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Suspicious minds: Police Attitudes to Mental Ill Health

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Abstract

Policing and mental ill health are inextricably entwined. The police have a role to respond to distressed persons and depending on the circumstances act as mental health practitioners or law enforcement officers.   Policing can have an impact on the mental health of those delivering the service. Those working within policing will either experience, work alongside and/or manage colleagues with mental ill health. Therefore it is important that the attitudes of police officers and police staff to mental ill health are established. The research employs the Time to Change Survey to bench mark police attitudes against the general public. Results indicate that police officers/staff hold similar attitudes to the public. However police officers are less supportive of community based interventions. Police data portrays an organisation where mental health related stigma persists, where discussing or seeking help is avoided and having a mental health issue seen as career destroying.

Keywords: police, attitudes, mental ill health, culture, stigma, discrimination

1. Introduction

Good mental health is the foundation for thinking, communication, learning, resilience and self-esteem. Mental health is also key to relationships, personal and emotional well-being and contributing to community or society (American Psychiatric Association, 2017). Poor mental health is associated with stressful work conditions, discrimination, stigmatisation, social exclusion, exposure to danger and poor physical health (Mental Health Foundation, 2016). Therefore it is understandable that people may not want to talk about poor mental health.

Mental illness can affect anyone. Depending on the definition of mental illness, between ten and twenty five percent of people living in the United Kingdom will experience mental illness at some point in their lives. (NHS, 2017). Research by MIND has revealed emergency workers in the UK are more likely than civilian counterparts to experience a mental health issue, but less likely to seek help (MIND, 2015).

Due to policing demographics, there is an overlap between groups known to be at increased risk of developing mental health problems and police officers (Samaritans, 2013). Police personnel top the scale with 90% of police personnel having experienced stress or poor mental health at work. Furthermore 61% have had personal experience of mental health problems – the highest of all blue light services (The Police Federation of England and Wales, 2016).

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, p16). Due to mental health-related stigmatization, '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). Similarly due to cultural issues police officers do not wish to be seen as weak by colleagues or to hamper their career prospects by seeking mental health support (Karaffa & Tochkov, 2013).

According to Cotton (2004) police officers attitudinal attributes can influence their behaviour when dealing with people with mental health issues and advocated measuring such attitudes.   More recently, Glendinning & O'Keefe (2015) highlighted a similar need to assess the attitudes of the police towards mental ill health as their attitudes can have a significant impact on the community. Yet studies of police attitudes to mental ill health are rare (Bell & Eski, 2016; Glendinning & O'Keefe, 2015; Hansson & Markstrom, 2014).

Police officers alongside the communities they live and work in share similar stereotypical views about mental health (Pinfold, et al., 2003; Cotton, 2004). However, the former 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. As stated above there has been limited research into the attitudes of police officers and even less so police staff attitudes to mental health. The aim of this study was to describe and compare police officers and staff attitudes towards people with mental ill health and the issues and influences associated with such attitudes.

The above indicates the need for a study such as this, to address the gaps in the literature. By using established scales and subscales, Attitudes to Mental Illness questionnaire (NHS, 2016) and statements developed by the author (see Table 4) the study aims to firstly measure police officers (warranted officers) and police staff (unwarranted employees who perform a variety of administrative and operational support functions, many performing duties previously delivered by warranted police officers) attitudes to mental illness and compare them to each other and those of the wider community and secondly by introducing a qualitative element to the survey by inviting participants to make comment alongside the questionnaire to capture the thoughts and opinions they associate with mental ill health (Kanika, et al., 2017). Employing such a mixed methods approach can provide context and a deeper understanding of survey responses than quantitative data alone (Creswell & Plano Clark, 2007).

2. Literature

Despite the prevalence of mental ill health and many public education campaigns such as Time to Change and MIND, stigma and discrimination continues to impact negatively on the lives of people with mental health issues. In fact 'Stigma and discrimination in relation to mental illnesses have been described as having worse consequences than the conditions themselves' (Thornicroft, et al., 2016). According to Time to Change, 87% of respondents in 2014 agreed that people with mental illness experience stigma and discrimination (Time to Change, 2015). Unfortunately, the workplace is the second most common area (after family and friends) where mental health stigma is encountered (Wahl, 1999).

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. '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). Therefore, it is possible that officers/staff are more critical of themselves than their peers 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 general 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 can be viewed as unreliable when responding to critical incidents. As a result, officers will invariably suppress their emotions (Bonifaco, 1991).Furthermore officers seeking counselling or support can be viewed as weak and lacking resilience by their peers further heightening feelings of stigmatisation (Toch, 2002). Therefore, fear about fitness to practice may prevent officers/staff seeking help and support (Ombudsman Ontario, 2012, UNISON, 2014) potentially leading to an intensification of the mental health issue.

Recent research suggests, stigma is still prevalent in policing (Bullock & Garland, 2017; Turner & Jenkins, 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, '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. It is questionable how many force initiatives have attempted to measure staff attitudes to mental illness at any stage in the process or indeed set a bench mark.

According to Houdmont (2017) police officer prevalence of minor psychiatric morbidity has reported between 42 per cent and 58 percent compared to the general UK working population of 19.5 per cent. *The Police Federation of England and Wales, Police Officer Welfare, Demand, and Capacity Survey* found that 39 per cent of police officers reported their job to be very or extremely stressful compared to 16 per cent of the general working population based on Health and Safety Executive data (Houdmont & Elliot-Davies, 2016). Likewise police staff appear to suffer similar stress. The *UNISON, Police Staff Stress Survey Report* found that 32% of police staff are 'very stressed' and 62% are 'moderately stressed' (UNISON, 2014).

These statistics can be associated with officers and staff seeking help for mental illnesses related to their role. UNISON report that 15% of police staff have been referred to their force occupational health department due to stress and PFEW 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 (31%) than the general population (24%).

Police work related mental illness maybe be organisational linked to poor management, shifts (Brown & Campbell, 1994), poor communication and lack of support from senior ranks and increased workload (Crowe & Stradling, 1993) or operational stressors in the form of traumatic incidents (Abdollahi, 2002). The latter appear to have less impact than the former (HSE, 2007; UNISON, 2014; MIND, 2015; Houdmont & Elliot-Davies, 2016). However, that is not to underestimate the impact of traumatic events on those who deliver policing. The most commonly classified police operational stressors   identified by Abdollahi (2002) are dealings with the judicial system, public scrutiny and media coverage, officer involved shootings, encountering victims of crime and fatalities, community relations and encountering violent/unpredictable situations' (Abdollahi, 2002).   Police staff are not immune from such stressors, they deliver a range of quasi policing roles with some operational crossover and or limited police powers exposing them to similar traumatic incidents as police officer colleagues (McCarty & Skogan, 2012; Regehr, et al., 2013; Alderden & Skogan, 2014).

The impact of these stressors on policing and thus the service to the public is striking. The figures are stark. In 2015 the British Broadcasting Company (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 to mental ill health. The data indicated that during the 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. 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 is against a backdrop of falling police officer and police staff numbers of 17,000 and 20,000 respectively (BBC, 2016).

3. Problem Definition

- As stated above there is scant research regarding police officer/staff attitudes to people with mental ill health issues and even less of their attitudes to colleagues with mental health issues. Understanding such attitudes are important as they have an influence on police officer values, behaviours and subsequent actions when dealing with the public or colleagues (Bailey, et al., 2001; Stuart, 2017). Therefore, the following research objectives were formulated. A critical exploration of police officer and staff attitudes to mental illness and its impact in the workplace.

- A comparative analysis of police officer and staff attitudes with members of the general public.

- A critical analysis of the factors that underpin these attitudes.

4. Method

4.1 Design

The current study aims to replicate within policing a survey carried out annually by *Time to Change* which examines the changing public attitudes to mental health. A bank of statements and raw data for the 2015 public survey was provided by TNS BMRB to the researcher for direct comparison with the police data. The survey consists of several self-report inventories outlined below under materials. Unlike the public survey, the police survey included open ended questions inviting participants to comment if they wished to do so. The responses provide the qualitative data and analysis below.

The Time to Change public survey employs random location sampling techniques to ensure respondents reflect the national profile for geography and social-economic status. Time to Change interviews were carried out by trained staff in respondents' homes using Computer-Assisted Personal Interviewing (CAPI). Such an option was not open to the researcher.   Instead the police survey was distributed via email by Police Federation of England and Wales (PFEW) to a random sample of 2000 serving police officers. UNISON did likewise to individual Branch Boards for onward transmission to police staff members. As it was at the discretion of each branch board this only occurred in 19 Forces.

  The difference in data collection can impact on results. However, Burkhill et al. (2016) when comparing differences in data collection methods found over 90% of responses did not change across modes, and the vast majority of respondents gave inconsistent answers to no more than a handful of questions. Research suggests online surveys are deemed to be effective methods of data gathering and respondents may find it easier to answer sensitive issues and are more likely to answer open questions in depth in an online questionnaire (Burkhill, et al., 2016, Tourangeau, et al., 2003). Furthermore a similar approach was undertaken by Brooker & Sirdifield (2009) to benchmark attitudes of probation staff to mental ill health against the general public and Glendenning & O'Keefe (2015) 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. However, the responses from individual Forces varied from single figures into several hundred. A more equally distributed response would allow for Force comparisons and

regional comparisons. Additionally further analysis is required to ascertain demographic impacts on attitudes to mental health.

The police study received approval from Liverpool John Moores University Research and Ethics Committee (Ref: 15/HSS/002 -9/2/15).

4.2 Participants

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. The disparity in forces between officer and staff returns is due to the regional branch distribution method employed by Unison members as opposed to national distribution by PFEW to officer members.

Table 1. Demographics

	Time to Change Public	Police officers	Police staff
Numbers	1747	764	291
Males	849 (49%)	473 (62%)	113 (39%)
Females	898 (51%)	279 (37%)	176 (61%)
Trans & Not Stated		10	0
Age range	16-34 years 33%	18-34 years 22%	16-34 years 25%
	35-54 years 33%	35-45 years 76%	35-54 years 59%
	55+ years 34%	55+ years 2%	55+ years 17%
Length of service		0-2 years 3%	0-2 years 7%
		3-10 years 22%	3-10 years 35%
		11-20 years 43%	11-20 years 34%
		21-30 years 30%	21-30 years 14%
		30 + years 2%	30 + years 10%
Ranks/grades		Constables 72%	Operational 45%
		Sergeants 18%	Administrative 43%
		Inspector 8%	Management 12%
		Superintendent 2%	

4.3 Materials

The research employed the Attitudes to Mental Illness questionnaire (TNS BMRB, 2015) which consisted of:

a. **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, 2013) and with police officers (Clayfield et. al., 2011; Glendinning & O'Keefe, 2015). The overriding 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, with the intention of identifying people who accept or reject people with mental illness within their community. The questions cover a wide range of issues, from attitudes towards people with mental illness, to opinions on service provision for people with mental health problems. The total score is calculated so that higher CAMI scores indicate less stigmatising attitudes. Its overall internal consistency in the data measured using Cronbach's α is 0.87.

b. **Mental Health Knowledge Schedule (MAKS)** (Evans-Lacko, et al., 2010). The MAKS comprises 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 is calculated so that higher MAKS scores indicate greater knowledge.

c. **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. Therefore Cronbach's α not required.

    d.   **Police specific questions**

In order to better understand police culture, the author included additional questions relating to policing 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 is calculated so that higher scores indicate more positive outcomes.

5. Findings and Discussion

Statistical analysis was carried out using SPSS 22. Significance of differences was tested using the two-tailed t-test for independent samples (comparing two variables) and multivariate analysis of variance with a Tukey test of significance being conducted post hoc (comparing three or more variables). The whole percentages shown in the data are rounded, but the significance tests have been carried out on the true percentages. Statistical significance levels were set at 0.05 that is 95% confident that differences reported are real rather than occurring just by chance.

5.1 CAMI and MAKS

Table 2. CAMI and MAKS Scale

*Signifies where ANOVA post hoc difference arose and results are significantly different.

Mean Scores	Public	Police officers	Police staff	Significance, p	F Value
Fear and exclusion	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	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	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	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	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*					
Total MAKS	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*					

The results above indicate that police officers and staff like members of the public generally hold positive attitudes about mental ill health. Members of police staff were more positive than their police officer colleagues and the general public. As far as police officers are concerned the results support findings from other studies (Cotton, 2004; Clayfield, et al., 2011) in contrast to Soomro & Yanos (2018) who found police officers were more likely to endorse negative streotypes. Using the CAMI scale (Table 3) as a bench mark police staff have the significantly highest total score compared to the general public and in turn police officers who share similar results. This would suggest that police staff have better attitudes to people with mental ill health than the public or police officers. However, 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.

Therefore, the total CAMI score could be construed as deceptive, as in three of the four subscales the police family score higher than the general public the exception being Integrating People with Mental Health Issues into the community. This relates to other research, as CAMI scales encompass broad concepts and statements and are open to interpretation therefore they are not mutually exclusive and 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).

Analysis of the Integration into the Community sub scale reveals that public respondents and police officers and police staff differed significantly. The results suggests that the public and police staff are significantly more likely to support integration into the community of people with mental ill health than police officers. Within the subscale (Appendix A) police officers were significantly less likely to be supportive of the statements, Q41'People with mental illness are far less of a danger than most people suppose', Q26 'Less emphasis should be placed on protecting the public from people

with mental illness' and Q43 'The best therapy for many people with mental illness is to be part of a normal community'. These statements resulted in the public being significantly more supportive than police staff and police officers with police officers being the least supportive.

This theme continues when exploring the statements, Q45 'Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services' and   Q27 'Mental hospitals are an outdated means of treating people with mental illnesses' which maintains the same pattern of public, police staff, police officer decreasing support.

The results indicate that police staff are less supportive of integration and police officers even less so than the general populace.

In contrast within the same subscale the police group scored significantly higher in response to Q48 'People with mental health problems should have the same rights to a job as anyone else', Q42 'Most women who were once patients in a mental hospital can be trusted as babysitters' and Q25 'Mental illness is an illness like any other'. It can therefore, be argued that the makeup of the responses reflect policing experience or perceptions of the dangerousness of some people with mental ill health and that the public require protection (Watson, et al., 2004; Cummins, 2012). Furthermore, there is a recurring frustration in having to deal with increased mental health related incidents caused by a perceived lack of activity from social services and mental health agencies. Combined with the impact of austerity measures this can have a negative impact on some police attitudes (Cummins, 2012; Morgan & Paterson, 2017). A male police constable summed this up,

> *Disagree strongly - 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*

Even then the genuineness or credibility of those seeking help is questioned (Watson, et al., 2004). A female police sergeant challenged the legitimacy and authenticity of some of the people police may encounter

> *'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 .....'*

Again this does not paint the whole picture, police officers/staff appear to be supportive of individuals with mental health issues, seeing mental ill health on a par with physical illness, supporting rights to employment and would be trusting of recuperative mental health patients looking after children.

Further examination of the CAMI statements within Fear and Exclusion (Appendix A) responses highlights a similar theme of social exclusion. 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' and Q38 'I would not want to live next door to someone who has been mentally ill' than the public or police staff colleagues. Despite this police officers and staff scored higher on the Fear and Exclusion subscale. 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.''

Employing the MAKS Schedule (Appendix A) the police family were statistically more knowledgeable about mental ill health than the public. 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) .

Comments submitted by participants were generally supportive of most statements. However, there was an underlying and consistent theme which drew attention to the 'deserving ill' and the supposed 'self-inflicted ill' who shun mental health services and engage in substance misuse. This is identified in many cases as a trait and not an illness. A male police staff member suggested that such ill health was as the result of life style choices, *'Drug induced i.e. cannabis related mental health issues, I have no sympathy for, as they had a choice'.* Whilst a female police staff member disapproved of those who disengage with support services, *'I have no sympathy for people who don't engage with the services once they have been offered and make no attempts to help'.*

Previous research suggest police officers make judgements about the causes and effects of mental ill health and to what degree personal responsibility and behaviour has on their wellbeing. (Watson, et al., 2004; Godfedson, et al., 2011). Watson, et al., (ibid) goes further suggesting that if people perceive that the cause of a situation is controllable, they will judge the individual to be responsible themselves.

5.2 Consulting and Talking about Mental Health

Table 3

*Signifies where ANOVA post hoc difference arose and results are significantly different. (Likert Scale 1 to 6)

Mean scores	Public	Police officers	Police staff	Significance, p	F Value
In the future I would be willing to work with someone with a mental health problem	4.16	4.51*	4.65*	0.001	61.782
Post-hoc Test: public vs officers: p=0.001*, public vs staff: p=0.001*, officers vs staff: p=0.101					
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 likely would you inform 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 likely would inform your 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					

Participants in both surveys were asked about their likelihood of consulting a GP (Table 3) and speaking to prospective employers and 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 as they were statistically less likely than members of the public to consult their GP (Q60), inform prospective employers (Q64), and talk to family or friends about a mental illness (Q62). Additionally police officers and staff were asked if they would seek help from their manager which the majority of respondents indicated they were unlikely to do so (Q61). 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.

Continuing the work place theme a number of additional questions were posed. The first asking Q68 'In the future I would be willing to work with someone with a mental health problem'. Police officers/staff were statistically more willing to do so than the general public.

Table 3 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 general 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.

5.3 Police Specific Questions

Table 4. Police specific questions

*Signifies where T test results are significantly different.

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

Police officers and staff were asked a series of questions (Table 4) 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 managers are not sufficiently equipped to manage officers who may have mental health issues. 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.'*

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 researchers have 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.'*

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 (see data above). 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 Im sure attitudes change towards the person confiding ……….it is the police   service where in my experience nothing it fully confidential'.* 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.

6. Conclusion

Analysis of the data presents police managers and indeed the service with a conundrum. The data suggests that by and large police officers and staff albeit it with some reservations are supportive of people with mental health issues. It appears that they are prepared to work with people with mental ill health yet they are unlikely to seek help from health care professionals or their employer, discuss or share their feelings with family and friends or confide in their colleagues or a current or future employer if they had a mental health problem. This 'won't tell, can't tell culture' must be detrimental to the individual, the organisation and the people they serve.

Forces are rightly attempting to address the issues in a number of ways. However it is clear from the data that much needs to be done in preparing officers, police staff and their managers to deal with the traumatic and stressful issues they deal with. As Dame Carol Black stated in her lecture at the College of Policing 'much of what is provided is window dressing which fails to invest and identify and support police officers and staff with mental health issues much to the detriment of the individual and the organisation' (College of Policing, 2017). The lack of trust amongst colleagues and line managers hinders disclosure and help seeking exacerbating problems further.

The nature of English and Welsh policing is that there are 44 (including BTP)   variations in promoting dialogue about mental health. Such a varied approach, where some work better than others, has provided police managers with a comfort blanket of discounting localised research as not generalizable or relevant to their force. However, this research shows there is significant evidence to suggest the majority of police officers and staff across England and Wales believe having a mental health problem and informing their employer is ruinous to their career.

As stated above, many forces are to be commended for introducing mental health awareness training and anti-stigma initiatives. However, it is questionable how many have thoroughly evaluated the impact of the initiatives. Turner & Jenkins (2018) suggests an education regime based on the findings of attitudinal and cultural surveys which deliver tailored training specific to each force to deliver cultural change. Conducting similar surveys as highlighted here will afford leaders with an opportunity to assess how the culture of their organisation is changing. Indeed the use of the CAMI scale and similar can be used effectivley to measure the impact of pre and post course mental health training.

Courses like Mental Health First Aid Training have be shown to increase participants' knowledge, decrease negative attitudes, and increase supportive behaviours toward individuals with mental health problems (Hadlaczky, et al., 2014). Likewise, peer support networks such as those at Greater Manchester Police and New York Police Department have similar benefits. Peer support can help overcome cultural barriers   to help seeking and provide evidence that an organisation values and is empathic to the needs of people with mental ill health. Andersen, et al. (2015) suggest

utilising peers for post-trauma support as well as facilitating dialogue about the impact of work placed stress.

Stuart (2017) suggests efffective internal antistigma programs delivered to police officers has the potential of improving officers' decision making when encountering people with mental ill health. However, the priority should be informed and able line managers who are trained and confident in supporting officers and staff, where those with 'suspicious minds' are confronted which will prevent officers and staff from concealing their mental ill health.

Acknowledgments

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Appendix A

		Public			Police officers			Police Staff		
	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									
q31R	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
q28R	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
q30R	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
q29R	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
q44R	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									
q41R	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
q26R	Less emphasis should be placed on protecting the public from people	37	31	3.11	16	56	2.39	25	40	2.76

	with mental illness								
q43R	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
q45R	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
q48R	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
q42R	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
q25R	Mental illness is an illness like any other	78	14	4.17	84	12	4.33	92	6	4.59
q40R	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
q27R	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**
	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
q52R	People with severe mental health problems can fully recover	64	11	3.87	59	18	3.66	59	21	3.70
q67R	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
q49R	Most people with mental health problems want to have paid employment	73	4	4.10	64	6	3.93	72	4	4.15
q50R	Medication can be effective treatment for people with mental health problems	78	5	4.13	81	4	4.13	77	7	4.03
q51R	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							

q58R	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
q55R	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
q54R	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
q57R	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
q56R	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**
	Reported and intended behaviour									
q68R	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

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

	Consulting GP for help	Likely	Unlikely		Likely	Unlikely		Likely	Unlikely	
q60R	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
q61R	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

	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	47	34	3.65	81	14	2.46	80	16	2.60

them you have a mental health diagnosis and how it affects you?

		Police officers			Police staff		
	Police Specific	Agree	Disagree	Mean	Agree	Disagree	Mean
q65R	If I had a mental health problem I think my managers would support me.	53	28	3.31	44	41	3.65
q66R	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
q71R	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
q73R	My Force adequately prepares managers to manage officers/staff who experience mental health issues.	12	64	2.13	21	45	2.56
q72R	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
q74R	Debriefing is used effectively to support officers/staff who have experienced stressful events within my Force.	37	46	2.76	41	25	3.24
q75R	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**

* R indicates reverse score

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