connotations in order to resist it. Thoits (2011) suggests there are five type of people whose response to stigmatising take different forms. Those that are most resistant the 'challengers' who resist personal and group stigma, refuting the stereotypes associated with mental illness demanding changes to societies views and conceptions. 'Deflectors' reject the public stereotypes as not applicable to themselves as they don't display the characteristics associated with the stereotypes. 'Avoiders' maintain secrecy and will not disclose any details about the condition. 'Self-restoration types', acknowledge their illness and stigma, and take steps to proclaim their improved health and status. Lastly, there are people who can be described as fitting the modified labelling theory and believe societal conceptions are relevant to themselves and others with mental illness (Thoits, 2011).

Thoits (2011) suggests that the act of resistance regardless of outcome is empowering even if efforts are unsuccessful with a caveat that confrontational resistance may raise self-esteem, while blocking may simply maintain it. Stigma resistance thus aims to protect those with mental illness from self-devaluation.

Mittal et al. (2012) in their review of self-stigma coping strategies highlighted the lack of research available regarding self-stigmatisation reduction mechanisms regarding more common anxiety disorders and post-traumatic stress disorder. However, they infer that research conducted on schizophrenia and depression is relevant to the above. Having examined several approaches, they highlight two emerging methods for addressing self-stigmatisation. One attempts to address the stigmatising attitudes and beliefs of the individual, whilst the other aims to improve self-esteem, empowerment and thus help-seeking capability by enhancing coping skills. The latter approach appears to have gained traction among stigma experts (Mittal, et al., 2012). Targeting high-risk groups to pre-empt self-stigma appears to be a promising area for future research.

Discrimination

Discrimination refers to inequitable or unfair treatment of people, which amounts to denial of the rights, and responsibilities that accompany full citizenship. Discrimination may occur at an interpersonal level and/or structural level when people are covertly or overtly excluded from society through a variety of legal, economic, social, and institutional means (Link & Phelan, 2001). Link and Phelan (2013) describe four broad mechanisms of discrimination: direct i.e. person-to-person discrimination, interactional discrimination, discrimination that operates through the individual and structural discrimination. Direct discrimination founded on Allport's intergroup contact theory (1954) where an individual is stereotyped or subject of prejudices and discriminated against based on the attributes of the stereotype. However, Link and Phelan (2013) argue that not all discrimination is obvious or recognised and is often subtle or imperceptible. Interactional discrimination occurs when a person behaves differently than they would normally do so when interacting with a stigmatised person resulting in the stigmatised person countering the exchange in a negative way to their detriment. When this occurs repeatedly, it can lead to exclusion and reduced status. Discrimination that operates through the individual may also be subtle and can occur when people with a mental illness know about the stereotypes that society places on them and may accept, confirm or assume the characteristics of the stereotype (self-stigmatisation). The discrimination may not be direct or obvious but once again can lead to a loss of status. Lastly, structural discrimination refers to the cultures, policies, legislation and institutional practices, which operate at the macro level. They are by their very nature exclusive and discriminate against those not appearing to be in the mainstream and disadvantage stigmatised groups.

Due to mental health-related stigmatisation, 'many people who would benefit from mental health services opt not to pursue them or fail to fully participate once they have begun' (Corrigan, 2004, p. 614). Stigma/being stigmatised can reduce self-esteem and in turn opportunities in employment, social interaction and accessing services; it is a vicious circle. Regardless of the severity or type of mental illness, people who are 'labelled' mentally ill are stigmatised more severely than people with other health conditions (Corrigan, 2000; Thornicroft, 2006). Unsurprisingly, police officers with mental ill health seek parity with colleagues with physical illness (Bullock & Garland, 2017; Turner & Jenkins, 2018).

Time to Change (2012), a UK Department of Health funded report into attitudes to mental illness, reported that 89% of respondents said that people with mental illness experience stigma and discrimination. Police officers like members of the public hold a number of

stereotypical views about mental health (Pinfold et al., 2003; Cotton, 2004). Stigmatisation of people with mental health issues by police officers can therefore occur.

Impact of stigma and discrimination

Studies (see: Stuart, 2008; Link & Phelan, 2013; Clement, et al., 2015; Thornicroft, 2006) have suggested that stigmatising attitudes towards people with mental ill health are held by a broad range of people across cultures and society including those who have knowledge and experience of mental health issues . Crisp et al., (2000) reported that that people with mental health issues are likely to be seen as dangerous, that some mental health issues were thought to be self-inflicted and that people with mental health issues were hard to talk to. Mental health stigma is also widespread in the medical professions (see: Chambers et al., 2010; Wallace, 2010) and policing (Koskela, et al., 2015) .

Thus, the negative attitudes of other people can be of greater detriment to the individual concerned than the illness itself. Thornicroft (2007, p192) tells us that

> 'The importance of discriminatory behaviour has been clear for many years in terms of the personal experiences of service users, in terms of devastating effects upon personal relationships, parenting and childcare, education, training, work and housing. Indeed, these voices have said that the rejecting behaviour of others may bring greater disadvantage than the primary condition itself.'

Workplace discrimination can be catastrophic with far reaching consequences as a diagnosis of a mental health problem is "one of the most potent ways to remove a person from the workplace" (Thornicroft, 2006, p. 50).

Countering stigma

Corrigan and Gelb (2006) suggest there are three methods to address public stigma, protest, education and contact. Protest which is often empowering (see: Corrigan et al., 1999; Thoits, 2011) aims to reduce and eliminate negative stereotypes by means of public protests and demonstrations including boycotts, public meetings and demands for improved services (Corrigan, et al., 1999). Education aims to challenge false beliefs and inaccurate stereotypes of mental illness by providing factual, evidenced based information, which counters widely held negative views (Corrigan & Penn, 1999). These take the place of public campaigns such as Rethink (Rethink, 2015), Time to Change (Time to Change, 2016) and within UK emergency services the MIND Bluelight initiative (MIND, 2015). Interpersonal contact involves face-to-face interaction with people with mental illness and groups of people in various settings in a positive contact situation. People are given an

opportunity to engage with a member of a stereotyped group and have an opportunity to challenge their own their own preconceptions and prejudices, which will hopefully be inconsistent with their stereotypes of that group (Corrigan & Penn, 1999).

Research suggests contact can be the most effective strategy of the three as it has better success in improving attitudes to mental illness (Corrigan & Gelb, 2006: Pettigrew & Tropp, 2006). However, Thornicroft et al. (2016) suggest from their review that the benefits of such contact could be short lived and that evidence of long term benefits is weak and that 'caution needs to be exercised in not overgeneralising lessons from one target group to another' (Thornicroft et al., 2016, p. 1123). They cite the Time to Change campaign in the UK and recognise the positive impact it has had on improving behaviours of the general population and reducing discrimination against service users between 2008 and 2011.

Studies have examined interventions within the medical profession (Schulze, 2007), military personnel (Iversen et al., 2011), teachers (Jorm et al., 2010) and emergency personnel in the UK (MIND, 2015). Research shows that anti-stigma approaches must be multi-level and multi-faceted to effectively reduce discrimination (Link & Phelan, 2001). Thornicroft et.al (2016) suggests that profession specific interventions experience similar results to population wide interventions with improvement in knowledge in approximately half of the studies, benefit in terms of attitudes in the majority of studies, and sustained improvement in the medium-term follow-up for about half of the studies. 'Social contact seems to be most effective when there is or participants, common goals for the interaction, and inter-group cooperation. This can lead to disconfirmation of negative stereotypical beliefs about mental illness, which could lead to behaviour change, especially because of reduced anxiety and enhanced empathy' (Thornicroft et al., 2016, p. 1128).

1.1.4 Measuring attitudes to mental health

Different scholars have employed different methods for measuring large numbers of people's attitudes to mental illness. One method employs the uses of vignettes the other uses validated scales. Those highlighted below are not exhaustive but reflect the history and breadth of approaches (Foster et al., 2014).

Vignettes

The vignette approach consists of creating a short description of a person or behaviour to which a participant responds to a set of questions, revealing their perceptions, values and prejudices (Corrigan & Watson, 2002). Lawrie, et al., (1998) and Dixon, et al., (2008) explored the attitudes of medical general practitioners and medical students towards prospective patients respectively using the same vignettes with slightly different Likert scales. Both approaches identified negative attitudes to those with mental ill health. The General Practitioners and Medical Students had identical median scores about 'accepting the patient on to caseload' supporting validity of the vignette approach (Foster et al., 2014).

Vignettes have been used successfully to measure public attitudes to mental ill health in the USA and globally. Corrigan et al. (2002) has used a vignette based approach to establish levels of mental health related stigma and difference and social desirability (Corrigan et al., 2015). Jorm et al., (1999) study used vignettes describing people with schizophrenia and depression to compare the attitudes of health care professionals to those of the public. They found health care professionals were more likely than the public to discriminate against mental illness and believe long-term outcomes for the subjects were poor. Link et al., (1999) and Pescosolido et al., (2010) adopted vignette methods for a survey of public attitudes to labelling and causes of mental illness, dangerousness and social distance.

Within policing Watson et al., (2004) and Clayfield et al., (2011) have used vignettes successfully to measure police officer attitudes to mental ill health (see 1.1.19 Police Attitudes to Mental Ill Health below).

Validated scales

In contrast, other academics favoured the development of validated scales. Cohen & Struening developed The *Opinions of Mental Illness* (OMI) scale (1962) to ascertain the attitudes of psychiatric staff at two hospitals. The original version had 70 items measured across five scales of authoritarianism, benevolence, mental hygiene, social restrictiveness and interpersonal causes. The scale was used widely and successfully for a number of studies and translated effectively from English into several languages (Foster et al., 2014). Early studies found authoritarianism and benevolence subscales were influenced by participant's occupation and level of education (Cohen & Struening, 1962) and ethnicity and familiarity with mental health (Corrigan et al., 2001).

Taylor and Dear (1981) adapted the *OMI scale* and created the *Community Attitudes to Mental Illness Scale (CAMI)* (Taylor & Dear, 1981) to establish public attitudes to outpatient

mental health facilities and services. They reduced the number of items to 40 and three subscales, which included authoritarianism, benevolence and social restrictiveness. The initial research conducted by Taylor and Dear (1981) suggested that older people had less sympathetic views than younger people did and again those with higher levels of education were more sympathetic.

Since 1981, the scale has been used successfully in several countries by the medical and other professions to ascertain workforce/students/trainees attitudes and test changes in attitudes pre and post mental health related training. Chambers et al., (2010) successfully used CAMI to measure nurses' attitudes to mental ill health across five European countries. They found nurses were mainly positive about mental ill health but due to cultural, social and organisational issues, attitudes did vary significantly across the countries. In line with Taylor and Dear (1981), Chambers et al., (2010) found that positive attitudes were more prevalent amongst females and those in a higher position.

Since 1994, the Department of Health and their partners have conducted an annual survey and report measuring the attitudes of the public to mental ill health (Time to Change - TNS BMRB, 2015). The survey employs the Attitudes to Mental Illness Questionnaire, which was adapted from the CAMI Scale (Taylor & Dear, 1981) and OMI Scale (Cohen & Struening, 1962) by the Department of Health. The scale consists of blocks of statements, Fear and Exclusion, Understanding and Tolerance, Integrating People into the Community and Causes and Needs of People with Mental Illness, with the intention of identifying people who accept or reject people with mental illness within their community. Higher scores are indicative of better attitudes. To date the study has found that attitudes to people towards mental illness have improved between 2008 and 2014 (Time to Change - TNS BMRB, 2015).

Table 1. Mean attitudes to mental illness scores 2008 to 2014

CAMI	2008	2009	2010	2011	2012	2013	2014	Max Total
Mean score	104.6	105.5	106.1	106.3	107.0	110.3	108.9	135

The Time to Change reports also contains the Mental Health Knowledge Scale (MAKS Scale) (Evans-Lacko et al., 2010) and Reported and Intended Behaviours Scale (RIBS Scale) (Evans-Lacko et al., 2011) which measure knowledge and reported and intended behaviours about mental ill health.

Research has also been undertaken using adaptions of the CAMI scale to understand how professional attitudes may differ from non-professional or professionals and members of the public. Sun et al., (2014) examined health care professionals to those of the public who found health care professionals were more favourable towards community based treatments than the public group. Smith & Cashwell, (2010) examined the attitudes of mental health professionals/students alongside non-mental health professionals/students. They reported that 'mental health training, education, and experience resulted in more positive attitudes toward mental illness' (Smith & Cashwell, p.197). Granello & Gibbs (2016) employed the CAMI scale to ascertain the impact of language (the mentally ill v people with mental illness) on tolerance towards people with mental ill health across a pool of students, community members and professional counsellors. The term 'mentally ill' resulted in lower levels of tolerance. Similarly, Brooker & Sirdifield (2009) found that intervention training for UK probation officers improved their CAMI scores above those of the public. Whilst Louden et al., (2018) in the USA using a combination of vignettes and the CAMI scale found probation officers rated offenders with mental illness as a higher risk and worthy of more punitive measure than generic offenders classified in the same risk classification.

The CAMI scale (Taylor & Dear, 1981) and adaptations of it have also been used successfully for measuring police attitudes to members of the public with mental illness (Cotton, 2004, Clayfield et al., 2011, Hansson & Markstrom, 2014) and towards offenders with mental ill health, benchmarking public versus police attitudes (Glendinning & O'Keefe, 2015).

1.1.5 Prevalence of mental illness in policing in England and Wales

Police officers experience the same combination of mental health issues as the general population (MIND, 2015). These experiences are compounded by regular exposure to traumatic incidents raising the risk of officers developing mental health problems (Ombudsman Ontario, 2012). Post-Traumatic Stress Disorder (PTSD) affects 2.6% of men and 3.3% of women in the general population (The Health & Social Care Information Centre, 2009). Worryingly, police officers propensity to PTSD is at least five times higher than that of the general population with a rate of prevalence of 17 % (Blue Light Programme, 2016). Ninety percent of police personnel have experienced stress or poor mental health while working within the service, and 61% have had personal experience of mental health problems – highest of all blue light services (Blue Light Programme, 2016). Compared with other emergency services, police personnel are more likely to report that their mental health has affected their performance. (MIND, 2016)

Specific demographics play a role in police officers' mental health. There is an overlap between groups known to be at increased risk of developing mental health problems and police officers. Men are at greater risk of taking their own life in the age groups relevant to emergency service workforce (MIND, 2015). Middle-aged men are the highest risk group (45-49 years) with male suicide rate being 3.5 times higher than females (Samaritans, 2013). This is worrisome, because amongst police officers there is reluctance to seek support for a mental health problem due to the fear of being stigmatised, leading to an intensification of the mental health issue (Miller, 1995; Violanti, 1995; Karaffa & Tochkov, 2013; Boshoff et al., 2015).

Research undertaken by Brown and Campbell (1990) and Collins and Gibbs (2003) in the UK identified what is now a long-standing problem of police stress. Johnson et al (2005) in a large-scale study of UK occupations places lower ranking police officers in the top six of occupations experiencing the most stress and least job satisfaction. However, they suggest senior police officers fared much better with lower levels of stress and higher job satisfaction than their junior colleagues. This indicates that there is a potential danger in using the collective term police or policing, when the size and scope of forces and roles are so broad. Even more so when relying or employing research from outside the UK where different policing styles and demographics exist in the size and make up of police forces.

Much of the research surrounding police mental health and attitudes to mental ill health has occurred in North America and Australia, less so from Europe and less again within the UK. Despite the similarities in policing in some of these areas, policing in England and Wales differs considerably. Therefore, it is important to be objective when considering the results and their application in the UK.

Police Staff

Several researchers have identified both organisational (Abdollahi, 2002; Gershon, et al., 2009; Deschenes, et al., 2017) and operational stressors (Abdollahi, 2002; Liberman et al., 2002) that can be detrimental to the health of police officers. Much overlooked is research examining the impact of these and other stressors on police staff (civilian or unwarranted personnel) who perform a number of roles within the service (McCarty & Skogan, 2012). They range from traditional administrative and personnel functions into a range of quasi policing roles with some operational crossover and or limited police powers ranging from intelligence analysis to police community support officers who are as much as the visible face of policing as their sworn colleagues. Police officers and police staff frequently perform

very similar or identical roles including control room dispatchers and custody suites. McCarty & Skogan (2012) analysis of several US forces found that police staff like their police officer counterparts experienced the same issues. As could be expected police staff veered towards organisational stressors including work life balance, relationships with managers and peers and expectations of fairness in the workplace. Despite the variance in roles Dick & Metcalfe (2006) found that members of the police family whether operational, administrative, police officer or police staff share similar commitment to the service and can be hypothesised to share similar responses to policing stressors.

Since the inception of Government austerity measures in 2010 police staff in England and Wales have endured repeated reorganisations, redundancies and allied job insecurity. In short, In England and Wales between 2010 and 2013 the number of police staff fell from 79,500 by 15,000 to 64,500 or 19% (UNISON, 2014). During the same period, 3,500 police community support officers (PCSOs) lost their jobs or a 22% reduction (UNISON, 2014). In a survey conducted by UNISON (2014) the top sources of workplace stress were increased workload, uncertainty over job security and lack of support from management. This could be compounded by the fact that police staff can view themselves as 'second class citizens' (Burke, 1995; King, 2009 in Alderden & Skogan, 2014) in a hierarchical organisation which is top heavy with police officers with few advancement opportunities for police staff (Highmore, 1993; Alderden & Skogan, 2014).

1.1.6 Police stress

Collecting data on police officer mental health is difficult within England and Wales as there is no central repository. Forces report medium and long-term absences to Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services and the Home Office. However, the term 'psychological disorder' fails to provide a breakdown of issues (McDowall, 2014). The categories are limited in nature. According to a HSE (Health & Safety Executive) report

> 'A lack of good data on the extent of mental health problems within forces was raised as another potential issue. Without effective monitoring information it was often difficult to fully understand the scale of the problem or to draw conclusions about the role of work in causing symptoms/illness' (HSE, 2007, p. 72) .

Furthermore, cultural issues within policing results in under reporting of mental illness (Royle et al., 2009 ; Violanti, 1995) and 'presenteeism' (Cooper & Dewe, 2008) and 'leavesim' (using leave entitlement to avoid sick leave) (Hesketh et al., 2014) can further skew the data.

Collins and Gibbs (2003) conducted research within a UK Force to identify the prevalence of stress related symptoms. They concluded that 'Policing is amongst the top three occupations most commonly reported by both occupational physicians and psychiatrists in the Occupational Disease Intelligence Network system for Surveillance of Occupational Stress and Mental Illness.' (Collins & Gibbs, 2003, pp. 256-257). Furthermore, a report by the HSE, highlighted that In relation to long-term sickness, the most commonly identified causes of absence were

> 'psychological problems (such as stress, depression and anxiety), musculoskeletal disorders and serious/fatal illness. Work-related injuries were also acknowledged as causing absence, as were psychological trauma, either from a single traumatic event, or a build-up of exposure to such events over time'. (HSE, 2007, p. 57)

Alarmingly it is extremely rare for work related stress to be recorded as an injury in the work place as both Health and Safety Executive and Force policies refer to it as a 'condition' and not an 'illness'. However, the symptoms mirror those of other CMD including anxiety and depression, irritability, declining intellectual capacity and tiredness (Houdmont, 2017). According to Houdmont (2017) police officer prevalence of minor psychiatric morbidity has reported between 42% and 58% compared to the general UK working population of 19.5%.

In 2016 research by MIND (MIND, 2016) revealed UK emergency workers are more likely to experience a mental health issue than the general population, but less likely to seek help. The data revealed 90% cent of police personnel have experienced stress or poor mental health while working within the service, and 61% have had personal experience of mental health problems – the highest of all blue light services.

In 2015, the BBC conducted a Freedom of Information request to 46 UK police Forces. From the 40 responses, it was evident that police officers and staff are experiencing high levels of absence due mental ill health. The data indicated that during the a five year period from 2010 to 2015 there has been a 35% increase in police officers and staff taking long term (in excess of 28 days) sick leave due to mental ill health (BBC News, http://www.bbc.co.uk/news/uk-35965223, 1st July 2016). According to the figures, there were 4,544 cases of psychological related absences in 2010 resulting in 19,825 days absence rising to 6,219 cases in 2015 resulting in 22,547 days absence an increase of 12%. This was against a backdrop of falling police and police staff numbers of 17,000 and 20,000 respectively (BBC News, http://www.bbc.co.uk/news/uk-35965223, 1st July 2016).

The BBC undertook a similar exercise in 2017 looking solely at police officer mental ill health. They conducted a Freedom of Information request to 46 UK police Forces. From the 26 replies, it was evident that police officers mental health was deteriorating. The data indicated that the number of officers suffering mental ill health and on long-term absences had increased by 70% from 2010 to 2017 (5 Live Investigates: Police Stress, https://www.bbc.co.uk/sounds/play/b09h3pz9, accessed 25 June 2019).

In 2019, *The Telegraph* undertook the same exercise with all but three forces not replying. The figures indicate that the problem is worsening with sickness absence due to stress, depression, anxiety and post-traumatic stress disorder increasing from 5,460 officer absences to 10,684 a rise of 96% between 2014 and 2019 (The Telegraph, 2019).

MIND in 2015 through its Blue Light Programme conducted research about the extent of mental ill health in the emergency services. The *Blue Light Scoping Survey* (2015) employed the Chartered Institute of Personnel and Development Focusing on Mental Health in the Workplace Survey (2011) as a benchmark. According to the Chartered Institute of Personnel and Development 26% of people in employment have experienced mental health issues in employment (CIPD, 2016). Not surprisingly the emergency services reported higher levels of 'lived experience' than the general public with police officers experiencing the highest levels of 'lived experience' and mental health service usage of the emergency services (MIND, 2015).

The *Police Federation of England and Wales, Police Officer Welfare, Demand, and Capacity Survey* found that 39% of police officers reported their job to be very or extremely stressful compared to 16% of the general working population based on Health and Safety Executive data (Houdmont & Elliot-Davies, 2016). Unfortunately, police staff appear to suffer similar stress. The UNISON, *Police Staff Stress Survey Report* (2014) found that 32% of police staff are very stressed and 62% are moderately stressed.

UNISON (2014) report that 15% of police staff have been referred to their force occupational health department due to stress and PFEW (Houdmont & Elliot-Davies, 2016) that 39% of Police Officers had sought help for feelings of stress, low mood, anxiety, or any other difficulties with mental health and wellbeing. Similarly, MIND (2015) reported that police personnel reported a higher mental health service usage (30.82%) than the general population (MIND, 2015).

According to UNISON (2014) and PFEW (Houdmont & Elliot-Davies, 2016) work pressures related to reducing resources, unsupportive management, and organisational stressors are responsible for the majority of the stress experienced by officers and staff. Operational stressors in the form of traumatic incidents appear to be numerically less than organisational stressors (see: HSE, 2007; UNISON, 2014; MIND, 2015; Houdmont & Elliot-Davies, 2016) but no less impactive on those who experience such trauma.

1.1.7 Police stressors and policing

As with many of these chapters, care must be taken when reading the literature of the inclination to group police officers into a homogenous group and overlook the impact of national policing cultures, which vary considerably between countries. Loftus (2009) argues there are not one but several police cultures and that 'recent reflection has called into question the existence and conceptualisation of a monolithic police culture' (Loftus, 2009, p. 8). Thus locations of police activity, whether urban or rural, inner city or suburbs, high exposure or low exposure to operational events and frequency and intensity of interactions with victims of crime all create a number of variables when trying to establish police officer job related stress (Webster, 2013). Particularly the carrying of firearms is still reasonably rare in forces in England and Wales with officers encountering offenders with firearms a rarity. As would be expected the prevalence of exposure to firearms and related stress features lower in UK (Brown et al., 1999) than USA studies (Violanti et al., 2006).

The public, press and politicians along with the police tend to agree policing is by its very nature inherently dangerous and therefore stressful. Although academics differ on the topic many researchers have argued that being exposed to traumatic incidents makes it one of the most stressful occupations (Liberman et al., 2002) leading to a host of medical issues many being of a psychological nature (see: Burke, 1993; Violanti, 1995; Liberman et al., 2002). Hart et al (1994) suggests a category below this group of traumatic stressors in the form of routine stressors or 'daily hassles' which officers will face on a regular basis unlike the traumatic exposure these daily hassles only impact on an officers quality of life if it is deemed to be threatening.

However, others have argued that it's not the operational risks like responding to potentially violent incidents or exposure to traumatic events that cause the most issues but organisational issues (Collins & Gibbs, 2003) like poor management, shifts (Brown & Campbell, 1990), poor communication and lack of support from senior ranks and increased workload similar to many other professions (Crowe & Stradling, 1993). Gist & Woodall

(2000) argue that officers have an expectation of exposure to critical incidents when considering and applying to join the police service, with there being some form of self-selection but what is less expected is the impact of poor organisational culture, structures and approaches to managing people (Burke & Paton, 2006).

Paoline (2003) explains police stressors as a two-path model describing 'interactions on the street with citizens (i.e. occupational) and those with supervisors in the department (i.e. organisational) as the two primary work environments of the police'. The streets are seen as *'dangerous, with the defining mandate being to display one's coercive authority over citizens'* (Paoline & Gau, 2017, p. 674) and

> 'the organisational environment as characterized by uncertain supervisor scrutiny of officer decisions (i.e. watchful and punitive superiors) and role ambiguity whereby officers are expected to perform all police functions equally, yet really only are recognized for crime fighting duties' (Paoline & Gau, 2017, p. 674).

Both environments can cause intense stress for police personnel.

Arguably the impacts of stressors can vary considerably on officers and that 'individuals, by virtue of their personality, biographical profile, or occupational status, will be differentially exposed to operational police stressors and organizational and management stressors (Brown & Campbell, 1990). These same features may also differentiate the degree to which individuals report felt stress and/or experience symptoms of distress' (Brown & Campbell, 1990, p. 307)

Operational Stressors

The most commonly identified police operational stressors include:

> '(a) dealings with the judicial system; (b) public scrutiny and media coverage; (c) officer involved shootings; (d) encountering victims of crime and fatalities (particularly children); (e) community relations; and (f) encountering violent/unpredictable situations' (Abdollahi, 2002).

It should be noted that these stressors are based on a literature review and are weighted towards research from outside England and Wales. The report Resilience and Wellbeing in a Scottish Police Force (Falconer et al., 2013) with the same policing style as England and Wales found the top three operational stressors to be delivering a death message, viewing a mutilated body, and presenting evidence in person in a Sheriff Court. Other stressors included dealing with children and adult victims of violent crime (more so children), attending domestic disputes and dealing with drug addicts (Falconer et al., 2013).

These lists overlook traumatic exposures such as major public order incidents (Riots and large scale disorder 1981, 2001, 2011), terrorist attacks (Manchester Arena, London Bridge) and major fatal accidents (Hillsborough, Marchioness, Grenfell Tower) which can all affect officers attending or supporting the response. According to Brown et al (1999) such events are 'low frequency but potentially high-impact events' and can lead to PTSD. Such events have been deemed to be potentially debilitating (Walsh et al., 2012). However, others suggest that such traumatic exposure or critical incidents may not only be negative but also positive (Paton et al., 2003). Paton (2012) suggested

> 'Positive outcomes include exercising professional skills to achieve highly meaningful outcomes, posttraumatic growth, enhanced professional capability, a greater appreciation for family, and an enhanced sense of control over significant adverse events.' (Paton, 2012, p. 198)

Arguably, much policing takes place in full view of the public and in modern times readily recorded and shared across media and social media. Therefore, officers are required to maintain high standards to meet increasing public expectations and be accountable for their actions (Stanko et al., 2012). Thus being continually in the public gaze facing constant scrutiny can be a source of perceived stress (Brown, 2016).

Johnson et al (2005) employed a stress tool to examine and compare occupational stress across 26 different occupations. Within the study, they differentiated between junior and senior police ranks to ascertain if the stressors varied amongst the two groups. The study encompassed emotional labour, or the effects of the demands of face-to-face or voice-to-voice interaction within an atmosphere of strict rules for example police officers de-escalating violent situations. The results are supportive of not treating police officers as a homogenous group in that senior police officers fared much better than junior ranks. Junior officers were found to be amongst the top six occupations experiencing most stress and least job satisfaction.

The research suggests that there are many operational stressors, which affect police officers. One of which is the impact of repeated exposure to highly challenging and difficult interactions with people in an emotional context, which can manifest itself as burnout (Bakker & Heuven, 2006). Burnout can result from a succession or repeated negative incidents leading to exhaustion and depersonalisation (Bakker & Heuven, 2006). Burnout in policing terms is defined as 'a prolonged response to chronic emotional and interpersonal stressors on the job' (McCarty & Skogan, 2012, p. 1). Burnout can result in distancing, cynicism and a loss of empathy and self-worth (Mealer et al., 2009). However,

Walsh et al. (2012) and Barak et al. (2001) argue that exposure to repeated stressors alone will not necessarily result in burn out and that organisational factors including 'high workloads, lack of influence over policy and work, perceived unfairness and lack of support have all been identified as contributing to burnout' (Walsh et al., 2012, p. 166)

Similar to burnout there are a number of conditions where professionals including police officers suffer detrimentally from 'the emotional, cognitive, and physical consequences of providing professional services to survivors' (Salston & Figley, 2003, p. 167) known as Secondary Traumatic Stress (STS) and similar variants including compassion fatigue, vicarious traumatization (VT), and traumatic countertransference (Figley, 1995). STS is a secondary trauma, which results from indirect exposure to trauma and is the natural consequent behaviours resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person' (Figley, 1995). Within policing Craun et al. (2014) suggest STS is particular prevalent within investigators investigating sex crimes and child exploitation. Compassion fatigue according to Figley (2002) 'is a more user friendly term for secondary traumatic stress disorder which is nearly identical to PTSD, except that it applies to those emotionally affected by the trauma of another' (Figley, 2002, p. 3). That it is the cost of caring and there is as potential a risk in assisting those in harm as being in harm oneself (Figley, 2002)

One of the issues for researchers attempting to understand police mental health and identifying the triggers or stressors and their outcomes is the approach to be taken. For example, Brown et al. (1999) argue the different approaches using accepted scales may not have been comprehensive enough. Hart et al. (1994) used the Daily-hassles Scale identified bothersome operational tasks dealt with in the previous month. The results included delivering a death message, dealing with a domestic-violence incident, dealing with victims, deal with road accident , abused children ; organizational activity (occupational hazards , shift changeovers) ; external; (court decisions , poor media coverage) ; workload ; danger (forcible arrest) ; frustrations (hoax calls) ; driving ; and complaints. The problem with these results is that there is no reference to major incidents/ traumatic exposure and a number manifest themselves as organisational issues rather than operational tasks. However, it is not always easy to separate the two.

Organisational Stressors

Research by MIND – *Blue-Light Survey* (MIND, 2015, p. 1) identified that within the emergency services in the UK 'Excessive workload (56%), pressure from management (55%), organisational upheaval (52%), and long hours (45%) were all considered bigger triggers of poor mental health than exposure to traumatic incidents (42%)'. This is not new previous researchers in the police environment have found similar results that organisational stressors and not critical incidents, are most strongly associated with perceived police stress (see: Brown & Campbell, 1994; Cooper et al., 1988; Gershon et al., 2009; Deschenes et al., 2017). In fact, Brown & Campbell (1990) found that organisational stressors were 4 times more likely to be cited as potential stressors than operational ones. Commentators like Gershon et al. (2019) have suggested that this is due to police officers anticipating operational risks when considering policing as a career but not expecting to be let down by poor leadership or insufficient support from the organisation (Gershon et al., 2009).

People with mental health problems experience discrimination in employment by finding it harder to get and keep jobs and not having their needs accommodated by employers, leading to higher levels of stress and underachievement (Mental Health Foundation, 2002). Manolias (1983) breaks these down further in the following areas: management support (policies and processes to manage health, welfare, education, counselling and grievances); management procedures for recruitment, training, career development, and discipline and management style or organisational climate reflecting the culture, behaviour and attitudes, of managers (Manolias 1983 in Brown & Campbell, 1990).

Poor managers and management style features frequently amongst organisational stressors. Officers often highlight inadequate supervision and poor relationships with managers as stressful (Abdollahi, 2002; Deschenes et al., 2017). Furthermore, the bureaucratic nature of policing with impersonal rules and quasi-military hierarchy reduces officer input and hampers effective communication potentially leading to feelings of alienation and another source of stress.

Of course, organisational stressors are not the sole reserve of managers. Colleagues can also be the cause of perceived victimisation or workplace bullying (Leymann, 1996). Such bullying can emanate from hierarchical relationships or from personal contacts or networks (Vartia, 2003). Whichever the source, what is key is the imbalance of power in the relationship and exposure to repeated negative behaviours where the victimised person

has little or no control with few possibilities to retaliate or gain an equal footing. The impact of low control, combined with high strain, increases stress and can be detrimental to health (Einarsen et al., 2003). During the early 1990s, the negative effects of such workplace bullying were encapsulated within the diagnosis of PTSD (Leymann & Gustafsson, 1996). Karatuna & Gok, (2014) cite several researchers supporting the diagnosis as late as 2011. However, they point out that 'that the A1 criterion for PTSD (report serious injuries or threats to physical integrity) generally failed to be fulfilled by the victims of bullying investigated' (Karatuna & Gok, 2014, p. 129). Post Traumatic Embitterment Disorder as proposed by Linden et al. (2009) has been used to describe the negative health impact of work place bullying and suggested as a more suitable diagnosis.

Officers and staff do not work in isolation. Family and friendships need to be balanced with work commitments. Greenhaus & Beutell (1985) in their study of work and family identified 'a form of inter-role conflict in which the role pressures from work and family domains are mutually incompatible in some respect' (1985, p. 77). By referring to family, this includes all its parameters and the roles and responsibilities experienced through employment/family life, which can cause tension when engaging in family/employment roles and responsibilities. Work family conflict can manifests itself in; 'time based conflict' (excessive hours, competing schedules, inflexible schedules, family and partners demands) 'strain based conflict' (the crossover of stress experienced in work/home life) and 'behaviour based conflict' (the incompatibility and tensions between working behaviours and home or family based behaviours) which can lead to increased stress (Greenhaus & Beutell, 1985). As females tend to have more caring responsibilities and the proportion of female staff within policing continues to rise (Brown & Woolfenden, 2011) these conflicts are likely to become more frequent and will require sensitive management.

1.1.8 Police culture

Schein (1992, p.3) defined culture as

> 'A pattern of shared basic assumptions, invented, discovered, or developed by a given group, as it learns to cope with its problems of external adaptation and internal integration, that has worked well enough to be considered valid, and, therefore, is to be taught to new members of the group as the correct way to perceive, think, and feel in relation to those problems'.

Reiner (1978) describes a distinct police culture based on conservatism, suspicion and cynicism with a pragmatic strong sense of mission, or 'canteen culture' as Waddington (1999) refers to it. Reiner (1985, p.85), stated that 'an understanding of how police officers

see the social world and their role in it – "cop culture" – is crucial to an analysis of what they do'. Traditionally, police culture has been seen to be one exemplified by masculine hegemony, racism, prejudice, discrimination and sexism (Charman, 2015).

Not all researchers describe police culture as a linear path being handed down from one generation to the next and applicable to all (O'Neil, 2016). Chan (1997) challenged this, as such a view does not account for differentiations in culture between or within police forces; overlooks police officer discretion as to how culture is adopted; minimises the wider context and constraints in which police officers assimilate culture; and that the linear path leaves little room for change. Chan's approach infers that 'it is possible to modify, mitigate, or reduce the culture and its impact' (Cockcroft, 2017, p. 229).

Loftus (2009) warns that it is important to question the perceived 'sociological orthodoxy' of negative behavioural tendencies that are presented as police culture by the 'classic ethnographers'. She like Chan (1997) argues that there are not one but several police cultures and that 'recent reflection has called into question the existence and conceptualisation of a monolithic police culture' (Loftus, 2009, p. 8). She suggests that rank, role, department and location can each have their own police culture. This indicates that police cultures are more diverse than usually considered. Notwithstanding Loftus found that despite considerable change both internally and externally in the social, political and cultural climate, some of these characteristics have endured (Loftus, 2009).

Not all aspects of police culture are negative. Several authors have argued that 'canteen culture' can have a positive impact on police officers and policing overall (Waddington, 1999; Loftus, 2009; Atherton, 2012). These authors argue that solidarity and camaraderie are essential traits within 'canteen culture' (Waddington, 1999) and provide 'a means by which officers can cope with the execution of their duties to meet the tensions of public demands, efficiency targets and maintaining the rights of citizens' (Atherton, 2012, p. 6). Police officers speak of camaraderie or solidarity as defining elements of police culture, and that officers are expected to demonstrate loyalty to colleagues above all else. As such, solidarity is of immense practical value, as it offers reassurance that other officers can be relied upon in dangerous situations (Crank, 2014).

Such positive aspects of police culture might be a stage for tolerance towards mental health issues, instead of being a domain of stigmatisation. Hence, police cultures may have the qualities to extend core networks (Kadushin, 1981) to close team members and become a supportive and inclusive environment for police officers experiencing mental health issues.

However, most police officers have seen the demise of police canteens and its social face-to-face interaction, leading to having less access to emotional support with and amongst each other (Griffiths, 2014). Furthermore, Hayday et al., (2007) found that the closure of canteens and removal of gyms were viewed as the withdrawal of managerial commitment to physical and mental fitness.

Charman (2017) suggests that cultural changes may be afoot, she identifies a 'new breed' (Charman, 2017, p 272) of younger officers who are culturally different from older officers (who display more traditional cultural leanings) and have different views about acceptable behaviours. This 'new breed' leans towards community engagement and effective communication rather than the previously accepted police culture valuing physical toughness and crime fighting. Perhaps changes in recruitment have had an impact on police culture. Academics differ on this, on the one hand, changes in recruitment demographics from a predominantly white, heterosexual male basis towards a gradual rise in, and a concerted effort to recruit, BME, female and gay and lesbian officers would be expected to alter attitudes and culture (Paoline et al., 2000). However, Loftus (2010) suggest some aspects of police culture has been driven underground but longstanding police culture endures because the basic pressures and inequalities associated with the policing remain (Loftus 2010).

Silvesteri (2017) suggests that 'the police organization is premised on an 'ideal worker'. This ideal worker is male' (Silvestri, 2017, p. 293) and that whilst policing continues to idealise 'manliness' cultural change will be difficult. Even though women make up 28% of warranted officers and 60% of police staff, the 'imagery of men and masculinity permeate organizational processes and cultural beliefs, marginalizing women and ultimately contributing to the maintenance of gender difference and segregation within organizational life' (Silvestri,2017, p.293).

Police culture has an impact on the lives of police officers both inside and outside the occupational environment (Coombe, 2013). Mental health issues readily cross this on and off duty divide. Police officers regularly deal with members of the public with mental health issues and will at some time or another inevitably have to work with someone experiencing mental health issues. Therefore, it is important that the relationship between police culture and mental health stigma is understood.

Furthermore, officers place a division between home and work, and are unlikely to burden or confide in family members having experienced traumatic or stressful incidents (Westley,

1970), therefore removing another source of support in times of stress. Subsequent or ongoing lack of family interaction can lead to alienation and further loss of support and potentially family breakdown (Kirschman, 2007). Research suggests that police culture manifests itself in officers tending to employ maladaptive coping mechanisms such as depersonalisation, authoritarianism, emotional detachment and self-medication with alcohol when subject to increasing stress (Evans et al., 1993)

Above, Coombe (2013) rightly identifies the crossover and impact of on and off duty police culture. Therefore, it could be argued that police officers face a 'double whammy' potentially adopting and facing both internal and external negative attitudes and stereotypes. The workplace is the second most common area (after family and friends) where mental health stigma is encountered (Wahl, 1995). Emergency services personnel with mental health problems are a marginalised community within the emergency services domain (MIND, 2015) police officers are no exception.

Police personality

Abdollahi (2002), Collins & Gibbs (2003), and Waters & Ussery (2007) describe a police personality and include personal traits such as pessimism, hardiness, authoritarianism, suspiciousness, solidaristic, conservative, alienated and bigoted. Personality characteristics that are hypothesized to be related to perceived stress (Twersky-Glasner, 2005). Hanewicz (1978) asked the question are these traits acquired on joining the police (sociological paradigm) or are they common to police officers (psychological paradigm). Is the selection process responsible for weeding out the non-police personality candidates or are applicants by their very nature self-selecting? Abdollahi (2002) in her literature review of police stress suggests the jury is out on the matter of police personality. 'Despite efforts to discover the "police personality," research in this area has yielded inconclusive results' (Abdollahi, 2002, p. 5). However, she accepts that there is some credence to the fact that police officers tend towards Type A personalities. Although empirically inconclusive, this personality type is believed to be more prevalent in police officers as compared to the general population (Kirmeyer & Diamond, 1985; Davidson & Veno, 1980; Abdollahi, 2002). Twerky- Glasner (2005) recognises that officers may have similar personality traits but not all police officers are alike. That police officers work behind a 'cultural shield which defines a working personality' (Abdollahi, 2002, p. 64). Furthermore, she suggests an anthropological paradigm suggesting officers develop an 'insider/outsider' approach to dealing with people and incidents taking an assertive and authoritative stance whilst maintaining their own individualism and personality. In short, Twerky-Glasner (2005)

proposes that the application, screening, training and assimilation into the Force provides the 'cultural shield' and police personality. As Loftus (2009) states there are potentially many police cultures and as police staff roles vary greatly so too will the personality types in police staff.

1.1.9 Police attitudes to mental ill health

Several researchers (Link, 1982; Corrigan, 2004; Stuart, 2005) have established the link between stigma and mental health problems. Police officers like members of the public hold a number of stereotypical views about mental health (Pinfold et al., 2003; Cotton, 2004; Lane, 2019). 'Public perception of police attitudes toward persons with mental illnesses has tended to be negative, viewing police as intolerant toward such persons in crisis, and as more likely to use excessive force when dealing with such individual' (Clayfield et al., 2011, p. 743). This is rightfully an area of concern, as stigma remains one of the biggest barriers to successful community integration of those with mental illnesses (Cotton, 2004). Watson et al. (2004), Broussard et al., (2011) and Lane (2019) argued that officers tend to perceive those with a mental illness as dangerous and reported that police officers may doubt the integrity or reliability of people with mental ill health. Watson et al., (2004, p. 52) , suggested 'a mental illness label was associated with greater perceived credibility of the person in need of assistance and with lower perceived credibility of the victim'. However, Cotton (2004) reported that she found police attitudes were at least as benevolent as those of the public were, whilst Trovato (2000) found police had positive attitudes albeit with an authoritarian stance.

Police officers' professional experience and interactions with members of the public with mental health problems in the criminal justice system can influence their perception and understanding of mental health, potentially discouraging them from seeking help (Royle et al., 2009). Police officers have a duty to be more knowledgeable and understanding of the issues surrounding mental health (Bradley, 2009), and would expect to find more positive attitudes. However, there has been limited research into the attitudes of police officers and even less so police staff attitudes to mental health (Bell & Eski, 2016; Bullock & Garland, 2017).

Corrigan (2004) identifies stigma on the public level and the self, arguing that they are inextricably linked and share the same characteristics of prejudice, discrimination and negative stereotyping. Therefore, it is possible that officers/staff are more critical of themselves than their peers are when it comes to mental health issues. In fact Soomro &

Yanos (2018, p.7) 'found that officers meeting criteria for current PTSD endorsed more stigma about mental illness and more negative attitudes about seeking mental health treatment' than the general population'. Which suggests officers with mental illness maybe stigmatising their colleagues in a similar position.

Karaffa and Tochkov (2013) suggest that police officers, like the public, experience the same social-cognitive effects of stigma, which in policing are compounded by their perceived relationships with colleagues. Officers who cannot control their emotions may be viewed as unreliable when responding to critical incidents. As a result, officers will invariably suppress their emotions (Bonifaco, 1991). 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., 2000).

Police officers are reluctant to seek help for mental health issues (Violanti, 1995; Bullock & Garland, 2017; Turner & Jenkins, 2018), officers seeking counselling or support can be viewed as weak and lacking resilience by their peers further heightening feelings of stigmatisation (Toch, 2002; Karaffa & Tochkov, 2013). Therefore, fear about fitness to practice can lead to officers/staff avoiding seeking help and support (Ombudsman Ontario, 2012; UNISON, 2014) potentially leading to an intensification of the mental health issue.

Mental health related stigma is prevalent in UK policing (Bullock & Garland, 2017; Turner & Jenkins, 2018; Lane, 2019). Bullock and Garland (2017) refer to police officers with mental ill health having 'a spoiled identity' as they are labelled as weak and unreliable and ostracised personally and organisationally from the group. Turner and Jenkins (2018) share a similar opinion that officers avoid seeking help due to a culture of invincibility, a lack of confidentiality and a fear of hampering their career progression (Fox et al., 2012). They suggest forces appertain to be supportive of those with mental ill health but due to cultural pressures, the reality is that officers revealing a mental illness are 'written off'. To add further salt to the wounds officers reporting stress or depression are seen by peers and supervisors to be malingering or 'swinging the lead' insinuating that reported absences are not genuine (Stuart, 2017; Turner & Jenkins, 2018; Bell & Palmer-Conn, 2018). Force Medical Officers have arrived at similar conclusions suggesting that police culture and pension regulations encourage officers to feign mental ill health to seek early retirement (Sumerfield, 2011).

Hansson & Markstrom (2014) like Cotton (2004) measured police attitudes to mental illness pre and post anti-stigma interventions. Their work mirrored the findings of the research

above concerning attitudes. The former is of note to this research as they included elements of the MAKS Scale (Evans-Lacko et al., 2010) and RIBS Scale (Evans-Lacko et al., 2011). Both articles reported on the anti-stigma interventions having a positive impact and the methodology effective in measuring police attitudes to mental ill health.

Glendinning and O'Keefe (2015) adapted the CAMI Scale (Taylor & Dear, 1981) to establish the Police and Community Attitudes towards Offenders with Mental Illness Scale. The study undertook to measure community and police officer attitudes to offenders with mental ill health. The results indicate that 'negative attitudes towards both offenders and those with mental health problems in police and public samples, demonstrating that stigma is still apparent (Goffman, 1963; Glendinning & O'Keefe, 2015). Of greater consequence to this study is the fact the CAMI scale can be used to benchmark public and police attitudes to mental ill health.

As stated above the variants to the Attitudes to Mental Illness Scale has been used by researchers to establish police attitudes to mental illness. Stuart (2017) developed the Police Officer Stigma Scale to ascertain levels of police mental health stigma. Her findings revealed that disclosure of a mental illness to a supervisor or colleague carried the highest stigma endorsement followed by expected discrimination at work and help seeking or treatment seen as a personal failure. This can explain why police officers with mental health problems are a marginalised community within policing. Their reluctance to speak up and disclose such conditions is detrimental to their mental health and impacts negatively upon career opportunities (Karaffa & Tochkov, 2013; Bullock & Garland, 2017; Turner & Jenkins, 2018; Bell & Palmer-Conn, 2018). 'The Ontario Ombudsman's noted that many officers felt betrayed by their supervisors and alienated from their peers when their operational stress injuries became known' (Stuart, 2017, p. 18). Challenges remain in addressing the problem in England and Wales, 'it was also clear that changing stigmatizing attitudes has been difficult and attempts have often fallen short of what was anticipated.' (Bullock & Garland, 2017, p.12).

Within the UK, several forces and the *Blue Light Campaign* have attempted to open the debate about mental health in policing. In response, the College of Policing has launched the Blue Light Framework (College of Policing, 2017) which provides guidance on improving police wellbeing and includes a self-assessment toolkit for forces to benchmark against. However, there is no requirement to measure police attitudes to mental ill health which could be argued is a deficiency in the process as without one there is no benchmark to

assess any improvement made. Bell & Eski (2016) argued that a national survey and measure of police attitudes to metal ill health would close this gap.

With the exception of the *Blue Light Programme,* the research conducted in England and Wales discussed so far was limited to single forces and relatively small number of participants (see Brown & Campbell, 1994; Bullock & Garland, 2017; Glendinning & O'Keefe, 2015; Turner & Jenkins, 2018). This is understandable as "Researching the police is notoriously problematic due the closed nature of the organization" (Turner & Jenkins, 2018). Fortuitously and integral with this research Bell & Palmer-Conn (2018) were successful in seeking the support of UNISON and PFEW and undertook a national survey of police officer and police staff attitudes to mental ill health. The research established a measure of police attitudes to mental ill health and bench marked them against a national public survey the Attitudes to Mental Illness Questionnaire (Time to Change - TNS BMRB, 2015). The study reported that police officers and staff were more knowledgeable about mental ill health than the community at large was and that police staff generally hold more positive attitudes about mental ill health than police officers and members of the public, who share similar views. Organisationally attitudes were less positive portraying a culture of "won't tell, can't tell" (Bell & Palmer-Conn, 2018, p. 33), where officers and staff view having a mental health issue as career destroying.

1.2 Background - Conclusions

This chapter explored the background to this research and examined the prevalence of mental ill health in England and Wales and within policing, the accompanying theories on stigma and discrimination, the prevalence and causes of police mental ill health and a police culture, which arguably stigmatises and discriminates against those with mental ill health. The latter relied heavily on research from North America and Australia which as can be seen from the lack of literature has been under researched in England and Wales.

Though police staff account for approximately one third of all police personnel and experience similar organisational and in some cases operational stressors they are regularly overlooked or excluded in studies in policing. There is a complete lack of available literature addressing police staff attitudes to mental illness.

Furthermore, research that has taken place in England and Wales has focused on individual forces, with national studies a rarity. Hence, there remain opportunities to undertake additional regional and national research to provide a more comprehensive analysis and improve generalisability. It is on this premise that this research has endeavoured to answer the questions:

What are police attitudes towards mental ill health in England and Wales?

To what extent do police attitudes to mental ill health impact on the lived experiences of police officers and police staff experiencing mental ill health in England and Wales?

The next chapter sets out the research aims and objectives followed by the overarching methodology used to address the research questions.

CHAPTER 2

Research aims

2 Research aims

2.1 Research aims and objectives

As stated in Chapter 1 there is limited research regarding police officer/staff attitudes to service users with mental health issues and a paucity of such regarding their attitudes to colleagues with mental ill health. It is important that we understand such attitudes as they have an influence on police officer values, behaviours and subsequent actions when dealing with the public or colleagues (Bailey et al., 2001; Bradley, 2009; Adebowale, 2013; Stuart, 2017). By better understanding attitudes, it may be possible to change police cultures and behaviours thus improving attitudes and decreasing mental health related stigma.

Therefore, this research aimed to deliver:

- A comparative analysis of police officer and staff attitudes to mental ill health with members of the public.
- A comparative analysis of police officer and staff knowledge of mental ill health with members of the public.
- A critical exploration of police officer and staff attitudes to mental illness and its impact in the workplace.
- A critical analysis of the factors that underpin these attitudes.

2.2 Compare attitudes to mental ill health

An attitude is "a relatively enduring organization of beliefs, feelings, and behavioural tendencies towards socially significant objects, groups, events or symbols" (Hogg & Vaughan, 2005, p. 150). Attitudes to mental illness can be positive such as acceptance, neutral in the way of tolerance, and negative such as stigma and fear and exclusion (Time to Change, 2016). The Time to Change (2016) report suggested that despite some improvement negative attitudes towards people with mental illness are widespread among the public. Similarly, police professionals have displayed negative attitudes towards people with mental ill health (Pinfold et al., 2003; Cotton, 2004; Clayfield, 2011; Blue Light Programme, 2016; Bell & Palmer-Conn, 2018). People's attitudes toward mental illness influence how they interact with and help support a person with mental illness. Such attitudes also dictate how they experience and express their own emotional problems and whether they choose to disclose the illness and seek help (Link & Phelan, 2013; Corrigan et al., 2015; McManus et al., 2016). Therefore, it is important that police attitudes to those with mental ill health be measured to establish what if any interventions are required to

ensure the police respond appropriately to members of the public and their colleagues who experience mental ill health.

This research contends that the establishment of such measures and results will only provide a partial answer. Policing and those who police do so in the communities they serve. If we are to measure police attitudes, it should not be done in isolation. Arguably, a benchmark can provide data for comparison and help position police attitudes to mental ill health against current norms. To date such, a benchmark is yet to be established in UK policing. However, it is important to ask the question as Yang & Link (2015, p. 2) suggest 'If we are to systematically reduce stigma and improve mental health and mental health care, we must have the capacity to observe and measure stigma.' This research sets out to measure police attitudes to mental ill health and compare the results to that of the general population.

2.3 Compare knowledge of mental health

Alongside positive attitudes, mental health literacy (Jorm, 2000) is one of the key drivers in reducing mental health related stigma (Jorm et al., 2010; Rusch et al., 2011; Kutcher et al., 2016). Jorm (2000, p.396) defined mental health literacy as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention". According to Kutcher et al., (2016, p.567) mental health literacy has four key components "(1) obtaining and maintaining good mental health, (2) understanding mental disorders and their treatments, (3) decreasing stigma and (4) enhancing help-seeking efficacy". Insufficient knowledge underpins negative attitudes and can lead to discrimination.

Like attitudes above, there is very little research on mental health literacy in policing in the UK (University of Greenwich & The Runnymede Trust, 2015). Cummings & Jones (2010) undertook a small-scale examination of the impact of police mental health training in Wales, which improved mental health literacy and interactions with people with mental ill health. Likewise, a larger study by Hansson & Markstrom (2014) in Sweden supported the use of a comprehensive mental health literacy component in police training to deliver positive outcomes for the officers and service users.

Since The Bradley Report (2009) there have been calls for enhanced police training in mental health issues and some forces have done so to greater or lesser extents (Adebowale, 2013; Home Affairs Select Committee, 2018). However, there is no evidence that any force has established a measure of their officer and staff knowledge of mental ill health. Therefore, this research aims to do so and compare those to the wider population.

2.4 Explain attitudes to mental health

Quantitative research, tests theories by measuring and analysing the relationship between variables. It aims to establish general rules of behaviour and phenomenon across different environments and perspectives. In the social setting, it more often consists of a questionnaire consisting of closed questions with a fixed number of options. They are easily analysed and if sample sizes are sufficient and representative can easily be generalised (Fink & Koesecoff, 1996). However, closed questions with fixed responses have their limitations as participants are not provided an opportunity to explain their choice or the rationale for it (O'Cathain & Thomas, 2004). This can be overcome with the inclusion of open-ended questions. O'Cathain & Thomas (2004) suggest that open-ended questions allow participants to elaborate their responses providing a beneficial opportunity to researchers of gaining extra insight and understanding of what is important to the participant. Moreover, such an approach can also confirm or verify other answers.

Thus in order to explain attitudes fully, a more rounded approach is required, which delivers a more holistic picture of the subject (Tashakkori & Creswell, 2007, Castellan, 2010). The use of open questions in the survey will provide a deeper understanding of how police officers and police staff perceive their personal and working environment and explain their attitudes and actions when encountering people with mental ill health.

2.5 Explore lived experience of officers and staff with mental ill health

So far, the aims of this research has been to measure and understand the attitudes of police officers and police staff towards those experiencing mental ill health. Due to the demographics of survey participants and the extent of mental ill health in the general population, it is anticipated a sizable proportion of potential participants are likely to have experienced mental ill health (McManus et al., 2016). However, this is unlikely to be revealed in the survey data. If we are to fully understand how attitudes to mental health play out in policing then it must be important to understand what the lived experiences are of the officers and staff who have or had a mental illness whilst serving in the police. This will provide greater understanding about their lives and the context and culture surrounding mental ill health in policing.

The aim is to identify the factors that are likely to contribute to police officer and police staff mental ill health and explore their experience in the work place according to the officers and staff themselves. The introduction of semi-structured interviews with police

officers and staff can provide a lived world experience of the impact of police colleagues' attitudes to those with mental ill health and rich data to better understand complex phenomena (Kvale, 1996).

2.6 Research aims - Conclusions

Police attitudes to mental ill health are important on two levels. From a public engagement perspective, it is suggested that one third of police public encounters are with people with an identified mental health issue and that in excess of 4,000 people are detained under Mental Health Legislation and removed to a place of safety each year (Morgan & Paterson, 2017). It is for this reason that several authors have rightly researched the quantity and quality of these encounters (Pinfold et al., 2003; Cotton, 2004; Watson et al., 2004; Cummins, 2007; Clayfield et al., 2011). Whilst this is not the primary rationale for this research the data gathered will enable future comparisons to measure changes in police attitudes and whether they track or differ from that of the public they serve.

This study whilst paying cognisance to police and public interface concentrates on the internal interactions between those employed in the police service. Police officers and staff are not immune from experiencing mental health issues (MIND, 2016) and related workplace stigma (Karaffa & Tochkov, 2013; Bell & Eski, 2016; Bullock & Garland, 2017; Turner & Jenkins, 2018). This makes it incumbent on police professionals, those acting in support roles such as unions, staff associations, policing charities and politicians to understand the scope and depth of the impact of mental ill health on the service.

The next chapter explains the research philosophy and overarching methodology to establish a measure of police officer and police staff attitudes to those with mental ill health and attempts to provide an explanation as to why the attitudes prevail.

CHAPTER 3

Overarching methodology and research philosophy

3 Overarching methodology and research philosophy

3.1 Introduction

When considering the methodologies available to answer the research questions it is easy to be drawn towards the arguments, which espouse a quantitative-qualitative dichotomy. However, this was not deemed appropriate on two levels. This research welcomes the opportunities and rewards to be gained from taking a pragmatic approach and implementing innovative mixed method research designs to answer the research questions. By doing so, it is anticipated the researcher will develop as an early career researcher a broad breadth of skills, which will equip him for developing future knowledge in the field.

> 'To a pragmatist, the mandate of science is not to find the truth or reality, the existence of which are perpetually in dispute, but to facilitate human problem solving' (Powell, 2001, p884)

3.2 Research philosophy

A research paradigm is "the set of common beliefs and agreements shared between scientists about how problems should be understood and addressed" (Kuhn, 1962, p. 45). It identifies the necessity for researchers to ensure that their own ontological perceptions, epistemological stances and methods for data gathering and interpretation are closely aligned.

> "Ontology is the study of being. It is concerned with what is, with the nature of existence, with the structure of reality as such. Were we to introduce it into our framework, it would sit alongside epistemology informing the theoretical perspective, for each theoretical perspective embodies a certain way of understanding what (ontology) is as well as a certain way of understanding what it means to know (epistemology)" (Crotty, 1998, p. 10)

By considering their ontology and epistemology, the researcher can understand and relate to how their experiences, values and judgements impacts on how they view and interpret current knowledge and the methodological strategies to be used in seeking further knowledge. Awareness of philosophical assumptions can increase the quality of research and can contribute to the creativity of the researcher.

Guba and Lincoln (1994) adopts an ontological and epistemological stance when defining research philosophies. Research philosophy deals with the source, nature and expansion of knowledge, it is a belief about the ways in which data should be collected, analysed and

reported. Guba & Lincoln (1994) propose four paradigms. In considering the most appropriate philosophy for this study, the following were considered.

Positivism has a scientific origin that advocates quantifiable observations leading to statistical analysis to establish the truth. It favours quantifiable methods where the researcher is limited to data collection and objective interpretation. Positivists believe that researchers should be independent from their studies and there is little or no contact with participants.

Realism advocates the idea of independence of reality from the human mind. Direct realists sees the world through human senses and tends to examine data on a horizontal level. Critical realists have a more open mind and argue that human senses can be unreliable and even illusionary and that humans operate on many levels and report accordingly. This approach favours a number of methods.

Interpretivism also known as constructivism has a humanistic approach and as the name suggests allows the researcher to be subjective and to interpret findings. Interpretists believe that reality is based on personal, social and cultural constructs. In order to understand the reality qualitative methods are preferred.

Pragmatism recognises that there are a plethora of different methods of interpreting the world and how people live. As a result, there are multiple realities and research methods should reflect this. Willig (2008, p. 22) states 'Strictly speaking, there are no 'right' or 'wrong' methods. Rather, methods of data collection and analysis can be more or less appropriate to our research question'. Therefore, qualitative, quantitative or mixed methods are open to pragmatists. Indeed Johnson & Onwuegbuzie (2004) and Denscombe (2007) suggests pragmatism is ideally suited to mixed method studies.

Pragmatic researchers recognise the value in using different, but complementary, strategies to answer research questions. Tashakkori & Teddlie (2003, p. 713) define methodological pragmatism as:

> '[…] a deconstructive paradigm that debunks concepts such as "truth" and "reality" and focuses instead on "what works" as the truth regarding the research questions under investigation. Pragmatism rejects the either/or choices associated with the paradigm wars, advocates for the use of mixed methods in research, and acknowledges that the values of the researcher play a large role in interpretation of results'.

(Creswell & Tashakkori, 2007) suggests that too much reliance on philosophical structures and prevailing paradigms may hamper researchers from developing the tools they require from achieving their objective.

> "Unquestionably, too, as an applied research methodologist my focus is on research designs or procedures, not on philosophical assumptions. Granted, these assumptions cannot be separated from procedures, but I position these assumptions in the background rather than the foreground, admitting openly that I am not a philosopher of education but rather a research methodologist" (Creswell, 2014, p. 11).

Methodological pragmatism involves research design and operational judgements based on 'what works best' when answering the research questions under investigation (Creswell & Plano Clark 2007). Pragmatic researchers are able to think beyond the traditional dichotomy of research methods and fixed paradigms that preoccupy methodological purists (Johnson & Onwuegbuzie 2004). In doing so they can be adaptable and flexible in their approach.

Philosophical assumptions of paradigms

According to Creswell (1997), there are six philosophical assumptions for research, ontology, epistemology, axiology, rhetoric and methodology. There are interdependent relationships between these assumptions, and that relationship formulates an understanding of fundamental philosophical assumptions within a particular paradigm determining how we understand the world (Creswell & Plano-Clark, 2007). Whilst addressing each assumption in turn the case is built for a pragmatic approach to the study.

Ontology seeks to understand the nature of reality. It is important that researchers examine their own ontological stance. The attraction of pragmatic mixed methods research is that it recognises the human element of how a researcher comes to understand the world and identifies the research question. Such an approach sits comfortably because having been a police officer, advocate for police officers with mental health problems and a researcher I believe that each of us has our own unique perspective of the world, shaped over our lifetime, and that an individual's reality is based on personal, cultural and societal experiences. Therefore, it is likely there is more than one reality. If this is the case, then conceivably researchers can only strive to provide multiple perspectives of phenomena, which viewed holistically, can provide better understanding of the problem (Teddlie & Tashakkori, 2009).

Epistemology, how the researcher knows what she or he knows. According to Bryman (2012) epistemology like paradigms have been viewed along quantitative/objective and qualitative/subjective lines. However, Creswell & Plano-Clark (2007) argue against adhering to such divides and suggest that such epistemology is replaced with a principle of practicality. To best answer the research question the researcher is at liberty to collect, analyse and weave the best available sources of data. In fact Teddlie & Tashakkori (2009) have suggested, viewing epistemology as operating on a continuum, rather than two opposing sides, which in all likelihood reflects the majority of researchers. Which also sits comfortably with this research.

Axiology, the role of values in the research and researcher. The role of personal values 'form a component of the context of social research methods in that they may influence the research area, the research questions and the methods employed to investigate these' (Bryman, 2012, p. 7). Bryman takes this a step further suggesting researchers can become overly reliant on certain methods and could be hampered by this. As researchers and their research are implicitly entwined this should be explicitly recognised as a potential influence on the design, management and interpretation of the results of the research.

Rhetoric the language and presentation of research findings. Bryman (2012) suggests academics employ rhetoric to convince or persuade an audience as to a point of view or credibility of their research. They must do so within the framework of academic standards and publishers requirements. Writing styles tend to differ and where formal writing styles and standard definitions are required can be restrictive to those who favour a more informal style that retains the flavour and vernacular of the original accounts in order to allow the voice of the participants to be heard.

Methodology the appropriate methods used in the research process. Traditionally researchers have advocated either a quantitative or a qualitative approach to research. Strict adherence to one principle or the other became known as the 'paradigm wars' (Hammersley, 1992; Oakley, 1999) where debate flourished about the ontological and epistemological stances, which characterise either type of research. The positivist notion of a singular reality, to be discovered by objective and value-free inquiry underpins quantitative research methods. In contrast, qualitative research methods with subjective inquiry is favoured by interpretists (Creswell & Plano-Clark, 2007; Bryman, 2008).

Blandford (2013) dismisses the *'method wars'*. She argues

> 'that there is no single correct 'method', or right way to apply a method: the textbook methods lay out a space of possible ways to conduct a study, and the details of any particular study need to be designed in a way that maximises the value, given the constraints and resources available'. Blandford (2013, p. 5)

Pragmatism attempts to neutralise the quantitative/qualitative argument by suggesting that the most important question is whether the research has helped *''to find out what [the researcher] want[s] to know''* (Hanson, 2008, p. 109). The drive for the pragmatist is not adherence to a particular paradigm but the use of methods, which will answer the research question.

> 'Pragmatism can be used as a guide not only for top-down deductive research design but also for grounded inductive or abductive research. It offers the chance to produce a ''properly integrated methodology for the social sciences'' (Morgan, 2007, p. 73)

In summary, pragmatism is not committed to any one philosophy or interpretation of reality. The methodology can be driven by the problem being studied and the questions that are asked. Pragmatism focuses on outcomes where truth or knowledge is based on what works at the time.

Insider/Outsider

The relationship between a researcher and their field of study and those who inhabit it has been subject to much debate. One such aspect of researcher positionality is that of the insider/outsider. Merton (1972, p. 21) defines these research players*: 'Insiders are the members of specified groups and collectivities or occupants of specified social statuses; Outsiders are the non-members.'*

Merton (1972) summarized two opposing views as the Insider Doctrine and the Outsider Doctrine. The Outsider Doctrine values researchers from outside the communities they study. Seeing them as neutral, detached observers who are valued for their objectivity arguing insider researchers are unable analyse clearly that of which they are a part. The Insider Doctrine, claim that outsider researchers will never truly understand a culture or situation if they have no experience of it. They contend that insiders are uniquely positioned to understand the experiences of groups of which they are members.

There are advantages and disadvantages associated with each of these players. Insiders can often engage with participants more easily and use their shared experiences to gather richer data (Dwyer & Buckle, 2009). In contrast, they may find it difficult to separate their personal experiences from those of their participants and are open to potential bias when analysing and interpreting results (Serrant-Green, 2002). Confidentiality maybe an issue when interviewing members of their community about sensitive subjects (Serrant-Green, 2002). Outsiders are frequently valued for their neutrality and emotional distance from a situation, but may find it difficult to gain access to niche research participants (Kanuha, 2000).

In keeping with the pragmatic approach to this study, dichotomous models maybe useful for academic debate but can overlook real world. More suited to this research is what Dwyer & Buckle (2009, p.54) refer to 'as the space' between. In doing so they recognise the changing roles of researchers, where researchers' identities, cultural backgrounds, and relationships to participants can vary within the same project and all these will influence how they are positioned in relation to participants and their research.

As such, the insider/outsider doctrines and the 'space in-between' was acted out during this research. If one were to attempt to categorise this researchers role it would be 'Outsider Insider' (Brown, 1996) being a retired police officer turned academic I have intimate knowledge of the organisation and culture but as an academic maybe viewed with suspicion. Similarly, my relationship with police staff may differ to that of police officers and with police officers and staff who have experienced mental ill health.

Historically academics find access to the police difficult (Turner & Jenkins, 2018). However, being a retired police officer and Police Federation Official in my policing career this opened doors to PFEW as a gatekeeper and their membership. Access to police staff members via Unison was more difficult despite introductions from local Unison officials. Researching interview participants was relatively easy within my old geographic region of policing as I had good relationships with colleagues in local forces to act as gatekeepers and referees. Although I had secured the assistance of a gatekeeper at a national police mental health support organisation, I did not have any credence amongst them and initially volunteers were slow to respond. However, once I had conducted an interview with a long-standing member of the group additional participants contacted me and referred me to other officers/ staff who also wished to be interviewed. The insider/outsider dynamic flowed and ebbed.

3.3 Description of research design and approach

Whereas quantitative methods lend itself to numerical data and statistics producing impersonal objective reports (Bryman, 2012), qualitative methods produces written documentation from observations, interviews or participation resulting in identifying themes and patterns to enable the report to be written (Castellan, 2010). Quantitative research and data can miss the nuances of personal feelings that qualitative data collection methods were developed to capture and express human feelings and emotions not readily identified in qualitative studies (Walliman, 2005).

Bryman (2012, p. 181) argues that applying a 'natural science model is inappropriate for studying the social world'. He goes on to state that qualitative research sees the world from 'the perspective of those being studied – what they see as important and significant – provides the point of orientation' so that 'the researcher can see the world from their eyes'(Bryman, p. 408).

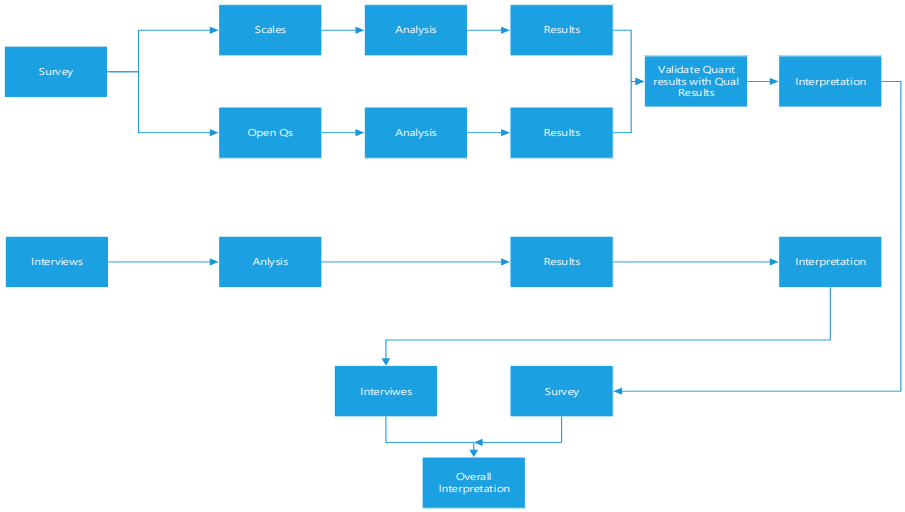
However, Bryman (2012, p. 19) suggests 'we should be wary of driving a wedge between them'. Those in favour of mixed methods are of the opinion that the two methods complement each other, providing a more holistic picture of the subject and that no singular approach can capture the full set of events or issues in connection with people based studies (Tashakkori & Creswell, 2007; Castellan, 2010). Therefore, a mixed method approach can provide a more holistic outcome.

Mixed methods is defined by Tashakkori and Creswell (Tashakkori & Creswell, 2007, p. 4) as 'research in which the investigator collects and analyses data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or a program of inquiry'. Creswell and Plano Clark (2007) provides a more comprehensive definition drawing in philosophical assumptions,

> 'Mixed methods research is a research design with philosophical assumptions as well as methods of inquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone.' Creswell and Plano Clark (2007, p5)

This study employed a simultaneous, Triangulation Validating Quantitative Data Model (Creswell & Plano-Clark, 2007). The first phase consisted of collecting quantitative data alongside qualitative data (Scale and open questions) and conducting additional qualitative data (semi-structured interviews). The intention was to explain quantitative results with in-depth qualitative data.

Figure 1: Survey design



A mixed-method approach consists of more than collecting and analysing more than one kind of data. By collecting and analysing a combination of data sets, the researcher can build a stronger study than relying on just one source of data (Creswell, 2014). "In quantitative research, theories are tested by assessing the relationship among variables. These variables typically can be measured on instruments so that numerical data can be analysed using statistical procedures" (Creswell, 2014, p. 4). On the other hand, qualitative research "is an approach for exploring and understanding the meaning individuals or groups ascribing to a social or human problem" (Creswell, 2014, p. 4). By using a mixed methodology, the researcher is "integrating the two forms of data and using distinct designs that may involve philosophical assumptions and theoretical frameworks" (Creswell, 2014, p. 4).

By using a mixed-methods approach researchers are able to use all the 'tools' available to them. However, this can create challenges as extra time and resources are required. However mixed methodology can make up for perceived weakness in quantitative and qualitative studies providing more comprehensive data affording greater understanding of the research findings (Tashakkori & Teddlie, 2003). Furthermore, mixed methods are

especially useful in identifying and understanding contradictory and unexpected findings (Wisdom et al., 2011).

Triangulation is a method used by researchers to establish validity by analysing the research data from multiple perspectives. Bryman (2012) defines triangulation as 'The use of more than one method or source of data in the study of a social phenomenon so that findings maybe cross checked' (Bryman, 2012, p. 717). The advantages of triangulation include "increasing confidence in research data, creating innovative ways of understanding a phenomenon, revealing unique findings, challenging or integrating theories, and providing a clearer understanding of the problem" (Thurmond, 2001, p. 254). These benefits largely result from the variety and extent of data that can be used for analysis.

However, Bazely (2014) warns,

> "Mixed methods are inherently neither more nor less valid than specific approaches to research. As with any research, validity stems more from the appropriateness, thoroughness and effectiveness with which those methods are applied and the care given to thoughtful weighing of the evidence than from the application of a particular set of rules or adherence to an established tradition" (Bazely , 2004, p. 149).

Therefore, it is vitally important that the research design is fit for purpose and not merely increasing the methods used with no additional value.

3.4 Key decisions

3.4.1 Data Gathering

From the outset, one of the overriding aims for this research was how to best use the results to identify key issues to inform and influence stakeholders to drive change in policy. It could reasonably be expected that in order to do so stakeholders such as chief officers and staff associations/unions would require a well informed and reaching breadth of data, which would challenge existing attitudes, policies and procedure and provide direction for improving them.

As described above the Attitudes to Mental Illness Scale (Time to Change - TNS BMRB, 2015) was the foundation stone in this research. A proven technique, not used previously in policing to measure attitudes towards mental illness. The intention here not just to measure police attitudes but also to benchmark them to the wider population. This would provide sound statistical data to analyse, interpret, comment upon and draw conclusions. However, it felt as if something was missing, a voice for the participants. Potentially there

was a national pool of prospective officers and staff who had the opportunity to comment and explain how their attitudes swayed or lead to the scores provided. There is sound theory to support this approach (Creswell & Plano Clarke, 2007; Tashakkori & Creswell, 2007; Castellan, 2010; Singer & Couper, 2017) which arguably would result in increased breadth and representativeness of the survey (Singer & Couper, 2017). On the other hand, such an approach requires a broader skills base and results in increased workload and demands on time (Bryman, 2012; Creswell, 2014). Thus, the adoption of the open questions required a greater personal investment in the project but the result was more appealing and arguably worth the investment.

The subscales within the AMI (Time to Change - TNS BMRB, 2015) were designed for a generic population and lacked a specific police dimension. It was anticipated that a work based scale examining the relationships with colleagues and supervisors alongside questions about how mental health is viewed within policing would provide supporting data and the ability to make further observations and commentary. This required the development of a new police scale to compliment the AMI (Time to Change - TNS BMRB, 2015) which mirrored the closed and open questions format discussed above.

The combined survey had the potential to deliver enough data to provide evidence of the current attitudes to mental ill health in policing. The use of open and closed questions provided a level of triangulation to give validity and confidence to the study (Thurmond, 2001; Bryman, 2012) and establish the desired benchmark. However, from my experience as a 'Fed Rep' an additional step was required to explain how attitudes to mental ill health are concealed and revealed in the work and personal lives of police officers and staff. Hence, the inclusion of semi-structured interviews with the intention of providing further triangulation of the survey data.

3.4.2 Data Analysis and findings

The chosen approach involved a mass of data. The CAMI subscales (Taylor & Dear, 1981) alone had four subscales with 27 statements with between 33 and 179 open responses made per statement. This resulted in a dilemma whether to analyse and report at sub scale level or to drill down into the individual statements, the latter increasing the analysis burden. Using the Fear & Exclusion subscale as a pilot revealed that the individual statements and open responses provided nuances not identified in the subscale total or collective open responses. This became more evident in the Integrating People with Mental Ill Health into the Community subscale where the tensions between personal beliefs and policing experiences were revealed, justifying the microanalysis.

The initial response to data analysis and reporting of the findings was to combine the open and closed questions as combined elements and to follow this up with the semi-structured interviews. However, this proved unwieldy and unworkable providing an overwhelming collection of data lacking fluidity when written up. Thus, the quantitative components of the AMI Scale (Time to Change - TNS BMRB, 2015) were analysed first and reported on in turns, followed by the police scale and ultimately the semi-structured interviews. This method provided the sequential build-up of the data where each step added value to the preceding findings and discussion.

In summary, only a mixed methods study that included quantitative and qualitative methods could provide the data required for a comprehensive multilevel assessment of police attitudes to mental ill health.

3.5 Research outline

The study consisted of a Likert Scale survey with open-ended questions and semi-structured interviews conducted with police officers and staff who had experienced mental ill health whilst serving in a police force in England and Wales.

For the survey, police officer responses were collected from 33 out of the 43 Home Office forces plus British Transport Police. Police staff responses were collected from 19 forces. Interviews were undertaken with 33 officers and staff from 12 forces.

The survey data was collected between 21/7 /16 to 12/8/16 and interviews from 13/12/16 to 13/4/17.

Population – Setting and sample

The target population consisted of 124,000 police officers and 76841 police staff up to and including the rank of chief inspector and police staff up to grade H working in Home Office Forces in England and Wales and the British Transport Police.

Ethical approval

LJMU Research and Ethics Committee reviewed and approved the study. Committee Reference, 15/HSS/002 -9/2/15.

This research involves human participants and ethical considerations were addressed in line with LJMU Ethics Guidelines and The Research Ethics Guidebook (Economic & Social Research Council, 2016). As such, the following measures were taken:

Survey - Participants were fully informed of the aims and nature of the research and were recruited by email via Gatekeepers PFEW and UNISON. A participation information sheet accompanied the email with an invitation to partake in the survey. The participant information sheet highlighted the fact that taking part implied consent. This was reinforced in the opening and closing statements.

Interview participants were fully informed of the aims and nature of the research and were free to withdraw at any stage of the research (up to submission of the thesis). They were made aware that quotes from the interview would form part of the final report on the research and any related published reports but that these would be anonymised. A participant information sheet and informed consent form was used that set out the aims and nature of the research, confidentiality and right to withdraw.

Data Protection: Interviews were recorded on a PIN protected Dictaphone and transcribed by an employee of a Police Federation Brach Board with the appropriate expertise. All participants were allocated a pseudonym and location names, venues etc. were replaced to ensure anonymity. Transcribed anonymised interviews were stored on LJMU password protected I.T. systems and recordings deleted. Personal details did not appear on any forms or paperwork. The identity of the participants remains confidential. All data was used solely for the purposes of the project.

Deception: No deception was involved

Risks and protection from harm

Participants: There was a risk that discussing mental health issues or recalling the experience of traumatic events could have been upsetting for participants. Risk was minimised by advising participants of the interview topics, advising them of this risk and reminding them of their right to withdraw. Officers and staff were sign posted to relevant support networks. Although risks were minimised, the researcher accepted that they still existed but that the potential benefits of the research warranted the means.

Researcher: Although the focus of the interviews was not on traumatic events, it was possible that the researcher would be exposed to such accounts. This had the potential to cause secondary trauma in the researcher. This risk was minimised by the researcher's knowledge of secondary trauma and LJMU control measures such as access to counselling and peer support.

Debriefing: Participants were fully debriefed by informing them of the research process, thanking them for their help and asking for any questions or comments, they may have had regarding their experience.

Limitations

The Time To Change - TNS BMRB, (2015) public survey employs random location sampling techniques to ensure respondents reflect the national profile for geography and social-economic status. TNS BMRB Trained staff conducted the survey in respondents' homes using Computer-Assisted Personal Interviewing (CAPI). Such an option was not open to the researcher. The Police Federation of England and Wales (PFEW) distributed the police survey via email to serving police officers and UNISON did likewise to individual Branch Boards for onward transmission to police staff members. The difference in data collection can affect results. However, online surveys are deemed effective methods of data gathering. Research suggests respondents may find it easier to answer sensitive issues and are more likely to answer open questions in depth in an online questionnaire (Tourangeau et al., 2003. Furthermore, a similar approach was undertaken by Brooker & Sirdifield (2009) to compare attitudes of probation staff with the public, Glendenning & O'Keefe (2015) did likewise with police officers and the public.

The research is one of the largest of its kind benefiting from a nationwide survey with police officer responses from three quarters of all police forces in England and Wales. (It should also be noted that Time to Change survey is restricted to England). The response rate differed across individual Forces varied from single figures into several hundred. A more equally distributed response would allow for Force and regional comparisons. Additionally further analysis is required to ascertain demographic impacts on attitudes to mental health.

3.6 Summary

This research takes a pragmatists approach, believing that human beings can and do influence their social world, and that categories and concepts within society can be considered to be socially constructed and that there are many approaches to understanding those views. This becomes evident from the findings and results that follow in the next chapter.

Chapter 4

Measuring attitudes

4 Measuring attitudes

4.1 CAMI Scale methodology

The study employed the Attitudes to Mental Health Illness Questionnaire (TNS BMRB, 2015). This consists of four subscales, Fear and Exclusion, Understanding and Tolerance, Integrating People into the Community and Causes and Needs of People with Mental Illness measured on a five point Likert scale. The intention to identify people who accept or reject people with mental illness within their community. The statements cover a wide range of issues, such as attitudes towards people with mental illness and opinions on service provision for people with mental health problems. The Attitudes to Mental Health Illness Questionnaire was developed from the Community Attitudes to Mental Health Index (CAMI) (Taylor & Dear, 1981). Variations of this questionnaire have been used effectively in several countries to test public attitudes to mental health and that of health care professionals (Chambers et. al., 2010; Morrison, 2011; Friedrich & Evans-Lacko, 2013) and with police officers (Clayfield et. al., 2011; Hansson & Markstrom, 2014; Glendinning & O'Keefe, 2015). The total scores are calculated so that higher CAMI scores indicate less stigmatising attitudes (where appropriate statements were reverse coded to reflect the direction of the correct response). Its overall internal consistency in the data measured using Cronbach's α is 0.87.

A survey is a research technique that employs questionnaires or structured interviews, to collect data from a sample representation of a population to which the findings of the data analysis can be generalised (Bryman, 2012). This research employed a questionnaire with open and closed questions. By using open and closed questions in the questionnaire, it provides participants with the opportunity for personal expression whilst collecting the statistical data required to identify patterns and relationships from closed questions (Bryman, 2012). As can be seen in Chapters 4 and 5 the survey encompassed open and closed questions providing an ability to triangulate and integrate quantitative and qualitative data, one of the most powerful tools in survey analysis (Thurmond, 2001).

The majority of the questions sought the participants to respond to a number of statements the majority of which were previously used and widely accepted Scales to measure knowledge and attitudes to mental ill health (Corrigan et al., 2012). Generally, questionnaires consists of a series of closed questions with a fixed number of options. They

are easily analysed and if sample sizes are sufficient and representative can easily be generalised (Fink & Koesecoff, 1996).

The survey was distributed by the Gatekeepers, The Police Federation of England and Wales & UNISON, utilising Survey Monkey (online survey software) using an anonymous email based questionnaire to ascertain serving police officers and staff attitudes to people and colleagues with mental health issues. The survey consisted of Likert Scale closed questions and an open question invitation to make comment if so wished. Survey data was transferred from PFEW to the researcher via email with a secure password. It was then stored on LJMU secure server with password protection.

4.2 CAMI Scale data analysis

In order to establish a benchmark the police data has been analysed in comparison to the results of the Time to Change annual survey, which examines the changing public attitudes to mental health. TNS BMRB provided a bank of statements and raw data from the 2015 public survey to the researcher for direct comparison with the police data. This was provided as an Excel spreadsheet and imported into Statistical Package for the Social Sciences (SPSS) a quantitative analysis software tool.

The data collection procedures were implemented in two phases. Phase 1 consisted of an electronic copy of the survey being distributed by email. Once the survey results were collected, the data was entered onto SPSS to calculate the mean measurement of central tendency, the standard deviation and the standard error. The mean and standard deviation were analysed to provide numerical values that were used to compare public survey results against the police survey results. Dependent on the number of items being compared statistical differences were established by using either a two tailed t test or ANOVA. The numerical data produced by SPSS was utilized to establish statistical themes in order to produce narratives.

4.3 CAMI Scale results

Table 2. Total mean sub-scale and total mean CAMI scale

Mean Scores	Public	Police officers	Police staff	p Value	F Value
Fear and exclusion Max Score 40	32.57	32.74	34.14	0.001	11.95
Post-hoc Test: public vs officers: p=0.462, public vs staff: p=0.001*, officers vs staff: p=0.001*					
Understanding and tolerance Max score 35	31.28	31.35	32.12	0.001	8.49
Post-hoc Test: public vs officers: p=0.396, public vs staff: p=0.001*, officers vs staff: 0.009*					
Integration into the community Max score 45	34.28	32.11	34.04	0.001	44.71
Post-hoc Test: public vs officers: p=0.001*, public vs staff: 0.995, officers vs staff; 0.001*					
Causes and needs Max score 15	11.52	12.99	13.05	0.001	113.97
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.804					
Total CAMI Max Score 135	109.64	109.51	113.83	0.001	12.878
Post-hoc Test: public vs officers: p=0.973, public vs staff: p=0.001*, officers vs staff: p=0.001*					

The results above indicate that police officers and staff like members of the public generally hold positive attitudes about mental ill health. However, they do differ. A one-way between subjects ANOVA was conducted to compare the public, police officers and police staff response to the Total CAMI scores. Between the groups at the $p<.05$ level for the three groups [$F(2, 2799) = 12.876$, $p = 0.001$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for police staff (M =113.83, SD = 11.86) was significantly different from the police officer group (M=109.51, SD 12.25) and the public group (M=109.64, SD = 14.19). However, police officers were not significantly different to the public. This suggest members of police staff were less fearful and more inclusive about people with mental ill health than their police officer colleagues and the public. The following sections will examine these more in more detail with analysis of the subscales.

4.3.1 Fear and exclusion of people with mental illness

This section explores fear and exclusion of people with mental illness. The below statements portray less favourable or negative attitudes towards people with mental illness. The analysis in this section focuses on the percentage of respondents agreeing with each of these statements (i.e. displaying a negative attitude). (See appendix 1 for percentage results)

Table 3. Fear and exclusion of people with mental illness sub-scale results

Mean Scores Fear and Exclusion	Public	**Police officers**	Police staff	p Value	F Value
Q47. Locating mental health facilities in a residential area downgrades the n'hood	3.99	3.49	3.84	0.001	49.01
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.104, officers vs staff: p=0.001*					
Q46. It is frightening to think of people with mental problems living in residential n'hoods	4.12	4.10	4.21	.337	1.09
Post-hoc Test: public vs officers: p=0.888, public vs staff: p=0.41, officers vs staff: 0.309					
Q38. I would not want to live next door to someone who has been mentally ill	4.14	3.50	3.91	0.001	87.93
Post-hoc Test: public vs officers: p=0.001*, public vs staff: 0.003*, officers vs staff; 0.001*					
Q37. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered	4.07	4.38	4.52	0.001	39.81
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.122					
Q39. Anyone with a history of mental problems should be excluded from taking public office	3.87	4.30	4.41	0.001	57.42
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.323					
Q36. People with mental illness should not be given any responsibility	4.05	4.44	4.54	0.001	62.92
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.356					
Q33. People with mental illness are a burden on society	4.44	4.16	4.38	0.001	21.1
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.567, officers vs staff: p=0.005*					
Q24. As soon as a person shows signs of mental disturbance, he should be hospitalized	3.90	4.50	4.50	0.001	100.7
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.992					
Total Fear and exclusion (Max score 40)	32.57	32.74	34.14	0.001	11.95
Post-hoc Test: public vs officers: p=0.462, public vs staff: p=0.001*, officers vs staff: p=0.001*					

Examination of the statements within Fear and Exclusion (table 3) subscale indicates that police staff scored higher on the subscale than members of the public and police officers. A one-way between subjects ANOVA was conducted to compare the three groups. Between the groups at the p<.05 level for the three groups [F(2, 2799) = 11.95 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for police staff (M =34.3, SD = 4.85) was significantly different from the police officer group (M=32.85, SD 5.03) and the public group (M=32.57, SD = 5.93). However, police officers were not significantly different to the public.

Note: ANOVA results are only reported where there are statistically significant differences.

Further analysis of the sub scale reveals that police officers and police staff are less likely to disagree with the statements **Q47 'Locating mental health facilities in a residential area downgrades the neighbourhood'** *(ANOVA Between the groups at the p<.05 level for the three groups [F(2, 2799) = 49.01 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for police officer group (M=3.49, SD 1.16) was significantly different than police staff (M =3.84 , SD = 1.17) and the public (M=3.99, SD = 1.16))* **and Q38 'I would not want to live next door to someone who has been mentally ill'** *(Q38: ANOVA Between the groups at the p<.05 level for the three groups [F(2, 2799) = 87.93 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for each group was significantly different, police staff (M =3.91, SD = 1.14), police officer (M=3.50, SD 1.18) and public (M=4.14, SD = 1.08) from each other.* It is of note that statements **Q47 'Locating mental health facilities in a residential area downgrades the neighbourhood'** had scores of less than 4.0 across the groups.

However, police officers were the most likely to agree with the statement, **Q33, People with mental illness are a burden on society** (ANOVA Between the groups at the p<.05 level for the three groups [F(2, 2799) = 21.1 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for each group was significantly different with police officer (M=4.16, SD 1.04) differing from the public (M= 4.44, SD = 0.93) and police staff (M =4.36, SD = .98) who held similar views.

4.3.2 Understanding and tolerance of mental illness

This section explores understanding and tolerance of mental illness. Analysis in this section focuses on the understanding/tolerance dimension of each statement. As there are positive and negative statements about these attitudes, for some statements this is the

percentage agreeing, for others it is the percentage disagreeing. (See appendix 1 for percentage results.)

Further analysis of the mean scores provides a deeper insight into the differences between the groups.

Table 4. Understanding and tolerance of mental illness sub-scale results

Mean Scores Understanding and Tolerance	Public	Police officers	Police staff	p Value	F Value
Q31. We have a responsibility to provide the best possible care for people with mental illness	4.67	4.64	4.80	0.002	6.04
Post-hoc Test: public vs officers: p=0.788, public vs staff: p=0.004*, officers vs staff: p=0.002*					
Q28. Virtually anyone can become mentally ill	4.65	4.90	4.88	0.001	46.88
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: 0.995					
Q34. Increased spending on mental health services is a waste of money	4.52	4.66	4.71	0.001	13.18
Post-hoc Test: public vs officers: p=0.001*, public vs staff: 0.001*, officers vs staff; 0.631					
Q32. People with mental illness don't deserve our sympathy	4.52	4.66	4.71	0.001	12.12
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.715					
Q30. We need to adopt a far more tolerant attitude toward people with mental illness in our society	4.55	4.34	4.54	0.001	18.04
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.986, officers vs staff: p=0.001*					
Q29. People with mental illness have for too long been the subject of ridicule	4.18	4.36	4.51	0.001	21.49
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.071					
Q44. As far as possible, mental health services should be provided through community based facilities	4.21	3.91	4.03	0.001	25.89
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.013*, officers vs staff: p=0.154					
Total Understanding and tolerance (Max score is 35)	31.28	31.35	32.12	0.001	8.49
Post-hoc Test: public vs officers: p=0.396, public vs staff: p=0.001*, officers vs staff: 0.009*					

Examining the total subscale score, overall police officers appear to share similar views with the public whilst police staff appear to be significantly more understanding and tolerant of

mental illness. A one-way between subjects ANOVA was conducted to compare the three groups. Between the groups at the p<.05 level for the three groups [F(2, 2799) = 8.49 p = 0.002]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for police staff (M =32.12, SD = 2.86) was significantly different from the police officer group (M=31.35, SD 3.03) and the public group (M=31.28, SD = 3.66) who shared similar views.

Results from **Q 31 'We have a responsibility to provide the best possible care for people with mental illness'** (% agreeing) suggests police officers and members of the public share similar views with police staff holding better views. (ANOVA Between the groups at the p<.05 level for the three groups [F(2, 2799) = 6.04 p = 0.002]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for the public (M=4.67, SD = 0.67) and police officer (M=4.65, SD 0.72) were similar but significantly different to police staff (M =4.80, SD = 0.54))

Police staff with their police officer colleagues are less supportive of the statement **Q44 As far as possible, mental health services should be provided through community based facilities' t**han the public (ANOVA Between the groups at the p<.05 level for the three groups [F(2, 2799) = 25.89 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for public group (M=4.20, SD 0.94) was significantly different from police officers (M =3.91, SD = 0.98) and police staff (M=4.03, SD = 1.01) who shared similar views.

In response to statement **Q30 'We need to adopt a far more tolerant attitude toward people with mental illness in our society' (**% agreeing) police officers were far less likely to support the statement compared to members of the public or police staff who shared similar views. (ANOVA Between the groups at the p<.05 level for the three groups [F(2, 2799) = 21.5 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for police group (M=4.34, SD 0.87) was significantly different than public (M =4.55, SD = 0.76) and police staff (M=4.54, SD = 0.74)) who shared similar views.

4.3.3 Integrating people with mental illness into the community

This section explores the theme of integrating people with mental illness into the community. There are positive and negative statements about these attitudes, for some this is the percentage agreeing, for others it is the percentage disagreeing. (See appendix 1 for percentage results.) Further analysis of the mean scores provides a deeper insight into the differences between the groups, see Table 5.

Table 5. Integrating people with mental illness into the community sub-scale results

Mean Scores Integrating people with mental illness into the community	Public	Police officers	Police staff	p Value	F Value
Q41. People with mental illness are far less of a danger than most people suppose	3.83	3.66	3.77	0.004	5.5203
Post-hoc Test: public vs officers: p=0.003*, public vs staff: p=0.743, officers vs staff: p=0.332					
Q26. Less emphasis should be placed on protecting the public from people with mental illness	3.11	2.39	2.76	0.001	98.14
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: 0.001*					
Q43. The best therapy for many people with mental illness is to be part of a normal community	4.27	3.8	4	0.001	67.679
Post-hoc Test: public vs officers: p=0.001*, public vs staff: 0.001*, officers vs staff; 0.007*					
Q45. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services	4	3.57	3.8	0.001	40.827
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.01*, officers vs staff: p=0.008*					
Q48. People with mental health problems should have the same rights to a job as anyone else	4.24	4.27	4.47	0.001	7.23
Post-hoc Test: public vs officers: p=0.671, public vs staff: p=0.001*, officers vs staff: p=0.009*					
Q42. Most women who were once patients in a mental hospital can be trusted as babysitters	3.07	3.22	3.32	0.001	9.214
Post-hoc Test: public vs officers: p=0.006*, public vs staff: p=0.001*, officers vs staff: p=0.361					
Q25. Mental illness is an illness like any other	4.17	4.33	4.59	0.001	17.982
Post-hoc Test: public vs officers: p=0.006*, public vs staff: p=0.001*, officers vs staff: p=0.003*					
Q40. No-one has the right to exclude people with mental illness from their neighbourhood	4.44	4.36	4.54	0.019	3.9815
Post-hoc Test: public vs officers: p=0.133, public vs staff: p=0.2356, officers vs staff: p=0.019*					
Q27. Mental hospitals are an outdated means of treating people with mental illnesses	3.15	2.65	2.96	0.001	44.382
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.04*, officers vs staff: p=0.001*					
Total (Max Score is 45)	34.28	32.11	34.04	0.001	44.71
Post-hoc Test: public vs officers: p=0.001*, public vs staff: 0.995, officers vs staff; 0.001*					

Examining the total subscale score, overall the public and police staff appear to share similar views whilst police officers appear to be significantly less supportive of integrating people with mental illness into the community. A one-way between subjects ANOVA was conducted to compare the three groups. Between the groups at the p<.05 level for the three groups [F(2, 2799) = 44.71 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for police officers (M =32.11, SD = 5.23) was significantly less than the public (M=34.28, SD 5.13) and the police staff (M=34.04, SD = 5.01) who shared similar views. Throughout the majority of the scale, police officers scored lower than the public or police staff colleagues did.

Note: ANOVA results are only reported where there are statistically significant differences. The following statements all had significantly different results to each other with police officers consistently reporting comparatively lower scores than recorded in this and other subscales.

Q26 'Less emphasis should be placed on protecting the public from people with mental illness' (A one-way between subjects ANOVA was conducted to compare the three groups. Between the groups at the p<.05 level for the three groups [F(2, 2799) = 98.14 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for public (M =3.11, SD = 1.25) was significantly different to police officers (M=2.39, SD 1.12) and police staff (M =2.76, SD = 1.15) who were significantly different to each other). It is of note that scores for the statement for the police family were less than 2.8 and less than 3.2 for the public.

Q27 'Mental hospitals are an outdated means of treating people with mental illnesses' (A one-way between subjects ANOVA was conducted to compare the three groups. Between the groups at the p<.05 level for the three groups [F(2, 2799) = 44.38p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for public (M =3.15, SD = 1.22) was significantly different to police officers (M=2.64, SD 1.23) and police staff (M=2.96, SD = 0.86) who were significantly different to each other).

4.3.4 Causes of mental illness and the need for special services

This section reports on statements about the causes of mental illness and the need for special services. The below statements portray less favourable or negative attitudes towards people with mental illness. In line with the Attitudes to Mental Illness Survey Research Report (2016), the analysis in this section focuses on the percentage of

respondents disagreeing (reverse scored) with each of these statements (i.e. displaying a negative attitude). (See appendix 1 for percentage results.)

Table 6. Causes of mental illness and the need for special services sub-scale results

Mean Scores	Public	Police officers	Police staff	P Value	F Value
Q35. There are sufficient existing services for people with mental illness	3.53	4.44	4.38	0.001	201.657
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.0.001*, officers vs staff: p=0.744					
Q22. One of the main causes of mental illness is a lack of self-discipline and will-power	4.05	4.32	4.38	0.001	23.08
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: 0.71					
Q23. There is something about people with mental illness that makes it easy to tell them from normal people	3.95	4.25	4.34	0.001	28.616
Post-hoc Test: public vs officers: p=0.001*, public vs staff: 0.001*, officers vs staff; 0.528					
Causes and needs (Max score is 15)	11.52	12.99	13.05	0.001	113.97
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.804					

Examining the total subscale score, overall the police officers and police staff appear to share similar, more positive views, whilst the public appear to be significantly less understanding of Causes of mental illness and the need for special services. A one-way between subjects ANOVA was conducted to compare the three groups. Between the groups at the $p<.05$ level for the three groups [$F(2, 2799) = 113.97$ $p = 0.001$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for police officers ($M =12.99$. $SD = 1.93$) was similar to police staff ($M=13.05$, SD 2.04) whilst the public ($M=11.52$, $SD = 2.74$) was significantly different to both groups. Throughout the majority of the scale public scored lower than police officers and police staff colleagues.

As with the total score above, analysis of all three individual statements indicated police officers and staff shared similar views, which were statistically different to members of the public who were less supportive in each case:

4.4 CAMI Scale discussion

The literature search suggests that UK police officers (MIND, 2015; Houdmont & Elliot-Davies, 2016) and police staff (UNISON, 2014) have high levels of poor mental ill health and that there is ‘a police culture that discourages officers from revealing any signs of fragility’ (Turner & Jenkins, 2018, p. 8).

The majority of researchers examining police attitudes towards mental ill have concentrated on police public encounters (Pinfold et al., 2003; Cotton, 2004; Watson 2004; Clayfield et al., 2011; Hansson & Markstrom, 2015; Lane, 2019). Growing in number but less well established are those examining attitudes to mental ill health within the workforce (Royle et al., 2009; Karaffa and Tochkov, 2013; Bullock & Garland, 2017; Turner & Jenkins, 2018; Soomro & Yanos, 2018).

The employment of attitudinal assessment tools to measure police officer attitudes to mental ill health is quite rare. Pinfold et al., (2003) in an English study employed a variation of the Taylor and Dear (1981) Community Attitudes to Mental Illness Scale (CAMI) scale to measure police attitudes pre and post mental health intervention training to measure such attitudes. Hansson & Markstrom (2014) undertook a similar study pre and post officer training in Sweden. Cotton (2004) employed the CAMI scale in a Canadian study to measure patrol officer attitudes. Clayfield et al. (2011) in a study in the USA adopted the CAMI scale and Cottons research to produce the Mental Health Attitude Survey for Police. More recently in England Glendenning & O'Keefe (2015) developed the Police and Community Attitudes towards Offenders with Mental Illness Scale (again an adaption of the CAMI Scale). In a similar vein Soomro & Yanos (2018) (USA) and Stuart (2017) (Canada) have developed scales to measure mental health stigma amongst police officers.

It should be noted that TNS/Time to Change Attitudes to Mental Illness Scale does not directly mirror the CAMI scale. The themes are similar but statements have been redistributed within subscales (Evans-Lacko et al., 2010). For example the Community Mental Health Ideology Subscale (CMHI) within CAMI contains twelve statements whereas the Integrating people with Mental Illness into the Community subscale in the Attitudes to Mental Illness scale only contains nine statements of which two are from the CHMI and the remainder Understanding and Tolerance and Fear and Exclusion sub scales. Therefore, direct comparison would not hold scrutiny.

Unfortunately, much of the literature paints a picture of a UK police service where stigmatization towards people with mental ill health is still prevalent (Bell and Eski, 2015; Koskela et al., 2015; Bullock and Garland, 2017; Bell & Palmer- Conn, 2018; Turner & Jenkins, 2018; Lane, 2019). Which begs the question is this a police issue or a societal issue? The wider literature suggests that it is wide spread in UK society (Evans-Lacko et al., 2013; Time to Change - TNS BMRB, 2015), in the emergency services (Blue Light Programme,

2016) and even amongst the caring professions (Wallace, 2010; Chambers et al., 2010). Such negative attitudes prevail in wider spheres than policing.

Police personnel operate not only as service providers to people with mental ill health but also as co-workers with colleagues who may be facing similar issues. How police officers and staff deal with service users and their contemporaries can have a considerable impact on their ensuing quality of life. Sir Robert Peel , the founder of modern UK policing declared 'The police are the public and the public are the police; the police being only members of the public who are paid to give full time attention to duties which are incumbent on every citizen in the interests of community welfare and existence.' (Reith, 1952, p. 154). Therefore, one would expect those who deliver policing might share similar views to the public they serve. Which begs the question how do the police compare to the public when measuring attitudes towards mental illness? To date such, a benchmark has not been established in UK policing. However, it is important to ask the question as Yang & Link (2015, p. 2) suggest 'If we are to systematically reduce stigma and improve mental health and mental health care, we must have the capacity to observe and measure stigma.'

Discussion

The Attitudes to Mental Health Illness Questionnaire (TNS BMRB, 2015) consists of four subscales, Fear and Exclusion, Understanding and Tolerance, Integrating People into the Community and Causes and Needs of People with Mental Illness measured on a five point Likert scale. The scale is used to identify people who may accept or reject people with mental illness within their community. Taking each subscale in turn, the statements within the subscales reflect certain attitudes that are associated with the stigma and discrimination of those with mental ill health. Fear and Exclusion is linked to negative stereotypes that those with a mental illness are violent and dangerous and should be avoided (Link & Phelan, 1998). Understanding and Tolerance recognises that everyone is susceptible to mental illness and should be treated similarly to physical ill health and not discriminated against (Corrigan, 2004). Integrating People into the Community involves support for community based care as opposed to institutionalised care. Causes and Needs of People with Mental Illness is linked to notions that mental illness is due to being weak willed or that it is brought upon by poor life style choices (Crisp et al., 2000).

The 'Attitudes to Mental illness 2014 Research Report' indicates that 'Analysis of summary scores across all of the community attitudes to mental illness (CAMI) statements confirmed

that overall attitudes towards mental illness have become more positive since 2008' (Time to Change - TNS BMRB, 2015, p. 4) (See Table 1).

This research maintains that police officers, police staff and members of the public broadly hold positive attitudes about mental ill health. Police staff were statistically more positive than their police officer colleagues and the public who held similar views. This research adds to the knowledge base as this appears to be the first large scale comparison of police officers and police staff (unwarranted police employees) attitudes benchmarked against the population.

As far as police officers are concerned the results support findings from other, studies (Cotton, 2004; Clayfield et al., 2011) that police officers have generally positive attitudes to those with mental ill health. This is in contrast to Soomro & Yanos (2018) who found police officers were more likely to endorse negative stereotypes.(It should be noted that Cotton's study was undertaken in 2004 and that she benchmarked her police scores against those of the Canadian public from Taylor and Dear's CAMI results from 1981. She argued that police attitudes and public attitudes were unlikely to have changed in the ensuing years. However, the year on year public data (Table 1) above suggest otherwise.)

It could be argued that the composite CAMI score maybe deceptive as further analysis reveals that in three of the four scales (Fear and Exclusion, Understanding and Tolerance and Causes and Needs) the public score lower than police officers and police staff. The exception being Integration into the Community where police officers score significantly lower than the public and police staff. This may be explained by the fact CAMI scales encompass broad concepts and as a result statements are open to interpretation and are not mutually exclusive as people may hold conflicting attitudes between fear and exclusion, understanding and tolerance, integration and causes of mental ill health at the same time (Wolff et al., 1996).

Cotton (2004) in her assessment of police attitudes to mental illness employed the CAMI scale and role related questions arguing that

> 'General attitudes such as those measured by the CAMI Scale are obviously only one factor in the prediction of officer behaviour. Answers to the ''role'' questions may be more a reflection of the reality of the officer's experience and job situation than of beliefs or attitudes.' Cotton (2004, p 135)

In doing so Cotton introduced survey questions to assess police officers role in the criminal justice and mental health system. In a similar vein, this research incorporated open-ended

questions to seek a better understanding of the culture within policing and to ascertain if it is feelings and sentiments in the form of personal views or a policing response.

It is of interest that with the exception of Integration into the Community police officer scores in Fear and Exclusion, Understanding and Tolerance and Causes and Needs sub scales sit between the police staff who consistently score higher than the public. This may be a reflection on the demographics of the police staff respondents as 55 % were not in what would traditionally be called 'operational roles' and therefore not public facing and may not have shared the same operational experiences and pressures commensurate with frontline policing. This is not surprising as even uniform police staff often feel they are outside the occupational culture of sworn officers (Miller, 1995; Cosgrove, 2016). This also lends support to the concept of multiple police cultures as opposed to a singular police culture (Chan, 1997; Loftus, 2010) which may influence police officer and police staff responses. However, the assimilation of police culture by police staff has yet to be established (Johnston , 2006). Therefore, further investigation into the differences displayed between police officers and police staff is worthy of further investigation.

The lack of police officer support for community integration may be accounted for by the increased demands and response to metal health related matters (Cummins, 2012; Morgan and Paterson, 2017; Lane, 2019) and that police officers do not consider such duties 'as real police work' (Trovato, 2000; Cummings & Jones, 2010; Adebowale, 2013; Lane, 2019). Within the Integration into the Community subscale, there is a clear division between police officer data and that of the public and police staff. On the one hand, police officers are supportive of the rights of people with mental ill health. They are more likely to agree they can be trusted as babysitters. Recognise that a mental illness is like any other yet there is a distinct resistance to community integration with police officers viewing people with mental health issues as potentially dangerous in a public setting and that institutional responses are favoured over community based interventions.

Arguably, these responses reflect operational policing encounters and perceptions of the dangerousness of some people with mental ill health (Pinfold et al., 2003). Despite the fact most encounters between the police and people with mental ill health are not violent they can become so. Watson et al. (2009) suggests the majority of people who assault police officers have been using drugs and/or alcohol or have a psychiatric disorder, which can result in officers reacting more forcefully than required in subsequent encounters with those with mental ill health. Therefore, a combination of self-protection and strong police

ethos of personal responsibility to protect the community (Watson et al., 2004; Cummins, 2012) could explain the reluctance to support community based interventions. Furthermore, the closure of residential and long stay mental health facilities has increased police frustration in having to deal with mental health related incidents. Combined with a lack of activity from social services and mental health agencies and reducing police numbers this can have a negative impact on some police attitudes (Cummins, 2012; Morgan & Paterson, 2017; Lane, 2019).

As stated above police officers fare less well than the public and police staff regarding community integration than the other subscales. However, analysis of the Fear and Exclusion subscale highlights a similar theme regarding social exclusion amongst several statements. Police officers were of the opinion that mental health facilities in a residential area downgrades the neighbourhood and were unlikely to be supportive of living next door to someone who has been mentally ill. Pinfold et al. (2004) found the later to be a key indicator of negative attitudes.

Cotton (2004) suggests police divergence in response for community integration can be accounted for by the fact police legislative and civic responsibilities can override their personal attitudes. As the emergency service of first and last resort, the police have to respond to individuals whose behaviour is beyond public norms. Often there is a public expectation to ‘‘do something,’’ such as remove or arrest the individual while at the same time the use of policing powers do not necessarily provide a solution, leaving the police with a difficult balancing act.

4.4.1 Fear and exclusion of people with mental illness

Within the Fear and Exclusion subscale, police staff appear to be less fearful and exclusionary than police officers and the public who share similar views. Police staff scored consistently high across the subscale with the exception of not wanting to live next door to someone who has been mentally ill, to which they share similar views to police officers.

Police officer responses appeared to display stigma and negative attitudes towards the impact of a mental facility in a neighbourhood and people with mental illness being a burden. The open-ended responses regarding burden below may go some way to explaining this. The responses suggest a ‘not in my backyard type of attitude amongst police officers’. They appear to see people with mental ill health as burdensome and wish to keep a social distance from them. Such responses are indicative of the emergence of a theme of social exclusion that can be seen here and in the following subscale of Understanding and

Tolerance and more significant in Integrating People with Mental Illness into the Community. Trovato (2000), in Cotton (2004, p. 143)) sheds some light on the apparent contradictory findings ‘‘On the one hand, officers feel a profound obligation toward emotionally disturbed persons as strongly indicated in the ‘Benevolence’ scores; while, on the other hand, they feel the public needs protection from them.’’

4.4.2 Understanding and tolerance of mental illness

Again the police staff score suggests that as a group they are more Understanding and Tolerant of Mental Illness (higher scores being more positive) than police officers and members of the public who share similar views. In four of the seven statements, police officers and staff shared better scores than members of the public. It is of note that compared to the public, police officers and staff are significantly less likely to agree that mental health services should be provided through community based facilities. In fact this was one of the lowest (negative CAMI) scoring statements for police officers and police staff and is a constant theme to the point it appears that this statement has had a detrimental impact on the overall subscale score. As discussed above the original CAMIS statements were redistributed under the AMI scales. It is not surprising to see that this statement was originally contained within the CMHI subscale and sits with police data discussed so far, providing further evidence of police exclusionary and NIMBY attitudes within strands of the CAMI scale.

Police officers in tandem with the public were significantly less likely to agree than police staff that ‘we have a responsibility to provide the best possible care for people with mental illnesses’, albeit the mean scores were relatively high. Police officers were significantly less likely to agree that ‘we need to adopt a far more tolerant attitude toward people with mental illness in our society’. Again, these responses may be influenced more by role than personal attitudes (Cotton, 2004). It is clear many officers do not perceive dealing with mental health related incidents are within the sphere of their responsibility (Trovato, 2000; Cummings & Jones, (2010); Adebowale, 2013; Lane, 2019) nor do they feel appropriately trained to do so (Pinfold et al., 2003; Cummins, 2007; Lane, 2019). In contrast, police officers and police staff favoured increased spending on mental health services than the public. The support for additional spending is line with the favouring medical responses in lieu of police responses to mental ill health.

Notably, (higher scores being more positive) the public are the least likely to agree, ‘people with mental illness have for too long been the subject of ridicule’. Police officers in a

professional capacity regularly interact with a wide cross section of society. Therefore, it is probable they have witnessed that mental health issues are not restricted by personal or social demographics. Perhaps this is because within policing they witness the negative impact of having a mental illness both on the individual and on how society responds to them.

4.4.3 Integrating people with mental illness into the community

As discussed above this subscale is significant in that police officers were far less likely to be supportive of Integrating People with Mental Illness into the Community than their police staff peers or members of the public who shared similar attitudes. In fact, collectively this subscale contained some of the lowest scores within the CAMI scales. This subscale had the highest differential between recorded score and variable scores than any of the other subscales. Of note is that 'less emphasis should be placed on protecting the public' attracted the lowest overall CAMI score for both police officers and police staff and 'mental hospitals are an outdated means of treating people' was their second lowest scores. It is noteworthy that the public did not fare much better. It is also interesting that 'protecting the public' and 'outdated mental hospitals' attracted some of the highest number of open-ended responses and is clearly emotive.

The responses are not all one sided. Within the same subscale, the police group were more supportive of employment rights for people with mental health problems and supporting the statement, most women who were once patients in a mental hospital can be trusted as babysitters. Again, the public like police officers/staff recorded lower than average score compared to the other subscales. It can be seen in other subscales that in their working and personal environment officers can be more supportive than the public

In order to better, understand police responses it is necessary to understand the conflict between personal attitudes and beliefs and the role of police officers as this appears to have most influence within this subscale. The apparent less positive desire for integration compared to other subscales maybe attributed to their role to protect the public and their professional experience of the failings of care in the community (Cummins, 2007).

Police officers and staff dealing with people experiencing mental illness in their work environment can and do have to make difficult decisions, often with minimal training and without the assistance of experts (Pinfold et al., 2003; Cummings & Jones, 2010; Godfredson et al., 2011). In many cases they are presented with a dilemma being at once the 'protective and coercive gatekeeper for those suffering mental ill health' (Morgan &

Paterson, 2017, p. 3) and will have to use their discretion in assessing what is the best response to any given situation. Watson, et al., (2004) research suggested that officer discretion and quality of response maybe influenced by the role of the individual as a person (in descending order) needing assistance, a witness or victim, and as an offender. However, people with mental ill health were also seen to be less credible. Similarly, those labelled with a mental illness such as schizophrenia were more likely to garner sympathy than someone with a mental illness but no label (Watson et al., 2004).

4.4.4 Causes of mental illness and the need for special services

Analysis of the subscale indicates that police officers and police staff had greater understanding of the causes of mental illness and the need for special services than the public. On all three statements, police officers and police staff were more likely to disagree with the statements than the public. Of note is 'There are sufficient existing services for people with mental illness' which was one of the lowest scoring statements for members of the public across the subscales. From a policing perspective, they have witnessed the reducing funding and services for mental ill health and the impact on mental health services and policing (Cummins, 2012; Morgan & Paterson, 2017; Lane, 2019).

The results suggest that police see it as their duty to be part of the overall response and provision of support to people with mental ill health but are often ill equipped to do so. Hence the debate whether mental health should be core police business when mental health has been a downgraded public health issue (Morgan and Paterson, 2017). Independent, governmental and police reports have all identified a lack of awareness, skills and confidence in police personnel when dealing with and engaging with people with mental health issues (NPIA, 2010; Adebowale, 2013; Home Affairs Select Committee, 2018). The Home Affairs Select Committee suggested that

> **'**that some police forces see mental health training as a 'nice-to-have', rather than an essential part of their officers' knowledge base and skillset.' And directed 'The College of Policing should take immediate steps to mandate a minimum two-day mental health course for all officers and PCSOs. We urge chief constables to regard this as an investment rather than a chore.' (Home Affairs Select Committee, 2018)

Notwithstanding that, the current Government has seriously reduced police funding resulting in less training overall so making this unattainable.

4.5 CAMI data – Initial conclusions

The Total CAMI results indicate that police officers, police staff and the public hold generally positive attitudes about mental ill health. Although police staff held statistically, more positive attitudes than police officer counterparts and the public did. Across three of the four sub-scales (Fear and Exclusion, Understanding and Tolerance and Causes and Needs) the public score lower than police officers and police staff did. The exception being Integration into the Community sub-scale where police officers scored significantly lower than the public and police staff. This significantly lower Integration into the Community score reduces the Total CAMI score for officers and provides an insight into police officer attitudes towards mental illness. It could be argued that the lower scores for Integration into the Community compared to the other subscales maybe due to a perception amongst police officers and less so but still prevalent amongst police staff that care in the community has failed. There also appears to be a conflict between a desire to support people with mental ill health evident in the other sub-scales and a professional and personal responsibility to protect the public. The data successfully provides a base line and benchmark for police officer and police staff attitudes to mental ill health. However, it is not a complete picture, as surveys with closed questions do not allow participants to elaborate on their responses nor allow them to identify new issues not captured in the closed questions. By seeking and analysing such open questions this research can provide further insight into police officer and staff attitudes to mental ill health.

CHAPTER 5

CAMI Open-ended questions

5 CAMI Open-ended questions

The CAMI Scale responses have so far provided statistically significant results, which have allowed comparisons of police attitudes to mental ill health compared to the public they serve and establishing key themes to provide explanations as to why they may differ, or not. By definition, close-ended questions and statements do not provide participants with the opportunity to share their own opinions but merely respond to the options available.

5.1 Methodology

For this research, participants were offered the opportunity 'to make a comment if you choose to do so'. O'Cathain & Thomas (2004, p.1) suggest 'general open question at the end of structured questionnaires has the potential to increase response rates, elaborate responses to closed questions, and allow respondents to identify new issues not captured in the closed questions'. Singer & Couper (2017) go a step further arguing

> 'Opening up the standardized survey in this way can be of benefit both to respondents (giving then a greater sense of engagement in the interaction) and to researchers (giving us more richly textured data on the topics we are studying and providing methodological insights into the process itself)'. Singer & Couper (2017, p. 128)

Therefore, there is an argument to include open-ended questions in quantitative surveys for which they have not been used previously to provide more respondent-focused surveys and more accurate and useful data (O'Cathain & Thomas, 2004; Singer & Couper, 2017)

In this instance this afforded participants an opportunity expand or elaborate on the statement in order to explain or shed light on their response to the quantitative question. Cotton (2004) in her study of Canadian police officers also introduced role specific statements to ascertain how the role and experiences of police officers may have more sway than their beliefs and attitudes in responding to survey statements.

O'Cathain & Thomas (2004) warn that accompanying open-ended questions may be neither strictly qualitative nor quantitative and therefore make analysis difficult. They argue that the closed questions impose constraints on participants when providing additional detail and the shortage of space may mean results lack context and richness. In contrast, participants can be considered as having a free hand and that if sufficient space is allowed the data can be treated as qualitative data.

The police survey open-ended questions were imported from an excel spreadsheet into NViVo, a qualitative analysis software tool and analysed using an adapted form of

Grounded Theory to ascertain if the comments shone further light on the statistical data to identify supporting, opposing or additional themes (See Chapter 10 - 10.2 Interview Analysis for further explanation of methodology).

5.2 Results

5.2.1 Fear and exclusion of people with mental illness

Analysis of the data provided four clear themes, fear of and dangerousness of people with poor mental health, the threat of violence posed to police officers, the perceived burden on policing responding to those with poor mental health and a perception of the deserving and undeserving ill.

Fear and danger

Where respondents mentioned fear it was generally associated with respondents being fearful about the implications for people with mental health disorders living in the community without adequate support and supervision. Respondents were fearful that without medical supervision those with mental ill health could be danger to themselves and others.

> *Those with mental health problems who are forgotten or not given the treatment/help they need/deserve could be problematic to themselves or the public. (Anonymous Participant Number 0662 Male Constable CID)*

Similarly, respondents highlighted community ignorance and knowledge regarding mental health, which could result in respondents supporting the statement.

> *ignorance and lack of knowledge and awareness breeds fear in a community. (Anonymous Participant Number 0631 Male Police Staff)*

However, from the police responses there is a suggestion that that there is an element of danger to the individual but also a danger to communities associated with some types of mental illness.

> *However it needs to be recognised that some people can become a danger to themselves and others and the public are entitle to protection against the consequences of a condition, this needs to be balanced with the needs of the 'patient. (Anonymous Participant Number 952 Female Police Staff)*

Some respondents alluded to the potential danger of violence associated with people with mental health issues.

> *Perception is everything and the general thoughts on mental health units is the severe cases with people 'out of control' and capable of causing harm to others. (Anonymous Participant Number 968 Male Constable Neighbourhood)*

Although limited, other responses were more specific mentioning those with perceived dangerous tendencies including psychopaths and arsonists.

> *In most cases yes but, again, it depends on the situation and circumstances. I do not want a Psychopath moving in next to my grand daughter's infant school and I suppose most people wouldn't. (Anonymous Participant Number 1229 Male Constable Response)*

N.B. From this point onwards, Anonymous Participant Number will only be identified with the four-digit number.

Threat to police officers

References were also made by police officers about the potential threats they face on occasions dealing with some individuals with mental health issues. Such experiences are likely to impact on officer responses to the statement.

> *I answer this question based on my personal experience of dealing with people identified as having mental health issues. The majority of people I deal with usually arm themselves with a weapon, i.e. knives in order to self-harm. On occasion, the person armed has made threats towards myself. This therefore presents a risk to professionals such as Police, Ambulance Service. (0598 Male Constable Response)*

Furthermore, a number of respondents alluded to the danger of substance abuse, drug paraphernalia, and alcohol consumption leading to anti-social behaviour.

> *depending upon the type of service user can have other impacts such as street drinking needle use and an increase in theft in the local area, as some persons with mental health issues are also addicts and offenders (0729 Male Constable Response)*

Respondents policing and personal experiences were cited to support their rationale recognising the failure of interventions and support services which result in poor outcomes for those with mental health issues and the community. There was some support for exclusion.

> *certain mental health issues manifest in a way which impacts on many other people in the community causing distress. Excluding some mental health patients does assist in protecting all parties (0786 Male Constable Response)*

Burden

There was a recognition of the financial and social cost of responding to and supporting people with mental health issue, which can be burdensome on society. However, this was seen as a community or society basis and not the attitudes of the individuals concerned.

> *I think that mental health can be a burden on society, but this is not the fault of the individual, rather that society does not put enough focus, time and investment into managing mental health' (1216 Female Police Staff)*

There was an acknowledgement that mental health knows no boundaries and that colleagues and other professionals maybe 'a burden'.

> *Many police officers, teachers, even priests I know have been diagnosed with stress/ptsd! (0680 Female Detective Constable)*

Financial pressures and the impact of austerity having reduced provision for mental health support services were revealed in some of the responses.

> *They can become more of a 'burden' due to lack of early intervention and so problems are allowed to worsen before they are treated and therefore require more of a treatment. (0004 Male Constable Response)*

Deserving and undeserving ill

Some respondents drew a line between the 'deserving ill' and the supposed 'self-inflicted ill' who are addicted or dependent upon alcohol or drugs. Indicating that the latter created a burden on society.

> *Only those who have no intention to help themselves and who cause mayhem in the process of their day to day lives. That could be down to them drinking/drug taking or down to their own personalities - those people are a burden. Decent people struggling with an illness are no burden at all. (0939 Female Constable Response)*

A number of respondents suggested that some mental health issues were self-inflicted or had contributed to their illness by substance or alcohol misuse.

> *I don't know about "most", but I know some are self inflicted through substance abuse. others by ignoring their own limitations, stressful relationships, employment, self imposed money worries. etc..). (1022 Male Sergeant Response)*

5.2.2 Understanding and tolerance of mental illness

Analysis of the data provided three clear themes; vulnerability, mental ill health is stigmatised and that interventions like improved training are required.

Vulnerability

It appears that respondents saw themselves and colleagues as understanding and tolerant of mental ill health and that education had taken been a successful part of this.

> *There is quite a good tolerance to mental health in the area where I police. This is due to education about mental health issues. (1116 Constable Neighbourhood)*

However, it was not widespread and in some areas had not benefited from the same training.

> *I think on the whole, attitudes are tolerant. What is lacking is knowledge on how to best deal/cope with those who have mental health problems. More education is required to raise awareness and dispel myths. (0915 Female Police Staff)*

For some their policing experience had improved their tolerance and understanding of mental health issues and how policing had changed their opinion.

> *When first starting policing I failed to understand mental health, I thought it was exaggerated and made up. Personal insight has changed my whole outlook. (1173 Female Constable Operational Support)*

Although in a minority, references were again made to the 'deserving ill' and the supposed 'self-inflicted ill'.

> *Because it goes on those patients who do not actually need it. To much effort is spent on people who are drunk, who are claiming mental health to get attention from loved ones and I do not trust that extra money will actually be spent on those that require it. (1355 Male Constable Response)*

Generally, there was an expectation that more emphasis is need on caring for individuals with mental ill health.

> *emphasis should go towards support and providing a positive message (1399 Male Police Staff)*

Respondents recognised the variety of mental health issues and varied impact on individuals and that people with mental health issues were more likely to be victims of crime than perpetrators.

> *More likely to be victims of crime than perpetrators from the stats I have seen. Hate crimes are on the increase, let's hope legislation can keep up. (0544 Female Police Staff)*

The negative impact of media reporting was also recognised as a reason why some people may be fearful of those with mental health problems.

> *Words like schizophrenia and bipolar can be tabloid bait. Very few people with mental health issues present a risk to anyone. They are more likely to be victims or self harm than to hurt others. (0824 Male Constable Response)*

Stigma

It appears mental health related stigma and discrimination are still prominent in policing.

> *Mental Health is still very taboo in my experience. It is a major issue that many will never discuss with others, in part because of intolerance/fear. (0824 Male Constable Response)*

It appears the use derogatory terminology to describe members of the public goes unchallenged.

> *mental health is laughed at still in the police and I witness this from a majority of officers.. it appears to be acceptable to say 'he's a nutter'.. we can't say this about other diverse matters. (1443Male Sergeant Operational Support)*

There is a recurrent theme of the 'deserving ill' and the supposed 'self-inflicted ill'.

> *it very much depends whether they are genuinely mentally ill, or whether mental illness is now today's equivalent of the 'bad back' (0749 Female Constable Response)*

Furthermore, within forces officers and staff can find themselves being the subject of dismissive and derogatory language used to describe colleagues who may be dealing with mental health issues.

> *It gets referred to as "going wibble" and sniggered at (1034 Female PCSO)*

The suitability of working in a police environment for people with mental health issues was questioned.

> *I do not believe someone who is currently suffering with anxiety should be employed as a Police officer (our job is stressful enough without an individual having to manage recovery from a disorder whilst starting the job) BUT I am very aware of a number of officers who have suffered from anxiety and depression and are excellent officers. (0663 Female Sergeant Neighbourhood:*

Small in number but still evident were disparaging statements about colleagues who were perceived to use poor mental health as an excuse for absence from work.

> *because have experienced people using mental health as excuse to be off sick (0780 Female Constable CID:*

Training

The training provided to officers and staff was deemed inadequate to respond appropriately to mental health related incidents.

> *: BUT there is only so much police can do to help, and too much responsibility currently seems to fall on us (beyond the scope of our training). (0782 Female Constable Response)*

Similarly, training was viewed as a path to tackle stigma and discrimination within the service.

> *I think on the whole, attitudes are tolerant. What is lacking is knowledge on how to best deal/cope with those who have mental health problems. More education is required to raise awareness and dispel myths. (0915 Female Police Staff Despatcher)*

Current training requires reviewing as it is primarily based on legislative responses and overlooks real world scenarios and the participation of 'service users. And /or other agencies.

> *As a police officer this is very difficult to follow through as we look at crime and offenders. Once you open the door to understanding that everyone has a 'story' then day to day policing becomes very difficult. Training in the police is generally poor and is based around legislation not around the best way to deal with the situation or person you are presented with. (0968 Male Constable Response)*

Similarly, others highlighted the fact it is not appropriate for police who are poorly trained regarding mental health being relied on to deal with people requiring specialist care.

> *Too much emphasis is placed on non qualified Police officers to deal with the every day care of members of the our community living with Mental Health (0463 Female Constable Response)*

5.2.3 Integrating people with mental illness into the community

Analysis of the data provided four clear themes. There is some support for community based care but with a caveat of not in my back yard (NIMBY). A perceived inadequacy of provision of mental health care and facilities to support it. That dealing with the fallout from a lack of mental health facilities is a burden on policing and that responding to those with mental ill health is not a police responsibility and the recurring theme of the genuineness of people's mental ill health.

NIMBY

Respondents were supportive of mental health facilities but not within their neighbourhood.

> *Although I want more facilities. I wouldn't want them on my street (0985 Male Constable CID)*

Respondents policing and personal experiences were cited to support their rationale recognising the failure of interventions and support services which result in poor outcomes for those with mental health issues and the community.

> *Problems can arise when a person with complex mental health problems have a crisis and are failed and do not get the support they need - this can have a massive impact on their neighbours if their behaviour becomes totally out of control and can be very frightening and intimidating. (0779 Female Police Staff PCSO)*

Substance and alcohol service users were cited as reasons to be fearful.

> *I think people would be fearful if the services were drug and alcohol related for example (0506 Female Sgt Admin)*

Excluding people with mental ill health from respondents' neighbourhoods was seen as necessary as they could be a threat to community safety.

> *Problems can arise when a person with complex mental health problems have a crisis and are failed and do not get the support they need - this can have a massive impact on their neighbours if their behaviour becomes totally out of control and can be very frightening and intimidating.* (*0779 Female Police Staff PCSO)*

Inadequate mental health provision

The perceived failure of deinstitutionalisation and 'care in the community' appeared throughout the open responses. Within this section, it was an overriding theme. Current funding is considered grossly inadequate.

> *we need to spend more on MH services (a) to help more people - preventing them reaching crisis by making MH services more easily accessible and timely, and by responding to crisis (b) to reduce demand on police (c) to reduce demand on ambulance (d) to reduce demand on A&E (0004 Male Constable Response)*

There was a wide recognition that some form of facility was required where intensive or specialist support could be provided.

> *A minority people need hospitalisation to protect the public, many more need it to enable a drug / alcohol free assessment and diagnosis, intensive treatment or a period of stabilisation on medication (0004 Male Constable Response)*

The lack of secure beds and resources were collectively deemed responsible for mental health patients being placed in vulnerable positions. It would appear there are strong arguments from the police family that there should be the provision of extra facilities.

> *People are being repeatedly sectioned by police and then immediately released from A&E only to go on and pose a risk to themselves and others again. There do not seem to be enough spaces in mental health hospitals to deal with the demand we put on them. (0523 Male Police staff Despatch)*

Impact on police resources

As seen above there is strong feeling that 'care in the community' lacks investment and fails to support some patients resulting in poor service and increasing police workload.

> *This is how it's supposed to be now and it doesn't work. The police are always picking up the pieces! (0452 Female Sgt Support)*

> *They can become more of a 'burden' due to lack of early intervention and so problems are allowed to worsen before they are treated and therefore require more of a treatment. (0004 Male Constable Response)*

There is a clear consensus that the police carry too much responsibility for caring for people with mental health issues and that other agencies are not providing the support and assistance required.

> *People with mental health issues take up so much police time and don't get me wrong we do this job because we care about people. But when you have been called out to the same person for the 50th time. it makes you wonder why? and where are the other agencies!!!!! (0603 Male Police Staff PCSO)*

Whereas others highlighted the fact, it is not appropriate for police who are poorly trained regarding mental health being relied on to deal with people requiring specialist care.

> *Too much emphasis is placed on non qualified Police officers to deal with the every day care of members of the our community living with Mental Health (0463 Female Constable Response) (0463 Female Constable Response)*

Policing is essentially seen as a crime-fighting role and not as mental health practitioners.

> *While we have a duty of care to serve and protect the public, it is not the police's role to deal with mental health issues. Our remit is crime related issues and we are not the most appropriate resource for dealing with mental health. (0915 Female Police Staff Despatcher)*

Genuineness

Genuineness is a recurring theme suggesting that people may feign a mental health illness.

> *If it is genuine (0430 Male Constable Response)*

Similarly, questions are raised about the 'deserving ill' and the supposed 'self-inflicted ill'.

> *If true mental health problem is of course a health problem, however sometimes it is difficult to tell if addiction is the primary motivator or if this is simply making symptoms worse from an underlying condition. (0729 Male Police Constable Response)*

5.2.4 Causes of mental illness and special measures

Analysis of the data provided resulted in the theme of 'will power and self-discipline'.

Will power and self-discipline.

Some respondents recognised the stresses and strains of modern living as causes of mental ill health.

> *with many illness there is usually a trigger and it is nothing to do with self discipline or will power.' (0506 Female Sgt Admin)*

A small number of respondents were willing to give evidence of their own mental health as reason for disagreeing with the statement.

> *I have more will power than almost anyone else my friends know but have suffered from depression for many years. (1034 Female Police Staff PCSO)*

However, there were a number of respondents who suggested that a lack of character or personal weakness contribute to poor mental health.

> *people need to face the adult world and manage with what they have got or work harder. (0606 (gender not stated) Constable Support)*

A number of respondents suggested that some mental health issues were self-inflicted or had contributed to their illness by substance or alcohol misuse.

> *I don't know about "most", but I know some are self inflicted through substance abuse. others by ignoring their own limitations, stressful relationships, employment, self imposed money worries. etc..). (0873 Female Police Staff Despatcher)*

5.3 Discussion

The responses provided richer data, which give greater insight into the attitudes of police officers and staff towards mental ill health (O'Cathain & Thomas, 2004).

5.3.1 Fear and exclusion of people with mental illness

The discussion is centred on four clear topics, fear of and dangerousness of people with poor mental health, the threat of violence posed to police officers, the perceived burden on policing responding to those with poor mental health and a perception of the deserving and undeserving ill.

Fear of and dangerousness of people with poor mental health

Research suggests social contact reduces anxiety and increases empathy about mental illness and is the most effective strategy in improving attitudes to mental illness (Thornicroft et al., 2016). As the police have, regular interaction with people experiencing mental illness it maybe anticipated that they would be less fearful. However, stereotypical views were evident that associated mental ill health with violence similar to the association between mental illness and violence found in public opinion (Link & Phelan, 1998). Previous research identified similar perceived dangerousness and that police officers believe the public require police protection from those with mental illness (Watson et al., 2004; Cummins, 2012).

> *Some forms of MH are very dangerous and the person may be of danger to the community. (0512 Male Police Staff Enquiry)*

Negative media reporting was also believed to be accountable for generating fear and an explanation as to why people may think this way (Wahl, 1995).

> *Words like schizophrenia and bipolar can be tabloid bait. Very few people with mental health issues present a risk to anyone. They are more likely to be victims or self harm than to hurt others.* (*0824 Male Constable Response)*

Threat to police officers

Participants cited the potential threats and risks they face dealing with some individuals with mental health issues. Police officers have limited mental health training and are reliant on their own professional expertise and experience than specialist knowledge. This frequently involves supporting other mental health professionals in detaining, sectioning patients and supporting medical staff to deal with violent incidents at A&E and psychiatric units (Cummings & Jones, 2010). Such experiences are likely to impact on officer responses.

> *I answer this question based on my personal experience of dealing with people identified as having mental health issues. The majority of people I deal with usually arm themselves with a weapon, i.e. knives in order to self harm. On occasion, the person armed has made threats towards myself. This therefore presents a risk to professionals such as Police, Ambulance Service. (0598 Male Constable Response)*

Several researchers have argued that police officers associated dangerousness and violence with mental ill health (Watson et al., 2004; Godfredson et al., 2011; Koskela et al., 2015). Broussard et al., (2011) made similar findings and that police officer perception of dangerousness and unpredictability were the most strongly correlated with social distance.

Burden

Within the CAMI scale police officers were most likely to agree with the statement 'People with mental illness are a burden on society'. Suggesting less desirable attitudes. However, examination of the open statements suggests the perceived burden may not necessarily reflect negative attitudes towards those with a mental illness but the reality of the size and scale of mental ill health in the community and the resources required to deal with it. The open responses appear to be influenced by the lack of services and support provided, that lack of treatment and increased demands on policing resources which may have prompted the lower score.

> *I think that mental health can be a burden on society, but this is not the fault of the individual, rather that society does not put enough focus, time and investment into managing mental health (1216 Female Police Staff)*

Deserving and undeserving ill

The open-responses introduced a theme of the 'deserving ill' and 'undeserving ill'. The latter group described as comprising of weak willed people with little self-control dependant on drugs and/or alcohol thus a burden on society (Lister et al., 2008). A similar narrative can be found in relation to sickness benefits payments where applicants and recipients are often referred to as workshy or unwilling to work regardless of their health. This acts as a form of 'othering' (Said, 1978) and misses the actual lived experience of people who may have fallen ill resulting incapability (Garthwaite, 2011). Similar circumstances which may befall colleagues.

Whether this is based on respondents' personal experiences, policing experiences or intolerance is uncertain. Nevertheless, statements like:

> *Only those who have no intention to help themselves and who cause mayhem in the process of their day to day lives. That could be down to them drinking/drug taking or down to their own personalities - those people are a burden. Decent people struggling with an illness are no burden at all. (0939 Female Constable Response)*

introduce an insight as to how mental ill health is seen within policing with lines drawn between the 'deserving ill' and 'undeserving ill'.

5.3.2 Understanding and tolerance of mental illness

Analysis of the data provided three clear themes; vulnerability, mental ill health is stigmatised and that interventions like improved training are required. The open-ended questions provided contradictory results. It appears that the police are broadly supportive of those with mental ill health yet mental health related stigma is prevalent. It is also evident that mental health related training is inadequate and not fit for purpose in the public arena nor within the organisation.

Vulnerability

There is an acceptance amongst respondents that the police have a primary duty to respond to and care for those with mental illness. This sits comfortably within UK society where the first and foremost role of the police is to protect citizens from others and in the case of those with mental health issues on occasions from themselves (Bradley, 2009; Adebowale, 2013; Morgan & Paterson, 2017). However, from a police perspective there is a widely held conception that such care unduly and disproportionally sits with the police service and that other agencies and ultimately government are failing people with mental health issues (Cummins, 2012; Morgan & Paterson, 2017).

Stigma

The results highlight a profession where mental health related stigma is still evident towards the public (Godfredson et al., 2011; Koskela et al., 2015). Where inappropriate behaviour and comments about members of the public with mental health issues go unchallenged.

> *mental health is laughed at still in the police and I witness this from a majority of officers.. it appears to be acceptable to say 'he's a nutter'.. we can't say this about other diverse matters.. (1443 Male Sergeant Operational Support)*

That public stigma and negative attitudes are mirrored within the service, officers with mental health issues can be doubted as to the authenticity of their condition and

derogatory terminology applied to them (Blue Light Programme, 2016; Bullock & Garland, 2017; Stuart, 2017; Soomro & Yanos, 2018).

> *It infuriates me that they have the audacity to pretend to be stressed when there are officers in other departments who are run ragged and are late off every day. (1105 Female Sgt CID)*

Furthermore, within forces officers and staff can find themselves being the subject of dismissive and derogatory language used to describe colleagues who may be dealing with mental health issues.

> *'It gets referred to as "going wibble" and sniggered at (1034 Female PCSO)*

The suitability of working in a police environment for people with mental health issues was questioned (Bullock & Garland, 2017; Stuart, 2017; Turner & Jenkins, 2018).

> *I do not believe someone who is currently suffering with anxiety should be employed as a Police officer (our job is stressful enough without an individual having to manage recovery from a disorder whilst starting the job) BUT I am very aware of a number of officers who have suffered from anxiety and depression and are excellent officers. (0663 Female Sergeant Neighbourhood)*

Small in number but still evident were disparaging statements about colleagues who were perceived to use poor mental health as an excuse for absence from work who are seen as malingerers (Stuart, 2017; Turner & Jenkins, 2018; Bell & Palmer-Conn, 2018) .

> *because have experienced people using mental health as excuse to be off sick (0780 Female Constable CID)*

Training

Unsurprisingly it is within this subscale that training or the lack of it is identified as a theme resurfacing over several scales. Respondents in line with Cotton (2004) identified the need for special training. This comes as no surprise as Pinfold et.al; (2003) and Cummins (2006) reported that there is consistently a lack of effective training for police officers and it is safe to assume that police staff in operational roles have fared no better. As recently 2013, Lord Adebowale came to a similar conclusion regarding the Metropolitan Police Service (Adebowale, 2013) as did Parliament in 2018 (Home Affairs Select Committee, 2018) that the majority of police training in this area is very limited and basic.

> *Training in the police is generally poor and is based around legislation not around the best way to deal with the situation or person you are (0968 Male Constable Neighbourhood)*

Similar to the pleas for improved training by respondents, a number of researchers have advocated anti-stigma interventions and training to improve police attitudes, mental health literacy and intentional behaviours (NPIA, 2010; Broussard et al., 2011; Koskela et al., 2015) to improve the outcomes of police interaction with those with mental health issues. Similarly, a number of researchers (Randall & Buys, 2013; Bullock & Garland, 2017; Stuart, 2017; Turner & Jenkins, 2018) have advocated that similar anti-stigma programs should be used for internal purposes to address the stigma and discrimination towards those with mental health issues working within policing.

Much of the old-fashioned 'chalk and talk' approaches were disparaged as was solely IT based solutions such as the police National Centre for Applied Learning Technologies (NCALT) system delivered previously by the National Police Improvement Agency (NPIA) and now the College of Policing. Best practice suggests that classroom based education alone is not a panacea for addressing stigma and that for it to be most effective in a public setting (Corrigan et al., 2012) and police setting (Watson et al., 2004; Cummings & Jones, 2010; Hansson & Markstrom, 2014) must include partner agencies and contact with people who have experienced mental ill health. Unfortunately, failure to do so will allow long held perceptions to endure and there is a likelihood that officers/ staff are more likely to rely upon their own experience or those of more experienced colleagues who will fail to challenge such stereotypes and indoctrinate them in operational responses and decision making. (Fry et al., 2002; Cummins, 2007; Godfredson et al., 2011). It was clear respondents were in favour of the inclusion of those who experienced mental ill health within the police environment. As such, training would be more credible if fellow officers / staff who had similar experiences would engage and deliver the training. As policing is seen as a 'closed shop', credibility is all-important when delivering training. If culture is to be changed then there should be less reliance on IT based, 'tick a box' delivery and a move towards more classroom / workshop based learning in conjunction with other agencies and preferably 'survivors' who have first-hand knowledge of the topic. Programmes like Mental Health First Aid have been proven to improve measured attitudes to mental ill health (Hadlaczky et al., 2014).

5.3.3 Integrating people with mental illness into the community

The discussion is centred on five clear topics; NIMBY, inadequate mental health provision, impact on police resources and the genuineness of the illness.

As discussed above this subscale is significant in that police officers CAMI scorers revealed they were far less likely to be supportive of Integrating People with Mental Illness into the Community than their police staff peers or members of the public who shared similar attitudes. Police officers were more likely to disagree with the statement 'less emphasis should be placed on protecting the public' and were more likely to disagree with the statement 'mental hospitals are an outdated means of treating people'. Interestingly 'protecting the public' and 'outdated mental hospitals' attracted some of the highest number of open-ended responses suggesting the topic is of concern to police officers. These concepts are reinforced within the open responses.

Police officer responses may be explained by the conflict experienced between personal attitudes and beliefs and their role as police officers. There is a tension between supporting integration and their role in protecting the public whilst witnessing the failings of care in the community (Trovato, 2000; Morgan & Paterson, 2017).

NIMBY

The open responses reinforced the sense of 'not in my back yard' (NIMBY) found in the survey data and some concerns displayed as to how such facilities can impact on the value of dwellings nearby. This was based on the one hand of an association between poor mental health and anti-social behaviour or even dangerousness (Watson et al., 2004; Broussard et al., 2011) and the desire to maintain social distance (Link et al., 1989; Jorm et al., 1999).

Inadequate mental health provision

Respondents questioned the lack of medical and social support available in the community. This was the reality of police work backfilling for partner agencies due to deinstitutionalisation and the perceived failings of care in the community (Cotton, 2004; Cummins, 2007; Paterson & Pollock, 2016).

> *Depends on the circumstances. Recently we have been to numerous calls where Mental Health Team have said the person should be admitted but there are no free beds. If they are too ill they should be able to go to hospital for treatment. (1059 Female Sgt Response)*

As above there is a recurrent theme which appears somewhat to lay at the frustration of police work, the perceived lack of activity and results from social services and mental health agencies along with the impact of austerity measures have a negative impact on some police attitudes (Cummins, 2012; Morgan & Paterson, 2017).

Impact on police resources

The continuing theme of the failure of care in the community, lack of secure beds, funding and resources continued which collectively affects the police service. It would appear there are strong arguments from the police family that there should be the provision of extra facilities to combat the *'revolving door policy'* in the mental health system (Godfredson et al., 2011, p. 192).

> *People are being repeatedly sectioned by police and then immediately released from A&E only to go on and pose a risk to themselves and others again. (0523 Male Police staff Despatch)*

Policing is essentially seen as a crime-fighting role and not as mental health practitioners (Adebowale, 2013; van Hulst, 2013; Morgan & Paterson, 2017; Lane, 2019). There is no dispute that the police are there to serve and protect but due to a lack of resources in health and social services the police are placed under an onerous responsibility to deal with mental health issues beyond their training, capability and remit (McLean & Marshall, 2010) .

> *While we have a duty of care to serve and protect the public, it is not the police's role to deal with mental health issues. Our remit is crime related issues and we are not the most appropriate resource for dealing with mental health. (0915 Female Police Staff Despatcher)*

Genuineness – 'Suspicious Minds'

There appears to be a police hierarchy of those with mental health issues who deserve sympathy and possibly worthy of community inclusion. Overt displays of such attitudes are detrimental to people with mental ill health and likely to lead to stigmatisation one of the biggest barriers to community integration (Link & Phelan, 2001; Thornicroft et al., 2007).

Similarly (Lauber et al., 2004; Jorm & Oh, 2009) those with substance misuse disorders ranked highly for social distancing. Respondents here appeared to have little or no support for those with alcohol or drug related addictions. *'sometimes it is difficult to tell if addiction is the primary motivator'.* Watson et al., (2004) suggest police officers first tendency is to question the credibility of persons with mental illness as they "often viewed as untrustworthy and unable to provide reliable information (Watson et al., p. 53). Which in turn returned us to the 'deserving ill' and the supposed 'self-inflicted ill' where the genuineness or credibility of those seeking help is questioned. The legitimacy and authenticity of some of the people police may encounter was challenged.

> *To much effort is spent on people who are drunk, who are claiming mental health to get attention from loved ones …..' (1355 Male Constable Response)*

As mentioned above each statement invited a response without further direction. It is interesting that participants submitted replies, which moved from an external outlook towards the working environment. The suitability of people with mental health issues working in a police environment was questioned.

> *I do not believe someone who is currently suffering with anxiety should be employed as a Police officer (our job is stressful enough without an individual having to manage recovery from a disorder whilst starting the job). (0663 Female Sergeant Neighbourhood)*

On balance, this was countered by respondents confirming they work in a police environment having experienced mental health issues or have worked alongside colleagues who have or had similar issues.

Again, authenticity was questioned within the workplace with further challenges that people may feign poor mental health. *'If it is genuine.' (0430 Male Constable Response)* Such comments are in the minority, as police officers/staff appear to be generally supportive of individuals with mental health issues. However, there is a thread of disbelief about members of the public and work mates who report mental ill health. This is not new and nor is it confined to officers and staff. Medical staff working in police positions have cast doubt on legitimacy of police officers seeking medical retirement related to mental illness (Sumerfield, 2011). This doubting of the genuineness or authenticity of mental ill health in a policing environment has been characterised by Bell & Palmer- Conn (2018, p33) as 'suspicious minds'.

5.3.4 Causes of mental illness and special measures

Will power and self-discipline

Respondents differed as to the impact of will power and self-discipline. Most believing there to be social or personal triggers. *'with many illness there is usually a trigger and it is nothing to do with self discipline or will power' (0506 Devon & Cornwall).* However, some albeit a minority thought it was a personal weakness. '*some MH issues are caused by drug and alcohol misuse, which is down to the self control of the person' (0484 Devon & Cornwall).* This sits with the literature, Corrigan & Watson (2002) wrote that people with mental ill health were far less likely to be treated as sympathetically as someone with a physical illness and more likely to be blamed or held to be responsible for causing or at least contributing to their illness and in more extreme cases acting with anger and disbelief. Such scientism was never far away, *Insufficient funding for true MH issues' (0553 Greater Manchester).*

The following does not necessarily reflect the police community and is probably worthy of further in-depth analysis. However, in this case I use it to link the open-ended statement responses to the analysis of the interviews of serving and retired officers. It provides an insight into the thinking of some individuals who may or not voice such opinions in the workplace but whether manifested or not is indicative of the negative attitudes, which can lead to stigma and discrimination towards service users or colleagues within policing.

> *I do wonder why more and more people are diagnosed and particularly more young people, inc teenagers. If exam pressure or peer pressure cause stress and anxiety, what is this saying about the individual. I can't help but feel, from what I experience and observe, that there is a distinct lack of stoicism in some quarters. I do on occasion have to question the power of the mind. We have to be so careful nowadays when dealing with young people. School sports day can't see winners or losers in case this causes self esteem problems. A vastly different mind set to those who were at the Somme, some of whom had even lied about their age in order to fight for their country. These individuals didn't know what a 'boy band' was, let alone receive counselling when said band split up. I do however, recognise that there are some very poorly individuals with very severe conditions, who through whatever reason, find themselves in dire situations and need professional help. We live in very different times now and there is a distinct shift in mind set. (0556 Female Constable Support)*

5.4 CAMI open-ended questions – Initial conclusions

The open-ended questions allowed respondents to elaborate on their choice of response and identify new issues not captured in the closed questions. The themes generated by the open-ended questions supported the established quantitative survey data and introduced new themes providing an insight and deeper understanding of the attitudes displayed.

5.4.1 Established topics

Stigma

Mental health related stigma is apparent both public facing and within forces. There is evidence of the use of inappropriate behaviour and derogatory comments towards those displaying or reporting a mental illness. The suitability of police work for those with a mental illness was questioned and those absent from the work place were deemed malingerers. It appears common mental health stereotypes are present in policing.

Fear of danger

The data suggests people with mental ill health are labelled as dangerous. Police officer respondents cited operational experience in restraining and transporting detainees and being called upon to support other health professionals to deal with violent incidents at

A&E and psychiatric units for doing so. They saw care in the community failing with potential danger to the community.

Integration of MIH is not favoured

Police officers were far less likely to be supportive of Integrating People with Mental Illness into the Community than police staff peers or members of the public. Austerity has led to insufficient mental health services being available and greater reliance on community-based care, which is overstretched and in turn increased demands on diminishing police resources. In their domestic setting officers were reluctant to have mental health facilities in local neighbourhoods.

5.4.2 Emerging topics

The inclusion of the open questions was justified not only in gleaning supporting qualitative data to the closed statements but also in the identification of interesting new themes.

Suspicious Minds / Genuineness of MIH

The open-ended responses revealed an underlying cynicism towards mental health and a police conception of the deserving and undeserving ill. This was manifested in attitudes towards members of the public and in the relationship of officers and staff when dealing with colleagues or supervisors with a member of staff with mental ill health. It was not uncommon for the genuineness and credibility of those seeking help to be questioned.

Training

The open-ended responses allowed participants to consider solutions to some of the issues highlighted. Unsurprisingly the lack of training was identified as a recurrent theme. Respondents in recognised the need for special training as they felt ill equipped or inadequate in dealing with many of the mental health related incidents they were required to deal with. Training was viewed as essential in improving attitudes, mental health literacy and intentional behaviours of police to improve the outcomes of interactions with those with mental health issues. Similarly, anti-stigma programmes are required stigma and discrimination towards those with mental health issues working within policing.

CHAPTER 6

Measuring mental health related knowledge

6 Measuring mental health related knowledge

6.1 MAKS survey methodology

Mental Health Knowledge Schedule (MAKS) (Evans-Lacko et al., 2010). The MAKS comprises of two scales measured on a five point Likert scale. MAKS A consists of six items covering stigma-related mental health knowledge areas: help seeking, recognition, support, employment, treatment, and recovery, and six items that inquire about classification of various conditions as mental illnesses. The overall internal consistency among items is 0.65 (Cronbach's α). The total score calculated so that higher MAKS scores indicate greater knowledge.

6.2 MAKS survey results

Table 7. MAKS Total Schedule results

Mean Scores	Public	Police officers	Police staff	Significance p	F Value
Total MAKS (Total max score is 60)	45.76	47.08	48.04	0.001	40.382
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.01*					

MAKS totals results indicate that the police family were statistically more knowledgeable about mental ill health than the public. A one-way between subjects ANOVA was conducted to compare the public, police officers and police staff response to the Total MAKS scores. Between the groups at the p<.05 level for the three groups [F(2, 2799) = 40.382, p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for all three groups were significantly different (public (M =45.76, SD = 5.01), police officer (M=47.08, SD 4.45) and police staff (M=48.04, SD = 4.16). This suggest police staff are the most knowledgeable and the public the least so.

6.2.1 MAKS A

Table 8. MAKS Schedule A subscale results

Mean Scores MAKS A Knowledge Scale	Public	Police officers	Police staff	p Value	F Value
Q53. Most people with mental health problems go to a health care professional to get help	2.73	3.87	3.91	0.001	315.8956
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.839					
Q52R. People with severe mental health problems can fully recover	3.87	3.66	3.70	0.001	10.8955
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.037*, officers vs staff: 0.867					
Q67R. If a friend/colleague had a mental health problem, I know what advice to give them to get professional help	3.70	3.87	3.82	0.006	5.1787
Post-hoc Test: public vs officers: p=0.005*, public vs staff: 0.305, officers vs staff; 0.819					
Q49R. Most people with mental health problems want to have paid employment	4.10	3.93	4.15	0.001	10.1859
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.6956, officers vs staff: p=0.002*					
Q50R. Medication can be effective treatment for people with mental health problems	4.13	4.14	4.03	0.2259	2.7653
Post-hoc Test: public vs officers: p=0.689, public vs staff: p=0.052, officers vs staff: p=0.237					
Q51R. Psychotherapy can be an effective treatment for people with mental health problems	4.32	4.35	4.44	0.001	20.5311
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.487					
Sub Total (Max score is 30)	22.85	23.57	23.82	0.001	20.5311
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.487					

MAKS A

Examining the total MAKS A subscale score, overall the police officers and police staff appear to have similar levels of knowledge and score significantly higher than the public. A one-way between subjects ANOVA was conducted to compare the three groups. Between

the groups at the p<.05 level for the three groups [F(2, 2799) = 20.5311 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for police officers (M =23.57. SD = 3.22) was similar to police staff (M=23.82, SD 3.01) whilst the public (M=22.85, SD = 3.25) was significantly different to both groups. Throughout the majority of the scale, the public scored lower than the police officers and police staff colleagues did.

Police officers were the least likely to support the statement **Q49 Most people with mental health problems want to have paid employment** whilst police staff and public shared similar more supportive views. A one-way between subjects ANOVA was conducted to compare the three groups. Between the groups at the p<.05 level for the three groups [F(2, 2799) = 10.19 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for police officers (M =3.93, SD = 0.98) was similar to police staff (M=4.15, SD 0.97) whilst the public (M=4.10, SD = 0,92) was significantly different to both groups.

6.2.2 MAKS B

Table 9. MAKS Schedule B subscale results

MAKS B					
	Public	Police Officers	Police Staff	p Value	F Value
Drug addiction	3.17	2.58	3.06	0	46.8764
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.459, officers vs staff: p=0.001*					
Grief	2.73	2.47	2.47	0	12.2912
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.006*, officers vs staff: p=0.995					
Stress	3.54	4.07	4.12	0	61.739
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.809					
Depression	4.37	4.69	4.72	0	49.2674
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.887					
Bipolar Disorder	4.51	4.65	4.78	0	21.3033
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: =0.038*					
Schizophrenia	4.60	4.83	4.89	0	45.5713
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.326					
Sub Total (Max score is 30)	22.92	23.21	23.90	0	16.3846
Post-hoc Test: public vs officers: p=0.039*, public vs staff: p=0.001*, officers vs staff: p=0.001*					

Examining the total MAKS B subscale score, overall the three groups scored significantly differently with police staff scoring highest, followed by police officers and then the public. A one-way between subjects ANOVA was conducted to compare the three groups. Between the groups at the p<.05 level for the three groups [F(2, 2799) = 16.38 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for all three groups were significantly different public (M =22.92, SD = 2.95), police officers (M=23.21, SD 2.51) and police staff (M=23.90, SD = 2.48).

Police officers were the least likely to agree that Q58 Drug addiction was a type of mental illness, whilst police staff and public shared similar views. A one-way between subjects ANOVA was conducted to compare the three groups. Between the groups at the p<.05 level for the three groups [F(2, 2799) = 46.88 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for police officers (M =2.58, SD = 1.34) was significantly lower than police staff (M=3.06, SD =1.32) and the public (M=3.17, SD = 1.43) who shared similar views.

In response to Q57 Bipolar Disorder, all three groups scored significantly differently with police staff scoring highest, followed by police officers and then the public. A one-way between subjects ANOVA was conducted to compare the three groups. Between the groups at the p<.05 level for the three groups [F(2, 2799) = 21.30 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for all three groups were significantly different public (M =4.51, SD = 0.82), police officers (M=4.65, SD 0.74) and police staff (M=4.78, SD = 0.52).

6.2.3 MAKS survey discussion

Good mental health literacy has been established as an effective method in reducing mental health related stigma (Jorm et al., 2010; Rusch et al., 2011; Kutcher et al., 2016). Jorm (2000, p.396) defined mental health literacy as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention”. Insufficient knowledge underpins negative attitudes and can lead to discrimination. The MAKS schedule (Evans-Lacko et al., 2010) establishes a measure of mental health literacy.

From the MAKS Schedule police officers and police staff were statistically more knowledgeable about mental ill health than the public. Interestingly police officers and staff were more confident than the public that they could signpost others to appropriate support. The Blue Light Programme (2016) had similar findings suggesting the police service

exceeded that of the other emergency services in doing so. Research suggests that people with better mental health-related knowledge display less personal stigma and less fear and discomfort when interacting with people with mental ill health. (Evans-Lacko et al., 2010).

Of note is 'Most people with mental health problems want to have paid employment' where police officers were significantly less likely than police staff or the public to be supportive of the statement. Similarly, police officers were less likely to agree that drug addiction is a mental illness than police staff or the public. This may be explained by the underlying and consistent theme of the 'deserving ill' and the supposed 'self-inflicted ill' (CAMI open-ended statements Chapter 5) who shun mental health services and engage in substance misuse. It can be seen manifested below in the MAKS open-ended responses where it is identified in many cases as a trait and not an illness and more of a lifestyle choice.

Like the CAMI scores, the overall MAKS scores are favourable for police officers and staff indicating better mental health literacy than the public. Therefore, it could be expected that mental health related stigma would be less prevalent in policing and improve help-seeking (Kutcher et al., 2016). However, as can be seen within the CAMI survey and CAMI open questions there is evidence that inclusion is not favoured, that those with mental ill health are doubted as to their genuineness and that mental health related stigma and discrimination are common within policing.

6.3 MAKS survey initial conclusions

The MAKS survey results have provided a measure and benchmark for police mental health related literacy and knowledge. Overall police officers and staff are statistically more knowledgeable about mental health than the public. However, the lack of agreement from police officers towards drug abuse being a mental illness is telling again as operational objectives and experiences appear to conflict with what appear to be generally supportive attitudes. The MAKS survey scores are generally more positive than the CAMI survey scores with the former underpinning the latter in establishing attitudes to mental ill health. However, the CAMI open responses provided additional insight into the thoughts of officers and staff, which revealed that there are barriers to inclusion and acceptance on face value of mental illness. Therefore, it is appropriate to examine the opens responses accompanying the MAKS survey.

6.4 MAKS open-ended questions

6.4.1 Methodology

The MAKS open-ended questions methodology replicates the CAMI open-ended questions above (See Chapter 5)

6.4.2 MAKS open-ended questions results

MAKS A

Most people with mental health problems go to a health care professional to get help

The statement elicited 114 responses. The vast majority disagreed with the statement. The responses were also somewhat unique as little or no mention of substance/alcohol abuse was mentioned as has been with similar statements and responses.

A small number of respondents thought that most people do go to a health care professional but possibly not all.

> *I think most probably do, but a fair proportion will just try to deal with it. (0782 Female Constable Response)*

However, the vast majority suggested that most people would be reluctant to seek professional assistance. A small number of respondents thought this would be due to a failure to recognise they may have a mental health issue or are slow to take the opportunity to seek assistance.

> *I think a lot of people suffer in silence for a long time before they seek help. (0574 Female Constable CID)*

It is for these reasons that some respondents believe the data regarding the number of people with mental health issues fail to record the true extent of people who should be engaging with mental health professionals.

> *I think there are more people with mental health problems than are registered in any medical database. An accurate number may never be known. (1054 Male Constable Response)*

The impact of revealing a mental health issue and the potential impact on employability, job retention and career development were cited by many respondents as an explanation as to why people do not seek professional help.

> *There is still a reluctance to seek help for fear of being ridiculed, seen as weak or their career suffering (0574 Female Constable CID)*

Additional respondents directly highlighted their opinions that the fear of ridicule/stigmatisation was key.

> *feeling is many people avoid going to a professional for a number of reasons, including fear of 'being stigmatized by others. (0476 Female Police Staff)*

Some respondents referred to their own personal experiences and how they waited many years to seek assistance, highlighting this is an issue for policing.

> *From a personal point of view I suffered almost in silence for approximately 12 years before seeking help and I think that's a common issue. (1396 Male Constable Neighbourhood)*

Respondents also raised concern that many 'service users' in their opinion had failed to seek professional help suggesting that many offenders are living with mental health issues and go unsupported.

> *The people with the most serious MH issues often only receive help or treatment following Police intervention/arrest or section (1154 Male Constable CID)*

People with severe mental health problems can fully recover

Responses to the statement were reasonably high (108). However, they were not very revealing.

The majority recognising the breadth of mental ill health and the approaches to dealing with it.

> *Depends on the illness, some forms of mental illness can be cured, others can be managed, some cannot be cured or easily managed (1420 Female Constable Support)*

There was a consensus that people with severe mental health problems may not fully recover because as there is always the potential for a relapse.

> *I think recovery is the wrong word. People with severe mental health problems can improve and live symptom-free, however I don't believe anyone who has suffered a severe illness (either physical and mental) can fully 'recover'. (1216 Female Police Staff)*

If a friend/colleague (amended version) had a mental health problem, I know what advice to give them to get professional help

The statement elicited 56 responses. The majority felt they would be in a position to do so, due to their own personal experiences.

> *Not because of the job but due to personal experience (1174 Male D/Sgt)*

Others felt comfortable in doing so because they were members of a union, staff association or peer support network and had training. One supervisor stated that he/she had taken responsibility to ensure they were equipped to do so.

> *I am not a trained counsellor or medical professional BUT as a supervisor I have made sure I have made sure I know where to go to get that advice. (1385 Male Sgt Support)*

There were a number of reasons highlighted why this would not be the case. Questioning how committed forces are to supporting mental ill health and that personnel wouldn't discuss the issue due to the stigma.

> *Its not done and the management only pay lip service to make it look like they are doing something (0792 Male Constable Response)*

Most people with mental health problems want to have paid employment

The statement elicited 56 responses. Several respondents thought they were unqualified to make an assertion. The consensus was to agree with the statement.

> *They want to be part of society like anyone else (0631 Male Support Staff)*

Some respondents highlighting how it was so important that this should be the case and challenging some of the stereotypes and that all is not well in the police service.

> *I myself have mental wellness issues. Being in work is my rehab! The media want us to believe that people with unseen health issues prefer to live on benefits than be in work. This is utterly not the case. Schemes that help people be in work and stay in work are so valuable. Yet even then, in the workplace itself, other colleagues can be judgmental about reasonable adjustments and the cost to the government/organization. I have experienced this first hand. (0473 Female Police Staff)*

A minority of respondents disagreed with the statement arguing that lifestyles or excuses were responsible for avoiding work.

> *quite the opposite, a lot use it as an excuse not to work (0606 (gender not stated) Constable Support)*

Medication can be effective treatment for people with mental health problems

The statement elicited 126 responses which collectively are encapsulated by the below. The statements recognise the worth of medication but suggest they should be well managed and used in conjunction with other therapies.

> *I do not consider that medication is always the answer. I am aware that there are a number of other ways to help people suffering with mental health problems (e.g. group therapy, CBT etc). (1280 Male Police Staff)*

Psychotherapy can be an effective treatment for people with mental health problems

The statement elicited 88 responses. The consensus being that psychotherapy is effective but may not be sole solution.

> *I agree to a point but depending on the level of mental illness this may not be enough. (1250 Female Police Staff)*

A number of respondents recognised that it had worked effectively for themselves or peers and in some instances that insufficient sessions were made available.

> *I wish I had been offered counselling or more therapy sessions. OTU told me I was only allowed 6 sessions and to keep 1 in the bank for the future (1117 Female Constable Response)*

MAKS B

Drug addiction

There were 142 responses to the statement. There were four schools of thought. One in the minority confirming drug addiction is a mental illness.

> *All addictions are (in part) mental health issues. (0802 Male Constable CID)*

The second confirming that people with mental health issues may turn to drugs to which they become addicted.

> *I think the cause of turning to drugs is due to an underlying mental health issue (0553 Female D/Sgt CID)*

The third confirming that continued misuse of drugs leads to poor mental health.

> *Addiction is Addiction, just like Alcohol, smoking, gambling etc... MH can be a result of addiction in many/most drugs cases (and other addictions) (0531 Male Police Staff)*

The fourth with the largest consensus that drug addiction is a life style choice and therefore not a mental health issue.

> *it's a choice. People with genuine mental ill health didn't choose to have it. People choose to take drugs.* (*0484 Female Police Staff Custody)*

Or perhaps life is just not that simple.

> *I don't know - the first step of taking drugs is a choice ??? (I understand drug use can cause mental health problems and some addicts have mental health problems before they use illicit drugs) (0779 Female Police Staff PCSO)*

Grief (% disagreeing)

The statement elicited 105 responses. The majority correctly disagreed with the statement.

> *It may be a trigger but Grief is an emotion (0956 Female Inspector)*

Stress

The statement elicited 89 responses. The respondents generally accepted that stress in its self is not a mental health issue but that negative reactions to severe stress is.

> *It can lead to mental illness if left untreated (0434 Police Staff)*

Of interest was the impact on individuals and perceptions within the service. Those that argue it is non-existent.

> *I know officers who believe stress doesn't ever exist! Stress in lots of circumstances I believe can be managed if the person is given the right tools to deal with. (0968 Male Constable Response)*

Those that believe it is being used as a smoke screen to avoid work or engineer absence.

> *Due to its difficulty to diagnose some people go to the doctor claiming they are suffering from stress to get time off work. (0630 Female Sgt Response)*
>
> *At extreme levels, yes. I will admit to cynicism sometimes when people are off with stress - we are all stressed to some degree, this is a difficult job, and it is hard to quantify beyond dispute. (0782 Female Constable Response)*

That police personnel can succumb to stress and are fearful of disclosing the matter at work.

> *I've suffered from stress. It caused my head to transfixed on my problem. I could not focus on anything else. I was depressed and my digestive system went to rat shit for 6 months. Didn't dare mention it at work. (0430 Male Constable Response)*

Depression

The statement elicited a remarkably low 35 responses. There was a generally acceptance that depression is a type of mental illness. A number of respondents referred to the impact of depression on their wellbeing.

> *In my own personal experience, depression is a mental illness. No one will understand depression until they are diagnosed with depression. It is a lonely and scary place to be! (0712 Female Constable Response)*

Some respondents, albeit in a minority, questioned whether it is a mental illness and if so due to life style or possibly fakery for perceived personal benefit.

> *It is a type of mental illness. It is also a default for those seeking to fake a disability benefit claim. (1304 Gender not specified Constable Response)*

Bipolar disorder

The statement elicited one of the lowest 27 responses. The majority of responses accepted that it was a type of mental illness or that respondents did not have enough knowledge to make comment.

> *Don't know enough about condition or the triggers. (0699 Female Constable CID)*

Some respondents were agreement due to their contact with detainees.

> *I see plenty of this disorder in custody (0526 Male Police Staff Custody)*

However, the reoccurring themes a minority but persistent throwing doubt on the condition.

> *It is a type of mental illness, but overly diagnosed and used an excuse for poor self control. Many claimed self diagnoses are an attempt to circumvent the need for personal responsibility and accountability. How long before rape is sexual urge suppression disorder? (1304 Gender not specified Constable Response)*

Schizophrenia

The statement elicited lowest (26) responses. The majority of responses accepted that it was a type of mental illness or that respondents did not have enough knowledge to make comment.

> *I agree but from the members of public I deal with this is brought on from drug abuse. (1392 Male Constable Response)*

Proportion of people who might have a mental health problem

Police officers and staff were more likely than the public to correctly identify that one in four of the population would have a mental illness at some time in their life.

6.4.3 MAKS open-ended questions discussion

As with the CAMI responses, the MAKS open-ended questions provided additional richer data, which give greater insight into the attitudes of police officers and staff towards mental ill health (O'Cathain & Thomas, 2004). The discussion is centred on six clear topics, consisting of established and emerging topics.

Established Topics

Stigma

From the MAKS open-ended questions mental health related stigma is present in policing both public facing (Godfredson et al., 2011; Koskela et al., 2015) and within the service (Blue Light Programme, 2016; Bullock & Garland, 2017; Stuart, 2017; Soomro & Yanos, 2018). Albeit a number of respondents were open about their own personal experiences of mental ill health in the survey it appears this was seldom shared with others in the organisation (Thoits, 2011; McDowall, 2014).

> *From a personal point of view I suffered almost in silence for approximately 12 years before seeking help and I think that's a common issue. (1396 Male Constable Neighbourhood)*

Such comments and disclosure of mental ill health are not confined to this chapter being replicated in other subscales. Combined they provide an interesting commentary on the attitudes towards mental illness endured by officers and staff with mental ill health.

Genuineness/ Suspicious Minds

As with CAMI data, the MAKS responses reinforced concepts of a policing culture that doubted the genuineness of persons with mental ill health. This too was viewed as a rationale for not disclosing a mental illness (Stuart, 2017; Turner & Jenkins, 2018; Bell & Palmer-Conn, 2018). Similarly, in the public sphere it was seen as a way to access benefits or work avoidance.

> *It is a type of mental illness. It is also a default for those seeking to fake a disability benefit claim. (1304 Gender not specified Constable Response)*

Thus reinforcing the stigma associated with mental ill health.

Lifestyle choice

The responses to the drug addiction is a type of mental illness provided one of the biggest disparities in the survey results. Police officers were clearly out of step with their police staff colleagues and the public who were more likely to agree that it was a mental illness. The responses to the open-ended questions placed value judgements on those taking drugs, which were not evident with the grouped, categorise about depression, bipolar etc. (Lister et al., 2008).

> *MH issues are caused by drug and alcohol misuse, which is down to the self-control of the person. (0484 Female Police Staff Custody)*

Emerging Topics

Police knowledgeable and comfortable to sign post for support are

The data from the MAKS open responses supports the MAKS survey scores suggesting that officers and staff are knowledgeable about mental ill health and likely to sign post colleagues with mental health issues towards specialist help (Jorm, 2000). However, the open responses suggests this has more to do with personal experience than input from the organisation to increase mental health literacy.

> *Not because of the job but due to personal experience (1174 Male D/Sgt)*

It is interesting that some respondents have taken it upon themselves to acquire the knowledge to support colleagues and peers.

> *Despite the lack of training from forces 'I am not a trained counsellor or medical professional BUT as a supervisor I have made sure I have made sure I know where to go to get that advice. (1385 Sgt Support)*

This on the one hand reflects negatively on the lack of training or preparation provided to supervisors to identify and respond to staff with mental ill health. On the other hand, it can be interpreted positively with supervisors identifying their lack of mental health literacy and being prepared to take ownership and improve their knowledge to support their staff. This is developed further in Chapter 9 Police Scale and Chapter 10 Interviews, that supervisors and their staff believe that the former are not adequately trained to support staff with mental health issues.

It is particularly important that supervisors have adequate mental health literacy and are comfortable in speaking with their subordinates about mental ill health (Reavley & Jorm, 2014) as supervisors are a key influence on individual and team attitudes towards mental ill health and whether they will chose to talk about difficult incidents or feelings (Evans et al., 2013). Without such conversations, supervisors are unable to assist and direct colleagues towards appropriate support.

Forces were questioned in supporting officers and staff with mental ill health

The quantitative data suggests that officers and staff know how to sign post or assist colleagues in seeking help. Unfortunately, there is a perception that despite varying wellbeing and mental health initiatives the support required is limited or unavailable via force occupational or health services. Forces were accused of 'paying lip service' to those with mental health ill health (Bullock & Garland, 2017; Turner & Jenkins, 2018).

Mental ill health affects employability/ career progressions

Despite the significantly positive scores regarding mental health related knowledge, the underlying theme of stigma and discrimination remains to the fore in the open-ended responses. Those reporting a mental health issue fear *'ridicule'* and being *'labelled as weak'* which is in turn is viewed as detrimental to career prospects (Karaffa & Tochkov, 2013; Bullock & Garland, 2017; Turner & Jenkins, 2018; Bell & Palmer-Conn, 2018). Such negative impacts on job retention and future career development or promotion opportunities are a blockage towards seeking professional help.

6.4.4 MAKS open-ended questions – Initial conclusions

On the face of it, the MAKS Schedule provides sound data indicating positive police mental health related literacy. However, the MAKS open-ended responses provides thoughts and comments, which are more nuanced than the reported statistics and provide further insight into police officer and staff attitudes to mental ill health. There is clear evidence police officers and staff are knowledgeable about the causes of mental ill health and confident to sign post colleagues towards professional help. Unfortunately as with the CAMI open-responses, there is additional proof that despite the positive scores mental health related stigma is prevalent, delaying or preventing disclosure and help seeking and detrimental to career prospects.

CHAPTER 7

Working with people with mental ill health

7 Working with people with mental ill health

7.1 Methodology

This statement is taken from the Reported and Intended Behaviour Scale (RIBS) (Evans-Lacko et al., 2011). The Time to Change survey employs four domains comprised: living with, working with, living nearby and continuing a relationship with someone with a mental health problem. However to reduce the overall size of the survey this research only employed the working with statement.

7.2 Results

Table 10. Working with people result

Mean Scores	Public	Police officers	Police staff	p Value	F Value
In the future, I would be willing to work with someone with a mental health problem	4.16	4.52	4.646	0.001	61.7815
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.0.001*, officers vs staff: p=0.744					

Police officers and staff are significantly more likely to indicate they would be willing to work with someone with a mental health problem. A one-way between subjects ANOVA was conducted to compare the three groups. Between the groups at the p<.05 level for the three groups [F(2, 2799) = 61.78 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for the public (M =4.16, SD = 1.04) was significantly different from the police officer group (M=4.52, SD 0.7) and the police staff group (M=4.65, SD = 0.67). Statistically, police officers and police staff shared similar views.

7.2.1 Open responses

In the future, I would be willing to work with someone with a mental health problem.

The statement elicited 44 responses. There was a general acceptance that colleagues do in fact have mental health issues and continue to do their job

> *I have, we have had inspectors and other colleagues who have openly stated that they have suffered with mental health issues. This did not have any adverse effect on the way they did their job or the way people looked upon them. I even had more respect for the inspector for being brave and telling people. He was an excellent inspector but now retired. (0667 Male Constable CID)*

Some placed a caveat on the willingness to work.

> *Depends on the person, I've worked with some who'd use it as an excuse, and others who I'd support through thick and thin. Depending on what the problem was. (0961 Male Constable CID)*

With a small number questioning an impact on the impact upon themselves.

> *I'm willing to work with anyone that pulls their weight. I'm prepared to make allowances but someone needs to be effective or I have to work twice as hard. (1218 Female Constable CID)*

Working with people with mental illness – Discussion and conclusion

Evans- Lacko et al. *(2010, p1) suggest, "Behaviours, are central to discrimination and could be argued to be the most meaningful outcome from the perspective of mental health service users/consumers". Measuring reported intended behaviours can be used to gauge behavioural outcomes and evaluate ant-stigma interventions in the workplace or society at large. Employing the Reported and Intended Behaviour Scale (RIBS) Schedule police officers and staff are more likely to be supportive of working with someone with a mental illness than the public.

There was some acknowledgement that officers are already unknowingly working with someone with a mental illness or are likely to do so. However, the 'suspicious minds' mind set was never far from the surface *" I've worked with some who'd use it as an excuse, and others who I'd support through thick and thin." (0961)*

CHAPTER 8

Consulting and talking about mental health

8 Consulting and talking about mental health

8.1 Methodology

This section examines the likelihood of people talking to people about their mental ill health.

8.2 Results

Table 11. Consulting and talking about mental health scale results

Mean scores	Public	Police officers	Police staff	p Value	F Value
If you felt you had a mental health problem, how likely would you go to your GP for help?	4.13	3.93*	4.13	0.001	8.137
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.995, officers vs staff:0.033*					
If you felt you had a mental health problem, how comfortable would you be informing friends and family	5.07	4.08*	4.41*	0.001	82.026
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.979					
If you felt you had a mental health problem, how comfortable would you be informing a current or prospective employer	3.65	2.46*	2.60*	0.001	127.17
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.523					
Total (Max score is 21)	12.87	10.46	11.1372	0.001	129.48
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.017*					

Examining the total for the three statements, the three groups scored significantly differently with public scoring highest, followed by police staff and then the police officers. A one-way between subjects ANOVA was conducted to compare the three groups. Between the groups at the p<.05 level for the three groups [F(2, 2799) = 129.48 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for all three groups were significantly different public (M =12.87, SD = 3.70), police officers (M=10.46, SD 3.37) and police staff (M=11.14, SD = 3.50).

Police officers were significantly the least likeliest to **consult their GP** than police staff and/or members of the public. A one-way between subjects ANOVA was conducted to compare the three groups. Between the groups at the p<.05 level for the three groups [F(2, 2799) = 8.14 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for all three groups were significantly different public (M =4.13, SD = 1.16), police officers (M=3.93, SD 1.16) and police staff (M=4.13, SD = 1.05).

Statistically police officers and staff shared similar views to **informing family and friends of a mental health issues** and **informing current or prospective employers**. They were statistically less likely to do both compared to the public.

Q62 Informing family and friends, A one-way between subjects ANOVA was conducted to compare the three groups. Between the groups at the p<.05 level for the three groups [F(2, 2799) = 82.03 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for all three groups were significantly different public (M =5.07, SD = 1.89), police officers (M=4.08, SD 2.01) and police staff (M=4.41, SD = 2.08).

Q64 Informing Current or prospective employer. A one-way between subjects ANOVA was conducted to compare the three groups. Between the groups at the p<.05 level for the three groups [F(2, 2799) = 127.17 p = 0.001]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for all three groups were significantly different public (M =3.65, SD = 1.96), police officers (M=2.46, SD 1.67) and police staff (M=2.60, SD = 1.70).

8.2.1 Open responses

If you felt you had a mental health problem, how likely would you be to go to your GP for help?

The statement elicited 60 responses. There was mixed reactions to the statement. A number of respondents would or have sought the assistance of their GP some doing so quite soon after feeling unwell others took some time to do so.

> *It took me over 3 years before I sought help properly. (1081 Female Constable Support)*

Others explained why they were reluctant to do so. Some because they were male and stating it is not what men do. Some expanding further seeing it as a matter of pride and or privacy.

> *In the past I would have been very reluctant to go to my GP. I may still be a little hesitant to do so - but that is my personal pride at play.* (*0476 Female Police Staff)*

A lack of confidentiality and a fear of current or future employers finding out was the basis of several responses or that the GP would set precedence over the employer than the employee.

> *I would have done in the past, but I wouldn't go now through fear it would be disclosed during future employment processes, and I think it would have a negative affect on my chances compared to other people. (0745 Female Constable CID)*

However, some respondents indicated that they would use support services of their current force instead of G.P. and that in doing so in some instances access to support could be quicker

> *Work actually provide a better and fast track service than my GP.* (0816 Female Constable CID)

If you felt you had a mental health problem, how comfortable would you be informing friends and family

The statement elicited 41 responses. There were mixed reactions to the statement. Some being willing to be more open than others doing so because it is personally helpful in doing so or in tackling the stigma related to mental health.

> *I'm very open with my family and close friends. In fact, it is talking to them about things that assisted me greatly in my own recovery. (0551 Male Constable Response)*
>
> *I am under my GP for postnatal depression. I am fed up of peoples negative attitudes people have towards others with mental health issues. I am more than happy to speak up about my battles with depression if it makes people more aware and allows them to be open minded about others. (0712 Female Constable Response)*

For others there is a clear boundary of not informing family. This is in order to protect them or for fear of being seen as weak.

> *As stated previously I suffer from depression. I have talked to my wife about it, but there are parts that I wouldn't ever consider telling her. I don't talk to my adult children about it, unless they ask, because I don't want to frighten them. I never talk to friends or colleagues about it (0475 Male Police Staff Support)*
>
> *Close friend maybe yes. Family -No- also we have a role that implies we are always strong, problems out and don't have our own. (0574 Female Constable CID)*

A single response highlights the perceptions of others and the negative viewpoint some may hold in policing circles surrounding mental health.

> *I think it's still like an admission of failure amongst reasonably intelligent working people and often seen as an excuse for laziness when time off is taken! (0862 Female Constable CID)*

If you felt you had a mental health problem, how comfortable would you be informing a current or prospective employer

The statement elicited 60 responses. The consensus in that there is a trust issue and that disclosure of a mental illness has negative implications for the individual and can hamper career development.

> *Unable to trust how that may affect prospects (0459 Male Constable CID)*
>
> *There is too much stigma and discrimination. I would do it only out of integrity and honesty. But I would know it would have a serious impact on my career. (0523 Male Police Staff Despatch)*

Confidentiality was a key concern for some.

> *the stigma that would follow as I'm sure attitudes change towards the person confiding and I would not be comfortable that the conversation would be confidential - it is the police service where in my experience nothing it fully confidential (0981 Male Constable Support)*

It was perceived that senior officers and managers would question officers/staff ability to cope and how attendance would be affected to the detriment of those involved.

> *Employers say they understand mental health but many have negative and pre-conceived ideas of how they think you would cope or not (0462 Female Constable Neighbourhood)*

8.3 Consulting and talking about mental health – Discussion

Participants in both the Time to Change – TNS BMRB Attitudes to Mental Illness Questionnaire (2015) and this study were asked about their likelihood of consulting a GP (Table 11) and speaking to prospective employers, friends, and family if they were to experience mental ill health. Police officers and staff indicated they were reluctant to do any of these things and were statistically less likely than members of the public to consult their GP, inform prospective employers, and talk to family or friends about a mental illness. Confidentiality was seen as an issue, respondents being fearful of the illness being shared with employers. A similar survey in the UK reported that a very high proportion of police respondents said that they would never seek help from Human Resources, Occupational Health, or the Police Federation or trade union and would not seek support from their managers (Blue Light Programme, 2016; Houdmont & Elliot-Davies, 2016). The Blue Light Report suggested the police placed a high importance on family support – citing it as the most likely place to seek help. However, respondents in this research were less inclined to do so. This is in line with previous research as Westley, (1970) found police officers place a boundary between home and work, and are unlikely to burden or confide in family about the risks, dangers and impacts they encounter. Karaffa & Tochkov, (2013) reported that

officers are reluctant to access mental health support in fear of being seen as weak or incapable of doing their job.

8.4 Consulting and talking about mental health – Conclusion

Table 10 indicates that police officers and staff are more supportive of others with mental health issues, and are more willing to work with people with mental health issues than the public but paradoxically they are less likely to share their experiences with others. Police officers are the least likely to consult their GP or inform their current or future employer or confide in family and friends about mental ill health.

CHAPTER 9

Police scale – Measuring attitudes

9 Police scale – Measuring attitudes

9.1 Methodology

Police specific questions: In order to better understand police culture, the author included additional questions measured on a five point Likert scale relating to policing and mental health including, provision of training, disclosure of mental illness, relationship with colleagues, and potential impact of disclosure on career prospects. The overall internal consistency among items is 0.791 (Cronbach's α). The total score calculated so that higher scores indicate more positive outcomes.

9.2 Results

9.2.1 Police specific questions

These questions examined officers/staff likelihood of speaking to mangers and colleagues about mental ill health and the potential impact it may have on their working lives.

Table 12. Police scale results

Mean scores	Police officers	Police staff	p Value
Q65R If I had a mental health problem I think my managers would support me.	3.31	3.65	0.01*
Q66R If I had a mental health problem I think my work colleagues would support me.	3.56	3.76	0.017*
Q63 In general, how comfortable would you feel talking to a work colleague about your mental health	3.05	3.42	0.001*
Q70 Disclosing a mental health problem in the police service is detrimental to future career prospects.	1.98	2.48	0.001*
Q71R Police Officers/Staff with mental health problems are treated as sympathetically as officers\staff with physical illness.	2.39	2.79	0.001*
Q69 Some people use stress as an excuse for being absent from work.	2.42	2.63	.026*
Q73R My Force adequately prepares managers to manage officers/staff who experience mental health issues.	2.13	2.56	0.001*
Q72R My Force adequately prepares officers/staff to deal with the stressful events they are likely to encounter.	2.07	2.63	0.001*
Q74R Debriefing is used effectively to support officers/staff who have experienced stressful events within my Force.	2.76	3.23	0.001*
Q75R Within my Force there is sufficient support for officers/staff experiencing mental health issues.	2.58	3.06	0.001*
Total Score (Max score is 50)	26.27	30.1	0.001*

An independent-samples t-test was conducted to compare police officer and police staff responses to the Total Scores for the Police Scale. There was a significant difference in the scores for police officer (M=26.27, SD=7.34) and police staff (M=30.10, SD=7.54) responses; t (850)=--6.60, p = 0.001. These results suggest that police officers share significantly poorer views about their experiences of mental health issues in policing than police staff counterparts.

As can be seen above this applied to all statements.

9.2.2 Open responses

As with the CAMI and MAKS open-ended questions provided additional richer data, which give greater insight into the attitudes of police officers and staff towards mental ill health within the police family (O'Cathain & Thomas, 2004).

If I had a mental health problem I think my managers would support me.

The statement elicited 94 responses. There was a mixed response. There was an acknowledgement that direct line managers were more likely to do so. However, this was not reflected in wider or more senior managers.

> *If by Managers you mean direct supervision - Sergeant/Inspector, absolutely. Beyond that, I don't have the same faith. (0824 Male Constable Response)*

A number of respondents questioned how genuine any support would be. There is a conception that adherence to policy or maintaining attendance as opposed to genuine support or humanity drives supervisors responses.

> *To a degree, this is true. But it is the corporate version of support, i.e. it has to be done to get you back to work, as opposed to genuine concern or involvement (1433 Male D/Sgt CID)*

Some respondents suggested that those with mental health issues were viewed as an encumbrance on the organisation.

> *Only works to a degree and if longer term then seen as a burden in terms of resource and workload management (0459 Male Constable CID)*

This manifest it's self in the use of threatened and actual misconduct and performance procedures, which it is argued, do little to support officer or deal with the associated issues.

> *First line managers are the problem, they have no idea how to deal with individuals, who they see as just a pain or a burden. They have no idea of what services are available. They also have HR breathing down their neck's to push staff down the Discipline line rather that a supportive one to assist their Mental health.*

The Discipline line puts the individual under even more pressure re their Mental health. Its a constant battle !!!!!!!! (0673 Female Constable Support)

Respondents appear to be fearful of taking time off.

The same as all health issues in the MPS - it's OK so long as you don't need to take sick leave. Taking sick leave is regarded as not far from murder by some senior officers (1352 Male Inspector Support)

If I had a mental health problem I think my work colleagues would support me.

The statement elicited 66 responses. There was a mixed response. There was an acknowledgement that support would be offered by some colleagues with most positive responses applying a caveat that some close colleagues would support them but certainly not the wider circle.

Some would. Some I would never tell. (0473 Female Police Staff)

There appears to be a belief that where support would be provided in a current working environment that a lateral move would impact upon this and that a transfer would remove such support.

My current direct ones would. But again, if I move department or team, I wouldn't be so sure as stigma still exists grossly within the police. (0551 Male Constable Response)

Several officers have suffered negative experiences and that name-calling and detrimental comments have been used.

I have been unable to discuss my mental health problems with the vast majority of colleagues due to their apparent lack of understanding and 'micky taking...' of other colleagues. (1081 Female Constable Support)

Though when others have had mental health issues, I have personally heard negative comments from others regarding not pulling their weight etc. or needing them to be moved.. (1415 Female Constable CID)

There is an acceptance that mental illness is not treated as sympathetically as physical illness.

I have been treated very differently, ie with lots of sympathy when I have had cancer but not when depressed. (1034 Female PCSO)

With one respondent providing an extremely harrowing account of their experience.

I was diagnosed with PTSD in 2013 and was treated like a leper by my Supervisor and peers. (1345 Male Constable Support)

The adherence to attendance and competency procedures identified a continuing theme of doubting the veracity of mental health within the service and continuing shadow casting over those diagnosed as such.

> *I believe some would, but having sat through numerous meetings where staff sickness is discussed, there is, sadly, clearly still a culture of thinking people who are off sick with conditions such as stress and depression are "not really ill" (1216 Female Police Staff)*

In general, how comfortable would you feel talking to a work colleague about your mental health, for example telling them you have a mental health diagnosis and how it affects you?

The statement elicited 89 responses. A sizable proportion of respondents suggested that a decision to inform colleagues or not was dependent upon who the colleague was. Close friends were more likely to be informed.

> *This would depend on the colleague - I have been able to discuss my depression with one colleague but there are others where I wouldn't be able to (1461 Female Police Staff)*

Others were plainly more reluctant to do so.

> *I have one. I prefer to keep my condition largely to myself. It's the stigma, stupid! :-) (0489 Male Police Staff)*

Some were fearful of the consequences believing that such disclosure could be shared with the organisation with negative impacts for the individual.

> *Do you want to end up inadvertently having your own personal life exposed and scrutinised. What impact will it have on your job, your future employment. Your state of mind. (1179 Male Constable Response)*

However, some respondents have experienced a benefit either personal or organisational in doing so and have the opinion by discussing the issues it tackle the negative perception surrounding mental illness.

> *I have got past the embarrassment it actually is a relief to say it! (0478 Female Constable Response)*

> *I hope that sharing my experience of mental health problems encourages others to talk (0488 Female Police Staff Operational)*

Disclosing a mental health problem in the police service is detrimental to future career prospects.

The statement elicited 77 responses. A small number of respondents tended to disagree with the statement. Suggesting that disclosing a mental health problem was probably damaging to a career in policing at some point or this is no longer the case.

> *A few years ago I would have agreed strongly however I really do believe things are improving within the police service - albeit slowly (1461 Female Police Staff)*

However, the general consensus was that such disclosure would be seen negatively or unfavourably when seeking career development.

> *The stigma is still there, despite rhetoric to the contrary (1370 Male Police Staff)*

Several respondents cited their own experiences as evidence of the problem and restrictions or barriers that had been placed in front of them.

> *I've already had a considerable experience of being 'paper sifted' for my restriction. Its destroyed any passion I have to better myself at work.* (*1402 Male Constable CID)*

> *I have purposely steered myself away from certain avenues I formerly had a desire to follow. ARV for example; as I feel that, as soon as it is noticed on my medical record, my application will be binned. I have been turned down for TASER twice in that time. (1365 Male Constable Neighbourhood)*

Despite attempts to address such matters and change the culture and perceptions of the police service, there is an underlying perception that this continues to be prevalent.

> *No matter how many promises and assurances are made in relation to being fair and confidential, there is still stigma and negative connotations to mental health problems. I do not believe any disclosure to management would not have any detrimental effect of career aspirations. (0730 Male Constable Response)*

Police Officers/Staff with mental health problems are treated as sympathetically as officers\staff with physical illness.

The statement elicited 84 responses. Very few accepted that mental and physical health were treated similarly.

> *Most won't even tell the employer. (0699 Female Constable CID)*

There are perceptions that things are changing and that 'peer support' networks assist in doing so.

> *We have a Wellness Programme which includes Mental Wellbeing Network with access to Peer Support and other services. So the culture and perception is changing. (0511 Female Police Staff)*

A number of officers were not aware of colleagues having experienced mental health issues, which is surprising considering the prevalence of people with mental health issues. This suggest many sufferers may hide it.

> *I don't (personally) know anyone who has mental health issues and I have never suffered from them myself so I wouldn't know. (0794 Female Constable Response)*

Many who responded identified problems or their own experiences and how their treatment by colleagues and or the organisation was detrimental to their wellbeing.

> *it's a lot better than it was , but more needs to be done. Especially with reassignments of roles and suitability, i.e. being put in an office for first time in their working lives can be disastrous! (0631 Male Support Staff)*

In keeping with much of the responses to many statements, the validity of officers/staff mental health was called into question. There is a sizable proportion of responses which question the illness and accuse colleagues of 'swinging the lead'.

> *I think it is very easy for a person with nothing wrong with them to go to the doctor and say they are stressed, in order to be signed off work. This has a negative impact on people who genuinely have mental health problems. (1105 Female Sgt CID)*

Furthermore, respondents highlighted the inappropriate responses and denigrating position some are placed whilst experiencing poor mental health.

> *M/H in the workplace is seen as a weakness and ridiculed by colleagues and supervisors behind the victims back. I have no trust in informing supervisors for support. (0875 Male Constable Response)*

Some people use stress as an excuse for being absent from work.

The statement elicited 123 responses. In general, there was some support for the statement most with a caveat.

> *Some people have used this as an excuse but they are absolutely in the minority. Most people who I believe are suffering with stress remain in the work place and continue to suffer with stress. (0553 Female D/Sgt CID)*

There was a consensus that officers/ staff doing so provided a negative environment for those how 'genuinely' required to be absent and that such behaviour led to the negative mind-set about mental ill health in the police.

> *Some inevitably jump on the stress bandwagon. This cheapens the ones who are actually stressed for real and need to take time off to recover. (0462 Female Constable Neighbourhood)*

Many respondents argued that as it was an 'invisible illness' it was easy to exploit as a means to secure an absence.

> *Our policing environment can be extremely stressful and people genuinely suffer from it. I know because I was one of them. However, some people do use it as an excuse to have time off work because it's not an obvious illness. (0472 Female Police Staff Despatch)*

My Force adequately prepares managers to manage officers/staff who experience mental health issues.

The statement elicited 88 responses. There was a recognition that forces are attempting to improve matters and provide training for managers some recognising that it will take time to improve matters.

> *But this is recognised and being tackled through the force wellbeing programme again - we are trying to change this but it will take years and a different culture of management. (0616 Male Superintendent)*

However, many doubted this to be the case and were not aware of any training being delivered to supervisors to assist them managing staff with mental health issues.

> *We have no training on how to spot/signpost/ help staff. It is purely down to the individual to use their own skills! And some don't have any and actually don't care (0452 Female Sgt Support)*

My Force adequately prepares officers/staff to deal with the stressful events they are likely to encounter.

The statement elicited 89 responses. There were some acknowledgments that training occurs but it does not appear to be widespread. Nor is there a mention of its effectiveness. Questions were also raised about some initiatives being provided as 'lip service'

> *Force has made great strides forward in this area as our Deputy Chief Constable is the National lead on Wellbeing however we can still do more to raise awareness and develop understanding and how to signpost and support. (0840 Female Chief Inspector)*

> *My force does not prepare us at all. " wellbeing " has become a brand with little real implementation. (0593 Male Inspector Response)*

Where it is delivered, it does not appear to meet the demands of front line roles. The reliance on IT based training was highlighted as a weakness.

> *in my opinion, HQ training is too fluffy and does not prepare you for real world policing apart from learning legislation - it acts like an overfriendly employer, which is good but there are times when it would be appropriate to start being physically hard as people come out of training in a "safety bubble" (having being there myself). (0788 Male Constable Response)*

Breeze packages do NOT prepare you for REAL LIFE EVENTS. (1081 Female Constable Support)

A number of respondents questioned whether appropriate training could be delivered as the range and variety of traumatic incidents could not be accounted for in a training environment.

It's almost impossible to do this in my opinion, due to the countless possible scenarios. Everyone will effect people differently. (0835 Male Constable Support)

However, the majority of responses indicate little is being done with in the service to prepare officers/staff to deal with the traumatic incidents they are expected to deal with. There appears to be an expectation that officers/staff receive their training in the field by working along more experienced officers or developing their own coping strategies.

We have no training in how to deal or cope with horrible jobs - however I have been in a very long so the training may have changed - I have never received any training in what to expect, what to do or how access help. (0715 Female Constable Despatch)

In many police quarters, TRiM (Trauma Risk Management) is recognised method for supporting officers after participating in traumatic or extremely stressful events. However, there appears to be limited delivery or uptake.

The training around dealing with high stress events is essentially nil. Post incident support is also essentially nil. A high stress event generally involves a quick "ARE YOU OKAY" and a dusting off with no formal debrief or offer of support. To illustrate, in 10 years in the Police I have been offered TRIM once. I have lost count of the amount of jobs where this should have been offered. (0824 Male Constable Response)

It appears offices/staff are reliant on their peers to provide guidance and support in order to be able to cope and developing coping mechanisms.

No one can give the emotional support to another unless they have been through it themselves and to have a colleague with you gives you confidence and it little more strength to deal with things. (0939 Female Constable Response)

Debriefing is used effectively to support officers/staff who have experienced stressful events within my Force.

The statement elicited 129 responses, which provided an array of data. There is a consensus that debriefing is sporadic and limited between forces and even departments. Where it is used, it is found to be beneficial.

Was involved in a critical incident de-brief some time ago and found it very useful (0793 Male Constable response)

As I said earlier, because you are in the control room and don't actually "see" an incident you are overlooked almost completely and just have to move onto the next job. (1012 Female Police Staff Despatch)

TRiM (Trauma Risk Management) appears to be deployed in some forces though not all are supportive of its use or effectiveness. It also appears to be used sporadically overlooking certain policing functions.

There is a TRIM system in place and work ongoing with the roads policing function in the force to provide support to those specialist officers continually exposed to traumatic incidents on the road. This is linked with our Occupation Health Unit. (0476 Female Police Staff)

Having been part of several de-brief - they are a ticky box exercise. (0715 Female Constable Despatch)

Where it is provided there is a suggestion that officers choose not to get involved.

In fairness staff *who encounter harrowing situations are offered that support. I would say in most cases though officers decline to receive it. (0939 Female Constable Response)*

An overwhelming number of respondents confirmed that they had not been offered or participated in any structured debriefings.

Never had one, despite being shootings, car crashes, murders, riots. (0430 Male Constable Response)

I have never been offered a debrief in 11 years of service, 9 of those as a front line CSI (Crime Scene Investigator) dealing with traumatic deaths (0488 Female Police Staff Operational)

Within my Force there is sufficient support for officers/staff experiencing mental health issues.

The statement elicited 118 responses. There was a limited acceptance that the support provided has been improving in some instances, despite the reducing police budgets forces are attempting to invest in or replace previously removed support structures.

It is improving but still has some way to go (0531 Male Police Staff)

EAP (Employee Assistance Programmes) were mentioned with mixed reviews suggesting more needs to be done to make them effective.

There is a confidential care line and a recently set up peer support network (however the take up for the latter is maybe not a high as it could be at the moment) (0476 Female Police Staff)

EAP is rubbish - their call takers clearly have no specialist training & seem to be following a script (0524 Male Police Staff Despatch)

The majority were dismissive of the support provided suggesting it is non-existent or very limited and that regional differences are evident.

> *Improving slowly and means of developing understanding emerging. However until there is a complete culture change from full understanding and the blame culture is eradicated the levels of support will never be as they should be (0459 Male Constable CID)*
>
> *We haven't had a referral system from MH for over 12 months!! (0416 Female Sgt. Response)*

9.3 Discussion

Police officers and staff were asked a series of questions (Table 13) about interactions with managers and colleagues if they had mental health issues. Police officers were less likely to agree that their managers or colleagues would support them than police staff. However, it should be noted that the figures are less than overwhelming in either case. Police officers and staff expressed the opinion that mental illness was not treated as sympathetically as physical illness, that police officers and staff were not adequately prepared to deal with the stressful events they may encounter. Consequently, respondents believed managers are not sufficiently equipped to manage officers/staff who may have mental health issues (Stuart, 2017; Turner & Jenkins, 2018). This mirrors the Blue Light Programme (2016) in England and Wales who found the police of all the emergency services 'agreed they would be treated differently if they disclosed a mental health issue'.

Debriefing is lacking or inadequate which, according to Turner & Jenkins (2018, p.6) is 'a glaring omission that leaves police officers to internalise the impact of involvement in traumatic events' without suitable interventions.

As above it appears police officers and staff are suspicious of mental health related work absences with majorities supporting the statement (Q69) 'Some people use stress as an excuse for being absent from work'. Traditionally officers reporting stress or depression were seen by peers and supervisors to be 'swinging the lead' insinuating that reported absences are not genuine (Stuart, 2017; Turner & Jenkins, 2018). Similarly to the scepticism displayed about mental ill health in CAMI and MAKS scales, the genuineness of colleague's mental illness is also called into question by respondents as displayed by a male sergeant, *'genuine illness - definitely, lead swingers - no.'(0771)*

Despite the overall aggregate scale scores, the qualitative statements reveal an underlying cynicism towards mental health externally and in the relationship of officers and staff when

dealing with colleagues or supervisors with a member of staff with mental ill health. It is for this reason the researcher has adopted the phrase 'suspicious minds'.

In general, police officers were less likely than police staff to portray a positive appraisal or agree that they were sufficiently prepared or supported by the organisation for dealing with the stresses of police work and the impact on their mental health. Police officers returned a lower score to all the statements than their police staff colleagues. It is of note that police officers and police staff were far more likely to agree than disagree with the statement (Q69) 'Some people use stress as an excuse for being absent from work'. The lowest scoring statement for both police officers and staff was (Q70) 'Disclosing a mental health problem in the police service is detrimental to future career prospects'. A male constable highlighted the pitfalls,

> *Do you want to end up inadvertently having your own personal life exposed and scrutinised. What impact will it have on your job, your future employment. Your state of mind. (1179 Constable Response)*

The survey suggests that police officers and staff hold similar attitudes towards people with mental ill health compared to the public. Police data indicates that they are more willing than members of the public to work with someone with mental health issues (Chapter 7). Likewise, police respondents are significantly more likely to agree with the statement (Q28) 'Virtually anyone can become mentally ill' than public respondents. This is in contrast to the police specific questions, which suggest that officers and staff are reluctant to disclose their mental ill health, and that doing so is detrimental to their career. A perceived lack of trust and confidentiality results in a fear that personal details maybe leaked to colleagues as revealed by a female police staff - *'the stigma that would follow as I'm sure attitudes change towards the person confiding ……it is the police service where in my experience nothing is fully confidential' (0981 Merseyside).* Of great consequence is that police officers and staff are of the opinion that disclosing a mental health problem in the police service is detrimental to future career prospects. Bullock and Garland (2017) in their research raise similar issues arguing that police culture side-lines those with mental health issues resulting in discrimination, which can prevent officers from disclosing or seeking support when it would appropriate to do so.

9.4 Police scale – Conclusion

The Police Scale and accompanying open-responses provides evidence that police forces fail to prepare police officers and staff to deal with the stressful and traumatic incidents, which are an unpleasant fact in policing and reasonably foreseen. Arguably, this is a failing in duty of care by the organisation. Similarly, managers are not adequately trained or prepared to recognise and support officers and staff who have mental health issues. Furthermore, with little or no medical or mental health screening and an inconsistent approach to debriefing officers and staff are left isolated in the aftermath of traumatic events.

Alongside such corporate failings, officers and staff have to contend with colleagues and managers who alarmingly doubt the genuineness of colleagues / subordinates mental ill health and are often accused of malingering. Regrettably, such a culture is not conducive to disclosing poor mental health, which results in under-reporting, delayed help seeking and can leave officers and staff isolated.

CHAPTER 10

Interviews – 'The lived experience'

10 Interviews – 'The lived experience'

10.1 Method

Semi-structured interviews

Qualitative researchers have several tools available from the complexities of ethnography studies to simpler forms of short open-ended questions or surveys with unstructured, semi-structured, structured interviews and focus groups somewhere in between. The terminology is not as fixed as would first appear and can be interchanged to some extent.

Surveys are generally but not exclusively a series of very structured interviews, which can be deployed in person or via other mediums. Structured interviews consist of a series of prepared fixed set of questions, asked in identical order to all respondents. There is little or no facility for interpretation by the interviewer or respondent. They are generally suited to short term descriptive data, easily quantified with easily generalised findings. (Bryman, 2012)

Unstructured interviews are best suited to long term fieldwork. They provide participants greater control over the interview. Researchers provide little or no direction to the participants instead allowing the conversation and data to develop. Participants are given free rein to go off script so that the researcher can understand what is important to the interviewee. This allows the participant the ability to direct topics and themes and provide a rich picture of the world as seen by the participant. Ongoing access to participants is essential for in this type of long-term project, as the researcher's understanding of the field is continually developing and will require the time to seek clarification and build data. (Bryman, 2012)

Focus groups share several similarities with interviews albeit in a collective setting. 'a form of group interview in which: there are several participants; there is an emphasis on questioning on particular fairly tightly defined topic; and the emphasis is upon interaction within the group and the joint construction of meaning' (Bryman, 2012, p. 712)

Members of a focus group may influence each other's responses during the discussion. A fundamental feature of the focus group is the ability to discover group norms since "the source of the data is the interaction among the participants" (Morgan, 2012, p. 162). Focus Groups are particularly helpful in understanding the impact of an issue on a community level, by identifying the cultural and social values that govern the community in question and how the respondents view these norms. However, researchers question the ability of

participants to speak up or air their views if they do not sit comfortably with group norms. As a result, they may not be suitable for sensitive topics (Morgan, 2012).

By comparison, to focus groups, the interview has no interest in-group dynamics, but rather focuses on the individual. It is the most appropriate method for seeking a person's own lived experiences, values and judgements. It provides a depth of data through its interpretive aspect, in that it allows the understanding of how the participant makes connections between certain experiences, events and beliefs. In short, it provides a richness of data (Hitchcock & Hughes, 1989).

Hitchcock and Hughes (1989, p. 83) describe the semi-structured interview as a process

> 'which allows depth to be achieved by providing the opportunity on the part of the interviewer to probe and expand the interviewee's responses. ... Some kind of balance between the interviewer and the interviewee can develop which can provide room for negotiation, discussion, and expansion of the interviewee's responses'.

Semi-structured interviews are one of the most common methods of data collection in qualitative research (Bryman, 2012). Fontana and Frey (1994) describe such interviewing as 'the art of science' as the interviewer has to adapt and respond as the interview progresses, gently weaving their way through the conversation to elicit and understand the key concepts being offered up by the interviewee. The interviewer initially dictates the topic and constructs a framework within which the interviewee responds. The interviewer must be alert to the nuances of the answers and probe deeper seeking answers, which align with the structure but does not limit the nature of the answer.

Interview participants were recruited via a Gate Keeper at a National Charity for Police Officers and Staff with Mental health issues. From this, there was some evidence of a snowball effect where participants volunteered themselves. The semi-structured interviews were carried out at participants' homes, places of work and via telephone dependent upon location and choosing of the participant. As it was a nationwide survey, travelling time and expenses were taken into consideration when determining face to face interviews. Interviews were recorded on a PIN protected portable device and transcribed by an employee of a Police Federation Branch Board with the appropriate expertise. All participants were allocated a pseudonym and location names, venues etc. were replaced to ensure anonymity. Transcribed anonymised interviews were stored on LJMU password protected IT systems and recordings deleted.

Semi- structured interviews:

The questions were derived from the authors own experience of being an advocate for police officers with mental health issues, previous research by the author at Masters level and the relevant literature. They were validated in consultation with serving officers, retired officers, HR professionals, Police Federation and UNISON representatives. The questions were designed to capture officer's/staff experience of interacting with colleagues and managers whilst experiencing mental health issues in a policing environment.

10.1.1 Interviewer and interviewee relationships

The one-to-one interview may not be formal but it is a social interaction where the relationship between the interviewer and interviewee will impact upon the outcome of the interview and the quality of the data to be gleaned. The interview may be seen as conversational and egalitarian but the relationship between those involved is not equal (Kvale, 1996). Both participants will experience and interpret the conversation differently depending on their previous experience, background, personality, and rationale in participating in the interview (Kvale & Brinkman, 2008). Haworth (2006) suggests that giving both parties in an interview proscribed roles produces a 'built in discourse asymmetry' in favour of the interviewer. Likewise, (Kvale, 2006) suggests the interviewer is in the ascendency in what is a hierarchical relationship and conversation where the interviewer holds all the cards when setting the agenda and interpreting the data. Thus, the interview is not one of equals but one where the power base resides with the interviewer. Fairclough (1989) defines power as controlling and constraining the contributions of less powerful participants in discourse by more powerful participants. This may be due to the socioeconomic status, educational or professional background, and gender or ethnic identity of the parties involved.

Whilst recognising this hierarchy Kvale (1996, 2006) infers that interviews are not powerless that they can adopt counter measures to retain and wield power. Participants hold an ace card in that they retain the right to withdraw. More importantly, the interviewee has control over what they introduce into the conversation and how they deliver it, either providing or not providing the required data (Kvale & Brinkman, 2008). Nunkoosing (2005) suggest that like tug of war the power shifts back and forth, as the interviewer holds the knowledge about the research and the interviewee possesses the knowledge and experience.

Astute interviewers can use subtle techniques to manage power shifts during data collection and delve deeper. In order for researchers to gain access to the interviewee's intimate and private experiences, the interviewer must build a rapport based on sympathy and mutual trust in the research project (Karnieli-Miller et al., 2009). Again being viewed as an insider can help to overcome barriers to rapport building and credibility with the project (Merton, 1972).

10.2 Analysis

The second phase of data collection included police officer and police staff structured interviews, which were audio recorded and transcribed and imported into NVivo where they were coded into nodes and themes employing adapted Grounded Theory Methodology (GTM).

According to Timonen et al. (2018, p.6) 'GT is a concept and theory-generating methodology that is able to work with different forms of data' Qualitative interviewing is the most commonly used data collection method in GT, although a variety of other methods can also be used. These include focus groups (Hennick, 2014; Hernandez, 2011), (participant) observation (Laitinen, Kaunonen, & Astedt-Kurki, 2014), GT analysis of quantitative data (Glaser & Strauss, 1967/2010), and analysis of visual and textual sources such as film, newspapers, biographies, and historical documents (Corbin & Strauss, 2015)'.

GTM evolved from sociological research in the 1960s. First by Glaser & Strauss (1967) and then developed by Strauss & Corbin (1990, 1998) and Charamaz (2000). As with other methodologies, GTM developed along different routes. What became known as the Straussian approach necessitated adherence to a precise coding paradigm and is more suited to researches looking for a prescriptive method. In contrast, the Glaserian approach rejects the forcing effect of the coding paradigm and suits researchers seeking a more flexible approach (Urquhart & Fernandez, 2016). Charmaz (2006) generated a third variation preferring flexible guidelines towards coding and proposed that theories are not discovered but constructed based on 'our past and present involvements and interactions with people, perspectives and research practices' (Charmaz, 2006, p. 10).

Urquhart (2013) and Bulawa (2014) suggests that the variance in GT methods by its founders and their followers provides researchers with an opportunity to adapt GTM in line with their research requirements. 'Such a divergence is an indication that researchers can use not only any other version of the grounded theory approach of their choice, but that they can also adapt it in a manner that suits their own studies'. (Bulawa, 2014, p. 165)

Despite the differences, common ground remains and the basic tenants and techniques of GTM prevail. The differing approaches share a Pragmatist influence; all ask questions that pertain to processes, interactions, and context endeavouring to approach the research with openness to new findings (Timonen et al., 2018). This is achieved by a process involving data collection from which codes are developed. Codes are grouped into concepts, and concepts are formed into concepts, which are the basis for generating theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998; Charmaz, 2006).

Within GTM, analysis commences with the coding process, which consist of three stages, open coding, axial coding and selective coding (Strauss & Corbin, 1998). Open coding commenced with the reading of the interviews when participants thoughts were labelled in order to reduce the data to smaller themes, which describe respondents' attitudes. Axial coding consisted of grouping or clustering the initial or discrete codes into conceptual categories. The selective coding stage consisted of identifying relationships between the categories and grouping the categories in a selective fashion.

GTM demands 'constant comparison', which is the analytical process of comparing data against data in order to identify similarities and differences between pieces of data. 'In making comparisons between data, the researcher looks for similarities and differences (variation) between conditions (i.e., context) and consequences surrounding key events, incidents, and patterns in the data' (Timonen et al., 2018, p. 7).

The transcribed interviews were imported into NViVo, a qualitative analysis software tool. The open-statements were analysed line-by-line with close attention paid to the kinds of words participants used. The final stages of coding in GTM involved scaling up core categories that incorporated or superseded other categories in importance and establishing relationships between these categories.

The holy grail of GTM is the production of substantive theory that can be integrated with existing theory. However, the reality may be something different. According to (Timonen et al., 2018, p. 4) 'the most common outcome from a GT study is greater conceptual clarity, or a conceptual framework, which is short of theory in the sense of a comprehensive system of ideas intended to fully explain and predict something. This is in fact more or less explicitly recognized in GT manuals as Bryant (2017, p. 99) puts it, "The grounded theory method should, obviously, lead to the development of grounded theories, although these may also be termed models or frameworks or conceptual schemas. '

Based on the identified themes, the findings are presented and discussed below.

10.3 Interview findings

10.3.1 Introduction

So far, the research has consisted of the interpretation of the quantitative data and some short statements from the respondents, some who have experienced mental ill health but the majority have not. Therefore, it goes someway to providing insight into the minds of police officers and police staff and their attitudes to mental ill health. However, it does not provide the experiences of those who have lived and worked with mental ill health in the police. This section gives a voice to those who have worked in policing. Consequently, participants' responses will feature significantly supported by comments to identifying the core and supporting themes that emerge from the data. All names are pseudonyms and identifying factors have been removed or where appropriate changed (locations, forces, departments, etc.).

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 and '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. Section 10.9 will go on to fully discuss the findings, evaluate the data in relation to the literature and consider the implications for the development of theory and practice.

Table 13. Interview core themes

Core Theme	Subsection
Cop This	Extent of MHI in police Diagnosis Denial in others Operational Stressors Organisational Stressors Austerity Personal Stressors
Cop That	Behavioural changes Denial Realisation Disclosure Career Implications Talking with friends and family Engaging with medical profession
Turning Blue	Culture Stigma Self-stigmatisation Camaraderie Derogatory terminology and bullying Suspicious minds Physical v MH divide Attitudes to responding to MIH Personal experience changes attitudes to MIH Professional experience impacts on colleagues with MIH Absence leading to exclusion Organisation Peers
Well Officer	Leadership Human Resources and Occupational Health Units Attendance and performance policies Contact with managers Gossip (should be in confidentiality Lip Service Prevention is better than cure

10.4 Cop This

This section examines the extent of mental ill health as witnessed by participants, the stressors causing mental ill health be they personal, operational or organisational and the impact played by workload and austerity measures as an additional stressor and on reducing support and interventions available to those facing mental health issues. Lastly, there is discussion of the diagnosis and type of mental health problems encountered by participants.

10.4.1 Extent of mental ill health in police

Respondents suggest that officers and staff who experience poor mental health is far more widespread than recorded. They are aware of the national statistics for the general

population and 'fail to understand how 25% of the force are not putting their hands up'. Such are the demands of policing it is believed to be unlikely that anyone remains untouched by their policing experience and is 'mentally damaged' in some way. This is attributed to the fact there is an overwhelming desire to conceal the fact and disclosure is the exception rather than the norm. Disclosing a mental health issues is seen as a weakness

> *Helen: Because it's seen as a weakness, we're meant to just get on with things in the police aren't you? You're meant to be able to cope. A lot of people can't but they won't admit it.*
>
> *Gill: Because of that, you highlight a problem and then all of a sudden, are they going to get rid of you, you know, are they going to take your role off you, is something going to happen to me because I've said this?*

However, there is a commitment to carry on working whilst concealing the condition.

> *Paul: Yes. The one guy who's coming to see me, I didn't know this until he came to see me and I'm glad that he did because he basically disclosed that he'd had issues, he'd gone to the doctors and he's still at work with quite a few meds to keep him on track so to speak, he's still working now.*
>
> *Kevin: Not at all. I can think of people who were at work and never should have been who most people knew should never have been at work and should have been getting help but they just carried on. If you pardon the phrase "completely barking, still at work", not through post-traumatic stress or anything like that but with real mental health issues. They should never have been at work.*

There is in some circles admiration for people who do disclose their mental ill health and find themselves as a confidante for others.

> *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.*

However, there is a recognition that others are in denial about their own mental health.

10.4.2 Diagnosis

The majority of interviewees stated the suffered from Anxiety, Depression and PTSD or a combination of these.

10.4.3 Denial in others

Officers with mental ill health are aware that the true extent of the problem will not be realised until others recognise it in themselves.

> *Mike: I still think there's a lot of taboo about it, it's the unspoken issue, the skeleton in the cupboard, they don't really want to discuss or go down that route. I don't think they know how to handle it.*

10.4.4 Operational stressors

As could be expected, police officers deal with serious traumatic incidents and fatalities. They leave their mark on some obviously so.

> *Neil : Then a boat capsized, it was fatal, persons trapped couldn't do anything about it. It was just really an accumulative effect of everything like that and basically the brain just said enough is enough.*

With little opportunity to make sense of what they are dealing with having to move onto mundane jobs and interact in low key manner immediately after dealing with a critical incident.

> *Paul: I can attend something that's pretty nasty, you know, step over a bloody decapitated motorcyclist in a road, and then 40 minutes later get sent for something else which may well be people running across a field, it may well be "let's go and talk to a neighbour dispute about a cat in the next-door neighbour's garden". You don't have time to process it so you put it to one side and get on with your job because if you don't do that, that leaves the shift short doesn't it?*

Officers in specialist roles removed from the trauma of front line duties still experience operational stresses and speak of secondary stress and emotional burnout.

> *Freddy: You're put in a place to be the conduit between the police and family to explain to them procedurally. The coroner's procedures, post-mortems Home Office pathologies goes to and what type of investigation is being led. I found that I was very good at trying to allay their fears however I wasn't aware that I was surrounded and consumed by their grief as well.*

> *Freddy: In one month I attended a mortuary over 30 times with one family*

Of course, operational stressors are not the preserve of police officers. Police staff experience similar feelings.

> *John: I am aware that the call handlers, that must be just about the most stressful job in the cops.*

Call handlers expressed their frustration about being left in the dark. Often moving onto handle other incidents and not been aware of the outcome of previous incidents.

> *Ivy : I suppose the difference within here which is very odd is day after day after day I'm dealing with trauma, that's all I deal with. You know like last night at half past 8 I dealt with a woman who was being strangled on the phone by her husband and she managed to phone 999 so she got strangled, we got an officer there, we didn't know where she was so we managed to find where she was and then we got an officer to her door. I then go home, I don't know what's happened to her, I'll have to have a look when I come in tonight to check, you know when I go on, but there is no sort of, that's in your memory bank now and you don't process it because you're not the officer going to the job.*

Kelly : No, no , I know a number of CSI's (Crime Scene Investigators) who went off. After murders especially those with children.

Even those who recognise they are disturbed by traumatic events and in need of support do not find it forthcoming.

Colin: There was no support whatsoever for me, in fact I was consistently put into quite difficult and traumatic situations despite saying "look, I've really had enough of this now, I just need some stability, leave me alone for a bit.

At some point, officers face a realisation that they are not super human and confront the challenges they are faced with and the potential consequences policing can have on their safety.

Eric: He was already arrested and on the floor, I wasn't really in danger but I remember going home that evening and suddenly my mortality hit me. I thought, and I genuinely say this to people, I still go cold about that.

John: All the ironworks were missing out of the road, they were setting cars on fire at the top of the hill and rolling them downhill towards us with acetylene or propane canisters in and at one point myself and a lad I was bullied with, we both agreed we had a fixed expectation of death that night.

Being constantly in the spotlight and under public scrutiny also takes a toll on mental health.

Mike: almost the government endorsed support of the press and their negative reporting against police officers continually, I think they've all got an impact on police officers because basically when we take the uniform off we're only human after all aren't we, it's kind of difficult to absorb all of that negativity all of the time.

Those who have experienced mental ill health issues reflect and recognise how they failed to deal with traumatic incidents at the time and how they had been storing up potential problems over the years.

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, not at the time because I have to say in all the years I've done it, yes I've been scared sometimes, yes I've been physically feeling sick at other times, but I've never once doubted my fortitude. ……but if I'd known what I know now I'd probably have looked, 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.

Traumatic incidents are not the sole source of stress in policing. Office sand staff cite the pressures of the organisation itself

10.4.5 Organisational stressors

Organisational stressors take on many guises; workload is cited frequently with workload and a lack of resources being identified as issues.

> *Ann: and there were occasions where I was the only Inspector and people would say "oh that can't be right" but I genuinely was the only Inspector on duty in the whole of the County.*

> *Jenny: They were trying to change my role, giving me more responsibility, more work. I was trying to explain that I didn't know how I was going to cope with that. The inspectors tell me one thing and the superintendent was having private meetings telling me a different thing.*

The lack of resources has increased the level of lone working diminishing opportunities for social interaction in the workplace.

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

As a result, officer welfare is often overlooked with officers missing refreshment breaks due to increase workload and missing the opportunity to share experiences with colleagues.

> *Neil: So you've got 2, 3 jobs, 2 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.*

Restructures and changes to work practices often increase workload and take their toll.

> *Orla: it was a restructure which meant that I was taking over basically the work of two people or the responsibilities of two people but we were assured that the work had been suitably considered and support mechanisms would be in place to ensure that we weren't overloaded, that didn't happen.*

> *Kelly: We had six staff there then there was a recruitment freeze four left we had two left to do the work of four people. A lot of pressure on the staff that were left. Timescales are very important meeting deadlines.*

The lack of opportunity to take time of off certainly at short notice is a recurring issue.

> *Ivy: Yes that bugs people more than the actual operational stress because for example we have to book our leave. Like, I know when I'm off until a year in April. We have to book our leave 18 months in advance. Now if I want a day off in 2 weeks I can't get it because we can't get anything under a month off.*

The current policing culture is seen to be destructive.

> *Ivy: everything's negative and it's just a culture and I don't know how you'd stop it and it's a horrible environment.*

With officers worrying about protecting themselves from criticism.

> *Frank: There's a culture of somebody's out to get you the whole time or you know, there's going to be a complaint and you'll be made a scapegoat, it's not a healthy cognitive productive environment at all from what I've seen over the past few years.*

Poor management styles are cited as a source of increased pressure.

> *Frank: I see officers breaking under the strain and the pressures that they're being put under by senior officers that kind of don't seem to know how to manage other than to kind of bark at you and that's just not appropriate if for kind of, young professionals who are doing a decent job making some hard decisions so everything I look at just seems broken and needs to be rebuilt*

> *Bill: bits of how we're treated, just everything kind of got on top of me.*

Officers experience a lack of control over their own destiny, often fulfilling a number of roles during a shift cycle which abstracts them from their primary roll to the detriment of the individual.

> *Colin: I can't manage the stress and the pressure that you're putting me under by constantly abstracting me into other roles". So for example in a cycle of 6 shifts, I might do 2 shifts in my neighbourhood policing role and I might do a couple of shifts on response, I might have to backfill in Custody and I might be put on the football duty on Saturday and I remember sending an email and speaking to my Chief Inspector saying "enough's enough, I can't do this anymore.*

Even when officers indicate they are mentally unwell, the pressure to perform overrides the welfare of the individual.

> *Gill: I tried to pull myself off the negotiating thing and said to like the Chief Inspector, like, I'm not coping, I'm not doing well myself and I don't think I should be sat on the bridge with somebody and he just said, well what are we going to do about the rota?*

Orla sums up the impact of the stresses of wanting to deliver a good service whilst being hampered by circumstances beyond their control.

> *Orla: I think a lot of cops who suffer with mental health is because they want to do a good job and it's just impossible to work how you want to work.*

10.4.6 Austerity

The impact of cuts in public funding and the subsequent reduction in officer and staff number has been highlighted as a key component of the organisational stressors.

> *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.*

Both police officers and police staff highlighted their belief that austerity measures had increased levels of mental ill health in the organisation.

> *Mike: I personally think that there's been an increase in mental health, that's an increasing due to the cutbacks in staff so that's going to be a self-perpetuating disaster*
>
> *Elaine: We have reached the point this will be the fourth round of job cuts…….. We are all aware that the cuts will be made, but how far can we go? It just can't be sustained.*

For police staff the constant reorganisation and redundancies is an almost cyclical experience with a constant threat of loss of job.

> *Sue: but certainly the information that I have and what people say to me having gone through six change processes since 2008 is they feel that police staff is very much an afterthought.*

10.4.7 Personal stressors

Not all stresses and strains are due to work as with society overall, there are police personnel who experience mental ill health, which is not related to working environment.

> *Colin: There have been periods in my life where I suffered from depression but where it sort of finally sort of really got a grip of me and began to affect me as a person was after my marriage broke down in the late 90s.*

However, for a number of officers they were overwhelmed by a number of issues in their personal and professional life, succumbing to mental ill health.

> *Liz : A mixture, you know, so if you're going through a messy divorce and then you're going to a messy death then you're going to a messy suicide and that's the majority of things that you deal with, and then the next day you're going, picking up your child after your ex-wife has given you a load of hassle, you know, things do build up don't they and sometimes you just need to process it, put it all into a bit of an order and then you can carry on but if you've not got an outlet to do that, that's where I think things go wrong.*

10.5 Cop That

This section examines the onset and developing condition of mental ill health as experienced by participants. It looks in turn at the realisation and often denial that accompanies such changes in states of mind, the impact of disclosure personally and professionally and how this can strain relationships with the family and friends and the organisation. Interventions and coping mechanisms are explored, as too are the consequences of failing to do so such as suicidal thoughts and feelings.

10.5.1 Behavioural changes

Participants reported changes in their behaviour, some noticed by themselves.

> *Diane: Instantly I became afraid of the dark and I had to have a night light, which I still do to this day, and it sounds completely random and crazy but I would think there was people hanging at the top of my stairs on my landing in my house.*

> *Eric: I suppose I became a bit sort of argumentative, a bit angry if you want to call it that and I became awkward. I was awkward with my Sergeant, I was awkward with my Inspector, I was awkward with my Chief Superintendent, I was just being awkward because I felt very, again, I didn't necessarily show it from the outside but I think internally I was just very vulnerable.*

Whilst others it was family members

> *John: my wife had left me a very nice little note saying 'if you can today, have a shower and if you feel up to it, take the dogs out later' because all this stuff was beyond me to do.*

And work colleagues for some

> *Colin: I was prone to extremes of moods, it was very obvious that my emotions were close to the surface and when a number of people expressed concern for my wellbeing, when I say people I mean friends I don't mean supervisors or in any sort of organisational capacity, I made the decision to disclose*

Being difficult – breakdown in relationship with force

Unfortunately, some officers experience a breakdown in relationship with their force.

> *Ged: I sent the message to erm, I spoke to my psychologist and I said I do not want to deal with authority any more. I found it hard to go into Police Stations. Personally I found it hard to go near police while I was going through a real bad time and I told them, I sent them an email saying I now do not want to deal with any police officers at all.*

This can be explained by managers and personnel failing to understand the complexities of the illness and the effect it has on people.

> *Paul: They are not treating their officers as vulnerable persons and they really are, honestly, I was, and maybe am to a certain extent. In the end, you know, I wrote a big ranting email to whoever it may concern, the Chief, my Sergeant, HR, etc. and it ranted on and on, the ultimate head word was, you have to treat me like a vulnerable person because I can't process what you're sending me.*

The participants recognised they could be construed as being difficult and hard to engage with. However, they stressed that this was part of the condition and that the organisation lacked the capability to recognise this.

> *Eric: Yes it was and it was a very, not helpful process, put it that way. I got threatened to be put on no pay and all these sorts of things would go on because obviously, I suppose it was 2-sided and I don't just blame the job fully but 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". If you ask me now I'd say "yes I'd happily engage" but then I wasn't thinking. I just thought you know, "they're out to get me, they don't want me here, they've damaged me, they don't want me". I felt very much like they wanted rid of me.

It is apparent that managers and force systems do not appear to differentiate that officers/staff with mental health issues may require a different approach when managing their illness that those with physical ailments.

Paul: they don't get that you can't deal with me as if I've got a broken hip because I'm not the same person. I'm not necessarily a sane person at that point in time and you can't deal with that person the same.

Failure to recognise and understand that a different approach may be required can place additional strain on the officers/staff wellbeing leading to uncharacteristic behaviour and unnecessary confrontation, which can only further exacerbate the condition.

Gil: I just need a bit of space and a bit of compassion and I spoke to him on the phone and he said "well you either come into work or you're reporting sick" so what happened then I had a massive blowout I think, well I could recognise not my mental health but I was in shock, you know, and I went into work, I stormed into the Chief Constable's office and had a, well, I just went mental, just creaming and shouting and saying "well then go on put me out then" I gave him my baton, my utility belt and

10.5.2 Denial

Generally, unless there was some single traumatic incident participants generally find it difficult to accept that they have a mental health issue.

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

Elaine: Maybe it was just personal pride I did not want to admit that I ended up with this.

It is not necessarily that they were in denial but that it can be a slow process of realisation.

Mike: I liken them to this, I'm not being dramatic but when a snake bites you, you don't die straight away, you are slowly paralysed and that's how I look at mental health…… something you live with you don't really realise the deterioration until you implode.

That even after medical intervention it is difficult to accept.

Kelly: Because I had it, never had before, I didn't treat as a mental health issue

10.5.3 Realisation

For some the realisation is gradual process.

> *Ged: I did not become aware of my mental health problem at work as such; I sort of suspected but pushed it away to the back of my mind. I justified it over the years, my mental health issues. I became aware of my mental health issues officially when I got diagnosed and then I started to think about taking it seriously.*

Where for others it can be more volatile.

> *Freddy: I feel like someone has jumped inside my brain with a pair of bolt croppers and took every pad lock of every chest I ever put away from when I was early teens to present. And then someone has opened them all. It's a Pandora's box of hurt,, guilt, guilt, remorse. It was just horrendous and I just broke down. It was the first time it took me a long time to acknowledge that I was a broken man.*

Officers in crisis can find themselves becoming overwhelmed and breakdown in the workplace.

> *Neil: Oh yes. The next thing I know is that I've grabbed the keys to a patrol car and I just disappeared off and I have no recollection at all of where I went, how I got there other than as I sat there, again, I can't remember what I was thinking about but all I know is the mobile on the car went and it was my Sergeant saying "where are you? What's going on? Come and see me" and basically I think I just had a full breakdown.*

10.5.4 Disclosure

Generally, there was a fear and trepidation of disclosing mental ill health for fear of the reception and lack of confidentiality. There was an overwhelming desire to limit or maintain some control over who would be informed.

Being open about mental health

Some respondents revealed that being open about their mental health issues had positive results and that they became a source of support to others.

> *Colin: it was identified by other managers that "oh (Colin) has been through this kind of thing he'd be good support to other people" and I went through a period where I seemed to be their go-to Supervisor whenever the job had a problem officer who was experiencing mental health issues, "oh, (Colin) will help him, he'll sort him out".*

However, others found there was a reluctance to do so

> *Bill: I think it's a hard subject to talk about. I think there's probably quite a lot to fear in the Police as well about whether it would happen to them.*

Others found colleagues privately disclosing their own experiences to them.

> *Neil: 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".*

Informing manager

Police Officers and staff had mixed experiences when informing their managers about their mental health. There is a trepidation informing Managers for fear of the response.

> *Gill: They're scared really, they're scared to come out with that because of consequences that could happen, they could be moved from roles, they may be getting support from colleagues or, you know, if you're lucky to have an understanding Sergeant or Inspector, everything gets managed under the radar*

As can be expected those who had supportive managers found the encounter more positive.

> *Bill: he was quite a new Sergeant for me at the time. He was good, he didn't really have that much contact with me, I suppose he didn't really know me. My Inspector at the time, she was excellent*

Some found a mixed experience within the chain of command.

> *Neil: My Sergeant, she was good, she accelerates promotion and she was ok about it. My Inspector was a complete arse. He bullied.*

Where supervisors had experienced their own mental health issues, better support was forthcoming.

> *Sue: When I did my boss herself was very supportive, she also had previously suffered with mental health issues so was aware of how that kind of feels and how it makes you feel so she was very good. She was very supportive.*

Informing colleagues

It may be more difficult for senior grades and ranks.

> *Ann: They're still officers, because they have officers of different ranks, they're still officers within the organisation and I know this other Inspector. There's no way I would go and talk to them, absolutely no way that I would go and potentially bear your sole to somebody because I know the type of person that they are and I would have concerns about them, I don't think they would disclose it to junior officers but I think they would have conversations with senior management.*

Some participants would only confide in close colleagues.

> *Bill: the only ones I would normally speak to would be the ones I'd consider kind of mates anyway and so the reaction's always quite good, but then, I don't know if many people are brave enough to give you a negative reaction to your face anyway. But there's others that, I know, it's interesting that they're the ones who can be quite negative about it*

There was some disclosure with caveats that the information would not be shared further.

> *Colin: I was a supervisor so I was circumspect about who I disclosed to and only people who I was very trusting of, I disclosed my diagnosis to, but certainly the disclosure was done on the understanding that it wasn't broadcast to the wider Force. I didn't want the job knowing that I'd had this diagnosis.*

Some respondents suggested colleagues have difficulty engage with officers who disclose their mental ill health.

> *Freddy: It's like the elephants in the room, Freddy is back but nobody wants to talk to Freddy. No one wants to address the issue or someone would just say are you okay and that's great but if the answer is no not what are they going to say.*

Some outright refused to tell colleagues.

> *Jenny: I didn't tell anyone then, no one. Still no one knew. I have never told anyone I work with I have been diagnosed with it.*

10.5.5 Career implications

A minority of respondents did not consider having a mental illness as affecting their career.

> *John: It didn't bother me in terms of any sort of progression of my service or career because I was a career PC (Police Constable) , that's what I wanted to be, I wanted to be a community bobby so certainly I wasn't going for firearms or anything sensitive like that or CTU, so I knew that that wouldn't be an issue for me.*

The majority of respondents indicated that disclosing mental health issues was generally injurious to career prospects.

> *Colin: I was hoping for further promotion, I certainly wanted to advance my career both sort in promotion and laterally and I had a view that if I disclosed that I had this diagnosis then there was no chance, you know; my career was effectively going to be over half way through.*

They were fearful that they would be seen as unable to continue to handle the policing environment.

> *Colin: I think that what impacts greatest is that it's still a taboo subject. There is still a culture that you've got to be seen to cope and I think there is still a massive reluctance on behalf of officers to disclose unless they feel safe and comfortable and confident that it's not going to have an adverse effect on them.*

Others were more forthright highlighting the stigma associated with mental health in policing.

> *Diane: I did ask for help and first of all I got a phone call from the Sergeant in Duties at the time who was trying to persuade me to go back to work and said "do I really want the stigma of being off sick with stress on my record?"*

Unsought redeployment was an issue, being removed from operational duties.

> *Orla: I thought I won't be capable of being operational again I just didn't think I'd be able to do it. I just thought I'd end up in an office job, which upset me because I like my job*

Firearms Officers experience further pressures as they can be withdrawn from a coveted role.

> *Eric: There's no way that I would have, you know, you see it now, with firearms, I mean I did my firearms training with the Met within a public order role and you know that was another add-on thing we did and that was all kept quiet but basically, ……., I'd be deemed as mentally unstable.*

Often certain conflicting restrictions are imposed on officers with mental ill health.

> *Helen: It's like, well if you're that worried that you're referring me to occ health and giving me a leaflet on counselling then why are you sending me back out? Oh and he's taken my Taser off me because I've not followed procedures right with that, but you're sending me back out single-crewed.*

As a result officers and staff are visiting their doctors and requesting that an alternative diagnosis is entered on sick forms rather than stress, depression etc.

> *Jenny: went to the doctors and he wanted to sign me off for stress and I said I wouldn't because if you sign me off with stress I'll never get promoted. He actually signed me off with a viral infection for three weeks.*

10.5.6 Talking with family and friends

Respondents were unlikely to discuss policing incidents with family members as there is cultural chasm between policing and the world as their families see it.

> *Frank: I think we're a closed shop. We do things differently, we experience different things the public don't understand us or perhaps the attitude we display. My friends and family don't understand us or can't understand*

> *Diane: Again the stigma. Just to see it as other people's perception, it took a really long time for me to get the courage up to tell only my closest friends that I was diagnosed with Bi-Polar*

In an attempt to deal with these different worlds strategies are adopted to keep these worlds apart.

> *Freddy: I said to the wife you feel like Worzle Gummidge and come home and have to shake your head off. Yet detective head to one side and your FLO head to one side put the dad head on.*

A reluctance to inform family members of their mental ill health was prevalent but not exclusive.

> *John: I think for the great majority of bobbies, that is as big a hurdle as any to tell your friends and family.*

Jenny: I didn't tell anyone other than my mum and dad but they had to know as later they moved in.

For officers and staff experiencing a mental illness it can take an additional toll on their relationship with their families leading to distancing and separation.

Diane: I have fallen out with most of my family, my friends, because I just shut myself away in my house for nearly 2 years, I hardly ever left the house, I was arguing with everybody…….. I split up with my husband as well, we are back together but in the midst of all this I threw him out. It's been devastating, absolutely devastating, not just for me but for my entire family, my parents have had to witness this,

10.5.7 Engaging with medical profession

The majority of respondents sought or were referred to GPs or Force Occupational Health Units. Force provision was viewed with suspicion, as there is a perceived lack of confidentiality.

Liz: Because it's not a safe environment because with the Occupational Health Unit everything can go back to your supervisor so for example when you've seen the Occupational Health, they will send an email to your supervision you know, "oh I met Liz today and I've referred her on to the counselling service", you know or whatever they say, so it's all linked within the Force then whereas the Benevolent Fund is an independent charity.

That Force provision puts greater emphasis on having the individual return to work than the welfare of the employee.

Neil: I got 6 weeks counselling with the Force Counsellor……it was very much geared towards "we need to get this person back into the front line again" it wasn't necessarily about me it was about what can we do to get this resource back working again.

However, this was not always the case.

Orla: I was paranoid about going to Occie Health because I thought they were under the cosh to get me back to work and when I got there and realised that they're there for me and I could talk to them about anything and getting the counselling with Jack, if it wasn't for Jill and Jack I don't think I'd still be here to be honest

A premium was placed by respondents on doctors and counsellors with experience of police culture.

Colin: It was my good fortune that I picked a counsellor from a website who understood what the police was about.

Eric: I got referred by my GP to …….. a Consultant and she used to be a police surgeon…….. I suppose I had a bit of a connection with her because she understood

10.6 Turning Blue

This section examines the impact of police culture on those who work within policing looking outward towards police interactions with people with mental health issues and attitudes towards colleagues experiencing poor mental health and endeavours to ascertain how they may be linked. It will also explore the discrepancy between the support and understanding shown to officers/staff with physical injuries in contrast to those with mental ill health and what influence having or experiencing a mental illness does to attitudes about mental ill health.

10.6.1 Culture

Stigma

Officers reasoning for the reluctance to disclose their illness followed a number of themes. The word 'stigma' was used very frequently and often cited for not admitting difficulties. In a close-knit community such as policing, officers do not want to be seen nor can afford to be seen as outsiders nor labelled with a mental health problem.

> *Diane: "do I really want the stigma of being off sick with stress on my record?"*
>
> *Gill: It all goes back, it's like the stigma, you know, oh they can't cope. They can't cope with that horrible thing that's happened you know, and again it's going back to the feel of the organisation again.*

Furthermore, there is a dilemma as whether officers disclose or conceal the problem.

> *Kelly: People wouldn't mention. I didn't want people to think I was a bit loopy or nutty or something.*

Weakness was a word used frequently by participants, as was the macho culture of the organisation, where physical and mental strength are seen as essential traits when being reliable at times of crisis is the key to survival.

> *Bill: You don't want to show weakness. I think a lot of it is you don't want to be seen as a weakling in a team. In some ways we don't have that camaraderie but in other ways we don't want to either let people down or be seen as weak and I think that's a lot to do with it. There is a lot of negative talk in the police station about mental health still even now.*
>
> *Jenny: It was macho are certainly anything I thought and talked about. We can do it and anyone who can't is weak.*

That stigma can be increased because of colleagues' lack of awareness of the implications of different conditions.

> *Kelly: there was a bit of a stigma around mental health. There were people waiting for you going completely mad. Punch somebody or screaming around the office or something so people didn't mention it so as not to set you off (Laughs).*

Self-stigmatisation

Participants not only expressed concerns about how others saw them but also how they perceived themselves.

> *Paul: I think shame. My underlying feelings and still are this shame and weakness.*
>
> *Orla: The illness makes you feel shit about yourself.*

That having a mental illness devalued them.

> *Orla: if you say you're stressed or you're upset about a job you've dealt then you feel that people are going to look down on you and I don't know if it's a perception within yourself,*
>
> *Jenny: I was then to be off with stress will be a sign that she can't cope, can't do the job. I felt I wouldn't get promoted.*

10.6.2 Camaraderie

There was a consensus that the police traditionally was recognised for its camaraderie, which was valued by officers who relied on and trusted each other at times of crisis. This manifested its self in the canteen culture where officers felt safe to unwind and share experiences, often employing humour as a coping mechanism.

> *Colin: Oh it's a loss, it's an absolute loss. Whilst there was certain behavioural traits that perhaps don't fit the modern era, that sort of esprit de corps, that being part of a shift, being part of a group where you looked out for your mates and your mates looked out for you, that was absolutely essential to the wellbeing of the job in my opinion, absolutely essential.*

The canteen provided opportunities to bond and supported team building the passing of which has been lamented by officers.

> *Kevin: The work got done, fun was had but the work always got done and you could trust who you were with, now I don't see that anywhere now.*

Loss of Camaraderie and 'canteen culture'

Many respondents mentioned the diminishing opportunities for social interaction in the workplace and to a lesser extent socialising off duty. They mourned the loss of camaraderie generated by the 'canteen culture', which was pivotal to successful working relationships and a support network of peers.

> *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 so you know you were friends with their families and they were friendly with yours. I guess more recently I've noticed that that has gone, whether it's because of shift patterns that we now work, are so demanding*

Along with the loss of the canteen culture, increased workloads and decreasing resources were mentioned as areas of concern. Further diminishing opportunities to share experiences, process feelings and peer debriefing.

> *Bill: In my area, I don't want to sound like I'm whinging because I'm not, it's a fact but rarely do we get to sit down and have a meal break.*

The loss of canteens and the diminishing daily contact amongst officers appears to have left a void in officer's ability to confide or counsel their peers with no replacement available.

> *Paul: It doesn't exist anymore I don't think really. I mean you'd be lucky to find a canteen to have a chat in anyway. I mean the black humour we used to have, and you could let off steam at scene or just around the corner out of sight or whatever, and you needed it at times you know*

10.6.3 Derogatory terminology and bullying

Policing over recent years has strived to clean up its lexicon of inappropriate phrases and colloquialisms when referring to minority groups. However, it was obvious from respondents that some of these words and phrase are still in use. People with mental health issues are still being laughed at.

> *Frank: so the first person I saw was Jim, who immediately made jokes about me being off sick and my mental health to a court clerk, sort of in front of them.*

This could hamper people from disclosing the fact they had issues.

> *Mike: Erm, I wouldn't say by every officer but that is a term, yes, "they're window lickers".*

> *Ann: Lost the plot, mad as a box of frogs, psycho, you know, he's probably sitting in the corner with his pants on his head and pencils up his nose.*

Unsympathetic, off the cuff comments and unintentionally sensitive phrases remain mainstream, which hampers open dialogue about mental ill health.

> *Jenny: We still having inspectors in the organisation telling people in the organisation to man up and grow a pair. So I think you need not just facts and figures but real life. This is how it impacts, this is what it did to me on a daily basis.*

That the terminology itself is not necessarily the problem it is the context.

> *Bill: As in like a name probably yes. The negative conversation around it, personally I think is worse. The connotation that that person's gone off just because they're lazy or they can't cope. "They should be able to cope" – I think I'd find that personally more insulting than just saying someone's wibbleness, it's just one word, it doesn't seem that harsh but it's the overall conversation, the context of that I think is actually what's worse.*

The culture is not conducive to help seeking.

> *Liz: I felt bullied that I was going out and I was getting counselling so I think if that culture's still there people decide not to get help because they're worried about what their colleagues think.*

Openly bullying behaviours from managers still exist.

> *Kelly: He went up to him in the middle of the office and said "Ahhh didums can't you cope with the work you need some help?" (Said in a demeaning childish voice)*

10.6.4 Suspicious Minds

Traditionally officers reporting stress or depression were seen by peers and supervisors to be malingerers or 'swinging the lead'.

> *John : with stress, depression or other associated conditions; they can't help but be acknowledged now. You'll get the odd one or 2 that are clearly just swinging the lead who aren't prepared to do the work and rather than get caught out, well they like to go off sick but there are too many good quality cops going off as well and people are actually looking round and thinking "shit, perhaps they're real".*

More recently the term 'stress is the new bad back' has been coined. Insinuating that reported absences are not genuine nor are an officer's incapability to work or carry out operational duties.

> *Jenny: It's the unspoken one, still is. People can't get their heads round it. Seen as we can't measure it we can't see it it's like the old bad back can't see it, can't measure it but it does still exist. They question are people pulling the wool over their eyes.*

> *Mike: you say you've got mental health issues or a bad back well you're telling us that but is that really true, are you playing the game?*

This 'new bad back' can manifest itself in managers displaying a lack of sympathy to officers/staff and colleagues questioning the authenticity of their colleague's illness.

> *Gill: It would be a real, a massive change in culture but it would have to start with senior officers and HR and even Occupational Health, you know, a big shift in culture and I don't know what it would take to actually change that perception, they are still ingrained that anybody with mental health is (incomprehensible) or is trying to do them over, that's what it is. It almost becomes like a personal battle and they won't let that person, there's no reference to it at all, none. They just, you know, I think they think people are putting it on.*

However, participants have reported that they have reported or been absent with physical ailments rather than disclose mental ill health.

> *Paul: I'm not going to tell the managers that I feel like I'm going mental or I'm having issues with my brain I'd just say that I slipped over and hurt my back, why wouldn't you? Because again there's all the fears of the repercussions from work, the fact that you're showing weakness and are ashamed of it and all of the stigma that goes with it, of course you would, absolutely, you'd say there was something else wrong with you.*

That even apparently sympathetic managers are more trusting of some staff than others and will shed doubt on one officer's mental illness and not others.

> *John: Inspector and one of the Sergeants would come round, I was having a race with myself to get back to work before he did because the Inspector had confided in me, "you take as long as you need, you'll get every support I can give you, you're a different kettle of fish to him. I know he's taking the piss but equally I know that you're not so don't worry about it"*

10.6.5 Physical versus mental health divide

Officers experiencing mental illness are of the opinion that colleagues view them less sympathetically than colleagues with physical injuries or illness.

> *Bill: In Flint House which is our local rehabilitation centre, I went there for 2 weeks and even at Flint House there's a massive divide between the officers who are there for kind of physio and physical injuries and the officers who are going off to the lodge for the day for kind of workshops, even then, where you'd think it would be maybe a bit more accepted, it wasn't.*

Senior managers are as likely to do so as junior colleagues.

> *Sue: I think what doesn't help is that as command teams, as leaders, we are being driven to improve sickness and basically it's an easy thing to pick on isn't it? If there's a non-visible injury if you like, a non-visible illness then it's easier to kind of say well, are they really off with that, they've off for an awfully long time, than it is if somebody's got actually something physical. You know, if you've got cancer the expectation is that you're not going to be in work, if you're off with stress then the expectation is that why aren't you back yet?*

This further alienated officers causing them additional unnecessary anguish and potentially hampers disclosure.

> *Helen: and the girl said "what's she got to be stressed about?", I just thought "who are you to say that, one, I'm not actually off with stress and two, who are you to judge my life or to feel that I've got to have certain things happening in my life in order to be stressed".*

Whereas once taboo illness are openly discussed, mental health continues to be concealed.

> *Jenny: I haven't got a problem telling people I have cancer. I find it much easier to talk about it. I find it much easier to deal with. If you give me the choice of the cancer or the mental health. I would have the cancer. It's easier to deal with.*

10.6.6 Personal experience changes attitudes to mental ill health

It was widely accepted that people who had been in close contact with people with mental ill health were more understanding and less critical of those experiencing mental health issues.

> *Bill: Yes, massively. I think if someone's experienced it then they seem far less critical of you.*

> *Gill: I've got a history in my family with mental health issues so I recognise it. I dealt with people there but Line Managers don't deal with it.*

Knowing someone else had been in close contact with mental illness also made it easier to confide in people.

> *Helen: I call him the nice Sergeant, nice and nasty, I took the nice one in the side room and I think I just told him everything and I went on but because he had a brother who had depression and had been suicidal*

10.6.7 Professional experience impacts on attitudes to colleagues with mental ill health

Mental health related incidents constitute an increasing proportion of police time. Respondents suggested that these interactions could have an impact on how police officers/staff interact with colleagues with mental health issues.

> *Neil: It wasn't talked about. It didn't happen. People with mental health issues were people outside the job. They were the ones "oh yes, ok, well they're going to go and commit suicide yes, well fuck it, do you know what? If they get on with it, so be it, it's only a bit of paperwork for us to do" do you know what I mean?*

That incidents involving mental ill health are seen as less worthwhile of police attention.

> *Frank: You see mental health on a log and it's "oh that's a shit job, you don't want to get that shit job" and that's how I think the police speak, that's just the nature of what they do. I think that's a really unhelpful perspective to take.*

That derogatory terminology is used when referring to people with mental ill health.

> *Eric: Yes because you deal with nutcases don't you? And that's me being very derogatory, I don't mean it but you come across, you know, I dealt with various nuts, there's me being derogatory, there's me doing what I don't want people to label me as but you know, that's how you express it don't you? And that is the problem. I dealt with lots of mental health people that were missing, particularly missing ones, you come across them don't you? They're found wandering in the street or they've attacked somebody and you think you're always dealing with what you saw were the, I think most cops experience of dealing with mental health patients are extremes of mental health so in other words you're dealing with somebody that's got schizophrenia, you know, highly medicated, and I think that taints you, that taints your view of mental health because then you think well that's someone who's off the scale and if I get labelled with a mental health issue I*

must be off the scale as well and you're not, and I'm not. I think that's what it did to me, it tainted me to probably pre-judge others and no doubt people have judged me as well so therefore it's sort of self-defeat.

There is a suggestion that officers/staff may display more sympathy to service users than to colleagues.

Bill: you hear it all the time, they're just attention seeking, that kind of thing. I think, yes, I think it probably does come across to how they see colleagues as well. You see some who are super-sympathetic on the street and occasionally they can be back at the station but I think 9 times out of 10 it's probably more negative towards their colleagues than members of the public.

10.6.8 Absence leading to exclusion

Many participants felt excluded by managers (organisation) and their peers. This was exacerbated by an absence from the workplace through sick leave or redeployment.

10.6.9 Organisation

Managers often failed to keep in contact leading to feelings of isolation.

Elaine: Being off Caused me more anxiety, nobody got in touch.

Such deliberate disregard suggested that absent officers and staff had already been dispensed with.

Sue: let's ignore them until it goes away or they go away

Even after returning to duty they would be seen as a hindrance.

Kevin: well lets keep quiet because they're just looking for a chance to either move you or get rid of you

10.6.10 Peers

Similarly, work place relationships were found to be tenuous. Believed friendships were not a reliable source of support or communication.

Ged: but the amount of people who just step back and don't want to know you, that's so weird, very upsetting.

10.7 Well Officer

This section examines how police forces manage officers and staff with mental health issues taking account of leadership, policies and procedures with particular reference to Human Resources and Occupational Health Units and attendance and performance regimes. It will also explore the how trust can break down and the perceived lack of confidentiality hampers officers and staff engaging with managers and support structures.

10.7.1 Leadership

The impact of supervisors has an impact on how subordinates perform. However, as people are involved consistency may be hard to find.

> *Orla: It was only having Peter as my boss, he was very reassuring saying "no, if it takes years, we'll support you, we'll get you back to full fitness" but I have friends on different teams who aren't getting that support.*

This can be to the detriment of those being supervised.

> *Diane: we had a great Sergeant, a great team, the workload was very busy but manageable and then we got a new Sergeant and a new Acting Sergeant and the new Sergeant was a flapper and would bang his head on the table when he was stressed, he would have nose bleeds when he was stressed, so his stress rubbed off on us, we all found ourselves getting very worked up with stress.*

Good supervisors

Good supervisors tended to be flexible and in some circumstances overlooked policy and procedure to enable a successful outcome, treating people as individuals with a desire to prioritise officer welfare over attendance policy

> *Mike: There's another person who's a Superintendent who can't abide the sickness scheme and he said "you know you're an officer, if you need time off then you're going to have time off and your welfare is paramount to me because that's how we should be"*

However, with technological advancements and diminishing resources managing 'under the radar' is becoming more difficult.

> *Gill: things like that that are managed under the radar because there's no flexibility and it's getting worse because now you've got your IR3 which is where you are, when you're on duty, if your radio's on, what calls you go to, so they're even taking that flexibility within it to do things under the radar, you know.*

Good managers recognise the stresses and strains of the job and manage people accordingly.

> *Orla: Steve, who was my DI is the DI of the Child Protection and Domestic Violence and he said "we're looking after the most vulnerable people, how can I do that if I can't look after someone vulnerable in my own workplace?"*

There is some suggestion that some mangers take responsibility for promoting discussion about wellbeing and actively endeavour to manage in a supportive style despite the rigors of austerity.

> *Kelly: You'll find as new people coming in with different attitudes. The big boss we got now he is very conscious that people have families. He tries to accommodate all things like that which helps out. We have all the MIND stuff, Blue light stuff, the champions and all that. Some people are more receptive willing to talk about it.*

Poor supervisors

Poor supervision fail to understand and/or acknowledge that they have a duty to provide support to staff with mental health issues and that their actions can have negative consequences and can instigate or prolong absences.

> *Elaine: So I said whom I go to for support. We had a conversation only just roared at me. He shouted just get out. I just left. I was on leave for a week and then I went sick.*
>
> *Helen: I just thought, I sat there and thought "you're a twat, why are you wanting to talk to me now? What's the point of that, you know that I'm ill, I'm restricted and you want to have a go at me, how's that going to help?" and after that meeting I went sick long term 2 hours later, that was the final point, that just pushed me over the edge.*

Some managers thought that officers/staff mental health issues would just go away.

> *Paul: It's the "oh I can't touch that because I don't know what to do with it" situation. It probably is just too hard to handle isn't it? If you stick your head in the sand it might go away. I don't know, I'd have to ask him.*

Failing to recognise that the ideal workforce does not exist and that subordinates will place demands on them.

> *Gill: it's like they want the best team around them and if they're going to bring up a problem then it's, like telling people, they're going to have to spend time dealing with you and helping you when they've got other things to do.*

That officers with mental ill health can be cast aside.

> *Mike: he's a Chief Inspector, he's a police officer, he carries a warrant card but first and foremost he has his prejudices and one of them is !if you're ill or got mental health issues, you're not on my team I'll chuck you overboard".*

Being over burdensome despite the evidence.

> *John: Yes. "Well there's my sick note, I need to go sick, sorry". "Well before you do could you just sort those crimes out for me?" I said "You don't understand I just cannot be here, I need to go". "Yes well just spend 5 minutes before you go". I said "sorry mate got to go"*

Superficially following procedures.

> *Helen : so I've not followed certain procedures right. So then they said "we'll refer you to occ health and here's the leaflet on counselling".*

That the only goal is to prevent or minimise any sickness to the detriment of the individual.

> *Mike: it's not possibly viable to be sick at work so if you've got mental health issues and you're sick then that's a double whammy because you've got an issue that they don't want to talk about and also there is a negativity at work about people being sick, they don't want it, they want to deny it, they'll do anything to get you back to work, to get you off the figures.*

That it is not only the junior ranks or grades who are treated as such.

> *Orla: she was traumatised by what she was dealing with but because she was a DI, the Superintendent said to her "make sure that the troops are ok" and she said "well I'm not too good myself boss" and he went "ah well you'll be alright" and just left her with it and she ended up in the toilets and being off sick for 6 months.*

Grade/Rank

There is a perception among more senior grades/ranks that having or disclosing a mental health issue is even more problematic.

> *Sue: So I think probably the higher you get up the rank structure the more difficult it is to perhaps be open. It doesn't mean that they're not suffering but probably that they're not, they're being less open about it.*

That disclosure was potential bar to promotion:

> *Jenny: I didn't know anybody in police who suffered with mental health problems and to be going for to be an acting sgt as I was then to be off with stress will be a sign that she can't cope, can't do the job. I felt I wouldn't get promoted.*

That more senior grades/ranks should be more resilient.

> *Gill: Yes. Again because even if you're dealing with, like PCs and Sergeants you know, you're the come-to person aren't you and you sort it out and then when you get to that rank I think they just expect you to just get on with it and you're letting the side down, you know, you're not you know, just pull yourself together and get on with it.*

There are some senior officers who are open about their mental health, but this is seen as nearly unique.

> *Jenny: It's strange because I had I had a conversation last year with my super who was discussing her mental health I was gobsmacked she discussed it in open forum. And I said to her, I can't believe you are happy to discuss this at your rank.*

Chief Officers

Participants thought it vital that Chief Officers are seen to promote wellbeing and create dialogue about mental ill health.

> *Gill: People won't open up about it until it's driven from the top …… if you haven't got the trust and know that you're going to get some support when you actually finally do come out and say some stuff you know.*

That an old guard is slowly being replaced who are keen to change the culture.

> *Eric: I think that is changing but I do still believe there are certain Chief Constables and so forth who are still, you know, it's finishing soon I suppose in the next 10 years those old style will hopefully have gone but there is still a lot of them around and there is still a lot of very senior officers who hold private views different from the public views and I think that's the problem. You've got people that say "yes we've got in place this stress management policy". Yes, ok they've got it in place but what does it actually mean and what does it actually do and how is that a*

detriment for the officers or is that beneficial? And I think that what we've got is a system where they put in place lip service, again, just so they can tick that liability box and say "oh well we do offer this".

In some cases events in force have driven change.

Ivy: a new Superintendent who's come in who said that he is big on mental health but it's more the fact that it's come in from an even more senior level, ACC level……. and it's because quite a few officers have killed themselves within the Force.

However, there is a suspicion about the sincerity of those driving the campaigns.

Paul: I know for a fact that she's been to see both Chief Constables and had lots of top landing meetings, briefings, etc. so I know for a fact that it's up in the forefront of their minds-ish. Whether its lip service or whether they really mean it I don't know.

10.7.2 Human Resources and Occupational Health, policies and people

Participants recognised that police forces are very driven by policy and procedure. That previous practices impact upon how staff see the organisation.

Colin: It was my perception of the culture of the organisation at that time. There was no acknowledgement, no support, no discussion and no talk around supporting people with mental health.

The perception is that adherence to process is more important than people management.

Colin: I think that nowadays the police service management is task orientated, it's not people orientated, so managers will expect a task to be done but they will give very little regard to the welfare of people they're asking to do that task. So I think there needs to be a cultural change on behalf of management

Eric: I mean the job wasn't particularly good to me because they started reminding me of policies, stuff like that.

That the role of HR is to protect the organisation in case of rebuke or litigation.

Eric: HR, they're kind of, riddled isn't the right word but there's just sort of a secrecy to what they do and it's like every step is a legal step so it's very defensive, doesn't commit to giving information because it's protecting itself from a litigious point of view

On one hand, a lack of consistency was seen to be an issue.

Sue: I think some people deal with it better than others as managers, as leaders, as areas, you know and part of that is experience unfortunately. So I think it's about training and then consistency, so what is the consistent approach that the Force has towards dealing with mental health?

That as individuals they had been managed inconsistently.

Colin: From my own experience Sean, some consistency in the way that I was dealt with would have perhaps averted some of the problems that I had later on.

Conversely, that processes lack flexibility to the further detriment of those with mental ill health.

> *Gill: There are strict guidelines on policy and there is no leeway either way on the policy, it is what it is, you know, like the 6 weeks and then there's the action plan and then there's the first stage and they plough through it regardless of what the situation is. Which just adds to people's illness and mental health problems.*

That the primary drive is to prevent or accelerate a return to work rather than the welfare of the individual.

> *Ivy: I did because I was still having massive panic attacks. I felt I was forced back to work you see. I was put under a lot of pressure and I ended up going to hospital a couple of times in here because I had a major panic attack and one time they thought I was having a heart attack and I did. I thought I was dying because I've never experienced anything like it. I was forced back to work too early no doubt about it.*

As a result, the organisation is seen to be uncaring.

> *Anne: I guess there's an assumption that the organisation would look after you and the organisation, and that then obviously refers back to my managers and the executive, they don't look after you. From that point it is really uncaring.*

The requirement to keep in touch with those on sick leave was varied. Some were left with little or no contact.

> *Gill: It's the not knowing and no contact which breeds anxiety*

Whilst others felt overburdened by contact.

> *Anne: even like too much pressing contact, because you've got a Sergeant who is adamant that they've got to comply with Force policy because it says they've got to ring you on Tuesday at 10, not taking into account how somebody may be dealing with their mental health issues at home at 10 on a Tuesday,*

It was apparent participants felt undervalued by some of the approaches and comments made by their HR/OH colleagues.

> *Ged: Yes, so I desperately wanted to because I felt that there were a couple of people within that circle of people that were dealing with me, not I felt, I knew they were, were just dismissive.*

> *Colin: In fact in the FMA is almost a mental health denier. He once said to me and he said to other officers that he doesn't believe that there is such a thing as depression and he abdicated meditation as a way of dealing with things.*

Mangers are instructed or feel compelled to invoke or progress attendance polices.

> *Gill: He was off sick for a while and then, you know, he was asking for resilience within that to help him care and manage you know, with the mental effects its having on him and his relationship and that type of thing and again, they wanted me to action plan him and basically told him to leave his wife, you know.*

The requirement to attend police premises for OHU or management appointments creating additional stressors.

> *Diane: Well, again, this sounds so silly now but at the time it was a huge thing for me just going onto police premises made me feel so ill, you would not believe.*

The default position with HR/OHU is that officer/staff are swinging the lead and that portrayed mental illness is not genuine.

> *Gill: It would be a real, a massive change in culture but it would have to start with senior officers and HR and even Occupational Health, you know, a big shift in culture and I don't know what it would take to actually change that perception, they are still ingrained that anybody with mental health is (incomprehensible) or is trying to do them over, that's what it is. It almost becomes like a personal battle and they won't let that person, there's no reference to it at all, none. They just, you know, I think they think people are putting it on.*

Alternatively, officers/staff were potentially trying to abuse the pension process to seek early retirement.

> *Ged: Human Resources, absolutely useless. They just passed me off – 'oh it's a pension thing, speak to pensions'. Pensions, they had one person from the Pensions Department who was never there, who didn't really know, and this is all done from me looking online and trying to work out for myself.*

Occupational Health Unit

All participants interacted with their Force OHU. The primary concern was the lack of delay in referral and attendance.

> *Freddy: All the help was offered and I said yes but then the help was delayed. So you can't tell someone in May that we are going to send you to occupational health the appointment in July. And then criticise you for not getting you worked on expeditiously*

That some officers/staff appear to go unnoticed whilst being absent long term and may miss the opportunity to seek support from OHU.

> *Neil: I've had no contact, I had to instigate contact with Occupational Health because they hadn't picked up on the fact that I was off work for such a long period of time.*

Confidentiality was of concern.

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

The lack of joined up working was questioned between Force and GP/ NHS provision.

> *Ann: it seems quite bizarre but there is no actual structure around the linkup between our Occupational Health and Police Surgeons and GPs*

Similarly voluntary networks.

> *John: that would be a big plus if HR works more closely with the voluntary network that we've got now, the peer support network, and with Occupational Health.*

It was apparent participants felt undervalued by some of the approaches and comments made by their HR/OH colleagues.

> *Bill: I had to see a doctor at the Occupational Health Unit as well who, if I remember rightly, his exact words were something along the lines of "this organisation hasn't got room for people who don't want to work nights any more" which, I stormed out of the office, not overly impressed with him and didn't go back since.*

There was an appreciation and preference for health care professionals who had experience of the police environment when dealing with officers/staff.

> *Colin: We had a Force Medical Advisor who had been connected with the Police for a long time. He understood the job, his father had been the FMA before then and everybody felt comfortable with him and he was very supportive and sympathetic, particularly to the nuances of policing and what it did to people.*

There is a reluctance to contact OHU.

> *Diane: No because the way of thinking is very much that you should all know that Welfare are there for you to phone them if you need them so it's left entirely down to you to pick up the phone and make that call to Welfare and say "I'm struggling, I need some help", well I certainly wasn't going to do that and I don't think many people would do that.*

Employee Assistance Program

Some forces provide a telephone based Employee Support Programme, which was treated with caution.

> *Elaine: There is always an element of how confidential is anonymous the fear factor. One of my biggest fears was that I was going to be having to go through the employee support which I knew wasn't good.*

Moreover, are being used in lieu of direct contact.

> *Kevin: and then they had a phone line called 'care first' which I've never used but from what I heard when I was there it was pretty hopeless.*

10.7.3 Attendance and performance

Returning to work

Returning to work could be painful after protracted absences:

> *Freddy: I was going there for four hours a day initially and that sounds like pitiful but the agony I went through in the morning just preparing myself to get up have a shave sort my head out and see what I was going to do,*

Participants suggested there was a compulsion to return to work even when not ready to do so.

> *Ivy: I was forced back to work too early no doubt about it.*
>
> *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 to a period of light duties which should have been 2 months but I ended up curtailing it by a month because I knew the shift was short.*

That the transition of returning to work was far from plain sailing.

> *Freddy: I came back and I was…… not initially put back into my old role basically but I was what (long pause) ostracised slightly by, I was in the same office as people I knew but I was but I was in a completely different office by my own. I wasn't allowed to get involved in any complex things.*
>
> *Eric: I had some long term sick, I went back, they'd taken my locker. I went back and I went "that's my locker" and they went "oh we've given it to a probationer" and I went "where's my stuff?" and they said "well we don't know". They lost all my stuff out of my locker, lost all my uniform. Now the only thing they kept was the radio, the only thing I could find was my radio because it was stuck in a Sergeant's drawer somewhere*

Colleagues were reluctant to engage with those with mental health issues returning to work.

> *Freddy : It's like the elephants in the room, Freddy is back but nobody wants to talk to Freddy. No one wants to address the issue or someone would just say are you okay and that's great but, but if the answer is no not what are they going to say.*

However, humour was seen as one way of dealing with the matter.

> *John: one of the bobbies came back in and we were sat together and then we heard the back door go, one of the other bobbies, I heard him shout "where's the raspberry?" raspberry, ripple, cripple, me. So he stuck his head round the door and said "Oh you're there, you might be a raspberry 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.*

Redeployed and restricted Duties

Redeployment appears to be a fact for many who are diagnosed with mental ill health. In some circumstances, it can be welcomed as part of a plan to relieve some of the stressors.

> *Elaine: It was dog's dinner. I kept saying to the head of HR can I work somewhere else I don't want to be off sick. Having been off before and didn't want to stay off.*

For the most part officers did not welcome it.

> *Ann: certainly a couple of officers that I've had who have different issues, one of their biggest fears was being taken off the shift and being taken away from the only support that they did have.*

Redeployment from operational roles to 'office jobs were not welcomed.

> *Orla: I just thought I'd end up in an office job, which upset me because I like my job, I was worried that I wouldn't get the support, I was worried that if I wasn't fit enough quickly they'd try and get rid of me.*

> *Paul : if your managers think that you're mental or you've got these issues they're going to take your police dogs off you, they're going to bloody ground you, you're not going to be able to do the job that you're doing so just a total, can't admit it, won't admit it, don't want people to know about it attitude from me really.*

The majority craved some attachment to familiar surroundings and colleagues.

> *Colin: I also felt that I needed some stability and reassurance and that was given by being in a role that I wanted to be in, that I was familiar with amongst people I could trust and you know all that was taken away from me and I was parachuted into Custody and felt very bitter, very alone, very resentful and in an environment which, certainly didn't help my mental health at all, very much the opposite.*

Preparation for returning to work with a different role was seen as inadequate.

> *Mike: I go back to work the first day, there's no chat, no debrief, no talk, no nothing. The Sergeant said "well you're back, I don't know what to do" and she gave me the most menial jobs, tasks and looking back on it now I think that was all set up to just of destabilise me which worked.*

Additional stress being caused by short notice redeployment.

> *Mike: I was then off duty at 5 and about 10 past 6 I got a text message saying "we've just had a meeting, we've decided you're not working in this station, you're going to Huxley from tomorrow".*

Some postings were thought to be stigmatised. Departments with a high proportion of people on restricted duties were seen as having disparaging connotations.

> *Helen: it's got officers in there that have been long term sick, just come back, or injuries, it has the nickname, the broken biscuit unit where they put the sick, the lame or the lazy.*

Half pay and unsatisfactory performance

The impact of reduction in pay related to absence is an additional stressor. The adherence to time scales for the implementation of pay related procedures were communicated insensitively and took little account of the state of mind of the recipients.

> *Paul: I was very ill and I'm getting blind emails from HR or blind letters from HR aying "oh such and such has been reached and your pay is going to go down" with no explanation about it, nothing personal about it, it's just as if you've got a broken toe they'd send you the same letter and you're dealing with mental health issues, I mean, these things, even the slightest indication I would just go off my head.*

There are conflicts between having to return to work whilst potentially not being well enough to do so.

> *Gill: 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, so hang on a minute, you're asking me now what we should do! You know, what do you want from me? You've got what you want". In the end they said "well you'd better go home". I said "thanks". And then they wanted to take me home and I told then to fuck off, you know, excuse my language.*

That officers/staff would be treated more favourably if they returned to work more quickly.

> *Kelly: Because I came back after three months the boss was like she has not tried to get the full six-month sick pay ill try being accommodating. That's why I was on reduced hours for so long.*

There is a double whammy of reduction in pay and Unsatisfactory Performance Procedures being initiated.

> *Neil: what's one of the biggest stresses that I had, I could get dumped onto half pay here, then what do I do? I know that when I go back to work I'm going to be subject to an Unsatisfactory Performance thing.*

Confidentiality and trust

Participants suggested there is a lack of trust with the organisation and colleagues. That confidentiality is hampered by processes and people. There is a perception that personal details will be made public.

> *Elaine: There is always an element of how confidential is anonymous, the fear factor.*

That sickness performance meetings unnecessarily shared information wider than required to maintain confidentiality.

> *Ann: there were documents that went around that identified officers and why they were upset which, you know, surely there's only certain people that need to know why you're off sick. An entire district of Sergeants doesn't necessarily need to know that a PC working somewhere else in the Force is off sick and why they're off sick.*

That OHU processes unnecessarily share information.

> *Liz: Because it's not a safe environment because with the Occupational Health Unit everything can go back to your supervisor so for example when you've seen the Occupational Health, they will send an email to your supervision you know, "oh I met Liz today and I've referred her on to the counselling service"*

That managers would openly disclose and undermine a person's mental health.

> *Kelly: What I didn't know was. When I was going home my senior manager was getting at the girls in the office saying that I wasn't physically or mentally well.*

A distrust of managers who are involved in close personal relationships with work colleagues who may disclose personal information about individuals to their detriment.

> *Ivy: So my line manager I don't trust because if I've got an issue, he's likely to tell the person he's having an affair with so right away that trust has gone. He shouldn't be working in this room but who do I tell? So again everybody sleeps with everyone, which is another massive issue within the branch. You know, it's like, if I go to my Inspector or Chief Inspector with that then, well, he'll find out.*

That colleagues are prone to gossip which reduces trust.

> *Bill: particularly at the moment it's very very gossipy, everyone is talking about everyone else, it's very strange at the moment. It's certainly changed; I've seen the changes since I joined in 2005 to what it is now. It's always like this, you don't trust anyone.*

Middle ranking officers were mistrustful of colleagues for fear of confidentiality being broken and senior officers being informed.

> *Ann: absolutely no way that I would go and potentially bear your sole to somebody because I know the type of person that they are and I would have concerns about them, I don't think they would disclose it to junior officers but I think they would have conversations with senior management.*

Similarly, officers/staff were suspicious of how confidential Employee Assistance Programs were.

> *Ivy: On the phone, so you're discussing with someone you've never spoken to before, you don't really know who they are, they don't discuss confidentiality with you, so they've got your collar number so right away does that go back to your Sergeant? I don't know.*

10.7.4 Contact with managers

Several respondents intimated that they had little contact from managers or peers. That this was an additional stressor.

> *Elaine: Being off Caused me more anxiety, nobody got in touch.*

That contact is to speed up a return to work not welfare orientated.

> *Gill: No visits. No phone calls. I had about 4 phone calls towards the end the 6 months and that was to try and get me back into work*

That those seen as close friends kept their distance.

> *Helen: Yes and they weren't even my closest ones that I got on with so I just thought fuck you. I thought, I've gone off, I'm off long term sick and you can't even be bothered to send a text message.*

This could be explained by the fact friends and colleagues did not know how to react or manage friendships with colleagues with mental health issues.

> *Kevin: I think it just drags you further down doesn't it? You know, colleagues, from my personal point of view certainly don't know how to deal with it, very few and very few kept in touch with me and some of those I would have described as*

good friends beforehand but the colleagues in the organisation haven't got a clue how to deal with it and what to do.

10.7.5 Lip service

Participants suggested that there was evidence of insincere support for those with mental health and mental health initiatives.

> *Eric: You've got people that say "yes we've got in place this stress management policy". Yes, ok they've got it in place but what does it actually mean and what does it actually do and how is that a detriment for the officers or is that beneficial? And I think that what we've got is a system where they put in place lip service, again, just so they can tick that liability box and say "oh well we do offer this".*

That promoting wellbeing is a promotion requirement rather than good practice.

> *Orla: one of our DI's was in a wellbeing group and he was, I would say, partly responsible for one of my friend's breakdowns so I think some people are going to the wellbeing side of things just to tick it on the promotion.*

10.7.6 Prevention is better than cure

Suggestions for improvement

Participants offered a series of solutions to improve attitudes and increase wellbeing. Officers suggested some roles like response had a heavy impact due to shifts or challenging locations from which they required some respite.

> *Neil: there should be a maximum time limit that people do on front line before they're rotated out, a maximum time limit of 4 years so you go off, you do 4 years on front line and then what happens is you get rotated out into another role where you're not faced with all the shit that you're facing on a daily basis, the aggravation, the threats, things like that.*

Regular screening to identify potential mental health issues in officers/staff.

> *Frank: I'd have the mental health MOTs.*

There is some evidence that screening is in place in some forces.

> *Ann: I think a lot of officers were sceptical about it and it was in place for the ZZZZ crash …… and on the back of certain incidents, ….., she would personally contact the officers and explain a bit about what Trim was and offer to meet with them, and there would be an initial discussion and then a follow up a month later when they would do some sort of scoring system and I got offered that on the back of the ZZZZ crash and accepted it.*

However, it was suggested screening candidates might not be truthful in their response to avoid being identified with mental health issues.

> *Ged: I think it was after a train crash where they gave you a questionnaire which I've done many a time since, mental health questionnaire, and that questionnaire, a lot of people, including myself lied on it because we didn't really want the facts*

or any rubbish, just, yes, tick, tick, tick. …… you're frightened of saying anything ……. As a geezer, you don't really want to, you know, and it was ugly,

There were doubts that Forces would invest in such exercises.

Eric: Screening is helpful but it's only if it really is that robust and you know how they cut costs, there's no way they're going to put the money into screening people properly.

Training was seen as essential in improving understanding about mental ill health and the enabling people to identify warning signs.

Orla: More training for the supervisors. More training for everybody about recognising it in themselves because I was a supervisor, I was trying my best to look after the team and I didn't realise I was ill myself.

By far the most suggested was greater use of advocates or mental health first aiders within work place teams.

Bill: I think maybe the easiest way to do it would be to have more advocates on each section maybe. …… someone who has been on a bit of an awareness of how to spot it even in other people,

Senior Officers/Staff to take on a similar role to improve communication and provide evidence that career progression is possible having a mental health issue.

Jenny: You have got to do something where people will stand up and be counted. Again like my Super, she said it but she can't be the only one like that, but I don't know a single one.

Campaigns

It appears that awareness campaigns are being undertaken within forces. In some cases the driver is from chief officers.

Kelly: We have all the MIND stuff, Blue light stuff, the champions and all that. Some people are more receptive willing to talk about it.

Elaine: the chief really supports well-being mostly comes from the chief to be honest been a big well-being launch the chief did three launches and the deputy one. There were support networks concentrating on well-being and mental health.

Not all forces have the same experience and that the communication of the message sits at the superintendent level.

Bill: No not really, I don't see much of ACPO levels, I see more from kind of middle management up to kind of Superintendent of our BCU but I've always found it a bit strange you see departments who work Monday to Friday 9 to 5 who seem to get given quite a lot of wellness time to sort things out yet on the coal face where arguably it's probably required more, they can't even give us enough time to do our day to day job.

In other instances, individuals have taken it on themselves to promote awareness.

> *Paul: Cheryl has had PTSD herself, and she's been treated, had counselling, gone back to work and been ok although she's not cured. She's basically lit a torch for police mental health and she's gone off on a charger, gone to see the Chief Constable of our Force and all around and is doing talks around all the Forces, getting support from the Chiefs so I think it might be going in the right kind of direction.*

There is a discussion about how effective such campaigns maybe. That some people may avoid participating or showing an interest in the workplace.

> *Jenny: The blue light campaign still something people will do in private. In their own time.*

That cultural change is a slow process.

> *Bill: I think it's a cultural change and cultural change in the police never happens quickly. I think over the years it probably will have a massive impact but how long's it been out, about 2 years maybe?*

The message may not be getting through to all:

> *Colin: No and it's not promoted. There's been no real promotion of it. I only know about the work that MIND are doing through Facebook.*

Training

The lack of appropriate education and training was a constant theme through the interviews. It was seen to be inadequate or non-existent.

Training for managers

It appears managers have received little or no training in mental health awareness.

> *Ann: No. Nothing internally for staff. My only sort of mental health training was through my, I was a Custody Sergeant so through Custody Courses*

The provision of such training has widespread support.

> *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.*

When provided the quality of the training was inadequate.

> *Colin: Useless. It's an insult to training.*

Some forms of training such as Mental Health First Aid are useful but lack sufficient detail to support managers dealing with staff with complex issues.

> *Elaine: No. I have been on a Mental Health First Aid course. It helps recognise symptoms. It doesn't help managers deal with the individual that is where we are wanting. Managers need to be more equipped to deal with it.*

One participant explained the impact Mental Health First Aid Training on her peers.

> *Sue: I could see literally see the penny dropping for some people around that room who clearly, and again probably less the cops who have been further exposed to mental health if you like, but some of the managers who weren't, yes I think it was a real kind of like, oh ok, you know, this is, there are different levels of this and it's not all, you know, just because somebody has a mental health issue doesn't necessarily mean they are going to go off sick, they can't do their job, you know, and I think one of the key things,*

Training for all

As with managers, there was no evidence to suggest officers or staff had received adequate mental health training to prepare them for their roles.

> *Eric: Not at all, no training whatsoever. Even at Training School and I say it's Training School because, obviously I went to a Home Office Training School, you would have done, so there was a standard of training and at that time that standard of probationer training did not address mental health issues of either people you might experience or the mental health issues that officers might have.*

> *Jenny: I don't remember getting any training at all saying you will you will have to cope with this. You are, you do all the things they have to deal with. They don't tell you how to deal with them, how to cope. They just tell you, you have to do A B C D E and get the job done. I can't remember any training what to do if you can't get the job done.*

For training to be effective, partner agency input was seen as essential.

> *Elaine: Training definitely training, training for managers to support officers and staff. Not necessary internal, with links with other support networks*

> *Colin: Probably external agencies because the police are not expert at this by any means*

It appears where training has been provided, it is IT based and seen to be lacking.

> *Mike: We had that basic paint by numbers Incal (ICAL) system which is about as effective as a chocolate ashtray in a furnace, yes, that was very basic, very basic.*

Debriefing

Debriefing appears to happen rarely.

> *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. The debrief after that was nothing, absolutely nothing.*

Officers complained of the lack of formal debriefing for officers who had experienced the most traumatic of incidents.

> *John: No, no, not at all. 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. The debrief after that was nothing, absolutely nothing.*

Time constraints can prevent debriefing.

> *Bill: (laughs) sorry I was laughing, I was at one on my last night shift and no, I was just laughing because I've had a run of them this year, last year 2016 was a particularly bad year for traumatic incidents I think. Just to put it into perspective, the level of caring I find from the Force is, erm, they recognise that we've had a run of traumatic incidents so they bought the Trim Coordinator in to our briefing but they couldn't even give us the time of the briefing because they had to send us out to jobs.*

That debriefs were unfulfilled promises. After the initial meeting, the procedure was not adhered to.

> *Colin: One of the members of the Occupational Health Unit came and spoke, they did a sort of around the table discussion. Each person who attended was asked what could they remember about the scene? What was significant? What stuck with them? Bearing in mind this was no more than 48 hours after the incident but there was no follow up. It was almost lip service, there was lip service paid to it.*

There was a strong consensus that debriefing was one of the keys to emotional survival within the policing environment.

> *Kelly: "I don't know whether someone decides after every major incident should there be a debrief. There has to be something. They're not getting a grip of what might affect people and when people are saying they're affected, they're actually not addressing it, in my mind, I'm certain of that."*

> *Eric: I think there's a normal expectation that somebody else will pick the pieces up but no-one is ever there to pick the pieces up.*

However, some suggested that group meetings were a bar to officers/staff sharing their emotions.

> *Dianne: About a week after the whole Section were taken to a meeting with 2 people from welfare in the Civic Centre, and so we all sat around the conference table and they basically said "we're here if anybody wants to come and see us", and obviously nobody put their hands up.*

That individual debriefs should be provided.

> *Diane: Yes I think they need to be done, as a group a debriefing, but to something that's quite horrific I think one-to-one is needed after.*

> *Gill: If it's like a firearms or something on Trim, I think it's bog-standard counselling you know, it's to tick the box for the Force, it's like, have they been offered counselling*

There is an expectation that it was traumatic experiences were all part of the job.

> *Paul: on no occasion have I ever heard anybody say "oh this was a bit nasty maybe we should sort this out and often you're given the choice if you don't want to go to a debrief then crack on, and that's what most people do because it's easier isn't it? It's human nature, what's the easiest thing to do? Not confront it, secondly get on with your job I guess.*

Peer support networks

Due to the strain on Force supporting mechanisms and the reluctance to use them peer support networks were well received whether informal or formal.

> *Diane: Eventually I did have a contact, I was never a member of the Women's Network or anything like that but an old Inspector of mine got in touch and she was part of that so I don't know if that's why I ended up getting in touch with her or not, and she was very supportive.*

That officers/staff who have experienced similar problems build their own support groups.

> *Bill: Interestingly I kind of developed my own support network. There's a girl who works the next district over who, she's quite astute, …… she kind of brought me into her fold and there was a small support group she'd already set up so I got brought into that but nothing by one of the official groups.*

Managers who had experienced their own mental health issues were seen to be more sympathetic.

> *Colin: "oh (Colin) has been through this kind of thing he'd be good support to other people" and I went through a period where I seemed to be their go-to Supervisor whenever the job had a problem officer who was experiencing mental health issues,*

That knowing others have experienced similar issues is reassuring in itself.

> *Ivy: It's the best thing that the Force has done. It's been set up so that anyone can contact me independently and get support if they're suffering with mental health and I could go and get support from somebody else.*

Not everyone was comfortable with the peer support networks. A senior manager thought there position to be a bar.

> *Sue: So I think before when I would have cared less about it, as I say I'm still very open about discussing it but as far as going to a kind of Support Network, I would feel uncomfortable doing that.*

Confidentiality was questioned and seen as a possible block to success.

> *Jenny: I think there is, I think I would go, but this is it how do you set it up and give people confidence. It is going to have to be confidential. How do you give people say you can't give people time to go to the meeting and keep it confidential?*

Lack of knowledge about the support available is a bar to accessing some services including peer support.

> *Helen: Yes, and Bluelamp and stuff like that so there is the help there I think it's just keeping that in the forefront of people's minds because a lot of officers just don't know. I said to a friend of mine, you know "why don't you get support from a Mental Health Peer Support Officers", she went "who are they?". I was just like "oh*

god", you've just come back off sick with depression and you're struggling at work because your supervisor's not helping and no one's even discussed that with you, it just does my head in.

10.8 Conclusion

10.8.1 Stigma and Suspicious Minds

As seen above, the survey data (Chapter 4) suggests that some police respondents thought of members of the public with mental ill health as weak-willed with little or no self-control. This is mirrored in force where displaying signs of stress and mental illness are regarded negatively as signs of weakness. This research has found that mental ill health continues to carry huge stigma within policing. Unfortunately, it appears that being immersed in such a culture results in further self-stigmatisation as participants reported decreases in self-worth and decreased usefulness. The interview data suggest those who experience mental ill health are viewed with suspicion both in-house and public facing. This is so engrained in police culture that officers experiencing mental ill health are often suspicious of peers in a similar position. These topics will be examined more fully in Chapter 10 Interview Discussion.

10.8.2 Managing those with mental ill health

The management of those experiencing mental ill health was questionable and arguably poor. On disclosure of mental ill health, personal interactions quickly deteriorated leaving the majority of respondents feeling isolated and unsupported. Policies and procedures which were designed to support people back into the workplace were often seen as vindictive and obstructive. A one-size fits all approach was commonplace and although there is flexibility and discretion built in, it was seldom implemented. Unfortunately those who disclosed a mental health condition were confronted with 'suspicious minds' as managers and colleagues doubted the genuineness of their illness. These topics will be examined more fully in Interview Discussion- 10.9.

10.9 Interviews – Discussion

10.9.1 Introduction

Having established police officer/staff attitudes to mental ill health the research undertook to establish the lived experiences of those who work/have worked in the policing environment whilst managing a mental health issue and to establish the connect if any between the attitudes recorded in the survey and the reported experiences of officers and staff. From the first reading of the data, it became readily apparent that officers with

mental health issues felt they were undervalued and treated with suspicion by colleagues and supervisors. Participant reported colleagues attitudes changed when it became apparent they had mental health issues. Although they believed, they had previously been well thought of and considered more than capable of performing their duties for many years this was no longer the case. In many cases, a sympathetic ear or emotional support was seldom encountered.

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

The concept of 'suspicious minds' emerged from the data supporting the survey in that officers were supportive of colleagues but doubted that all reporting mental health issues were genuine.

As outlined in Chapter 3 Methodology, the aim of Grounded Theory is to develop theory from the data rather than to test hypotheses (Urquhart, 2013). In 10.1 Interview Findings, I set out the four concepts, which emerged in the data, which provides understanding of the impact negative attitudes namely:

Cop this – Examines causes of mental ill health

Cop that – Examines the impact of mental ill health on their professional and personal lives.

Turning Blue - Explores police attitudes to mental illness

Well Officer – assesses how officers and staff with mental ill health are managed

During data collection, the focus was on attitudes towards mental ill health but in line with the principles of grounded theory, the participants were empowered to direct their responses towards their own experiences and circumstances.

10.10 Cop This

10.10.1 Extent of mental ill health in police and underreporting

Respondents were adamant that there is huge under reporting of mental ill health within policing in England and Wales. They found it incredulous that only a handful of officers/staff disclosed mental health problems when one in four of the general population, which they emanate from, have problems (Blue Light Programme, 2016).

The reasons provided mirror that of the open responses in the survey. Mental health issues are stigmatised. Therefore, officers/staff are reluctant to discuss or disclose it for the fear

that one will be considered to be swinging the lead or pulling a fast one and maybe ostracised by colleagues, restrictions placed on working conditions/duties , the curtailment of promotion and ultimately job loss (Bullock & Garland, 2017; Bell and Palmer-Conn 2018; Turner & Jenkins, 2018).

What was telling is that respondents recognised the symptoms and indicators of mental ill health in colleagues who had either not recognised it in themselves or had not disclosed it to colleagues. Working in close proximity and in small shift teams officers/staff become familiar with each other's traits and characteristics. As with those with specific physical ailments become more knowledgeable about their illness so to do those with mental ill health who recognise the physical, psychological and behavioural issues, which can be, signs of mental ill health (Link et al., 1989).

10.10.2 Operational Stressors

As can be expected police officers highlighted numerous traumatic incidents they dealt with which impacted on their mental health. Officers recalled dangerous confrontations and threatening incidents where their own lives had been put at risk from confronting and restraining violent persons through to large-scale public disorder and riots (Brown et al., 1999; Walsh et al., 2012). However, the majority of respondents concluded that it was not such personal threats that negatively impacted on their mental wellbeing but responding to and witnessing the upsetting aftermath of violent incidents which left them unsettled and leading to long standing upset and distress (Bakker & Heuven, 2006; Mealer et al., 2009).

This was not confined to police officers with pockets of police staff having similar experiences. Unsurprisingly, Crime Scene Investigators who are more frequently and for longer duration exposed to violent crime and murder scenes reported similar issues (Mrevlje, 2016). Other police staff in operational roles reported similar issues. Communication Officers spoke of overload and burnout whilst being left with 'emotional voids' as few operational encounters they managed were done so to fruition (Regeher et al., 2013). As pointed out in the literature review research into police staff wellbeing is often overlooked and is an area worthy of additional attention.

What was common amongst all respondents was the lack of follow up or debriefing which with support may have prevented the onset of mental ill health. Furthermore, although specific incidents were cited as having an impact on wellbeing (with over half the respondents stating they had PTSD) it was not the initial diagnosis that led to the longer

term problems and for some early retirement or medical retirement but poor organisational responses.

10.10.3 Organisational Stressors

Abdollahi (2002, p11) in her meta-analysis of police stress 'found that although some officers report discomfort related to the nature of police work, the key stressors in this profession appear to be more related to organizational factors than to the dangerousness of the work or encounters with human misery.'

For the majority of respondents 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 meaningful support available (Deschenes et al., 2017). The data here supports that of Gershon et al. (2009) who suggested that potential recruits are aware of the inherent risks in policing but there is an expectation that the organisation will support and recuperate those who succumb to injury. Such organisational stressors had a more detrimental impact than operational stressors on the individuals concerned (Houdmont, 2010).

In fact, in several instances managers failing to or choosing not to recognise that officers or staff were in distress increased such stressors. Repeatedly respondents bemoaned the lack of training and expertise of managers. This comes as no surprise as Houdmont & Elliot-Davies (2016) reported that 73% of police line managers had no training and of those who had only 23% replied that the training was very/good.

Officers and staff sought temporary solutions from their problems in a number of ways. The two most common were to remain in role where they felt comfortable and supported, the other to seek respite by short term removal from the operational arena or pressure point. Unfortunately, in many cases organisational stressors such as workload, lack of resources, bureaucratic and hierarchical working environment hamper and prevent flexibility for such respite. Thus leaving participants with little or no control over their welfare whilst experiencing poor mental health (Einarsen et al., 2003).

In a number of circumstances supervisory officers made great play if participants were absent from work or placed on restricted duties and insisted that by doing so they were by default letting their colleagues or victims down. In an organisation where team working, reliability and public service are core values (Chan & Doran, 2009) this can be seen as tantamount to blackmail where supervisors deploy such organisational stressors to circumnavigate medical advice and HR policy and procedure

Diane: "think of your victims you're letting down, think of all your work sitting here not getting done".

10.10.4 Workload and austerity

Workload and lone working were cited as the greater causes of organisational stressors. Police officer numbers have diminished with police staff experiencing prolonged and increasing job insecurity. In fact, they bore the brunt of the initial austerity 2010 measures and job cuts resulting in increasing workload. Unison (2014) reported that police staff cited increased workload and job insecurity as the top two organisational stressors. Whereas Police Federation members cited workload and not having enough officers to respond to demands (Houdmont & Elliot-Davies, 2016).

In this study police staff respondents reported being subject to the continuing redundancy cycle as relentless, unsustainable, and impacting on their wellbeing. This had additional consequences in the form of 'presenteeism' with police staff frequently attending work when unfit to do so due to fear of attendance policies being used in any deselection process (Hesketh et al., 2014) and having a further detrimental effect on wellbeing (Turner & Jenkins, 2018).

Police officer respondents experienced similar issues regarding workload, stating that it had doubled in recent years. This often resulted in officers missing refreshments breaks and an opportunity to engage with colleagues. Further hurt is perceived when resourcing requirements take precedence over the welfare of staff. Where individuals sought to highlight increasing workloads, managers were likely to be dismissive and even derogatory '*Superintendent emailed me saying "stop whinging".'* Such responses diminishes officer credibility and hinders effective communication leading to embitterment and feelings of alienation and another source of stress (Abdollahi, 2002)

Much was made of increased organisational emphasis on lone patrolling leaving officers feeling vulnerable and isolated. Single crewing policies further diminish officers' contacts with their peers and opportunities for 'off loading' some of the stresses of police work. Turner & Jenkins (2018, p.8) described a similar isolation or disconnect in an English police force which has 'destroyed vital informal support mechanisms'.

10.11 Cop That

10.11.1 Behavioural changes

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). This had an impact on professional (Bullock & Garland, 2017) and family relationships (Greenhaus & Beutell, 1985) . Moreover, several respondents were saddened by the fact the job they loved doing became a source of anguish, upset and distress. It appeared for some their vocation was slipping away from them and/or being taken away from them. Where they had previously been positive about policing, they experienced a growing dissatisfaction and growing chasm between themselves and the organisation (Chan & Doran, 2009) and the organisation and themselves. Certainly the hierarchical structures and those representatives of what was seen to be an oppressive and not as they expected a supportive regime (Abdollahi, 2002; Bullock & Garland, 2017; Turner & Jenkins, 2018) added to their frustration and exacerbating potentially negative behavioural changes. Such behavioural changes can lead to 'othering' (Said, 1978) where people are placed into groups of 'them and us' who can be seen as or deemed to be problematic inferior, or not worthy. Sadly, such 'othering' could result in the exclusion or withdrawal of officers from their workplace community and in turn shrink their social circle leading to feelings of isolation or abandonment, which is discussed in more detail in the chapter Turning Blue below.

10.11.2 Being difficult - Breakdown in relationship with force

Such behavioural changes in many cases led to a breakdown in relationships with supervisors and line managers and with organisational HR and OHU staff and functions. Thus, officers and staff felt that there was a lack engagement with their Force, which was not always one sided. That in hindsight they could have or were deemed 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).

Once these barriers were erected and relationships failing then attendance at their place of work became difficult or impossible. Potentially creating further barriers to engagement and further exacerbating the situation providing more evidence to be labelled difficult. In several instances, welfare visits to respondent's homes by supervisors and line managers

were vetoed by the respondent and in some cases a cessation of all communication. Once this became a reality this was a serious hurdle to overcome.

It became apparent that participants were of the opinion that managers and HR personnel did not have sufficient understanding of behaviours attributed to mental health conditions and therefore were likely to be view them as being obstructive. As one respondent put it 'Kevin - *you're not being a pain in the arse for the sake of it.'* It was argued that HR and OHU staff along with line managers should be receive sufficient training to enable them to deal with such possibilities.

There was consternation that supporting vulnerable members of the community is a policing priority and that the Police Code of Ethics and force policies demands that vulnerable people are treated with dignity and respect, yet these principles are not afforded to their own personnel.

By adhering to processes and policies managers, HR and OHU staff were committed to *'a one size fits all'* approach and failing to treat their colleagues sensitively and as individuals with specific needs. This is counterproductive, as research suggests that officers need to feel in control of their destiny (Mitchell et al., 2001). Thus, the wrong reading of the employee's behaviour is seen by those representing the force as a lack of respect, being obstructive and difficult resulting in a breakdown in communication between the staff member and the organisation. This hampers further communication and further breakdown in relationships.

10.11.3 Denial

Within this study, it is submitted that within policing people conceal the truth about their mental ill health from themselves, their colleagues and to a greater extent members of the public. Rudofossi, (2009) suggested people are reluctant to accept negative emotions and according to Lazarus & Folkman (1984) may use suppression, avoidance or denial as coping mechanisms. Here the evidence is that there is a culture of *'just getting on with things'.* There is no desire to bring attention to oneself and this is best avoided by reporting for duty, completing the tasks in hand, and doing as required. However, respondents suggested this is not achievable in the long term and unless there is some intervention than a *'breakdown will occur'*.

Repeatedly officers and staff mention 'personal pride' and describe it as the 'mentality of policing' not wanting to admit one may be struggling and certainly not seeking help. Though

not directly referred to by participants in initial interview about the development of their mental illness this is a manifestation of early signs of self-stigmatisation where those with a concealable stigma have to consider the consequences of disclosing sensitive personal information and who they chose to inform (Corrigan & Watson, 2002; Bullock & Garland, 2017). The working environment and the threat of potential discovery makes possessing a concealable stigma a difficult predicament for many individuals to maintain even when there is little or no desire to do so (Pachankis, 2007).

It is from here on in that the survey data supports the accounts and descriptions of police officers and staff as to why the wider culture of the organisation generally and the stigma and discrimination towards mental ill health in particular prevent disclosure and help seeking of those experiencing mental ill health issues.

10.11.4 Realisation

The combined data suggests 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 and colleagues or managers. They tend to avoid discussing the illness and prefer secrecy to disclosure (Thoits, 2011; McDowall, 2014). Respondents manage to conceal their condition for some time until they '*imploded'* or *'the Pandora's box'* was opened which lead to '*break down*' and inevitable personal acknowledgement and subsequent enforced disclosure.

In a limited number of instances it was only after engaging with support services that acceptance occurred. There was a realisation that '*all was not right*' after encountering traumatic events but there was a conception that mental ill health was something that happened to others and not police. It was by engaging with counsellors or peer support networks that symptoms were explained and understood and respondents could relate their feelings towards having a diagnosis of anxiety and depression, PTSD etc. Such realisation is imperative providing an opportunity for self-restoration, acknowledging an illness seeking a path to improved health and wellbeing (Thoits, 2011).

10.11.5 Disclosure

As with the survey data, interview participants were highly reluctant to disclose their poor mental health. Maintaining secrecy was seen as a twofold priority, avoiding the 'stigma' as officers and staff do not want to be seen nor can afford to be seen as outsiders nor labelled with a mental health problem and the accompanying fear of personal or professional career related repercussions (Thornicroft, 2006).

Participants had to assess the risks of disclosure and judge the benefits of doing so (Corrigan et al., 2010). Their decisions relied on their perception of the trustworthiness, effectiveness and competency of potential internal or external support provision. Unfortunately, for many having a binary choice of deciding to seek help in-house or thorough GP services caused anguish, as they feared neither routes were confidential because of perceived data sharing protocols, which would expose their secret. Fortunately, for some there were peer support or staff associations provisions, which were deemed to be safe and secure (Dowling et al., 2006; Ombudsman Ontario, 2012; Blue Light Programme, 2016; Stuart, 2017).

A lack of trust in supervisors, occupational and personnel support departments was evident (Bullock & Garland, 2017; Stuart, 2017; Bell & Palmer-Conn, 2018), participants doubted whether their illness would remain confidential if they sought support. *Ged: No I didn't trust em, didn't trust anybody.* 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. This appeared to be easier to maintain in the short run but became progressively more challenging to do as time passed.

Police officers and staff have wide networks within the organisation and there is a belief that these networks are *'very gossipy'* and used to discuss and share details about colleagues' wellbeing to the detriment of the individual. Intimate conversations have the potential not to remain so and are then discussed more widely. Participants were apprehensive about 'offloading' to a colleague or a manager and the disclosure subsequently '*snowballing*' out of control and shared more widely.

It was perceived self-standing and personal pride would be dented by disclosure and that they may be deemed or judged as not fit for purpose (Beyond Blue, 2012; Bullock & Garland, 2017) in line with Corrigan & Watson (2002) self-stigmatisation theory. This was not restricted to police officers nor operational support staff but also those in administrative roles suggesting the impact of police culture is not restricted to frontline staff and permeates all levels (Schein, 1992).

In fact, police culture weighed heavily as a reason for not discussing or disclosing mental health issues. The fear of disclosure was perceived as ultimately admitting to failure, that the individual could not cope, lacked resilience (Evans et al., 1993; Bullock & Garland, 2017) provoking feelings of shame.

Diane: the mentality of being a police officer, you don't want to ask for help, you don't want to admit that you're struggling

Unfortunately, without some form of disclosure it is difficult to access support and find remedies to rectify the causes or improve wellbeing. However, the fear of being labelled with a diagnosis prevents such access to support networks. Again, participants feared being labelled, as they feared dismissal from the organisation or prevented from carrying out a role that that have invested in or taken effort to acquire or carries additional status, which can further compound stigma.

Colin: I had my diagnosis and I made a conscious decision at that point to keep it to myself and not disclose it to work in any way.

10.11.6 Disclosure from others – 'secret' selective disclosure

Research to date (UNISON, 2014; Blue Light Programme, 2016) suggests that there is considerable underreporting of mental ill health amongst police officers and police staff. This research adds further weight to this proposition as the majority of participants stated that once they had divulged their mental health issue and made it known that they were 'out' about their mental illness they were confided in by colleagues who had experienced similar issues. Therefore, it is possible to construe that the current statistics regarding officers/staff with mental illness fall far short of reflecting the true numbers of officers experiencing such issues.

It is of note that these revelations were done so on the understanding and proviso that such information would not be shared with colleagues or the organisation. Bos et al., (2009) refers to this as 'selective disclosure' (Bos et al., p.512).

Neil: "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".

Bos et al., (2009, p509) suggests, "selective disclosure optimizes social support and limits stigmatization". I would suggest that from this police perspective it be termed 'secret' selective disclosure, as there appears to be a caveat, which requires continued silence. However, this 'half way house' may only provide some limited improvement. On the personal level it can be therapeutic to share one's story (Thornicroft 2006), exchanging mental health experiences with colleagues can lead to supportive responses but it can also be stressful in that the mental illness remains largely concealed (Pachankis, 2007) and can induce increased self-stigmatisation. Furthermore, Corrigan & Penn (1999) submit that concealment can perpetuate stigmatisation as close contact and interaction with people with mental illness has proven to reduce stigma as people are forced to challenge their own

stereotypes. Therefore, if people with a mental illness conceal their condition, this greatly reduces the opportunity for changing people's attitudes towards the mentally ill.

Certainly, there were positive notes that such openness could have potential benefits for the organisation and other people experiencing similar issues offering another informal level of support. As in this case, participants became unofficial advocates or mentors for colleagues experiencing similar issues. In some cases, they were sought out by supervisors as a source of knowledge and advice relating to procedures and policies and on occasions commissioned to manage individuals with mental health issues as other supervisors were lacking in the requisite skills. However, the data suggests that 'secret' selective disclosure is not the key to improving attitudes or the welfare of those who maybe experiencing mental ill health.

10.11.7 Informing colleagues

There was enormous reluctance to disclose a mental health diagnosis to colleagues. This was based on participant's preconceptions how colleagues would perceive the illness. Non-operational staff expressed doubt as to how they could possibly be conceived as having or reporting a mental health issue when their operational colleagues are exposed to danger and trauma during the course of their job. A member of police staff actually questioned what right she had to be off with a mental illness as it were only the preserve of those in the front line. As there is only limited research comparing civilian employees' views to that of their warranted colleagues (McCarty & Skogan, 2012) this research adds to the knowledge, provides additional detail and is worthy of further investigation. It should be noted that McCarty & Skogan (2012) found little difference in burnout rates between civilian and sworn staff suggesting both are as likely to experience mental health issues and those in support functions face an additional barrier to disclosure and thus help seeking.

However, the overriding feeling was a fear of being seen or labelled as weak. Weakness is anathema within policing and aligned culturally with mental ill health. The survey data above suggests that some police respondents thought of members of the public with mental ill health as weak willed with little self-control and burden on society (Lister et al., 2008). This is mirrored in the organisation where it can also be seen as a personal weakness, lacking fortitude and unable to be relied upon (Toch, 2002; Karaffa & Tochkov, 2013). Consequently, in line with Corrigan's (2009) theory of self-stigmatisation such thoughts are a barrier to disclosure.

A major concern when disclosing to colleagues was the recurring theme of 'Suspicious minds'. There was an overriding perception that colleagues would doubt the authenticity of their illness (Stuart, 2017; Turner & Jenkins, 2018). Terminology like 'lead swingers' and 'head workers' were deemed to be common place within policing culture and often attributed to those experiencing mental ill health. It was often felt that those suffering a physical illness would not be subjected to such doubts or labels. This research like that of Turner & Jenkins (2018) found that even those who have mental ill health issues can at times hold similar views and doubt their colleagues genuineness of having a mental health issue and are not indeed workshy. *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'.* Here the interview data mirrors the survey data, where 61% of police officers and 54% of police staff agreed with the statement 'Some people use stress as an excuse for being absent from work.'

As personal mental ill health is not often discussed amongst colleagues, respondents reported a trepidation of disclosing to peers as it was difficult to anticipate what type of response they would receive. There was a consensus that colleagues would be ignorant about or uncomfortable talking about mental ill health (Pattyn, et al., 2014). It was anticipated they feared being embarrassed by using inappropriate or incorrect terminology, which may cause (additional) stress or anxiety to both parties. It was suggested this could be addressed by targeted mental health training to raise awareness and understanding of the issues and that this should be a mandatory requirement for all supervisory roles.

Furthermore, the police like many large organisations are in a constant state of flux with staff frequently being posted geographically to and from specialist departments and promotion resulting in a 'churn' of staff. This can hinder the development of long-term friendships and acquaintances. From my own experience, uniform and front line roles are often the areas with highest turnover of staff, which means friendships are often fleeting and seldom long standing. The camaraderie that is often spoken of in policing exists in the present but is not always based on long standing established relationships. As such, colleagues are more often than not trusted professionally but interpersonal bonds and trust may be far less solid (Carpentier & Ducharme, 2003).

10.11.8 Informing manager

The process of informing a manger was deemed a lottery with the majority of participants portraying negative experiences. There was a common theme of supervisors being more concerned about managing workloads and priorities over the welfare of staff. It was perceived that staff welfare only got in the way of police work and that some supervisors expected officers and staff to 'leave their problems at home'. It was seen as a folly to discuss or seek support from such supervisors as they lacked empathy and were unlikely to provide direction or referral.

It appeared to be challenging for managers as to how to manage people when they did not or could not understand what their subordinate was experiencing. Participants found it very difficult to try and explain the impact on their wellbeing when practical knowledge of mental ill health amongst supervisors is low. This mirrors the above reluctance to inform colleagues where they may lack understanding of the condition. Specifically participants suggested supervisors need training to detect early signs of stress to prevent the escalation of mental health issues to dangerous levels, as well as understanding and supporting different coping mechanisms. Randall & Buys (2013) suggest that this can be overcome by training and targeted campaigns, which 'promote understanding about prevention and rehabilitation within the police service' (Randall& Buys, 2013, p.8).

However, where supervisors had been exposed to mental ill health in their family or their own personal experiences then participants reported more positive and supportive interactions. As such, experiences are not necessarily in the control of supervisors participants deemed it necessary that supervisors should undertake training in recognising and supporting colleagues with mental health and wellbeing problems (Karaffa & Tochkov, 2013; Houdmont & Elliot-Davies, 2016; Turner & Jenkins, 2018).

Many supervisors were considered dismissive of the illness or that the response was viewed purely as a 'tick box' or 'back covering exercise'. Such supervisors often had a reputation for strict adherence to attendance and sickness polices lacking flexibility and were deemed by participants to be unlikely to appreciate the need for reasonable adjustments (Randall & 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 respondents, feared managers would be sceptical about the reality of their illness (Stuart, 2017; Turner & Jenkins, 2018).

Mike: you say you've got mental health issues or a bad back well you're telling us that but is that really true, are you playing the game?

Unfortunately, this is not confined to senior personnel, Sumerfield (2011) suggested force medical practitioners held similar questioning views that police culture and pension regulations are a source and explanation for fabricated mental ill health in the service. Thus, 'Suspicious minds' placed a barrier to disclosure to the organisation and help seeking.

In defence of supervisors, as mentioned above there is a certain amount of fluidity amongst police personnel with postings and promotions the norm. This can hamper supervisors' ability to get to know staff and even with effective training may limit supervisors' ability to detect potential problems and organise an appropriate response.

10.11.9 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 (Fox et al., 2012; Karaffa & Tochkov, 2013; Bullock & Garland, 2017; Bell & Palmer-Conn, 2018, Turner & Jenkins, 2018). Officers disclosing mental health issues are routinely moved or placed on restricted duties with little or no dialogue or consultation (Bullock & Garland, 2017). Surprisingly this is mentioned in a limited number of articles but does not appear to mandate further consideration as to the impact on the officers/staff.

Redeployment or withdrawal from operational duties appears to be of great consequence within policing. As this can be seen as an attack on professional competencies and therefore the individual, which may result in being angry and aggrieved with increasing loss of wellbeing. Redeployment often takes them away from their peer support and in the views of participants was seen as detrimental to leading to feelings of exclusion and subsequent additional stigma (Rogers & Pilgrim, 2010). More threatening to those who were unwillingly redeployed was that they were now labelled with a mental health issue in a new environment and having to account for themselves and in many cases repeated recounting or disclosing of their mental health issues. Doing so can result in officers and staff feeling isolated and excluded from the organisation which can result in a break down in relationships and an unwillingness to engage.

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 redeployment may be appropriate 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, 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'.

Furthermore, declaring a mental health diagnosis is detrimental to promotion opportunities and lateral moves to specialist units, which can be seriously hampered. Whether intentionally or unintentionally, direct or indirect organisational discrimination is evident (Toch, 2002; Waters & Ussery, 2007). As Mike stated:

> *If somebody's got aspirations to go far in the job they wouldn't want that on their CV.*

Thus, mental health stigma may remain long after an episode has finished or a return to full health. Officers and staff are often left with a negative legacy and near permanent challenge, which can be difficult to overcome (Link & Phelan, 2001). For the above reasons officers are fearful of disclosing mental health issues as it is seen to have adverse impact on career development or continued employment. Again, the interview data supports the survey data in that 75% of police offices and 56% of police staff agreed with the statement 'Q70 Disclosing a mental health problem in the police service is detrimental to future career prospects'.

10.11.10 Talking with family and friends

Officers and staff are generally unwilling to discuss the stresses and strains of policing or their mental ill health with friends and family. There is a perception that the fearlessness, authority and control they exercise in the workplace should be mirrored at home and socially (Westley , 1970).

> *John: "I'm a police officer, I'm here to look after you, I'm here to take charge of the situation and I've got to be brave enough to face it, ..., that is as big a hurdle as any to tell your friends and family.*

Such a gap is an impediment to discussing or sharing potentially negative feelings or concerns and not considered as an option for a coping mechanism. This reduces family interaction and can potentially lead to family breakdown (Kirschman, 2007) dissolving support networks. As much as the 'closed shop' was the favoured method, not all or were able to maintain such a silence. Several participants confided in their spouse or partner.

Unfortunately as with disclosing to peers or managers, even where there was a willingness to reveal an illness, spouses or relatives were not necessarily well placed to understand or offer support.

> *Sue: he's got actually no clue what I'm talking about and looked at me like I was broken because it was just so far from his reality and that's not his fault, we're just different people.*

A number of respondents commented how friends had now distanced themselves after becoming aware of the participants mental ill health. This fits with Carpentier & Ducharme (2003) findings, as withdrawal of friendship is another encumbrance but not unexpected association with the disclosure of mental ill health. Close family tend to remain but peripheral friends and colleagues are likely to disengage.

Several respondents lamented the loss of camaraderie and 'espirt de corps' which was historically more evident in policing. Such was the culture that teams worked and socialised together and there was a greater sense of community (Waddington, 1999; Loftus, 2010). This may have provided a listening ear and support network whilst in the workplace which now seemed to be a distant memory. However, there was no evidence to suggest this was maintained on disclosure of mental ill health or any protracted absence from the workplace (see below).

10.12 Turning Blue

Turning Blue examines police attitudes to mental health within the organisation.

10.12.1 Stigma

There was overwhelming evidence that there is an enormous stigma to mental illness within policing (Karaffa & Tochkov, 2013; Bullock & Garland, 2017; Stuart, 2017; Soomro & Yanos, 2018; Turner & Jenkins, 2018). The word 'stigma' was used frequently by participants and often alluded to for not admitting difficulties. In a close-knit community such as policing, officers do not want to be seen nor can afford to be seen as outsiders nor labelled with a mental health problem (Karaffa & Tochkov, 2013). This has been ingrained in the organisation for many years. Participants suggested they would be judged unfairly by their peers.

Supervisors would warn their staff not to be open about mental ill health due to the stigma associated with it. Participants were routinely challenged by supervisors and asked "*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).

Thus, some supervisors would attempt to support their staff with mental health issues without drawing unnecessary attention to the fact and attempt to manage issues under the radar.

Interviews revealed that there is something of a paradox in that officers appear not to be discriminatory about members of the public with mental health issues but will be dismissive about colleagues in a similar position.

> *Bill: you go to jobs and you see like the true heart of officers come out when you're with someone who's having a breakdown and yet they desist acceptance when it happens to officers*

This is in tandem with the survey data which identified the police appear to be generally supportive of members of the public with mental ill health but whose personal experiences are far less comfortable within the work place.

Weakness was a word used frequently by participants, as was the macho culture of the organisation, where physical and mental strength are seen as essential traits when being reliable at times of crisis is the key to survival. Therefore, displaying signs of stress and mental illness are regarded negatively as signs of weakness (Karaffa & Tochkov, 2013; Bullock & Garland, 2017; Stuart, 2017; Soomro & Yanos, 2018; Turner & Jenkins, 2018). This resulted in further humiliation and embarrassment attacking one's self pride.

> *Paul: from a cops point of view, the shame of it, the absolute shame and feeling of weakness is just overwhelming, it's horrible.*

Participants reported decreases in self-esteem and diminutions in self-efficacy. Self-stigmatisation is possible where participants succumb to stereotypes with a loss of self-esteem and self-devaluation (Corrigan et al., 2009) exacerbating the fear and consequences of disclosing a mental health issue and seeking support. Thus self-stigma deters officers and staff from discussing distressing issues with other officers lest they be considered unfit to respond to operational demands.

10.12.2 Loss of camaraderie and canteen culture

Longer serving officers spoke of previous times when there was greater sense of camaraderie with opportunities to socialise in and outside the workplace. This manifested its self in the canteen culture where officers felt safe to unwind and share experiences often employing humour as a coping mechanism (Loftus, 2010; Waddington, 1999).

Similarly, police bars or routine gatherings at a local pub after work provided similar experiences and opportunities to share events, informal debriefs and unwind. However,

officers would have been candid about discussing mental ill health as that was a taboo subject. Many respondents lamented the fact that there has been a reduction in such interactions and that there is evidence of a demise in camaraderie and team spirit (Bullock & Garland, 2017; Turner & Jenkins, 2018). More recently lone working has aggravated the demise in camaraderie. The loss of canteens and the diminishing daily contact amongst officers appears to have left a void in officer's ability to confide or counsel their peers with no replacement available (Charman, 2015).

As mentioned above the turnover in staff is also detrimental to a feeling of belonging. This is most evident during times of absence when feelings of isolation from the work environment are heightened. Paul best captured what appeared to be better times and bemoaned the changing police culture which has reduced opportunities for personal contact with peers, removed support networks and left officers feeling isolated.

> *Paul: now there's no such thing as debriefing amongst yourselves really I don't think, certainly not in my situation. We're single crewed now with such a big area, I'm lucky if I see anybody off my department*

10.12.3 Derogatory terminology

Respondents reported that that had heard or been subject to derogatory abuse or bullying because of their mental ill health. These amounted from what were referred to as the less intentional or 'off the cuff' comments to the more severe and abusive words and behaviours.

> *Mike: "ah they're only window lickers don't worry about it"*

It was not necessarily the words were the issue, what had the greater impact was the narrative. Such as insinuating 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 & Watson, 2002). Such narrative permeates into everyday language and becomes part of the lexicon of policing, to the point people do not question how inappropriate such language maybe. This was to the point a participant admonished himself for the use of inappropriate terminology.

Managers and supervisors were not exempt from the use of demeaning language. A participant recalled a manager bullying a subordinate in an open office in front of work colleagues.

> *Kelly: I pointed out to him 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 "Ahhh didums can't you could you cope with the work you need some help?" (Said in a demeaning childish voice)

As well as the overt participants feared the covert conversations which would undermine their credibility. They became suspicious of what their peers may say behind their backs. The two-tier response to physical and mental illness (see below) suggested that such abuse appeared to be reserved for mental ill health as opposed to physical illness. At times participants were incredulous about their colleague's reactions to peers with mental ill health problems.

Some thought there was a place for humour and that deprecating language may have its place amongst close colleagues. One officer described how the light-hearted 'banter' deployed by his colleagues towards his condition was indicative of their support: 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.

Bullock and Garland (2017) found similar issues in a UK police force. However, it was obvious from the data that this was an exception and that the narrative and culture of the organisation towards personnel with mental health issues were far short of the standards and values of the police service creating an environment where stigma and self-stigmatisation are rife.

10.12.4 Suspicious Minds - Swinging the lead

Traditionally officers reporting stress or depression were seen by peers and supervisors to be 'swinging the lead'. More recently the term 'stress is the new bad back' has been coined. Implying that sickness absences are not genuine nor are an officer's incapability to work or carry out operational duties (Stuart, 2017; Turner & Jenkins, 2018). Such thoughts were also shared by some of the participants who were experiencing mental ill health.

Ann: I have no doubt that there are officers out there who potentially take advantage

That mental ill health can be used as excuse for unnecessary absence or avoiding operational duties. Moreover, those who are aware of the personal impact and stigma surrounding mental ill health in the workplace question why anyone would use it as a smoke screen (Bell & Eski, 2016). It is apparent that the current sceptical and mistrustful management of people with mental health issues has to be addressed. This requires root

and branch reform across the organisation with particular emphasis for those with leadership roles.

10.12.5 Physical versus mental ill health

Participants experiencing mental illness are of the opinion that colleagues view them less sympathetically than colleagues with physical injuries or illness. This further alienated officers causing them additional unnecessary anguish and potentially hampers disclosure (Bullock & Garland, 2017). That even those attending counselling support or rehabilitation services at Police Treatment Centres find themselves to be demeaned in comparison to colleagues carrying physical injuries. Jenny's experience of having (unlinked) depression and cancer is a very telling indicator of the response to mental ill health within policing.

> *Jenny: I haven't got a problem telling people I have cancer. I find it much easier to talk about it. I find it much easier to deal with. If you give me the choice of the cancer or the mental health . I would have the cancer. It's easier to deal with.*

10.12.6 Personal experience changes attitudes to mental ill health

It was apparent that officers/staff personal experience of having poor mental ill health made one more receptive and less judgemental of colleagues with mental illness (Corrigan & Penn, 1999). That managers who had first or second hand of mental ill health were more approachable and likely to be more sympathetic.

10.12.7 Professional experience impacts on colleagues with mental ill health

A small number of respondents thought it unlikely that professional experiences with members of the public with mental health issues would influence their perceptions of colleagues with mental ill health. However, there was a general acceptance that professional experience did influence their perceptions of colleagues with mental ill health (Royle et al., 2009). There was a recognition of the breath and severity of the conditions dealt with and that the police were more likely to deal with those who were a danger to themselves or others or some form of criminality, which may influence negative attitudes (Watson et al., 2004; Broussard et al., 2011).

> *Eric: I think most cops experience of dealing with mental health patients are extremes of mental health .....and I think that taints you*

Thus, it is obvious that in many quarters police officers and staff stereotype people with mental ill health (Clayfield et al., 2011; Soomro & Yanos, 2018).

> *Helen: I'm to blame for that as well because I see people that we go and deal with, "oh I'm off with depression, anxiety" and I thought well if you weren't sat on*

your arse all day, got a job and actually do something with your life you might not feel so bad,

Despite the police/public interfaces and experience some officers were probably more tolerant and sensitive than the majority of colleagues (Cotton, 2004). However, this was not always repeated with colleagues.

Ann: I think 9 times out of 10 it's probably more negative towards their colleagues than members of the public.

10.12.8 Absence leading to exclusion

Participants reported how a sickness induced absence could result in the exclusion or withdrawal of officers from their workplace community and in turn shrink their social circle. Further increasing feelings of isolation or abandonment. The responsibility for the exclusion was generally lodged with the organisation (Bullock & 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 (Link et al., 1989, Link et al., 1991).

10.12.9 Organisation

It was obvious from the data that respondents felt they were marginalised and excluded by the organisation especially after a period of absence. Participants often felt ignored and isolated. This often led to a perception that managers hoped the problem and hence the individual would merely go away if they were disregarded or ignored. Managers and in turn the organisation routinely failed in their duty to maintain contact with their staff. This is contradictory to good practice and policy (HSE, 2007; McDowall, 2014). Failure to maintain contact resulted in participants questioning their professional competence leading to increased feelings of anxiety and embitterment towards the organisation. Participants were in agreement with Randall and Buys (2013) that it was incumbent on managers to directly communicate and engage with injured personnel throughout the rehabilitation process. Without which occupational bonds break down and are hard to establish.

Elaine: Being off Caused me more anxiety, nobody got in touch.

Participants' self-identity is closely coupled with their job and the responsibility, thus absence accompanied a mourned loss of identity or 'spoiled identity' as Bullock and Garland (2017) termed it. Due to the lack of contact experienced during an absence, those contemplating returning to work were reluctant to do so and expressed an opinion that they would be shunned by managers and seen as a burden.

10.12.10 Peers

It was not only managers who avoided or excluded officers and staff with mental ill health issues but also workmates and long standing supposed friends. Again, on return to the workplace avoidance is maintained. Workmates were described as 'stepping back and not wanting to know' or as one participant put it, he was 'the elephant in to room and avoided'. Kadushin's (1981, 2004) interpretation of Social Network Theory argues that these peripheral relationships are quite fragile and not unusual for them to break down. This is of no benefit to the absent or returning officer/staff member who seeks familiarity and normalcy. Thus, avoidance and rejection undermines self-belief and confidence inducing further stigma (Link & Phelan, 2001).

All in all the return to work process is challenging for those contemplating or attempting to return to work.

10.13 Well Officer?

10.13.1 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 (Karaffa & Tochkov, 2013; Bullock & Garland, 2017). However, there were mixed responses as to the commitment and genuineness of those involved. It appeared some chief constables had taken personal responsibility and were 'fronting' campaigns such as the Bluelight campaign and Wellbeing initiatives and involved other chief officers. Unfortunately, many respondents thought some chief officers' support was insincere or were 'paying lip service' to mental health initiatives. They are suspected of holding private views, which are very different from their public views. Some drivers were not seen to be altruistic but perhaps to protect reputational risk and that publicity surrounding officers taking their own lives provided the emphasis and not the wellbeing of the officers and staff.

> *Gill : they're not interested in the issues. They just don't want the headline "ZZZZ Force Police Officer Dies"*

However, the majority of participants strongly desired leadership being displayed from the highest level. The active participation and effective communication of chief officers was seen as fundamental to driving cultural change. Several 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 & Garland, 2017).

In contrast, there was a perception that it appeared to be not across the board and that responsibilities may have been delegated or taken up by the superintending ranks. This may partially be due to the hierarchical nature of policing and geographically difficulties of chief officers being located away from the majority of police officers and less so police staff. However, modern communication techniques can counter these difficulties if there is a desire to do so.

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 programs for staff. *Paul: 'She's basically lit a torch for police mental health and she's gone off on a charger*'. Such 'challengers' (Thoits, 2011) working under or alongside strategic leaders and role models can breakdown cultural barriers, acknowledge primary and secondary trauma and the acceptability of seeking help to the benefit of the service and public alike (Loftus, 2009; Bell and Eski, 2016; Turner and Jenkins, 2018).

Good supervisors and poor supervisors

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). Similarly the majority of respondents their direct line supervisors had most impact on their experiences and relationships with the organisation. It was obvious that good supervisors were knowledgeable about their staff and be supportive of them if undergoing stressful life experiences. Line mangers were dependent upon each rank having a similar approach.

However, there were different responses from within the same command chain. This inconsistency was highlighted as an issue. Officers/ staff craved consistency on a personal and corporate level. However, it was obvious to participants that supervisors with close companions who had experienced mental health issues or their own mental health issues were more sympathetic (Corrigan & Penn, 1999). They were seen as more responsive and consultative. They listened to staff seeking agreement when putting workplace remedies in place.

In line with the survey data, it was suggested managers lacked knowledge and training in dealing with staff in such cases. 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. Likewise, there were instances of

managers recognising poor stress levels of officers but failing to deal with it preferring to deploy them back into an operational sphere rather than seek support (Stuart, 2017).

There was some suggestion that the same drivers and values placed on protecting the public (NPIA, 2010) were not always reflected in how supervisors look after the welfare of their staff. Thus poor managers were a source of additional stress and poor interactions often resulted in what was felt like an enforced absence due to the behaviour of the manager. Elaine: *'He shouted just get out. I just left. I was on leave for a week and then I went sick.'* Such oppressive sickness policies and management created an environment where managers malign those who should be provided with compassion and support (see attendance and performance below). This led to instances of oppressive behaviour in order to achieve a return to work much to the detriment of the individual (Cooper & Dewe, 2008; Hesketh, 2014; Hesketh et al., 2014).

10.13.2 Human Resources and Occupational Health, policies and people

Respondents shared much consternation about interactions with HR and OHU departments. Respondents were reluctant to let others know they were attending OHU and were wary of having OHU appointment on working rosters or team calendars. Thus what should have been seen as a confidential appointment becomes almost a public announcement. In an environment where seeking or receiving treatment for mental ill health adds to the stigma such processes are problematic and becomes a barrier to help seeking (Toch, 2002; Royle et al., 2009; Karaffa & Tochkov, 2013; Clement, et al., 2015).

For those who overcome the stigma of receiving treatment (Clement et al., 2015) and opted to attend OHU they were frequently met with lengthy delays (Turner & Jenkins, 2018). It is possible that austerity measures which 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 OHU departments have created a bottle neck where demand out strips supply. Increasingly staff associations and police charities are taking up the slack in providing counselling and others services to meet the shortfall (North West Police Benifit Fund, 2019). Unfortunately the withdrawal of key support roles were according to some participants accompanied by an overall hardening of attitudes towards mental ill health amongst personnel working in HR and OHU functions.

Similarly, amongst police officers there were doubts as to how knowledgeable OHU/HR personnel and medical staff were about the realties 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 OHU/HR personnel and medical staff as 'outsiders' who are incapable of understanding the challenges and dangers of operational policing (Alderden & 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 & 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 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 & Kessler, 2000) had been broken. The organisation was seen to *'break them but not fix them'* which led officers and staff to withdraw leading to a breakdown in relationships with the force. This had a further detrimental impact on the mental ill health of those concerned as they felt excluded, unsupported and removed from their professional identity (Link & Phelan, 2001; Bullock & Garland, 2017). In many cases, this was insurmountable and irretrievable resulting particularly amongst police officers in premature medical retirement.

10.13.3 Attendance and performance policies

Process and policies were believed to be used to walk rough shod 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 & 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 polices which are portrayed by forces as supportive and encourage a return to work were seen by participants as punitive and oppressive. The one size fits all approach took no account of the individual requirements and needs of officers/staff with mental health issues. 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 polices on return to the

workplace. Though Police Regulations and guidance and Staff Policies and guidance suggests managers have discretion and should not rigidly apply polices (HSE, 2007) this is seldom the case.

According to Randall & Buys (2013) in their literature review of managing stress in the police service minimal research has been undertaken into the application of disability and attendance management policies and practices. Yet these policies proliferate in policing despite being seen as punitive (Hesketh, 2014). These researchers suggest that attendance management and return to work plans should require active participation from not only managers but injured workers alike and not used as a threat as in the often used unsatisfactory performance procedures. It is a widely held belief managerial necessities override their individual welfare. 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 six months, officers and staff are subject to a cut in half their pay. After twelve 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 & Garland, 2017; Turner & 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.

All in all attendance polices and default changes in pay caused greater stress and lead to withdrawal and further distancing from the organisation to the point resentment replaces

vocational ideals of belonging. Further research would be worthwhile in establishing the impact of attendance management policies and their effectiveness in supporting wellbeing as opposed attendance performance.

Returning to work

The thought of returning to work and actually doing it increased negative feelings increasing anxiety. Returning to work was seen as difficult after any absence but having a mental health issue exacerbated the matter, as they would be labelled (Link & Phelan, 2013) as returning with such.

Worse still the returning officer/staff member was not necessarily met with welcoming open arms. Officers expecting to return to work had in some instances been side-lined or outcast with their personal and working belongings and equipment lost or transferred for the use of others. Such discrimination may not be intentional or obvious nonetheless it can lead to loss of status (Link & Phelan, 2013). Thus recovery was seen to be two fold, recovering from the mental illness and recovering from the effect of being labelled mentally ill (Deegan, 1993).

In many cases resuming was unbearable as old friendships and acquaintances had become distant during the absence creating uncomfortable and self-conscious reunions. The awkwardness often manifested itself by colleagues avoiding conversations about the absence and more often the cause of the absence.

> *Sue: ok she's coming back, and then nobody really knows how to treat you and that's weird as well then because it makes you coming back harder.*

Similarly, it can be ineffective to return to the same stressful workplace and redeployment becomes necessary but this can create similar concerns and if not managed properly with the agreement of the returnee can add further distress.

Despite such anxieties, respondents in many cases felt overwhelming pressure from supervisors to return to work regardless of their ill health (see attendance polices above). All in all the preparation and process of returning to work is fraught with hurdles, which real or imagined suggests much more should be done to improve the process.

Redeployed and restricted

Redeployment was seen as an opportunity in some instances. More so where there was conflict with managers or relationships became untenable. By doing so staff could be retained in the workplace and not taking sick leave (Randall & Buys, 2013).

However, more often than not staff valued the familiarity of their existing workplace and the established relationships with their peers. As a result the fear of redeployment was uppermost in minds especially police officers. This was allied to removal from operational duties, which are seen as being core to being a police officer. That somehow having a mental health issue is an immediate restraint curtailing an officer's ability to perform full police duties (Bullock & Garland, 2017).

> *Ivy: because if they've got mental health issues, can they be operational? That's the fear isn't it?*

Being confined to an office role was not considered policing. Furthermore, many redeployments took place without any consultation with the officers concerned. A number of forces had support or office based roles within units or departments whose responsibilities varied but had a high proportion of officers on restricted duties or those convalescing from illness and injury. This should be seen as commendable, supporting officers' recovery. However, the unofficial but widely used terminology used to identify the units was often derogatory or inappropriate and therefore discriminatory.

> *Helen: it has the nickname, the broken biscuit unit where they put the sick, the lame or the lazy.*

There seemed an inevitability that disclosure of mental ill health would result in redeployment at best and expulsion from the organisation at worst (Bullock & Garland, 2017). What was certain was that officers felt like they had a rug pulled from under their feet. At a time when they felt most vulnerable the organisation took decisions without conferring with them or involvement in the decision making process which resulted in moves which was injurious to their wellbeing and often exacerbated the existing condition.

All in all what officers and staff craved was continuity and consistency whilst dealing with their mental ill health.

10.13.4 Contact with managers

As mentioned above absence from the workplace especially those of a protracted nature can lead to a sense of isolation or abandonment by the organisation. It appears that line managers do not adhere to force policies about maintaining contact with officers/staff during medium to long-term absence. The lack of contact can exacerbate symptoms.

> *Elaine: Being off caused me more anxiety, nobody got in touch.*

Unfortunately even where they occurred not all had a good experience of home visits. The interactions appeared not to be supportive but an interaction to coerce people back to

work without an awareness of the current state of mind or readiness of the individual to do so. In such circumstances, some respondents found attendance policies and frequency of contacts to be too rigid lacking any flexibility to take account of the wellbeing of the staff member. It appears that the one size fits all approach is not suitable in many instances.

The problem with contacts and visits centred not only on the administrative and logistical matters but also on the ability of managers to undertake the task. It was suggested that many of the issues surrounding poor interactions or preventing contact was a lack of training on behalf of supervisors (see above).

10.13.5 Prevention is better than cure – Suggestions for improvements

Tenure

Tenure has operated in policing as a method to increase access to specialist departments and increase levels of expertise across the workforce. This has been based on fixed time frames in particular posts and /or personal performance which is somewhat more flexible. Participants have suggested there is an argument for placing a ceiling or review option for redeployment from frontline response policing.

> *Neil:, you do 4 years on front line and then what happens is you get rotated out into another role where you're not faced with all the shit that you're facing on a daily basis, the aggravation, the threats, things like that.*

Screening – Mental health MOT

Participants proposed some forms of regular mental health screening or as Frank put it *' I'd have the mental health MOTs.'* Others suggested it should be based on exposure to traumatic incidents as opposed to time scaled. It would break down the barrier or stigma associated with help seeking.

It was recognised that officers/staff may not always be able to identify they had early symptoms or warning signs of diminishing mental health. Such screening processes may well help identify such issues. However, albeit screening was seen as an opportunity it would be seen by forces as an additional expense and not justifiable.

Again due to cultural issues it was suggested that participants were likely to lie or fail to respond to routine screening in order to conceal a problem or for fear of disclosure.

This lies well with the work of Tehrani (2016, p. 405) who found 'The initial screening of police officers from two police forces entering a high-risk role has shown that on average 80% are fit and have no significant symptoms of trauma, 15% have scores which are

concerning, and 5% have clinically significant symptoms of PTSD'. The information did not deter operational deployment but provided an opportunity to monitor those who may potentially be more at risk.

Debriefing

Participants complained of the lack of formal debriefing for officers who had experienced traumatic incidents (Turner & Jenkins, 2018). This appears to be unusual for an organisation, which routinely debriefs operational responses. However, it appears supervisors were ill equipped to identify where debriefing would assist. It appeared there was no checklist or risk analysis for considering which type of event may impact on officers' mental wellbeing. At best, it was *'tea and biscuits'* with no desire to raise any potential issues.

Yet there was a strong consensus that debriefing was one of the keys to emotional survival within the policing environment. It just appeared not to be done or very limited. However, how this would be achieved and what the take up would be raised several issues. Many participants questioned how willing officers and staff would be willing to engage in the process or admit to having had negative or traumatic experiences in a public arena.

> *Paul: 'even if you did feel a bit vulnerable or thought "god I really, really didn't like that", you're certainly not going to admit that to 30 colleagues so you don't and you don't go to the debriefs'*

It was felt that there is a need for 24/7 debriefing from qualified personnel and not 'keen amateurs' or for career development. Such failings miss an opportunity to identify officers requiring line manager support, sign posting or other interventions.

Support networks

A number of positive support networks were highlighted as good practice. It was evident that someone with operational policing experience would be more credible than someone who had not experienced the stresses of policing (Miller, 1995; Karaffa & Tochkov, 2013). Unfortunately, they were not widespread. Some networks were informal and relied on officers/staff sharing their own experiences and providing support for others.

Others were part of a formal peer support network. Trained to recognise signs and symptoms associated with mental health and empowered to sign post colleagues to the appropriate support (Blue Light Programme, 2016).

Participants had been referred to colleagues via the networks to good effect building up long-term support. However, there was evidence that communication about peer support networks was not as good as it could have been and that additional measures were needed to ensure the message was delivered.

Employee Support Programme

Many forces had Employee Support Programs, which offered different levels of support, a minority used the service reluctantly. Even where the facility had been outsourced there were levels of distrust about confidentiality and the potential to negatively impact on careers (Fox et al., 2012).

In many cases, staff were unaware of the facility being available. Respondents questioned the efficacy of telephone assessments. As a result, Employee Support Programs did not receive good press and appeared to be avoided by those it may have been able to support.

Training

The lack of suitable education and training was a constant theme through the interviews. It was generally seen to be inadequate or non-existent. This was viewed as a significant issue across all grades and ranks but of even greater significance for line managers. It is seen as the key to changing organisational attitudes and tackling stigma (Randall & Buys, 2013).

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). The organisation had been seen to rightly invest in providing training to improve police responses to dealing with members of the public with mental health issues. A provision, which had not been extended to inform the debate internally.

> *Helen: I remember at the time thinking "why aren't we discussing things for police officers? Why aren't we bringing that into the workplace?"*

It was obvious that those with mental ill health issues lacked confidence in their manager's ability to recognise the signs and symptoms of generic and specific symptoms. Because of this it presented problems in identifying potential solutions or signposting people. Training was therefore thought be key. However, careful consideration should be given to how the training is delivered. Some forces were accused of providing an inferior product, which relied on generic IT media.

Mike: We had that basic paint by numbers ICAL system which is about as effective as a chocolate ashtray in a furnace, yes, that was very basic, very basic.

Officers and staff would like to see mental health awareness training integral to basic training.

The ideal was to include training incorporating shared experiences from colleagues, this would provide context and more importantly within policing context and credibility.

10.14 Interviews – Conclusion

10.14.1 Stigma and Suspicious Minds

The interviews have provided rich data which provide evidence that mental ill health continues to carry huge stigma and associated discrimination within policing. Due to the negative connotations associated with mental ill health participants reported symptoms of self-stigmatisation and feelings of decreased self-worth and value to the organisation. Concerningly, the data suggests that those who experience mental ill health are viewed with suspicion. This is so entrenched in police culture that officers experiencing mental ill health are often suspicious of peers who report or are absent with mental ill health.

Police forces in England and Wales subscribe to the Code of Ethics (College of Policing, 2017), which sets out the standards and values of the organisation. Unfortunately, it appears that the narrative and culture of the organisation towards personnel with mental health issues falls far short of these standards and values, creating an environment where stigma and self-stigmatisation are rife.

10.14.2 Managing those with mental ill health

The management of those experiencing mental ill health was largely questionable and for many aggravated the symptoms. The majority of respondents, including those that remained in the workplace, felt isolated and unsupported. Personal contact was haphazard and often non-existent and policies and procedures which were designed to support people back into the workplace were frequently seen as punitive. Strict adherence to policies meant that mangers seldom displayed flexibility or discretion to the detriment of the individual.

Respondents experiencing mental ill health expected that the organisation would be supportive and provide an adequate occupational health response to aid their recovery. Unfortunately, ‘suspicious minds’ were evident as managers and colleagues doubted the genuineness of their illness. There was evidence of sickness and attendance polices being

on the one hand neglected and the other as punitive. In a number of cases, participants were unable to comply with policies, meetings or timescales and found themselves subject to unsatisfactory performance procedures and even dismissal.

The disparity of management between those with physical and those with mental ill health was evident. One of the most contentious being the application of half pay and no pay polices. It is at the discretion of chief officers to maintain full pay if the illness is life threatening or is the result of an injury in the execution of duty. None of the participants reported being retained on full pay despite their injury being work related. At a time of crisis, this was seen as an additional burden and further evidence of discrimination.

Redeployment was also another controversial issue. Placement on restrictive or recuperative duties seldom involved consultation or negotiation. Although potentially supportive, it often resulted in removal from familiar surroundings and support networks. The removal of police officers from operational roles impacted on self-esteem and was seen as stigmatising. The lack of consultation was disempowering causing further stress and injury exacerbating the existing condition.

Participants craved a safe environment where a mental illness could be disclosed, when doing so that they would be believed and that managers deploying processes and policies would be applied fairly and equitably with personalised responses meeting the individual needs of the officer or staff member. Sadly, in the majority of instances this was not case (Jorm et al., 2010)

CHAPTER 11

Overall Discussion

11 Overall Discussion

> "Almost nine out of ten people with a mental health problem face stigma and discrimination. This can have a profound effect on a person's life, affecting their work, their social life and their relationships. Locally, all NHS and other public sector staff should be trained and supported to challenge and eliminate stigmatising attitudes and behaviours towards people with mental health problems." (Mental Health Policy Group, 2019, p. 8)

The Mental Health Policy Group Report (2019) provides a damning indictment on the experiences of people with mental ill health in 2019 and a plea that appropriate training be provided to change attitudes towards mental illness. The police are no exception as recent research by several authors provides evidence of stigma and discrimination towards those with mental ill health in policing both locally and nationally in England and Wales (Blue Light Programme, 2016; Bullock & Garland, 2017; Bell & Palmer-Conn, 2018; Turner & Jenkins, 2018). The fact that police officers and police staff have high levels of poor mental ill health (UNISON, 2014; MIND, 2015; Houdmont & Elliot-Davies, 2016) makes it important that police attitudes to mental illness can be measured and therefore understood (Yang & Link, 2015).

11.1 CAMI Survey

In addressing the research questions this study has in the first place provided a national police measure of attitudes to mental ill health. It has established that within policing the measures can vary. In this instance between police officers and police staff and that, these measures can be benchmarked against the civilian population. Previous studies involving police officers have employed scales to measure officer attitudes and analysed the results within the parameters of the scales, making comment and conclusions with regards the numerical position on the scale and attributing findings according to the headings of benevolence or authoritarianism etc.

When considering the methodology to address the research questions this was a constant niggle as the establishment of a measure on a point in time without some sort of benchmark appeared to lack a foundation or comparison to establish if police attitudes were in line with the society they exist in or out of kilter for better or worse. Thus the permission of TNS BMRB was sought to use the results of the Time to Change – TNS BMRB Attitudes to Mental Illness Questionnaire (2015) as benchmark for the results of this study. The results provide for the first time a national benchmark of police attitudes to mental ill health (Bell & Palmer-Conn, 2018). This will allow future researchers to establish how the

current crop of wellbeing and mental ill health campaigns and interventions such as *Oscar Kilo*, and *Bluelight* are successful at achieving their aims of improving attitudes towards mental ill health in the service.

The results from the Community Attitudes to Mental Illness Scale (CAMI) (Taylor & Dear, 1981) element of this this research provide evidence that statistically police officers and the civilian population share similar attitudes to mental ill health surmounted by police staff who score higher and have statistically better attitudes. The gap between police officer and police staff results maybe a cultural one as 55% of police staff respondents were in administrative roles and may not have shared the same operational experiences as police officers and operational police staff in frontline roles. As Chan (1997) and Loftus (2010) suggest there are multiple police cultures as opposed to a singular police culture, which may influence different police officer and police staff responses. Furthermore, the absorption of police culture by police staff has yet to be established (Johnston, 2006) and uniform police staff remain outside the occupational culture of sworn officer colleagues (Miller, 1995; Cosgrove, 2016). Therefore, further investigation into the differences displayed between police officers and police staff is worthy of further investigation.

On closer examination, it becomes evident that the Integration into the Community subscale is an outlier as it is only within this subscale that police officers statistically score lower than the population at large indicating less positive attitudes towards inclusion. It is from here that the theme of exclusion or failure to support inclusion emerges and then becomes a continuous theme through the rest of the data. Several authors including Cummins (2012), Morgan and Paterson (2017) and Lane (2019) suggest that the increased demands and response to metal health related matters has eroded police officer support for community integration. Furthermore police officers are reported as not considering such duties 'as real police work' (Trovato, 2000; Cummings & Jones, 2010; Adebowale, 2013; Lane, 2019). The cause of which is exacerbated by the closure of residential and long stay mental health facilities and increasing police frustration in having to deal with mental health related incidents (Cummins, 2012; Morgan & Paterson, 2017; Lane, 2019).

The Fear and Exclusion subscale provides generally supportive results for police staff and police officers, the latter sharing similar scores with the public. However, there are elements of 'not in my backyard' (NIMBY) from police officers reinforcing the negative attitudes towards neighbourhood and community based mental health services and 'living next door to someone who has been mentally ill' both key indicators of negative attitudes

to mental illness (Pinfold et al., 2004). Similarly, the Understanding and Tolerance subscale reinforces the NIMBY attitude towards inclusion. Cotton (2004) counters this to some extent suggesting the lack of police support for community integration can be attributable to adherence to legislative and civic responsibilities, which can override their personal attitudes. Likewise, Trovato (2000) argues police officers experience a conflict between supporting those with mental ill health and a duty to protect the public (Watson et al., 2004; Cummins, 2012, Morgan and Paterson, 2017). In contrast, police officers and police staff were more supportive of 'increasing spending on mental health services' than the public. Arguably, increased spending on mental health services would decrease the policing burden, reducing demand and improving perceived workloads and potently improve attitudes. This is reflected in the Causes of mental illness and the needs for special services subscale, which reveals that police officers and staff have a greater understanding of the causes of mental illness than the public and the requirement for improved specialist services. The police scores decry the lack of mental health services. This is not unsurprising, as the police have witnessed the impacts of austerity on mental health services and subsequent increased policing demands (Cummins, 2012; Morgan & Paterson, 2017; Lane, 2019).

Thus far the research has established that statistically police officers and staff have generally positive attitudes towards mental illness but there appears to be some rejection of community based care and services especially amongst police officers and to a lesser extent police staff. In relation to the location of such services and residing next door to such establishments or residents, there is an element of 'NIMBYism' with police officers and staff exhibiting a desire to maintain social distance (Link et al., 1989; Broussard et al., 2011). These themes continue through the qualitative data where an element of exclusion continues in the CAMI open-responses and in the interviews where participants reported feeling isolated and unsupported.

11.2 CAMI Open responses

In order to seek greater understanding and give a voice to respondents, officers and staff were invited to make free text comments in response to the survey statements. This provided additional insight into police officer and staff beliefs and attitudes towards those with mental ill health and possible explanations for those attitudes. From the open comments, it was evident that police personnel recognise that people with mental ill health can be vulnerable and there is an intrinsic responsibility to support those at times of crisis,

something they can often feel ill equipped to do. However, there is little doubt that mental ill health is stigmatised within policing to the detriment of the public and colleagues and that there is a demand for work place interventions such as appropriate training and changes to policy and personnel practices to improve the lot of officers and staff and those they police with mental ill health.

The open responses supports the statistical data in that respondents saw themselves and colleagues as understanding and tolerant of mental ill health with a duty to respond to and care for those with mental illness (Bradley, 2009; Adebowale, 2013; Morgan & Paterson, 2017). This is important as people with mental health issues are more likely to be victims of crime than perpetrators (Office for National Statistics, 2019) and unfortunately can be viewed as less credible as a witness or victim by police officers (Watson et al., 2004) resulting in poor policing responses.

The open responses reflected the CAMI scores with the former supporting the statement 'that more emphasis is need on caring for individuals with mental ill health'. From a police perspective the open responses start to provide some explanation as to why the Integration into the Community subscale scores are lower for police officers as there is a belief that such care is failing and unduly and disproportionally has transferred to a policing responsibility in lieu of medical or social care provision (Cummins, 2012; Morgan & Paterson, 2017). The CAMI scale provided proof that police officers were more likely than police staff or the public to think that 'people with mental ill health were a burden on society' which appears to be less desirable attitude. However, the open statements allow those who chose to do so an explanation for their thinking which does not apportion blame on those with mental ill health but deinstitutionalisation (Cotton, 2004; Cummins, 2007; Paterson & Pollock, 2016) and societies failure to invest in appropriate services (Cummins, 2012; Morgan & Paterson, 2017). Furthermore, respondents argue that they are crime-fighters and not mental health practitioners (Adebowale, 2013; van Hulst, 2013; Morgan & Paterson, 2017; Lane, 2019) and that they are compelled to deal with mental health issues beyond their training, capability and remit (McLean & Marshall, 2010).

It can be seen that respondents provide some explanation for their attitudes to the 'burdensome' statement based on their policing experience. Likewise respondents policing encounters with people with mental ill health provides evidence that people with mental ill health are seen as potentially threatening and violent (Watson et al., 2004; Godfredson et al., 2011; Koskela et al., 2015) and that respondents see it as their duty to protect the

public (Watson et al., 2004; Cummins, 2012). This is justified by being called upon to support mental health professionals in detaining and dealing with violent incidents at A&E and psychiatric units (Cummings & Jones, 2010). There are no surprises that police officers were more inclined to suggest the public require protection from those with mental ill health. Nor that they were more likely to think mental hospitals are not an outdated requirement. Similar thinking was evident in the 'NIMBY' responses, which associated mental illness with violence and antisocial behaviour (Link & Phelan, 1998).

It is from here that explanations about practical police responses and experiences to dealing with incidents involving people with mental ill health becomes an apparent disclosure of mental health related stigma within policing. The open comments provides evidence that inappropriate behaviour and comments about members of the public with mental health issues go unchallenged and that people with mental health issues coming into contact with the police are stigmatised (Godfredson et al., 2011; Koskela et al., 2015).

Respondents appeared to be of the opinion that there were categories of people with mental ill health who could be deemed to be the 'deserving ill and undeserving ill'. The latter described as weak willed people displaying little self-control, dependant on stimulants and a burden on society (Lister et al., 2008). In a similar vein the genuineness of mental illness was challenged by respondents , as Watson et al., (2004) puts it a police officer's first tendency is to question the credibility of persons with mental illness. Police colleagues were not exempt from such suspicion as there is evidence that police officers and staff face similar issues and are often doubted as to the authenticity of their illness and subject of derogatory comments and labelled 'headworkers' and 'lead swingers' (Blue Light Programme, 2016; Bullock & Garland, 2017; Stuart, 2017; Soomro & Yanos, 2018). Their suitability to work in a police environment was questioned (Bullock & Garland, 2017; Stuart, 2017; Turner & Jenkins, 2018) and in some cases accused of malingering (Stuart, 2017; Turner & Jenkins, 2018; Bell & Palmer-Conn, 2018).

The paucity and deficiency of police mental health training was highlighted for failing to address mental health related stigma and poor management for officers and staff with mental ill health. Unsurprisingly researchers have advocated anti-stigma interventions and training to improve police attitudes, mental health literacy and intentional behaviours (NPIA, 2010; Broussard et al., 2011; Koskela et al., 2015) when dealing with mental health incidents. Likewise, anti-stigma programs are recommended to address the stigma and discrimination towards those with mental health issues working within policing (Randall &

Buys, 2013; Bullock & Garland, 2017; Stuart, 2017; Turner & Jenkins, 2018). Respondents were critical of existing IT based training solutions and front loaded tuition instead favouring an integrated multiagency training environment with service users and/or colleagues who had experienced mental ill health believing such training would be more credible.

11.3 MAKS Schedule

The Mental Health Knowledge Schedule (MAKS) (Evans-Lacko et al., 2010) establishes a measure of Mental Health Literacy (Jorm, 2000) which researchers have established is an effective tool in reducing mental health related stigma (Jorm et al., 2010; Rusch et al., 2011; Kutcher et al., 2016). The MAKS results indicate that the police family were statistically more knowledgeable about mental ill health than the public, which would suggest that they are more likely to be supportive of people with mental ill health. The generally positive CAMI police scores are replicated within the MAKS police scores, which collectively should be indicative of an organisation with positive attitudes about mental ill health. As with the CAMI survey, the MAKS Schedule has some interesting results. Police officers were unlikely to see drug addiction as a mental illness and unlikely to support the idea people with mental health problems want to have paid employment. Further evidence of an underlying theme of the 'deserving ill' and the supposed 'self-inflicted ill' (CAMI Survey and open-ended statements).

11.4 MAKS Open responses

As with the CAMI open responses the MAKS open responses provide respondents with an opportunity to build the narrative and provide an insight into the thinking of respondents and what contributes to or lies behind the scores. On the face of it, the scores provide a knowledgeable workforce confident in dealing with mental ill health. It appears the majority of officers and staff can identify mental health issues and would be comfortable sign posting colleagues for support. However, the open comments are not as complementary as they provide additional evidence of mental health related stigma within policing. Respondents would be unwilling to inform their force that they had a mental illness as they feared being doubted or labelled (Karaffa & Tochkov, 2013; Bullock & Garland, 2017; Stuart, 2017; Turner & Jenkins, 2018; Bell & Palmer-Conn, 2018) and thought it unlikely they would get the support they required (Bullock & Garland, 2017; Turner & Jenkins, 2018).

11.5 Consulting and talking about mental health and working with people with mental ill health survey and open responses

Despite some contra indicators, the numerical data so far is generally a positive assessment of police attitudes to mental ill health. So too police officers and staff are statistically more positive about working with colleagues with mental ill health compared to public respondents. However, this is not the case when talking about mental ill health, as police officers were less likely to seek the help of their doctor than the public or police staff. Likewise, police officers and staff appeared to be reluctant to inform family or their employers if they had a mental illness (Blue Light Programme, 2016; Houdmont & Elliot-Davies, 2016). Westley, (1970) argued police officers place a boundary between home and work, and are unlikely to burden or confide in family as is evident in this research as borne out by this research.

Respondents were also fearful that GPs and other health professionals might break confidentiality and inform employers (Fox et al., 2012). Confidentiality is a recurring theme as officers and staff are fearful of the perceived negative consequences of the revelation of mental ill health on career prospects.

11.6 Police specific questions

So far, this research has employed scales and measures developed and used by other researchers within policing and other professions and the wider community. Albeit the introduction of the open-ended options for respondents seen above have added a new dimension to the data produced and provided an additional insight into the attitudes and beliefs of the police family towards people with mental ill health. However, at the commencement of this research no studies were found that employed a police specific scale to measure the attitudes of police officers and staff to the support provided by colleagues, managers and the organisation to those working in policing with poor mental ill health. Using well-tested methodology to assess attitudes and stigma a 10-item police scale was developed to measure such attitudes.

The results are indicative of an environment, which fails to prepare officers and staff for the stresses associated with policing and managers are ill prepared for supporting colleagues with poor mental health (Stuart, 2017; Bell & Palmer-Conn, 2018; Turner & Jenkins, 2018). It is obvious that mental ill health is not treated as sympathetically as a physical illness (Corrigan & Watson, 2002). Moreover, officers and staff are routinely doubted as to the genuineness of a mental illness or related absence and are often accused

of malingering (Stuart, 2017; Bell & Palmer-Conn, 2018; Turner & Jenkins, 2018). Unsurprisingly, such a culture is not conducive to disclosing poor mental health and help seeking can leave officers and staff isolated. It is a damning indictment of policing when 75% of police officers and 56% of police staff are of the opinion that 'Disclosing a mental health problem in the police service is detrimental to future career prospects'. Moreover, the concept of 'suspicious minds' which emerged from the research thus far is validated by the item 'Some people use stress as an excuse for being absent from work' which resulted in 61 % of police officers and 54% of police staff agreeing with.

The qualitative statements reinforce these themes revealing an underlying cynicism towards mental health and colleagues or supervisors doubting the veracity of colleagues with mental ill health.

11.7 Semi-structured interviews

Based on the data analysed so far this research has gone some way towards measuring and describing police attitudes to people with mental ill health and the impact this has within policing. The open-ended survey responses provides some narrative but they do not fully explain the lived experiences of the police officers and staff who have experienced mental illness and their relationship with their colleagues and the organisation. The semi-structured interviews add another dimension to establishing if there is a connection between the attitudes recorded in the survey and the reported experiences of officers and staff.

Based on the data gleaned from thirty three interviews it has been challenging to condense the large number of themes which emerged from the data into an overarching descriptive of the impact of police officer and staff attitudes towards mental ill health. However, as seen in the interview chapters above (Chapter 10) this has been realised as 'Stigma and Suspicious Minds' and 'Managing those with mental ill health'.

The interview data is not fully in agreement with the survey data. Whereas the numerical survey data suggested police officers and staff are generally positive about mental ill health the interview data has more in common with the survey open-ended findings and analysis which alluded to a less supportive regime and gave rise to evidence of stigma and discrimination towards those with mental ill health. This has been confirmed by interview participants who have provided evidence that mental ill health continues to carry stigma and discrimination within policing (Karaffa & Tochkov, 2013; Bullock & Garland, 2017; Stuart, 2017; Turner & Jenkins, 2018; Bell & Palmer-Conn, 2018). They reported feelings,

which amounted to self-stigmatisation, and decreased self-worth and value to the organisation. Arguably, officers and staff with a mental illness, working in an organisation that acquiesces to stigmatising ideas and stereotypes, will internalise these ideas and believe that they are less valued to the detriment of their self-esteem and standing amongst peers (Corrigan, 1998; Link & Phelan, 2001). It is difficult to understand how this compares with the survey data, which has very positive results about officers and staff willingness to work with a colleague with mental ill health yet the majority of those with mental ill health are fearful of discovery or disclosure.

The interview data supports the open-ended responses that those who experience mental ill health are viewed with suspicion (Karaffa & Tochkov, 2013; Bullock & Garland, 2017; Stuart, 2017; Turner & Jenkins, 2018; Bell & Palmer-Conn, 2018). This is so entrenched in police culture that interview participants stated they too were on occasions suspicious of peers who report or are absent with mental ill health.

The management of those experiencing mental ill health was questionable and for many aggravated the sense of stigma and discrimination (Bullock & Garland, 2017; Turner & Jenkins, 2018). The majority of participants, including those that remained in the workplace, felt isolated and unsupported mirroring the lack of support for integration of those with mental ill health identified in the survey data. Despite strict guidelines absent officers and staff reported that personal contact with managers was sporadic and often non-existent. Whereas guidance about regular contact was flouted strict adherence to policies and procedures meant that managers seldom displayed flexibility or discretion to the detriment of the individual. As such, participants frequently saw policies and procedures, designed to support people back into the workplace, as punitive.

Respondents experiencing mental ill health expected a duty of care from the organisation, which would be supportive and provide adequate occupational health response to aid their recovery. Unfortunately, managers were as likely as peers to doubt the genuineness of their illness (Bullock & Garland, 2017; Stuart, 2017; Turner & Jenkins, 2018). Further discrimination was reported in the distinct disparity evident between the management of those with physical and those with mental ill health (Turner & Jenkins, 2018). In fact, the survey data bore out these findings as respondents were firmly of the opinion that officers and staff with mental ill health were treated less favourably than those with physical ailments were.

The positive results of MAKS Schedule (Evans-Lacko et al., 2010) suggested the police family are knowledgeable about mental ill health and understanding of the impact of any interventions, which may be introduced or adopted. However, this was not evident in the use of redeployment or placement on restrictive or recuperative duties, which seldom involved any consultation or negotiation with the officer or staff member. Despite high levels of mental health literacy (Jorm, 2000) the removal of police officers from operational roles was common place with managers failing to identify the subsequent loss of self-esteem and lack of consultation in disempowering causing further stress and exacerbating the existing condition (Bullock & Garland, 2017).

11.8 Overall Discussion – Conclusion

Overall, the interviews provided rich data, which veers away from the supposedly positive interpretations of the quantitative survey data, the former mostly providing evidence of stigma and discrimination encountered by officers and staff with mental health issues. That is not to say the survey data is to be doubted it has provided a measure and a benchmark for attitudes of officers and staff towards mental ill health in 2016. The police quantitative survey data is like that of the public generally positive. However, as mentioned above 'the police are the public and the public are the police' (Reith, 1952) then it would not be unreasonable to expect the police and the public share similar attitudes.

Research in England and Wales suggests attitudes to mental ill health are improving (Time to Change - TNS BMRB, 2015) but that is not to say people with mental ill health are not stigmatised and discriminated against (Mental Health Policy Group, 2019). Therefore, it is not unsurprising that the quantitative survey produces apparently positive scores/attitudes whilst at the same time officers and staff with mental ill health are describing negative experiences. This justifies the methodology and provides an explanation as to the apparently divergent results. It is also an argument for repeating the police survey on a recurring basis to establish and track cages in attitudes. Furthermore, where sufficient responses exist data could be analysed to identify variations in attitudes between forces and demographic groups or to measure the impact and outcomes of training and mental health literacy campaigns.

CHAPTER 12

Overall Conclusions

12 Overall Conclusions

This research has established a valid method for measuring and understanding police attitudes to mental ill health. The conclusions centre on the paradox of measured positive attitudes and an underlying stigmatisation of mental ill health and a culture and environment which requires significant change if those with mental ill health are to be valued and supported.

12.1 The establishment of a benchmark measure of police attitudes to mental illness.

Much of what has been written about attitudes to mental ill health veer towards the negative. This has been the case for the general public employing citizen based surveys and within specific groups such as professions, student bodies and service users. People's beliefs and attitudes dictate how they respond to, deal with and ultimately support a person with mental illness. Likewise, beliefs and attitudes toward mental illness determine how someone will experience and express their own wellbeing and whether they chose to disclose symptoms and seek care. Therefore, in order to reduce stigma and improve mental health and mental health care, we must have the capability to measure stigma.

Employing the Attitudes to Mental Illness Questionnaire (Time to Change - TNS BMRB, 2015) this research has successfully provided a national measure of police officer and staff attitudes to mental ill health. From the results it can be concluded that within policing, police staff hold statistically better attitudes to mental ill health than their police officer counterparts and members of the public and that police officers hold not that dissimilar views to the public.

The police family consistent with their professional standing were statistically more knowledgeable about mental ill health than fellow citizens were. Therefore in line with the above, one would reasonably expect police officers and staff to display less personal stigma and less fear and discomfort when interacting with people with mental ill health. However, it should be noted that whilst police officers and staff were generally supportive of those with mental ill health they are sceptical about the desirability and effectiveness of community based care.

The establishment of the current measures provides future researchers with an ability to quantify the success or otherwise of police anti-stigma and wellbeing campaigns. However, the statistical data alone does not provide a full picture or policing mind-set towards mental

ill health. Analysis of open-ended survey statements and interviews introduced the concept of 'suspicious mind' revealing an element of scepticism towards the genuineness or credibility of those disclosing or dealing with mental ill health. It appears that whilst being generally supportive of those with mental ill heath police officers and staff make value judgements about life styles and perceived personal choices, which can be detrimental to mental wellbeing. Judgments were made about the 'deserving ill' and the supposed 'self-inflicted ill' who shun mental health services and engage in substance misuse. This is at its most evident where police officers were far less likely to support the idea that drug addiction was a mental health issue and more so a character flaw.

Interestingly, despite the statistically different results between police officers and police staff both shared similar lived experiences.

12.2 The establishment of a benchmark measure of police attitudes to disclosing mental illness.

This research has successfully provided a national measure of police officer and staff attitudes to disclosing mental ill health which provides future researchers with an ability to quantify the success or otherwise of police anti-stigma and wellbeing campaigns.

This research has established that police officers and staff are significantly less likely then fellow citizens to disclose a mental illness. They are particularly reluctant to consult their GP as they fear being seen as weak and do not wish to have a mental illness recorded on medical records for fear of disclosure to employers. Following on officers and staff are loath to inform their employer as it is seen as career destroying to have a mental illness recorded on their personal record. Unsurprisingly police officers and staff were unlikely to seek help from their manager for the reasons above and a perceived lack of confidentiality.

One would expect that home would be a safe haven to confide in family and relatives. However, this was not the case, as again they did not want to be seen as weak. An interesting finding which mirrors the notion of 'suspicious minds' is that police officers and staff are statistically more supportive of others with mental health issues, and are more willing than fellow citizens to work with people with mental health but surprisingly less likely to share their experiences with others.

In many cases disclosure was hampered by a fear of colleagues being ignorant about or uncomfortable talking about mental ill health. Doubts as to how co-workers would respond

and a desire not to cause them embarrassment in the likelihood of the use of inappropriate or incorrect terminology, which may cause (additional) stress or anxiety to both parties.

12.3 The establishment of a benchmark measure of police organisational attitudes to mental illness

This research has successfully provided a national measure of police organisational attitudes to mental illness which provides future researchers with an ability to quantify the success or otherwise of police anti-stigma and wellbeing campaigns.

It appears that police forces fail to adequately prepare police officers and staff to deal with the stressful events they may encounter. That debriefing is rare and when it occurs is often inadequate leaving officers and staff to their own devices to internalise and cope with the aftermath of involvement in traumatic events. There are failures at managerial levels as it appears managers are not sufficiently trained or equipped to identify and manage officers/staff who may have mental health issues.

Unfortunately such short comings are compounded by further exposure to colleagues' and managers' 'suspicious minds' who disturbingly doubt the genuineness of colleagues' / subordinates' mental illness and are often accused of 'swinging the lead'.

Regrettably, such a culture is not conducive to revealing a perceived weakness such as poor mental health resulting in under-reporting and delayed help-seeking, which can leave officers and staff isolated.

12.4 Stigma and Suspicious Minds

Policing is seen as a vocation with officers generally aiming to complete the majority of their adult working life serving the community. Likewise, police staff share a similar commitment and as a result, very few leave the organisation voluntarily prior to reaching pensionable age. Therefore, police officers and staffs self-identity is closely connected to their job and the status of working in the emergency services. In line with other male dominated emergency service, policing is seen as having a macho culture where physical and mental strength are seen as essential traits.

As seen above, the survey data suggests that some police respondents thought of members of the public with mental ill health as weak-willed with little or no self-control. This is mirrored in force where displaying signs of stress and mental illness are regarded negatively as signs of weakness. This research has found that mental ill health continues to carry huge stigma within policing. Unfortunately, it appears that being immersed in such a culture

results in further self-stigmatisation as participants reported decreases in self-worth and decreased usefulness. Interestingly despite the overall positive results of the Attitudes to Mental Illness Questionnaire (Time to Change - TNS BMRB, 2015) the overall data suggests that those who experience mental ill health are viewed with suspicion. This is so engrained in police culture that even officers experiencing mental ill health are often suspicious of peers in a similar position.

Police forces in England and Wales subscribe to the Code of Ethics (College of Policing, 2017), which sets out the standards and values of the organisation. Unfortunately, it appears that the narrative and culture of the organisation towards personnel with mental health issues falls far short of these standards and values, creating an environment where stigma and self-stigmatisation are rife.

12.5 Managing those with mental ill health

The management of those experiencing mental ill health was questionable and arguably poor. The majority of respondents, even those who successfully remained in the workplace, felt isolated and unsupported. Personal interactions were often non-existent and policies and procedures which were designed to support people back into the workplace were seen as vindictive and obstructive. A one-size fits all approach was common place and although there is flexibility and discretion built in, it was seldom implemented.

In many cases, the cause of the mental illness was work related, more often due to organisational stressors than operational stressors. Therefore, there was an expectation that the organisation would be supportive and provide an adequate occupational health response and provide a road to recovery. Unfortunately those who disclosed a mental health condition were confronted with 'suspicious minds' as managers and colleagues doubted the genuineness of their illness. Supposed friends and supervisors distanced themselves leading to feelings of avoidance and rejection, which undermined self-belief and confidence resulting in further isolation.

There was evidence of sickness and attendance polices being on the one hand neglected and the other as punitive. For instance despite a requirement for managers to make scheduled regular personal contact, this was often downgraded to infrequent text messages or in several instances was non-existent. Frequently however, due to the illness, participants were unable to comply with meetings or timescales, only to find themselves being considered for unsatisfactory performance procedures.

Particularly irksome is the disparity between those with physical and those with mental ill health. One of the most contentious being the application of half pay and no pay polices. As with most human resource policies chief officers can use their discretion to maintain full pay if the illness is life threatening or is the result of an injury in the execution of duty. None of the participants reported being retained on full pay despite arguing in many instances that the poor mental ill health was work related. Officers and staff often at crisis point could not understand how they were being discriminated against and how such an additional burden was being placed upon them.

Redeployment was also another controversial issue. There was little in the way of consultation or negotiation when officers were placed on restrictive or recuperative duties. Although they are dissimilar, the execution was not. It was rare for officers or staff to be consulted about such moves. Although the process was seen as potentially supportive, in the majority of cases it resulted in removal from familiar surroundings and support networks. For police officers removal from operational roles impacted on self-esteem and was seen as stigmatising. The lack of consultation was disempowering causing further stress and injury exacerbating the existing condition.

All in all what officers and staff craved was continuity and consistency whilst dealing with their mental ill health and parity with those facing physical illness.

12.6 Contributions to knowledge

This study explored, compared and critically analysed the attitudes of police officers and police staff in England and Wales towards mental illness and identify various factors that influence such attitudes. It has also explored the lived experiences of police officers and staff with mental ill health and how the attitudes of colleagues and supervisors and the participants themselves influences their decisions to or not to disclose their mental ill health and to or not to seek help.

In line with previous research, this study has proven the worth of employing derivatives of the CAMI Scale (Taylor & Dear, 1981) to establish police attitudes to mental ill health (Cotton, 2004; Clayfield et al., 2011; Hansson & Markstrom, 2014 & Glendinning & O'Keefe, 2015). It has also provided what is believed to be the first national study benchmarking those attitudes against those of the civilian population. This data can be used as an established measure and base line for future similar research. Furthermore, the development of a scale (See Findings, Table 14 in Appendix 1) to measure police

organisational attitudes to mental illness can provide forces with additional measures to assess the outcomes of changes to police and processes.

The majority of studies into police attitudes to mental illness in England and Wales have been confined to single forces. Valuable as they are and reflective of the issues involved it is arguable they have their limitations. This research is more extensive in providing data and findings, which because of their national scope are arguably more readily generalisable.

Likewise, studies in policing often overlook unsworn or unwarranted staff (collectively known as police staff). This could be seen as a weakness because the lines between operational and support roles have become blurred over recent years. With this diversification, police officers and police staff often find themselves working directly alongside each other and in a number of cases managing or reporting to a police officer or police staff. This research goes some way to filling this gap as it examines in depth police staff attitudes to mental ill health.

The publication of *'Suspicious Minds – Police attitudes to mental ill health'* (Bell & Palmer-Conn, 2018) covered many of these key themes. It was reviewed and recommended in *Policing Insight* (Muranova & Kealey, 2019) as a valued piece of research, contributing to the renaissance of studies into policing and mental ill health. This paper, along with its predecessor *Break a Leg it's all in the Mind – Police Attitudes to Mental Ill Health* (Bell and Eski, 2015), is available via Research Gate and continues to be read by fellow academics and police professionals.

CHAPTER 13

Next Steps

13 Next Steps

13.1 Recommendations for further research

The findings highlight several areas that could benefit from further research. As much of the current studies are qualitatively based I would recommend that there are opportunities to employ the scales used in this study to better understand the variances in attitudes to mental ill health and identify good practice which may be shared within the service.

13.1.1 Replicating the survey

As the Attitudes to Mental Illness Questionnaire (Time To Change - TNS BMRB, 2015) has proven successful in measuring and tracking public attitudes to mental ill health so too could the deployment of this survey on a recurring basis. It is timely in that a number of forces and the College of Policing have initiated a number of well-being and anti-stigma campaigns. Unfortunately, only 17% of organisations measure the impact of their wellbeing initiatives (Mamujee, 2018). This would allow a measure of the impact and success of such programmes on changing attitudes, which could be tracked over time.

Likewise, individual forces should consider running the survey pre and post well-being and anti-stigma campaigns, education and training initiatives and similar learning provision.

13.1.2 More emphasis placed on police staff

Albeit this study covered England and Wales the response rate varied across forces and a poorer take up amongst police staff. Therefore, a greater emphasis on recruitment of police staff may provide a richer more generalisable understanding of police staff attitudes to mental ill health.

13.1.3 Examination of the impacts of attendance and absence polices on wellbeing

Furthermore, there is obvious dissatisfaction with the deployment and strict adherence to sickness and absence policies and their implementation by supervisors, OHU and HR staff. This is worthy of further study on how they influence officer and staff well-being 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.

13.1.4 An examination of the phenomenon of 'suspicious minds'

Finally yet importantly further qualitative research should be considered to identify the drivers and culture which manifests itself as 'suspicious minds', a widespread mind-set amongst officers and staff doubting 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. Addressing these issues may prevent unnecessary long-term absences and premature retirement.

13.2 Implications for practice

It is widely reported that despite many major initiatives such as *Time to Change*, *Blue Light Campaign* and Oscar *Kilo* those with mental ill health feel stigmatised and discriminated against. This is true of citizens and those who work within policing. As the police provide a public service, it is important that such negative attitudes be addressed to ensure effective service delivery to communities and essential support to protect officers and staff in their working environment.

13.2.1 Recognition

The wider literature as discussed is not conclusive about police attitudes towards those with mental ill health. The majority of the text is to some extent historical in nature, albeit researchers are making a welcome return to the subject matter. However, there is an acceptance that matters are not ideal and there is much room for improvement to address the stigma and discrimination directed towards mental ill health. Much of this is based on societal attitudes as the police do not police in isolation but are part of the communities and society they live and work in. Saying that, policing like most professions has its own culture and subcultures, which influence attitudes and behaviours. It is widely accepted that police culture plays a significant part in determining how the police respond to those with mental ill health outside and inside the organisation and potentially react to the experience of personal stress and trauma.

Unfortunately, there is insufficient recognition that 'all is not well' regards mental health in policing. It is a poor reflection on the service that those with mental ill heath are doubted and castigated about the authenticity of their illness. This must be challenged. National initiatives such as the *Blue Light Campaign* and the *College of Policing Wellbeing Programme* are welcomed as 'a step in the right direction'. However, it is unlikely they will deliver root and branch reform. To do so, requires visible leadership from the highest ranks and most senior managers. Failure to do so hinders disclosure and early intervention to the detriment of employees and the organisation.

Forces could address this gap by taking cognisance of this research as it has established a national benchmark for attitudes to mental health within policing. It is recommended that forces undertake an in-house or commissioned version of the survey to provide real evidence about current staff attitudes. Doing so would provide the ability to measure the impact of national and local police wellbeing and training initiatives and how effective they are on changing attitudes. Revisiting the survey on an annual or biannual will measure long term changes.

13.2.2 Training

Research has established that good mental health literacy (MHL) is an effective method in reducing mental health related stigma and promoting both help seeking in individuals and peers. What is evident and supported by this research is that current education and learning regarding mental ill health is fractured and in many cases non-existent. As stated above current campaigns such as *Time to Change, Blue Light Campaign* and *Oscar Kilo* go some way to improving the matter but for effective MHL local initiatives must fit into the context in which they are deployed. A local element is of great importance the development and application of training should be based on the normal working environment alongside partner agencies and supporting bodies.

This research found that the majority of supervisors lacked confidence in talking about mental ill health and were likely to shun having such conversations with staff. Therefore, there is an overwhelming need to improve the situation with enhanced training for those in supervisory and managerial positions. All supervisory ranks and line managers must be appropriately trained in mental health awareness and the relevant support mechanisms.

Such training can take many forms but the current IT based delivery appears to 'tick a box' exercise unable to deliver cultural change. Respondents were in favour of classroom / workshop based learning with personnel from other agencies and preferably 'survivors' who have first-hand knowledge of the topic. Programmes like *Mental Health First Aid* have been demonstrated to improve measured attitudes to mental ill health and can be tailored to different levels of the organisation.

Importantly this research has provided a benchmark for MHL. Forces should adopt The MAKS schedule (Evans-Lacko et al., 2010) alongside the Attitudes to Mental Illness Scale

(Time to Change - TNS BMRB, 2015) to establish the measure of mental health literacy within their forces to establish the effectiveness of training and awareness programs.

13.2.3 Treatment

Furthermore, as this research and others have identified there is a fear of disclosure and having a mental illness can lead to isolation, which in turn exacerbates the problem. Officers and staff require a safe environment ideally inhabited by people with similar experiences who have credibility on two counts, as co-worker and as a 'survivor'. As seen here colleagues who have experienced similar issues often confide in those who disclose a mental illness. Therefore, the introduction of a peer support network would provide well-needed support and signposting towards more formal help.

It appears that this is where the barriers are namely a lack of service and treatment provision and an unwillingness or reluctance to seek support. The former will require an investment in qualified personnel to support officers and staff in-house, and an option for those who feel they cannot disclose their illness to the organisation a free confidential service accessible away from the force.

13.2.4 Managing

This research has established that those with mental ill health feel 'like second class citizens' or worse still disenfranchised compared to colleagues with physical illness. The Police Scale provides a telling indictment of the poor interaction between those with mental ill health and their supervisors and their forces. There have been few compliments regarding the management and support of officers and staff who experience mental ill health in policing. As described above much needs doing regarding the lack of preparedness of supervisor's for dealing with those with mental health issues. However, on the rare occasions when managers have been found to be supportive they are often hampered by bureaucratic and inflexible HR policies and procedures that fail to meet the needs of the officer or staff member. For example, the criteria for half pay/no pay is weighed heavily in favour of those with physical injuries or illnesses. The now discredited Bradford Factor was adopted wholesale by the police service without academic scrutiny.

To ensure existing policies are not unfairly detrimental, a full root and branch review of attendance management policies needs to be undertaken to ensure they meet the needs of those with mental ill health. This will avoid the one-size fits all approach, ensuring officers and staff with mental health issues are adequately supported in the workplace or

during any absence, taking into account the uniqueness of each case. Facilities for such audits already exist having been jointly introduced by the College of Policing and National Police Chiefs' Council (College of Policing, 2017; College of Policing, 2017). Unfortunately, both bodies are generally advisory and there is no compulsion on individual chief officers to undertake such a review. The use of such audits will provide a foundation for addressing structural issues, which can reduce the organisational stressors found within policing.

The Police Scale developed with in this research provides a relatively short assessment tool, which forces should use to identify how well they prepare and support staff to deal with the stressful and traumatic incidents common place within policing. Likewise, it will assist in identifying if managers are adequately trained and prepared to recognise and support officers and staff who have mental health issues. This is essential if staff are to feel secure in disclosing emerging or established mental health issues and promote help seeking to minimise long-term absences and unnecessary early retirement.

CHAPTER 14

Reflection

14 Reflection

I commenced the research at a time of huge personal change. As with most police officers, I passed my years of service counting down to retirement. This was not a reflection on my policing career, which I enjoyed immensely. It is just what police officers do. During my thirty plus years, I never had a grand scheme for 'life after the police'. That is not until my appointment as a full time Merseyside Police Federation role brought me in to close contact with fellow officers experiencing poor mental health.

During those three years, I stood their corner with them attending meetings, medical assessments, supporting them and their families to enable them to return to full duties or if more appropriate to seek early or medical retirement. It was not always plain sailing and at times, I found it difficult to do so. Perhaps I was not always successful in assisting them in achieving their aims but I did become a champion for those with mental ill health. This was easier in the workplace as I had access to chief officers and senior personnel where I had countless conversations about mental ill health in the police and the stigma and discrimination, which accompanies it. I used Merseyside Police communication networks to challenge perceptions of 'lead swingers' and 'head workers' amongst our own membership and sad to say fellow 'Fed Reps'. This led me to this research. I knew there was a story to be told. I just did not know how to do it.

So began the PhD journey and a new world of enlightenment. The step from an MRes to PhD was greater than I imagined. The feeling of elation of having been accepted onto the course with an accompanying LJMU bursary and the tag 'Post Graduate Researcher and Graduate Teaching Assistant' changed to trepidation as I had to grasp with statistical processes, theories and ethical and research topics and methods at doctoral level. The ethics application being the first hurdle or several hurdles in fact. Persistence and support of my supervisor and guidance from the Chair of the Ethics Committee resulted in the go ahead to commence my research and a place on LJMU's Ethics Committee.

I was never one who was afraid to ask for help and my battle with statistics and SPSS analysis software saw me seeking out additional tuition. This resulted in a ten-week module at The University of Liverpool Statistical Analysis for Social Scientists. Fully armed with my newfound knowledge and skills I began one of the most challenging phases of my studies. The SPSS course unfortunately ran some time before my data was ready to process. By the time it arrived, my memory had faded and SPSS as far as I was concerned was the 'work of the devil'. Persistence, persistence, persistence became my moto. My supervisor was at

hand and with a nudge towards You Tube and SPSS textbook I continued my learning path picking up new skills and a slowly growing confidence.

I still considered myself more of a retired cop than an academic. However, subsequent to the publication of my discussion paper (Bell & Eski, 2016) in a prominent policing journal I was invited to peer review fellow academics work. This was the point where I felt my transmission into a genuine academic researcher was established. I cannot underestimate how useful this role has been in my personal development and learning about my chosen field.

As I come to the conclusion of this research, I have to ask myself, "Have I done what I set out to do?" To me the answer must be "Yes". I have gathered, with the assistance of Police Federation of England and Wales, UNISON Criminal Justice Branch and Safe Horizons Police PTSD quantitative and qualitative data. I have managed and analysed the data, which measured police attitudes to mental ill health and provided a comprehensive account of the lived experiences of those who have mental ill health issues in policing. More importantly with the publication of 'Suspicious Minds – Police attitudes to mental ill health' (Bell & Palmer-Conn, 2018) I have contributed to the knowledge in the field providing fellow researchers and policing professionals with an understanding of the contemporary issues surrounding mental ill health in policing in England and Wales and voice to the participants for which I am extremely grateful. As such, I hope to remain a champion for those with mental ill health.

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16 Appendices

16.1 Appendix 1: Survey questionnaire incorporating results

		Public			Police officers			Police Staff		
	Table 14: CAMI Scale	Agree	Disagree	Mean	Agree	Disagree	Mean	Agree	Disagree	Mean
	Fear & exclusion	%	%		%	%		%	%	
q47	Locating mental health facilities in a residential area downgrades the neighbourhood	14	68	3.99	22	49	3.49	15	62	3.84
q46	It is frightening to think of people with mental problems living in residential neighbourhoods	11	74	4.12	10	74	4.10	8	76	4.21
q38	I would not want to live next door to someone who has been mentally ill	9	74	4.14	20	47	3.50	12	63	3.91
q37	A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered	9	69	4.07	4	82	4.38	3	85	4.52
q39	Anyone with a history of mental problems should be excluded from taking public office	15	64	3.87	5	81	4.30	3	84	4.41
q36	People with mental illness should not be given any responsibility	10	72	4.05	2	88	4.44	1	91	4.54
q33	People with mental illness are a burden on society	6	84	4.44	10	76	4.16	7	82	4.38
q24	As soon as a person shows signs of mental disturbance, he should be hospitalized	16	67	3.90	3	88	4.50	3	84	4.50
	TOTAL			**32.57**			**32.85**			**34.30**

Understanding and tolerance of mental illness

q3	We have a responsibility to provide the best possible care for people with mental illness (% agree)	93	1	4.67	93	2	4.65	96	4	4.80
q28	Virtually anyone can become mentally ill (% agree)	93	2	4.65	99	1	4.88	99	0	4.88
q34	Increased spending on mental health services is a waste of money (% disagree)	4	88	4.52	2	93	4.66	2	93	4.71
q32	People with mental illness don't deserve our sympathy (% disagree)	5	87	4.52	1	93	4.66	2	92	4.71
q30	We need to adopt a far more tolerant attitude toward people with mental illness in our society (% agree)	90	2	4.55	83	3	4.34	90	10	4.54
q29	People with mental illness have for too long been the subject of ridicule (% agree)	77	7	4.18	86	3	4.36	90	4	4.51
q44	As far as possible, mental health services should be provided through community based facilities (% agree)	79	5	4.20	68	8	3.91	69	3	4.03
	TOTAL			**31.28**			**31.47**			**32.16**

	Integrating people with mental illness into the community									
q41	People with mental illness are far less of a danger than most people suppose	63	12	3.83	58	16	3.66	59	14	3.77
q26	Less emphasis should be placed on protecting the public from people with mental illness	37	31	3.11	16	56	2.39	25	40	2.76
q43	The best therapy for many people with mental illness is to be part of a normal community	81	5	4.27	66	9	3.80	72	8	4.00
q45	Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services	70	11	4.00	55	19	3.57	62	14	3.80
q48	People with mental health problems should have the same rights to a job as anyone else	79	7	4.24	83	7	4.27	86	5	4.47
q42	Most women who were once patients in a mental hospital can be trusted as babysitters	31	25	3.07	31	16	3.22	35	15	3.32
q25	Mental illness is an illness like any other	78	14	4.17	84	12	4.33	92	6	4.59
q40	No-one has the right to exclude people with mental illness from their neighbourhood	86	6	4.44	84	8	4.36	90	5	1.01
q27	Mental hospitals are an outdated means of treating people with mental illnesses	37	27	3.15	26	49	2.64	31	38	2.96
	TOTAL			**34.28**			**32.22**			**34.26**

	Causes of mental illness and the need for special services.									
q35	There are sufficient existing services for people with mental illness	20	50	3.53	6	87	4.44	6	83	4.38
q22	One of the main causes of mental illness is a lack of self-discipline and will-power	13	69	4.05	5	79	4.32	7	80	4.38
q23	There is something about people with mental illness that makes it easy to tell them from normal people	16	67	3.95	8	77	4.25	7	79	4.34
	TOTAL			**11.52**			**12.99**			**13.05**
	Total CAMI Score			**109.64**			**109.51**			**113.83**
	Table 15: Mental Health Knowledge Scale									
q53	Most people with mental health problems go to a health care professional to get help	46	30	2.73	11	73	3.87	7	74	3.91
q52	People with severe mental health problems can fully recover	64	11	3.87	59	18	3.66	59	21	3.70
q67	If a friend/colleague (my version) had a mental health problem, I know what advice to give them to get professional help	64	19	3.70	74	16	3.87	72	15	3.82
q49	Most people with mental health problems want to have paid employment	73	4	4.10	64	6	3.93	72	4	4.15
q50	Medication can be effective treatment for people with mental health problems	78	5	4.13	81	4	4.13	77	7	4.03
q51	Psychotherapy can be an effective treatment for people with mental health problems	83	2	4.32	85	1	4.35	90	3	4.44
	Sub Total			22.85			**23.57**			**23.82**

	Identification of mental health	Agree								
q58	To what extent do you agree or disagree that Drug addiction is a type of mental illness?	48	34	3.17	33	53	2.58	44	34	3.06
q59	To what extent do you agree or disagree that Grief is a type of mental illness?	52	31	2.73	61	26	2.47	58	25	2.47
q55	To what extent do you agree or disagree that stress is a type of mental illness?	61	25	3.54	79	13	4.07	80	11	4.12
q54	To what extent do you agree or disagree that depression is a type of mental illness?	86	6	4.37	95	3	4.69	95	4	4.72
q57	To what extent do you agree or disagree that Bipolar Disorder is a type of mental illness?	87	3	4.51	92	3	4.65	96	0	4.78
q56	To what extent do you agree or disagree that Schizophrenia is a type of mental illness?	88	1	4.60	97	1	4.83	98	0	4.89
	Sub Total			**22.92**			**23.21**			**23.90**
	MAKS Total			**45.76**			**47.08**			**48.04**
	Table 16: Reported and intended behaviour									
q68	In the future, I would be willing to work with someone with a mental health problem	75	6	4.16	92	1	4.52	93	1	4.65
	Table 17: Identifying the proportion of people with mental health problem									
q20	What proportion of people do you think might have a mental health problem?									
	1 in 1000	6			3			2		
	1 in 100	12			6			8		
	1 in 50	17			12			12		
	1 in 10	29			31			27		
	1 in 4	22			34			34		
	1 in 3	13			15			17		

	Table 18: Consulting about mental health	Likely	Unlikely		Likely	Unlikely		Likely	Unlikely	
q60	If you felt you had a mental health problem, how likely would you be to go to your GP for help?	78	12	4.13	76	16	3.93	82	11	4.13
q61	If you felt you had a mental health problem, how likely would you be to go to your manager for help?				34	54	2.65	44	41	3.02

	Table 19: Talking to family and friends and employers	UC	C		UC	C		UC	C	
q62	In general, how comfortable would you feel talking to a friend or family member about your mental health, for example telling them you have a mental health diagnosis and how it affects you?	23	68	5.07	46	48	4.08	40	56	4.41
q64	In general, how comfortable would you feel talking to a current or prospective employer about your mental health, for example telling them you have a mental health diagnosis and how it affects you?	47	34	3.65	81	14	2.46	80	16	2.60

		Police officers			Police staff		
	Table 20: Police specific statements	Agree	Disagree	Mean	Agree	Disagree	Mean
q65	If I had a mental health problem I think my managers would support me.	53	28	3.31	44	41	3.65
q66	If I had a mental health problem I think my work colleagues would support me.	63	19	3.56	67	13	3.76
q63	If you felt you had a mental health problem, how likely would you inform your colleagues	27	68	3.05	35	60	3.42
q70	Disclosing a mental health problem in the police service is detrimental to future career prospects.	75	8	1.98	56	19	2.48
q71	Police Officers/Staff with mental health problems are treated as sympathetically as officers\staff with physical illness.	20	59	2.39	30	43	2.79
q69	Some people use stress as an excuse for being absent from work.	61	18	2.42	54	24	2.63
q73	My Force adequately prepares managers to manage officers/staff who experience mental health issues.	12	64	2.13	21	45	2.56
q72	My Force adequately prepares officers/staff to deal with the stressful events they are likely to encounter.	15	71	2.07	25	44	2.63
q74	Debriefing is used effectively to support officers/staff who have experienced stressful events within my Force.	37	46	2.76	41	25	3.24
q75	Within my Force there is sufficient support for officers/staff experiencing mental health issues.	27	48	2.58	41	31	3.06
	Total			**26.27**			**30.11**

16.2 Appendix 2: Interview questions

Questions for retired and serving police officers/staff (semi-structured interview)

1 When you became aware of having a mental health problem at work, what were your experiences when:

A. Informing managers,

B. Informing colleagues,

C. Informing support networks?

2 What support were you given by:

A. Managers,

B. Colleagues,

C. Support networks?

3 What would you change if you could?

4 Do you think police officers/staff experiences and perceptions of members of the public with mental health problems are reflected in their attitudes to colleagues with mental health problems?

Questions for police manager/federation (semi-structured interview)

1 How effective is the Force in:

A. Identifying officers/staff with mental health problems,

B. Supporting officers/staff with mental health problems,

C. Training managers in dealing with officers/staff with mental health issues?

2 What would you change if you could?

3. Do you think police officers/staff experiences and perceptions of members of the public with mental health problems are reflected in their attitudes to colleagues with mental health problems?