Police Staff and Mental Health: Barriers and Recommendations for Improving Help - Seeking

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Abstract: *Mental disorders are prevalent among public safety personnel (PSP) yet many people working across public safety professions appear reluctant to seek care for mental health - related concerns. Given the prevalence and impact of compromised mental health on these populations, finding ways to increase use of psychological support for police staff and officers is necessary. We conducted an interview, workshop in police station, mental health awareness program and focus groups (n= 12) with police service members (n= 35) to examine the barriers police officers (n= 25) and communicators (n= 8) report facing when seeking treatment, and their suggestions for improving access to treatment. We identified three main barriers: stigma, worries about confidentiality, and occupation - specific experience with people in the community who present in mental distress. Three suggestions emerged from our participants that may improve current mental health support, namely, ensuring confidentiality, easy - to - use electronic resources, and access to occupation - specific content. We discuss the implications of our results with suggestions for policy and practice.*

Keywords: clinical psychology

1. Introduction

Poor mental health and a lack of support have been found to contribute to early termination of work, marital challenges, and sleep disturbances, Finding ways to increase the use of psychological support among PSP is necessary given the prevalence and impact of compromised mental health among police officers, specifically, and PSP in general. Police officers have many duties that may contribute to negative mental health outcomes; duties that include dealing with violent persons or emotionally distraught victims, testifying in court, and responding to critical incidents, Critical incidents, defined as situations evoking a strong emotional reaction, may interfere with an officer's ability to function during the current incident or in the future. An officer with increased exposure to critical incidents is, as a consequence, more likely to experience symptoms of posttraumatic stress disorder (PTSD). In addition to policing duties, there are many other occupational challenges that may contribute to officer stress, potentially contributing to psychological burden, Regarding communicators and police officers, their different role requirements possibly result in different frequencies of exposures to different potentially psychologically traumatic events. Police officers, by the nature of their occupation, are used to solving problems, but when police experience mental health related concerns they become the 'problem haver'In the current study, we examine the barriers police officers and communicators report facing when seeking treatment, recognizing the diversity in roles and in the pathways through which both police officers and communicators manage their mental health needs. Completing interviews (*n*= 1) and focus groups (*n*= 12) with a total of 35 police service members, both police communicators (*n*= 8) and police officers (*n*= 25), we unpack their concerns tied to mental health treatment - seeking.

2. Current Study

The high prevalence of mental disorders among officers and communicators suggests that, despite the available mental health treatment and support, substantial barriers to care - seeking still exist within police services. Through semi - structured focus groups and interviews, we sought to understand the barriers that officers and communicators face when seeking mental health treatment or support, and what both groups prioritize or consider most important in overcoming barriers to accessing mental health resources. We further included both police officers (typically sworn members) and communicators (typically civilian members) to examine differences in accessibility needs and perceived barriers across the two groups. To our knowledge, ours is the first study to use focus groups – which provide a relational component for analysis and opportunity to observe how relational and hierarchical dynamics shape interactions – to learn about help seeking behaviour and mental health among police and communicators.

3. Methods

We conducted focus groups (*n*= 12) and an interview (*n*= 1) with 35participants in 2020, including police communicators (*n*= 8) and police officers (*n*= 25) of police service in Delhi and Gurgaon. At the time of the study, the police service reported employing 290 police officers, and 160 communicators who serviced in Delhi NCR areas. A qualitative researcher moderated each focus group, and when possible, a clinical psychologist co - moderated the group. Collectively, the moderators provide a qualitative and a clinical perspective for probing responses and for interpreting and observing the dynamic group interactions with respect to the diverse occupational roles and rank of our participants.

For recruitment, the health and wellness manager conduct workshop in police station. We informed potential participants about the study purpose and invited voluntary

participation. provided the time slots for the focus groups and the approximate number of people who could be in each group, we conducted all focus groups and the interview during working hours with officers and communicators on shift. Before each focus group or interview, participants provided informed consent and filled out a demographic self - report survey to obtain details about their occupational experience and position. Our study commenced once granted ethics approval from the institutions. All participants had completed high school, 16 had a college diploma, and the highest level of education competed was a post - graduate degree. In total, 32 participants, Most participants (*n*= 27) had children and were in a martial union (*n*= 20). Regarding occupational tenure, participants varied from their first day on the job to 32 years of service, with an average of 16 years of occupational experience within the police service. Participants were from various departments (e. g. patrol, internal investigations, investigation officer) and different roles (e. g. patrol and communications), providing a diverse representation of the service. We conducted focus groups in person, in a space at the police service. The focus groups averaged approximately one hour in duration. The moderator used a semi - structured research instrument to guide the conversational paths, but the tool served as more of a checklist of topics to cover than a structured focus group guide. Since our attention was centred on participant treatment seeking practices and desires, we did not pose personal questions, and participants who shared personal stories did so by their own choice.

4. Barrier's to Care – Seeking

1) Stigma associated with care - seeking

The majority of our participants, both communicators and police officers, reported feeling there is a stigma associated with seeking care for their mental health. Specifically, our participants referred to how seeking care for their mental health may label them as being weak within the police service, which they attributed to organizational culture. They explained that stigma is a barrier to care - seeking, because seeking care is perceived, in his view, as a sign of weakness. Specifically, being portrayed as weak counters the perceived policing cultural norms and is associated with staff being deemed a liability rather than an asset. Our participants also expressed that different roles within the service were stigmatized differently for care - seeking behaviours. For example, communicators expressed concern about being judged by peers for seeking care because communicators tend not to have in - person 'front line' experience with potentially psychologically traumatic events when compared to police officers. Communicators highlighted that although they may not have been on the scene witnessing events, they do experience potentially psychologically traumatic events indirectly, as well as vicariously, and are often in dialogue with responding officers. Such indirect exposure, communicators reported, may have lasting effects on well - being, but they do not want to seek care and seem weak, already feeling they are in an inferior position given their largely hidden occupation in comparison to police officers. For police officers, seeking care was thought to potentially impact their career. challenge here is that police commonly tie negative outcomes to care - seeking rather than the personal outcomes tied to improved mental health and well -

being that result. Such uncertainty about the repercussions of care - seeking are exasperated by concerns about the confidentiality of their treatment - oriented behaviours, if they were to engage.

2) Trust in confidentiality

Fear that their choice to attend therapy would not remain confidential was a prevalent theme among communicators and police officers within our sample. Many worried if they were to avail of mental health services their colleagues would learn of their choice to seek care and many were not comfortable with their colleagues having such information.

The potential 'flagging' of a person's file because of mental health, a concern voiced by few officers during interview, reinforces the notion of the perpetual label and stigma that treatment seeking is thought to impose. Although some police may want to seek care for their mental health, they worried that in using available resources, such as the EAP program, management or colleagues would learn they attended therapy and label them. To demonstrate the severity of such concerns, an officer disclosed that they chose to attend therapy with a private therapist and paid out of pocket in hopes to prevent others from learning about his experience.

3) Occupational experiences with mental health

Communicators and police officers respond to calls from civilians for mental health services, often within the communities that the police members themselves live. Communicators and police officers from our sample expressed that, because of their occupational responsibilities, they were aware of a mental health stigma informed by adverse experiences with civilians that required mental health interventions or services and by negative past experiences with diverse mental health facilities. Many participants stated they would not utilize available mental health facilities, even if there were resources offered specifically designed for PSP, as a result of both the mental health stigma and the stigma associated with the facility. Some participants further reported negative occupational experiences where available mental health resources themselves create a barrier to care - seeking. During the interview experience, seeking care at the hospital is time consuming, and generally results in the client not receiving the care required. Accordingly, believing that existing resources are inefficient, both for the client and for officers, is perceived as another barrier to care - seeking.

Overcoming barriers to accessing mental health care
Participants voiced three strategies for overcoming barriers to accessing mental health services: 1) ensuring confidentiality; 2) providing an accessible, uncomplicated electronic resource; and, 3) customizing resources specific to police.

Ensuring confidentiality
Both communicators and police officers discussed the importance of confidentiality when considering access to mental health resources. If participants were to utilize a resource, they would want to ensure that their identifiable information remained confidential with respect to their access, including in - person services.

Providing an accessible, uncomplicated electronic resource

Both communicators and police officers reported that a proposed mental health service must be accessible in time and place to be useful. The majority agreed that, ideally, the service should be one that they can use on their cell phone, such as an app, because a mobile application would give participants the ability to explore services when they have downtime, regardless of place and time. Beyond accessibility, to make this resource user friendly, both communicators and police officers expressed not wanting to be overburdened with too much information presented on the application.

Customizing resources specific to police

Within the app, our participants suggested several police - specific electronic tools and resources that would be useful in overcoming barriers to accessing mental health resources: a mental health self - screening tool; a list of services covered by insurance; a simplified service booking tool; and, a PSP - specific service rating system. Our participants stated they would like a screening tool for particular mental disorders they may be experiencing, including those common to police and other PSP. Participants' reported feeling that although they may suspect they need care, they likely will not know exactly what is wrong (e. g. if they are experiencing symptoms consistent with, for instance, Major Depressive Disorder, General Anxiety Disorder or PTSD). Without knowing what exactly they are experiencing, participants may use a screening tool to identify specific resources that are most beneficial or relevant to them. Our participants further suggested that resources like the screening tool could provide immediate access to relevant information that may benefit them, and direct them toward steps they can take to improve their well - being. Furthermore, communicators and police officers expressed a need for a list of services in their area that are covered under their insurance policy and the ability to book an appointment with a selected (covered) therapist. A convenient, online booking system was emphasized, as booking an appointment is a difficult but important first step for many. If participants can immediately book an appointment when they feel distressed or are open to such a booking, they may be more likely to avail of professional mental health services. Moreover, participants would like to see descriptions of each therapist and their area of expertise, and some suggested a 1rating system specific to PSP to help facilitate the selection of a therapist that is 'right' for them. Finally, communicators and police discussed they would like this resource to be available for their family members. Police officers spoke about how being a first responder can affect their children. For example, officers may work long hours with rotating schedules and as a result may not be able to attend family events. Other officers believed that being a police officer negatively impacts the mental health of one's family. As a result, police officers believed that their families should be provided with mental health resources in response to needs that arise from being the family of a police officer.

Many police officers reported that their spouse would be the first person they would go to if they wanted to seek support for their mental health, which may be taxing for the spouse who may not know how to navigate their spouses' concerns.

Accordingly, it is unsurprising that many police officers and communicators in our sample suggested that improved mental health resources for their families would be beneficial.

5. Results

Three thematic barriers to officers and communicators seeking care for their mental health emerged from our participants' voices: i) stigma associated with care - seeking; ii) trust in confidentiality; and, iii) occupational experiences with mental health. Moreover, when describing strategies to overcome barriers to accessing mental health resources emergent themes revealed that our participants prioritized: i) ensuring confidentiality, ii) providing an accessible, uncomplicated electronic resource; and, iii) police - specific services. We unpack the barriers to care - seeking, and the qualities of resources police staff members would find most accessible to support their mental health.

6. Discussion

Our objective in the current study was to understand barriers that may deter police officers and communicators from seeking care for their mental health. Communicators and police officers identified barriers to seeking care, specifically the stigma associated with seeking - care, trust in confidentiality, and occupational experiences with mental health. With these barriers in mind, we wanted to identify what police and communicators desire from resources for their mental health. The current results indicate that although police officers and communicators do have access to resources, like EAP, there are still barriers to accessing these resources. Some of the barriers identified were officers not wanting to be labeled (or stigmatized) as weak, which they believe could potentially impact future promotion and their overall career trajectory. Furthermore, officers were concerned that their choice to attend therapy would not remain confidential – thus leading to stigma and labeling. While our participants generally described feeling stressed by their occupational duties and responsibilities, they expressed reluctance to seek care due to the concerns of stigma – the stigma being less about mental health struggles per se but more oriented toward care seeking itself. The essence of the stigma suggests that police members recognize mental health difficulties may be common, even expected, but feel uncomfortable seeking treatment and support. In select cases, although not the norm, some participants did disclose seeking care despite the stigma, and discussed the positive effect of seeking care for their mental health, which was met favourably by others in the focus group. Thus, despite discussion of the stigma associated with care - seeking for mental health, such practices were not opposed or met with visible judgment among participants, suggesting a tension exists between how care - seeking is perceived versus the support for such behaviours in police services. As such, while undoubtedly stigma does exist, it is the perceived stigma that has the most influence over the behaviours of police officers and communicators. Future research unpacking the nuance of mental health stigma as interpreted by police officers and communicators is necessary to fully understand the nuances around the stigma associated with mental health. Another barrier to help

seeking identified was the result of occupational experiences, namely, interactions with people in the community presenting in severe mental distress and/or occupational experiences with mental health facilities. Both police officers and communicators shared concerns about attending treatment in the same facilities as the persons they serve. Moreover, their work experiences, particularly responding to or coordinating a response to an individual experiencing mental health symptoms so intense that law enforcement are required to intervene, may have the latent function of skewing or narrowing interpretations of mental disorders. Future research examining how experiences responding to individuals in mental health crisis shape police officer and communicators views of mental health and interpretations of their own mental health (e. g. minimizing their own experiences due to extreme comparisons) is warranted. Nonetheless, there remains a need for accurate and evidence - informed training and education about mental illness for police officers and communicators. each, we qualitatively unpacked what officers and communicators would like to see in potential services, identifying three main themes. Participants would like to be assured that their confidentiality will be maintained when accessing psychological services but also when using work specific insurance benefits or other resources. Second, officers reported that they would like mental health resources to be accessible and user friendly. They articulated resources could be in the electronic form, such as a mobile application they could access at any time and from any location. Finally, participants reported specific elements they would like to see in a resource, identifying mental health screening tools, resources for families, and an online booking system for mental health services as central components. Future research, however, is necessary that explores if police officers and communicators will reliably use a mental health application built specifically for PSP. Many of them suggest that breaking down barriers must start during cadet training. New recruits should be informed of early warning signs associated with mental illness, occupational risk factors, individualized self - care practices, and a list of mental health resources that are available to them. Psychologically traumatic events they may experience on the job may affect them negatively. New recruits may benefit from evidence - based mental health educational training, which, as has been demonstrated, may reduce stigma and minimize barriers.

Our study is not without limitations. Being qualitative in nature and of a limited sample size, we caution regarding any generalizability of our findings across or within police services. Participants willingly consented to join the study, with the knowledge that our focus was on mental health, thus, our population may have been more willing to speak about their mental health than those who did not participate. Furthermore, our data consisted mainly of long serving, high ranking officers. Although gaining the perspective of high - ranking officers is important, as these officers may be in the position to make policy change, these officers would have received different training than new officers and may have different views about mental health and treatment seeking. Police services have made strides towards recognizing the mental health of their employees, thus, there is a possibility that more tenured officers are less aware of the resources and supports offered currently, which presents as a

limitation of our study. Finally, the focus groups and interview took place at one of the police service's stations, which may have introduced a bias as some participants may have felt less comfortable speaking freely at their place of employment and/or some individuals may have declined to participate because the location was not ideal. Future researchers may wish to examine the mental health training received by police officers and communicators as well as how such training shapes interpretations of mental illness, well - being, and treatment - or support - seeking for mental health needs.

7. Conclusion

Many communicators and police officers may not seek mental health care due to many barriers such as, 1. the stigma associated with seeking care, 2. trust in confidentiality, and 3. occupational experiences with mental health. To address these barriers, officers would like a resource that, 4. will ensure confidentiality, 5. is an accessible, uncomplicated, electronic resource, and 6. is a PSP specific resource. Assuring police officers and communicators have appropriate resources may decrease the psychological burden related to the duties of the occupation.