Male police officers' mental health: the double-edged sword of masculine ideologies.

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I declare that this thesis is my own work and has not been submitted for the award of a higher degree elsewhere.

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Abstract

Policing is a high-risk occupation that exposes officers to psychological harm; research indicates rising mental ill-health among UK officers with wide operational and personal consequences. Despite suffering higher levels of psychological distress than the general population, officers' use of available mental health services remains markedly low due to stigma, confidentiality concerns and difficulties accessing care.

Moreover, the masculinised culture of policing-often implicated in shaping male officers' mental health awareness and help-seeking-remains underexplored. Although hegemonic masculinities theory has informed civilian men's mental health studies, it has yet to be applied to the distinct experiences and support needs of UK male police officers.

Filling that gap, this study explores how masculine norms indigenous to policing culture shape recognition of distress and engagement with care. Sixteen male officers with lived experience of mental ill-health and successful help-seeking were interviewed using a semi-structured format. Following reflexive thematic analysis, their experiences and suggestions are presented via four themes; "The Rise and Fall of Robocop", "Help-seeking ... How you're under control?", "Raging against the machine" and "The Human/e solution".

Contrary to current understanding, this study shows that male officers do seek help, however multiple systemic misalignments meant that successful support engagement required repeated attempts, escalation in clinical severity or the intervention of a trusted intermediary.

The findings are discussed in the context of current policing culture, highlighting how male officers' lives are influenced by the hegemonic ideals around them, enabling effective public service to the detriment of their wellbeing, and how austerity-driven resource cuts and performance indicators in policing are neglecting the needs of male officers specifically.

This study extends present understandings of police mental health aetiology and highlights the inequities faced by male officers experiencing mental ill-health. It concludes with practical recommendations for policy and practice, advocating gender-sensitive, culturally competent interventions within policing.

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Abbreviations and terminology

CID	Criminal Investigation Department
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
MHA	Mental Health Act 1983
Section 136/S136	Section of the MHA granting police powers to take an individual from a from a public place to a place of safety if they appear to be suffering mental distress and need immediate care
WHO	World Health Organisation
Double crewing	Deployment of two police officers together
Single crewing	Deployment of an unaccompanied police officer

Chapter 1 - Introduction

This chapter sets the scene for this PhD and starts with an overview of policing in the UK and mental health in the general population pre- and post the COVID-19 pandemic, before progressing to mental health within the police population. This is not only because my research straddled this time frame; the proposal was informed by literature pre-pandemic and post-pandemic the need for work in this area has not lessened; the immense global burden of mental ill-health is widely documented (WHO 2002) and continues to require improvements in service provision worldwide (WHO 2022).

It then presents the gendered patterning of mental health experience and the prevalence within policing; this research's target population along with the underpinning personal observations and motivations to this work.

1.1 Policing in the UK

The policing service operates non-stop, responding to a wide nature of emergency calls, investigations and public need. Aside from this reactive function, policing is also proactive in crime prevention, detection and public safety. The organisation therefore comprises of a wide range of teams, disciplines and skills undertaken by a diverse nature of individuals working around the clock. Running a public service is also challenging; funding and austerity measures over the years have incurred significant organisational and practice changes (Bell, Palmer-Conn and Kealey, 2022., Houdmont, Elliott-Davies and Donnelly, 2018).

In 2024 there were nearly 148,000 full-time equivalent (FTE) police officers across the UK (Home Office, 2025). Although this is reported as a twenty-year high and one that suggests a stronger police service, further statistics show a different picture. Death in service is higher than in the previous five years and there are record numbers of voluntary resignations, many leaving within five years of joining and the number of warranted police officers on long-term absence is also rising (Home Office 2025). Policing is a physically demanding role and whilst Home Office (2025) statistics do not present separate categories of sickness absence, research by Quin (2024) reveals a significant increase in

absences relating to mental ill-health, that left unaddressed could threaten the sustainability of frontline police services.

Adding to this picture is also an increase of injuries on duty, internal disciplinary action and officers on limited, adjusted duties (Home Office, 2025); a process commonly used when an officer is unable to perform their substantive duties for medical reasons. Furthermore, policing has, and continues to experience, a wide range of organisational challenges; policing the COVID-19 pandemic, austerity measures, civil unrest and widespread rioting and the reputational difficulties through media reporting and the disreputable actions of a select minority of (now ex-) police officers. This all adds to a complex picture regarding the mental health of police officers and the wider organisation.

The effect of work-related stress is well documented; Collins and Gibbs (2003) discuss how working conditions, organisational pressures and workloads affect officers' wellbeing and Houdmont and Randall (2016) demonstrated the association between the long hours typical in policing to common mental health disorders within officers. In 2015, Mind's scoping survey revealed that almost 90% of emergency services workers reported to have/have had poor mental health resultant of their roles. Given the above Home Office (2025) official police statistics, this suggests little improvement or potential deterioration despite the growing number of blue light-related health education and service developments.

To complicate this, a key policing duty involves responding to members of the public who are in distress and/or a mental health crisis for the purposes of managing risk to life or of harm or disruption to other people or services. In this function, police have powers to detain someone believed to be requiring of urgent mental health support. In the UK, this is under Section 136 (S136) of the Mental Health Act, pending review of an appropriately qualified mental health professional. This process has been researched with regards policing practice (Menkes and Bendelow, 2014) and the experiences of delivering urgent mental health related care are thought to negatively impact officers' perceptions of mental health services (Bell and Palmer-Conn, 2018).

Further pressures experienced by officers include a more widespread use of single crewing; the deployment of lone officers to incidents, which although may be cost-efficient is also associated with an increase of assaults on officers (Houdmont, Elliot-

Davies and Donnelly, 2018). Policing can offer varied and highly challenging experiences and carries Post-Traumatic Stress Disorder (PTSD) potential. In the UK, 20% of serving officers report clinically significant trauma symptoms (Brewin, Miller, Soffia, Peart and Burchell, 2022). Overall mental ill-health and suicidality within the policing workforce is concerningly high; pooled prevalence for depression, PTSD and suicidal ideation stand at 14.6%, 14.2% and 8.5% respectively (Syed, Ashwick, Schlosser, Jones, Rowe and Billings, 2020). This contrasts strongly with 7.2% depression, 3.9% PTSD and 3.96% suicidal ideation equivalents in the general population (Tsai et al, 2024).

However, research also shows that despite this clear need there are considerable barriers to engaging in psychological support for the policing population (Bell, Palmer-Conn and Kealey, 2022., Casas and Kegel, 2023).

This study therefore looks to understand these obstacles and how they were overcome by exploring the narratives provided by officers post-treatment. It looks to explore the effects of the policing culture on police officers' views and understanding of mental health along with their learning and suggestions on how services may be more accepted within this population.

1.2 Mental health before and after the pandemic

Before the COVID-19 pandemic, mental health services in the UK were reporting ever-decreasing resources despite a clear service demand (The Mental Health Network, 2016). Indeed, that was not new; mental health services had long been under-prioritised (Saxena, Thornicroft, Knapp, & Whiteford, 2007) despite this being the country's highest illness prevalence (Department of Health, 2011). Yet evidence points to an unequal level of service uptake.

Malcher (2011) revealed extensive pan-european gender health disparities, advocating specialised services and further research. Similarly in the UK a gendered mental health patterning is reported (McManus, Bebbington, Jenkins and Brugha, 2016), evidence points to complex variations in mental health experience, behaviour and help-seeking.

Statistically women are more likely to seek support and are less likely to complete suicide. Male suicide remains around three times higher than female suicide (The Office for National Statistics ONS, 2016). Additionally, there is a higher proportion of men in secondary care services and with multiple health needs (Malcher, 2011., McManus et al, 2016). It is thought that delayed engagement with health services is a contributing factor to these statistics (Pattyn, Verhaeghe & Bracke, 2015., Needham & Hill, 2010). Men can be prone to comorbidities because of their mental health coping mechanisms (Malcher, 2011., WHO, 2002a., WHO 2022b).

Since the COVID-19 pandemic however, this has only deteriorated; the World Health Organisation reports a global 25% increase in anxiety and depression (WHO, 2024) and in the UK the ensuant demand placed on the NHS and other mental health services has exponentially increased (Centre for Mental Health, 2025). In a review by Duagi, Bell and Obateru (2024), the negative effects of the pandemic are reported to be immeasurable and far reaching; the pandemic and related lockdowns incurred significant impacts on mental health, physical health including those associated with comorbid common mental health difficulties, self-care ability, social isolation, education, employment and thus financial risks. They also report a patterning of need, inequality and difference across and within sub-populations; being a frontline worker during the pandemic for example, incurred an additional layer of complexity, due to the balancing of occupation, lockdown responsibilities, family, homeschooling and critically increased virus exposure (Duagi et al, 2024). Police officers were part of this frontline response, and a UK paper reported that 74% of police officers reported the pandemic had affected their mental wellbeing (Tehrani, 2022).

The impact of mental ill-health is not limited to individuals' illness. There is a social and economic ripple effect around the affected person. The Organisation for Economic Co-operation and Development (OECD) reports the social and economic impact of poor mental health as up to 4.2% of GDP (OECD, 2021). In 2019, researchers at the London School of Economics and Political Science estimated that mental ill-health in the UK costs around £118 billion from lost productivity, informal caring, service provision and disability-adjusted life years (McDaid and Park, 2022). After the COVID-19 pandemic, researchers from the Mental Health Economics Collaborative (MHEC) reported this to have risen to £300 billion (Cardoso and McHayle, 2024) when the economic, human and

care costs are combined. However, the impact on family and friends, as well as the individual affected by psychological or psychiatric condition are hard to quantify and may be immeasurable, particularly where suicidality, family breakdown or other irreparable life events feature. This all paints a suboptimal mental health picture that has worsened since the pandemic, and many illnesses including psychiatric conditions had not regained pre-pandemic levels in 2021 (Mansfield et al, 2021) and it is thought that due to this ongoing inability to catch up, overall life expectancy is affected (Centre for Ageing Better, 2024).

1.3 Mental ill-health and the role of gender

Overall, the rates of psychopathology are generally gender equitable (Pattyn et al, 2015), however other evidence points to complex variations in mental health experience, behaviour and help-seeking (WHO 2002., WHO, 2022). Male suicide is around three times higher than female suicide for example and women are more likely to seek support for mental ill-health (ONS, 2016). According to Pattyn et al (2015), it is thought this engendered patterning is due to differences in the experience and expression of emotional distress. Women are thought to be more proactive at health improvement, whilst men alternatively, can exhibit more behavioural concerns (risk-taking behaviours) and problematic mental health coping mechanisms (Malcher, 2011., WHO, 2002), which in turn can result in comorbidities and thus longer treatment trajectories. Adding to this can be a heightened reluctance to seek help and resultant deterioration in presentation (Rice, Aucote, Parker, Alvarez-Jimenez, Filia and Amminger, 2017). Clinicians are therefore encouraged to consider the role of gender throughout their practice by appreciating the trends associated with suicidality, lethality means, peak ages and risk indicators. Yet despite this, men remain underrepresented across all health services regardless of male specific health campaigns (Robertson and Baker, 2016).

Because of these health needs and service access inequities, theorists have sought to explain these challenges. Hegemonic masculinities theory, originating from the work of Connell (1995), offers a dynamic, temporal and social appreciation of what it may be like to be a man. Researchers have drawn on hegemonic masculinities to seek to explain differences in health service use (Addis and Mahalik, 2003., Branney, Witty, Bagnall, South & White, 2012., Oliffe et al, 2016). This theory asserts that individuals aim to subscribe, embody and perform the most desirable cultural ideals; mainly pertaining to

strength and superiority. Hegemonic masculinity theory (HMT) suggests that men 'should' be 'strong' and 'in control'. In brief, it is a patriarchal hierarchical stance where being culturally deemed suboptimal equates with subordination. Hegemonic masculinities practice is associated with poorer health choices and unhealthier behaviours such as not frequenting health clinics, alcohol consumption, sexualised behaviours, and potential violence to maintain 'being a man' (Robertson, 2007).

Hegemonic masculinities theory has been used extensively in understanding engendered health practices and men's difficulty accessing necessary healthcare in civilian populations (Robertson, 2007., Gough and Robertson, 2010) and suggests healthcare access is avoided, as routinely medical attention tends to infer 'weakness' or 'inadequacy'. This can however be alleviated if addressing ill-health confers to achievement of other hegemonic ideals such as returning to work, sport or sexual performance (O'Brien, Hunt & Hart, 2005). This presence of dynamic, engendered concepts can have far reaching consequences affecting men's biological, psychological and social health (Emslie, Ridge, Ziebland & Hunt, 2006).
These ideals also maintain mental health stigma and thus serve as a deterrent; it is thought that male underrepresentation in psychiatric services may be because such mental health and talking therapies are not congruent with some hegemonic practices (Robertson, 2007). Furthermore, proactive and preventative health care is also thought to be a feminised concept (Branney et al, 2012) and less healthier practices (such as poorer diet, excessive alcohol, smoking, working late) more masculine and thus 'attractive' or unavoidable (Robertson, 2007).

Hegemonic masculinities theory has also been used to explore professions typically seen as elite male spaces; Barratt (2001) reviewed how it may explain practices within the US Navy. Here, he portrays how ideals conducive to military life such as valour, integrity, physical performance and loyalty are facilitated and co-constructed through layers of social ideologies. At ground level this hegemonic practice can be seen by individuals and groups of sailors striving for their best, glorifying actions and achievements associated with male strength and performance, and negatively describing those of (perceived) lesser ability. Overarching social ideologies comprise those depicting what the profession and wider military service stands for at national and international level, not only formally but also as portrayed by popular culture; films and media perpetuate societal views of the

ultimate traditional, strong male. Being in a military (or other uniformed) occupation can therefore be glorified and situated within multifaceted aspects of official status - hierarchy, authority and thus power - which if not sustained, can clash dramatically (Barratt, 2001., Donald, 2001). Emotional expression is therefore not encouraged despite the high stress potential, and psychological help-seeking deemed incompatible to the profession and individual's military and male identities due to the presence of these hegemonic ideals (Clary, Pena and Smith, 2023).

Therefore, these contributions have offered some insight into male health psychology and the need for male gender-sensitive options and education, not only for civilian males but also where masculinities practice may be heightened due to occupational specialty. The work of Barratt (2001) is useful in outlining how the US Navy as a profession can be observed through a hegemonic masculinities theory lens where help uptake is incompatible (Clary et al, 2023). It is, however, not transferable to UK policing; the US Navy and UK police service offer entirely different services, with different working terms and conditions and are situated culturally and physically in two separate areas of the world.

1.4 Mental health in Policing

Policing is a profession associated with physical health problems (Violanti, 2014) and poor mental health (Irizar, Gage, Fallon and Goodwin, 2022). In a review by Syed et al (2020), police mental ill- health was presented as double that previously reported in samples of mixed first responders. Furthermore, PTSD and depression prevalence was reported as 14.2% and 14.6% respectively, harmful alcohol consumption at 25.7% and suicidal ideation at 8.5% (Syed et al 2020) however this could be higher as research by Thoen et al (2020) found that 12.4% of serving officers reported they would contemplate suicide. Workplace and operational pressures are thought to be key antagonists to mental wellbeing (Syed et al, 2020).

In recognition of this, police forces within the UK have some form of specialist occupational health provision in addition to mainstream NHS services and police specific

charities. Police mental health literature highlights a range of ongoing help engagement barriers: stigma, concern for career consequences, limited emotional insight and lack of accessible options (Casas and Kegel, 2023) and yet despite raising this awareness, statistics show a year-on-year increase in poor mental health and workplace health outcomes (Home Office, 2025), suggesting something is still missing. Given that in England and Wales the policing workforce comprises 64.6% men (Home Office, 2025) and men may delay and underutilise health care (Rice et al, 2017), it is important to consider the role of gender within officer mental health help-seeking.

Some research has connected policing culture to mental health outcomes, but the influence of masculinised norms is still underexplored (Buhrig, 2023). In a study of Canadian police, Buhrig (2023) considered the effects of masculinised contest cultures; where masculinised practices are promoted and/or rewarded within organisations, on wellbeing outcomes. He reported that these ideals and practices are particularly harmful for female officers and generally contribute to overall poorer workplace wellbeing suggesting that hegemonic practices warrant consideration in tackling problematic organisational dynamics and workplace health. Although this situates masculinities practices within Canadian police organisations, this again cannot be easily extrapolated to the UK police service given the differences in culture and policing practice. Similarly, despite some gender separation at analysis, the impact on male officers is scantly described and the resultant effects on actual help-seeking not addressed. The role of hegemonic masculinities is therefore not able to discuss Canadian officer mental health service use, despite some use of the theory to explore the wider culture there and its influence on wellbeing, moreover the theory has not been applied to explore policing and its effects on the mental health of the UK police officers.

Policing can draw on masculinised ideals such as strength, action, control and fitness and the influence of masculinities practice has been considered in the UK by Silvestri (2017), but on women in the profession. She states that gender in policing is not purely describable by male presence alone but an organisational subscription to performative concepts that “do” masculinities, the police is therefore not a “gender neutral” organisation (Silvestri, 2017). Shelley, Morabito, & Tobin-Gurley, (2011) further add that the service is not one that can correct its reputation purely through the recruitment of women into varying ranks.

Masculinised norms are portrayed as highly desirable qualities to be aspired to and largely hinge around fitness and presence or 'physicality' (Silvestri, 2017). Discourse in policing perpetuates these ideals; as Silvestri (p.294, 2017) illustrates, fighting crime "implies physique…hence policing by men". Women do not generally have the same physical advantage and therefore are open to marginalisation and subsequently the maintenance of masculinities ethos. Silvestri (2017) cites the machismo culture as being almost the purest form of hegemonic masculinity, this subculture advocates virility, strength, sport and masculinity. If as she asserts, the organisational subculture is set by the organisation itself then the performative machismo present within policing may need thorough reform (Silvestri, 2017).

However, it is noteworthy that much of the research on gender within the police focuses on the experience of women within the organisation and there is little direct enquiry into men's experiences. The effects of masculinities practices on men's mental health, or specifically how any rigid masculine ideals impacts on the wellbeing of male officers, remains unclear. Given the lack of research into the effects of culture and mental health experiences of male officers within UK policing, the potential application of HMT within this study's population is important because it may offer some explanation as to how men experience these pressures and practices with the aim of understanding how their mental health and subsequent health care access could be improved.

1.5 Personal observations and motivations

To best address mental health needs, research and evidence-based practice such as those set out by the National Institute for Health and Care Excellence (NICE) inform clinical response. Health care practice is therefore evidence driven and research informed by questions and patterns identified in the field.

In mainstream mental health care, the consideration of illness patterns, treatment trajectories and patient demographics are imperative to clinical formulation and treatment planning. However, when I started working as a psychological therapist in police mental health there was little specialist information regarding UK police mental

health and having previously appreciated the differences in gendered mental health experiences, I was unable to appreciate any transferability or relevance in my new clinical population. What I did notice were discrepancies, it was widely reported that police officers were reticent to engage with help providers and the service I worked in had a waiting list. Further to this, in the Increasing Access to Psychological Therapies (IAPT) services (the then civilian equivalent), men were typically less represented, in 2016 only 36% of those accessing IAPT were male (McManus et al, 2016) yet in the same year my caseload was overwhelmingly (and sometimes exclusively) to the contrary and finding literature and guidance specific to male officer needs, particularly of UK origins provided a challenge. This research was therefore motivated by my lived experience as a mental health professional within the police wellbeing field.

When I started first working with police personnel, mental health was a rather 'new' concept where bespoke services started being more openly offered. This was not because mental health had not existed in the policing population but rather because it was being more discussed and accepted. The acknowledgment of mental health experience across the UK blue light sector following Mind's 2015 review affected several service provision changes and a ripple effect across the corresponding charities. I joined the Police Treatment Centres (PTC) in early 2016, and this came therefore at an interesting time where officers were able to request mental health support by applying to the charity's "Psychological Wellbeing Programme". Prior to this the support offer had been informal via listening, signposting and pastoral care. Joining the PTC at service build was therefore informative, iterative and above all a privilege.

Since 2015 there have been other academic publications, particularly within the UK, regarding wellbeing within policing; whilst there were some key contributions discussed in this chapter, much remains unclear and the field generally under-researched (Bell, Palmer-Conn and Kealey, 2022., Edwards and Kotero, 2021). Although police wellbeing is somewhat better understood than when I started my PhD, there remain multiple inequities that will be discussed in this thesis. UK policing is also underrepresented generally in research with contributions mostly of US origins. This may be affecting UK clinical understanding and subsequent service offer. Adding to this are multiple contemporaneous cultural and social factors; policing as a profession is experiencing several challenges; resourcing and reputation being significantly affected particularly

within our country. Furthermore, it is not possible to transfer findings from international research as policing practice differs operationally; many countries carry firearms as standard for example.

1.6 Research Questions

The research questions for this study are:

1. How do hegemonic masculinities practised within the police culture influence male officers accessing formal psychological support?

2. How can police officers' mental health help-seeking be improved?

1.7 Aims and Objectives

This chapter has outlined the growing problem of mental ill-health and a lack of research relating to male officer wellbeing alongside a lived experience of irregularities within the police wellbeing field. Adding to this is a slowly growing yet insufficient academic provision, to which this paper seeks to contribute through the following aims and objectives:

To understand the ways in which hegemonic masculinities within the police culture influence male police officers accessing formal psychological support;

- To explore how masculinities within police culture acts as a barrier or facilitator to mental health help-seeking.
- To examine how hegemonies within this masculinised culture influence male officers' approach to their own mental and emotional wellbeing.
- To explore police officers' differing views and perspectives of mental health.
- To explore potential ways to improve officers' understanding of mental and emotional health.
- To investigate ways of improving police officers' mental health help-seeking.

1.8 Intended contributions to knowledge

In exploring male officer help-seeking, this study intends to highlight the barriers and facilitators to accessing support through drawing on the accounts of those with lived experience. Engaging with 'experts by experience' forms good healthcare practice and is therefore congruent with service improvement and clinical governance. This learning may offer valuable considerations regarding treatment facilitators and gender sensitivity for the purposes of increased service utilisation.

The needs of men have been identified and advocated in mainstream healthcare through a hegemonic masculinities lens but have not yet been considered within police mental health research despite the profession being an overwhelmingly male landscape. This perspective therefore hopes to offer insights into how the gap between service need and uptake may be better bridged. If services can be designed to meet the needs of male officers, then this could have a positive impact in improving health outcomes. Not only is this to the benefit of individuals and their families, but it could also offer support to operational and occupational health policy and practice.

Chapter 2 – Literature review

2.1 Introduction and background

The need for police specific mental health support is clear; occupational stressors are widely evident (Syed et al, 2020., Brewin et al, 2022., Irizar et al, 2022) and yet mental ill-health is underreported, and services underutilised (Bell, Palmer-Conn and Kealey, 2022., Casas and Kegel, 2023). The visible impacts of this are increasing levels of sickness absences, workforce pressures (Quin, 2024) and decreasing employee retention (Home Office, 2025). The impacts on the individual and their family networks are gaining visibility (Lennie, Sondhi and Abinashi, 2024) but much remains hidden. What is not known and of interest in this research, is how male officers experience mental health healthcare. Men comprise two-thirds of the UK police workforce and mainstream (civilian) health providers are encouraged to appreciate gender differences in mental ill-health and help-seeking, yet this is less researched for clinicians supporting male police personnel.

This chapter presents a review and appraisal of yielded literature specific to the research area. Its aim was to understand current knowledge on police officers help-seeking of mental health care. In preparation for this literature review, a scoping search was undertaken in 2018 and found that research regarding police mental ill-health was limited. The papers discovered in this initial scoping search informed the PhD focus, research design and interview questions. Due to intercalations, it was important to re-review current literature in the field, therefore the search was updated in October 2024.

Between 2018 and 2024, five reviews of police mental health were published; “A state of the art review” on trauma experiences and associated mental health stigma (Velazquez and Hernandez, 2019), a systematic review and meta-analysis of the global prevalence and mental health risk factors of police personnel (Syed, Ashwick, Schlosser, Jone, Rowe and Billings 2020), a scoping review on barriers to law enforcement officers’ help-seeking (Richards, Suarez and Arocha, 2021), a further scoping review on police officer attitudes to seeking mental health support (Grumley Traynor and Rydon-Grange, 2024) and a

systematic review of qualitative research on law enforcement mental health (Casas and Kegel, 2023).

To summarise the contributions of these reviews in turn, Velazquez and Hernandez, (2019) sought to explore why US police officers do not seek mental health treatment. The authors presented three main barriers; stigma being inadvertently perpetuated at individual, and organisational levels and a poor understanding of the psychological impact of natural disasters. The review did not discuss generic (non-natural disaster-related) mental health help-seeking and may be limited in its UK relevance. Richards et al's (2021) scoping review on help-seeking used grounded theory. They present three help-seeking factors - "Environmental" (family influences, department culture, society's view of law enforcement officers), "Behavioural" (career consequences, stigma) and "Individual" (awareness/education, negative perception of services and identity; particularly where this is masculinised). However, this review also focuses exclusively on US and Canadian Law Enforcement and therefore raises questions regarding its UK transferability potential.

Syed et al's (2020) review of international contributions considers quantitative research from 24 countries regarding prevalence of and risk factors for poor mental health within the policing community. They report policing to be twice as affected by mental ill-health than previously stated within the first responder population. This paper highlights police mental ill-health vulnerability in connection to occupational demands, poor social support and maladaptive coping strategies such as alcohol misuse. Their findings report women being more at risk of depression and PTSD and suggest this may be connected to gender dynamics in the workplace (such as challenges with accessing effective peer support and discrimination). Yet wider in the data, gender specific breakdowns are inconsistent, and the gender reporting within the reviewed papers unclear. Some of the included papers are based on self-report measures, so it is unclear whether the higher female incidence reported here is due a higher level of self-disclosure by women. Similarly male gender is higher associated with alcohol misuse; a pattern seen in the general public as men may lean on this to cope, so this may be indicative of a non-reported (hidden) comorbidity suggesting mental health is equally affected but less openly discussed by male officers. Syed et al's 2020 review offers some thoughts regarding gender-appropriate services for women in policing but the needs of men are not

discussed, nor are any learnings around service uptake, completion of treatment or how male officers may engage with support. There is also nothing of UK specificity to extract, although this published acknowledgment of mental ill-health parity across policing internationally is informative.

Casas & Kegel's (2023) US published systematic review presents a synthesis of globally derived qualitative work regarding law enforcement officers' subjective experiences of occupationally derived mental ill-health. The authors present organisationally driven mental health stigma, concerns of negative career repercussions, clinicians' cultural competency and poorer mental health sequalae to the occupation. The workplace culture was in fact "unanimously identified as the most problematic organisational stressor" (pg. 943) due to lack of trust, process or support. Given this is first reported in Abdollahi (2002), it suggests little positive change in 21 years. What this review does offer is a depth regarding the effects of help-seeking on the officer's family and the inability to engage with services (where they exist) due to the logistics of the policing lifestyle. In conclusion of their review, Casas and Kegel (2023) promote the need for independent but law enforcement familiar health services and a need to rebuild fractured trust not only of these services but also with the employer. The practical suggestions offered are US-focused so again have limited utility here in the UK. What this review however cannot describe are the experiences specific to male Law Enforcement Officers and/or how the reported barriers have been successfully negotiated. It presents a collection of established treatment obstacles but not the subjective experiences of those requiring *and* engaging in mental health support.

Grumley-Traynor and Rydon- Grange's (2024) scoping review look at how attitudes of police officers in the UK correlate with mental health care usage. Their rationale being "police help-seeking is a rapidly developing area of research" (p3) and a UK-based critical review is overdue. Their search terms followed the three categories of "police/LEO", "mental health service/healthcare/help" and "attitude/belief/perception" to elicit and critically appraise 21 quantitative studies. Presenting 102 correlates to help-seeking attitudes, the most consistent positive associates included past help-seeking, perceived service availability and prior mental health diagnosis (which itself requires a mental health professional, typically a psychiatrist). However, this cannot explain how those with previous mental health service experience managed to help seek originally but does

suggest that previous uptake can mediate later need. The authors themselves noting "it is not possible to state with certainty which factors are associated with help-seeking attitudes amongst police officers" p.26). Interestingly the presence of trauma symptoms (PSTD/CPTSD) was consistently negatively associated with help uptake and with this occupation being high trauma facing warrants further study. This work is however not male focused, although gender was considered and revealed varying correlates. For example, a positive correlate was found with regards alcohol use as stress coping strategy (men reported a higher consumption) and correlates regarding promotion stress (the process of gaining a higher rank) pertained more to women's experiences.

To summarise, these reviews highlight factors limiting mental health service uptake and concerns regarding police officer service underutilisation. The need for psychological support within the policing population is clear and internationally applicable; police officers have a high incidence and potential for mental-ill health. There are also clear concerns around attitudes to mental health help-seeking, stigma and occupational ramifications. However, what is not yet clear is what limitations and barriers are experienced by UK officers and how can help-seeking behaviours be better understood. Qualitative UK based research on officers' experiences of help-seeking and support uptake also warrants further exploration; what influences service engagement and how can this be improved? Therefore, this review explores police mental health help-seeking.

2.2 Literature review design

The below PICOC outlines the area of interest, operationalising the terms and inclusion criteria contained within the review question:

Population – police officers
Intervention –mental health services, engagement, help-seeking, treatment
Comparison – masculinities and mental health,
Outcome – treatment/engagement, mental health, psychological health, suicide, self-harm, anxiety, depression, stress, wellbeing, Post Traumatic Stress Disorder (PTSD), emotional health
Context – all studies, all methodologies. English language only, 1990-2024

2.2.1 Review question

What is known about police officers' mental health help-seeking?

2.2.2 Search strategy

The search was undertaken using the following search terms:

1. Police OR Police Officer OR Law enforcement
2. mental health OR mental illness OR mental disorder OR psychiatric illness
3. help-seeking OR treatment seeking OR treatment engagement OR service utilisation

Inclusion	**Exclusion**
Papers exploring Police and Law enforcement officers	Dissertations and theses
Police officers own mental health experiences and care seeking.	Police operational experiences of responding to mental health needs of others - care giving
Police mental health culture	Police policy and practice/guidance for mental health responding
Police mental health stigma	Generic male mental health stigma
All methodologies	Non-English language publications
Help-seeking or need for help	Help provision
Any country	Grey literature
	Reviews

Due to the wealth of research focusing on police operational duties of responding to those with mental health needs, the search provided a broad subject variety in the outputs.

For example, Web of Science returned an initial 550 papers, with 56 remaining after title sift alone and this was mirrored across other databases. Advice was therefore also sought from a specialist librarian. Their review of the area revealed similar challenges and necessity for casting the search net wide and sifting out papers regarding police responding to the needs of others. Additional manual searches were conducted using 'cited by' and following relevant articles in the reference lists. After duplications were removed, 102 papers remained. Following removal of dissertations and full text review, 42 papers remained: 11 from within in the last five years.

2.3 Review and synthesis of results

Of the 42 papers from this search, 20 were of UK origins, the remaining coming from the US (12), Canada (3), Australia (2), South Africa (1), Netherlands (1), Norway (1) and Sweden (2). Publication varied and spanned not only psychology and psychiatry journals but also policing practice/criminology and occupational health related papers. The data spanned the last 33 years (1991 – 2024) and provided a multifaceted picture of police mental health, their need to receive support, operational and organisational complexities within policing.

Papers of all methodologies were included so to gain a rich view and comprised 22 qualitative, 17 quantitative and three mixed methods papers. All the quantitative papers drew on surveys. Of mixed methods studies, one utilised existing coronal statistics in conjunction with reviewing descriptive data (Barron, 2010), another (Bell and Palmer-Conn 2018) implemented a UK survey (Time to Change) and incorporated free text boxes for comments to qualitatively consider. The third mixed methods study (Thoen, Dodson, Manzo, Piña-Watson, and Trejos-Castillo, 2020) was a two-part piece that elicited information from US police agencies and singular officers nationwide. It firstly looked to understand what service provisions existed and officers' knowledge of these, then reviewed some symptoms experience and text box analysis from individuals.
This review took an inclusive approach and therefore eleven non-empirical papers were included. These were typically narrative papers describing and presenting current knowledge regarding a specific phenomenon such as child homicide effects on police officers or the response to and impact of two key mass tragedies. Others presented knowledge for the purpose of application or suggested best practice; how police trainers may equip new recruits better to understand mental health for example or what may alleviate organisational stigma. These were included as they provided valuable information around the need to seek support and how this has been previously received but were not empirical evidence or a systematic presentation of literature searched. Also in the qualitative selection was a case study and two ethnographies. Interviews comprised the remaining seven and all were semi-structured but analysed differently

drawing on grounded theory, interpretative phenomenological analysis, content analysis and thematic analysis.

2.3.1 Review synthesis methods

The identified empirical studies papers were appraised using their methodologically appropriate Critical Appraisal Skills Programme checklist (CASP, 2024).

For example, CASP's (2024) qualitative review framework asks 10 questions as the basis of appraisal within 3 areas: results validity, research finding and application of findings. Quantitative papers were reviewed separately using CASP's (2024) cross-sectional framework which considers validity and presentation of findings in more detail and encourages the reviewer to look for positive, negative and unclear components of methodology so to achieve an overarching view of the paper's rigour.
Once individual papers had been considered and scored, they were then ranked under 'High' 'Medium' or 'Low' and resulted in ten papers scoring high, 16 medium and five low. A worked example of a CASP reviewed paper can be found in Appendix A.

To aggregate and present the results, it was important to understand each paper's contribution to the field. Many papers reported help-needing for reasons of stress, trauma exposure, isolative conditions and inability to decompress. Others reported barriers to help engagement due to stigma, negative career consequences, concerns regarding confidentiality and clinician competency. A few papers referenced masculinised culture as an influence on help-seeking, yet none explored this further. Aggregating the contribution/s of each paper facilitated a Braun and Clarke (2018) guided thematic analysis, which draws on a stepped model of data review and appraisal (Braun and Clark 2006). To do this, data from each paper's results or findings section was extracted and coded, following which six core themes were developed and are discussed below. This process facilitated a cross-methodology thematic analysis. For example, in their mixed methods paper, Bell and Palmer-Conn (2018) surveyed UK police attitudes to mental health using the general public's Time to Change survey outcomes. Their results revealed an "underlying cynicism" of services (p.33), profession-wide stigma and concerns regarding occupational consequences. These were thus coded as 'Stigma (self)', 'Stigma

(other)' and 'career impact' and then collapsed into the resultant themes of "Environment (culture)" and "Accessibility".

2.4 Review findings

To address the review question "What is known about police officers' mental health help-seeking?", six themes were developed from the thematic synthesis: illness experience, environment, suicide, masculine ideals, language and accessibility.

2.4.1 Illness experience

This theme comprises literature regarding the nature and characteristics of mental health experienced by this population and the need for services which in turn, supports the disconnect between the individual needing support and health provider.

This validates that police are requiring of psychological support and that there are significant risks associated with their chosen occupation (Bell and Palmer-Conn, 2018). These are multifaceted and span organisational and operational demands (Abdollahi, 2002) the latter being now more understood (Fielding et al, 2017., Houdmont and Randall, 2016). These pressures can then be further worsened by "normal" life events such as bereavement, relationship challenges, childcare and financial pressures, and indeed research shows that it is the culmination of different (work and life) pressures that cause most issues within this population (Patterson, 2003). On top of this, particularly aberrant or physical events can place extra demands on psychological and physical health (Backteman-Erlanson, Jacobsson, Öster, & Brulin, 2011; Duckworth, 1991; Maceachern, Jindal-Snape, & Jackson, 2011)

Whilst officers can be highly resilient (Tuttle & Papazoglou, 2018) this can diminish over their career resulting in the higher-than-average incidence of anxiety, depression, substance misuse and PTSD which continue into retirement (Porter and Lee, 2024). Despite high illness prevalence, there remains a reticence to seek help (Bell and Palmer Conn, 2018., Arjmand et al, 2024). This is multifaceted; according to Bell and Eski (2016) there is a lack of insight, reluctance to be associated with poor mental health based on negative operational experiences of assisting those in distress and widely held mental

health stigma throughout the profession. Therefore, police officers are influenced by their professional duties of assisting mentally unwell civilians and this affects their own help-seeking and/or ability to define their subjective experiences as help warranting.

Another interesting finding by Brewin and colleagues (2022) was that male officers were more likely than female peers to be affected by Post Traumatic Stress Disorder (PTSD) and Complex PTSD (CPTSD). The risks of this were also heightened by regular trauma exposure, being rank of constable and experiences that may be humiliating or shame inducing. Threatened or actual physical harm or verbal abuse did not contribute to men's trauma presentations and the authors speculated this may be due to their acceptance of normalcy.

There are also other police cultural impracticalities contributing to the disconnect between help needing and service engagement and these are presented in the next theme.

2.4.2 Environment and organisational culture

This theme concerns results regarding the policing culture and its role on mental health help-seeking. The police culture itself has been widely researched (Abdollahi, 2002., Loftus, 2010., Van Hulst, 2013., Silvestri, 2017) and is recognised to be a unique and heavily masculinised setting (Loftus, 2010., Bell and Eski, 2016.) This section will discuss how this links to the mental health of officers, and not necessarily in a helpful way.

Police-specific help is available in-house and via peers; many forces use internal trauma support, such as Trauma Risk Incident Management (TRiM) as a peer support option and most have internal occupational support options including psychology, psychiatry and welfare. However, engagement can be avoided or minimised (Watson & Andrews, 2017) or the needs for these services underestimated by officers (Biggam, Power, Macdonald, Carcary, & Moodie, 1997a). Furthermore, officers can be mindful of sharing graphic operational detail outside of their peerage, seek to protect non-operational staff from trauma and distrust professionals unacquainted with policing (Woody, 2005). Therefore, there are calls for the organisation and leadership teams to promote mental health change from the top down (Bullock & Garland, 2018; Cohen, McCormick, & Rich, 2019) as well as from police basic training upwards (Hansson & Markström, 2014).

The police culture, whilst it has some overlap to other emergency services and the armed forces, is unique to other occupations and has been the focus of research over the years (Van Hulst, 2013; Loftus, 2010). In all, researchers portray it as closed, patriarchal and full of hegemonic ideals. However, this has some psychologically protective factors where officers can support each other. Van Hulst (2013) assimilates a range of ethnographical research into the "Canteen Culture" and how these types of environments (locker rooms, police bars) served as safe places for officers to discuss both their stressors and triumphs and speculates that this has negated some previous need for formal psychological support. It appears that there is a correlation between financial constraints and resultant closures or cessation of extra-curricular police activities (social networks, sports, canteens etc) and rising police stress (Turner and Jenkins, 2018).

Another contributing factor is the widespread use of "single crewing", the deployment of unaccompanied police officers. A study of 11,000 officers in the UK revealed that three quarters were either 'often' or 'always' single crewed (Houdmont, Elliott-Davies, Donnelly, & Houdmont, 2018). This study highlights the increased risk of verbal and physical assault on the attending officer, which in turn can be related to psychological burnout. These single crewed officers can spend an entire shift isolated from any peer support or opportunity to informally debrief (discuss) events and often attend calls back-to-back. This can again heighten stress responses and/or diminish previously accessible and effective stress reduction strategies which in conjunction with help-seeking reluctance alludes to a pressure cooker scenario. Emotional exhaustion is deemed high within British Police (Houdmont & Randall, 2016) which reduces officers' self-efficacy when single crewed thus also heightening risk of victimisation towards them (Houdmont et al., 2018). Austerity measures, reduction of available police, single crewing and shift patterns can be linked to poorer health outcomes (Houdmont & Randall, 2016) and subsequent presenteeism or sickness absence thus creating a further subculture and challenge to effective policing.

The routine nature of stressors and potential for mental distress are well documented (Biggam et al. 1997; Brown et al. 1999; Abdollahi 2002). There are also team-specific considerations contributing to this section. Firearms departments for example have a stringently? avoidant view of mental health, due to their additional specialist training and

firearms permit requirements. In the UK, firearms access is typically withdrawn where mental health concerns present for safety reasons. Whilst safeguarding is paramount, many firearms? holders fear the removal of their operational suitability, distancing them from their colleagues and prevailing stigma within the hyper masculinised sub-culture of this department, therefore presenteeism is "huge" and overtime the norm (Turner and Jenkins, 2018 p.4).

Other teams are advocated to have limited occupational 'shelf lives' due to the nature of psychological stressor encountered; Maceachern et al (2011), for example examine the longer-term effects of child abuse investigation. Similarly, Roach, Cartwright, & Sharratt, (2017) report the cognitive and emotional changes encountered by Officers investigating child homicides and how this is a heightened effect over adult homicides. Better practice was seen where Officers had had a six-month gap before reallocation to a child death case as this facilitates reflection and successful stress adaptation (Roach et al, 2017). Although this is likely unfeasible within current policing demands.

In sum, the policing environment has a pivotal influence on officers' wellbeing. There have been recent drivers to change the understanding of mental health and facilitate peer support; however, uptake has still been sporadic. It may be that operational demands (staffing, resources) faced by departments hinder support being accessed. It also is clear that barriers are implicit as well; the dynamics and messages concerning the acceptability of support need to be authentically conveyed throughout and moreover help needs to be delivered in an officer friendly and realistically accessible manner.

2.4.3 Suicide

Suicide within US policing reveals that "12.4% stated they were 'quite' or 'very likely' to attempt suicide someday" despite bespoke services being available (Thoen et al, 2020 p129). This section discusses this further.

This is an interesting phenomenon given that occupational preselection criteria determines that only individuals with the desired level of physical and emotional fitness are recruited (Barron, 2010) so suicidality or vulnerability to this would therefore be expected to be low. That said it is thought to be two to three times higher than the general

population (Dixon, 2021). Similarly, the number of non-fatal attempts are unknown although deliberate self-harm is thought to be higher for Law Enforcement officers in the US relative to other professions (Fielding et al, 2017). This suggests that harm to self is connected to officers' occupational experiences.

Exacerbators to police suicide were discussed further by Dixon (2021). These include coexisting job and relationship pressures, suicide acts being markedly increased and associated with alcohol use, and in men; and hyperarousal symptoms associated with PTSD. Contradictory to the general literature, police suicide was not associated with severe mental illness but more with perceiving unsurmountable problems in multiple domains (Nick, 2015 in Dixon, 2021). Police culture is also enmeshed with the phenomenon; Dixon (2021) states that law enforcement agencies have done little to address the concerns that have been raised over decades of premature police deaths.

Lifestyle and healthier options are also greatly hindered by shift patterns, unexpected overtime and difficulties accessing vital facilities (comfort breaks, food) which led to higher intakes of fast food and resultant health stress (such as on the digestive and urinary tract systems) (Abdollahi, 2002). These health compromises hinder Officers' adherence to their necessary fitness standards and in turn may be a further source of stress (Abdollahi, 2002).

In sum, risks within policing pose a challenge. Whilst their occupation incurs high stress it is not entirely clear why this profession of highly trained problem solvers, who face rigorous pre recruitment screening and are thus deemed low risk upon entry, then undertake professional training to face adversity daily, resort to self-injurious or suicidal behaviour. This is also not adequately explained by the current literature. Some links are however made to their unprecedented stress levels although this alone appears to be an incomplete answer too, as policing is stressful but not every officer self-harms. Little is known of the aetiology of these acts. Abdollahi (2002, p.5) discusses the potential for a "police personality"; one that is driven by conscientiousness, diligence and doing 'right' that is counter effective for stress and whether this in conjunction with operational and organisational factors increase police stress. It is also thought that stress-related risk behaviours are a consequence of habituation to adversity and desensitisation

(Papazoglou and Tuttle 2018). Where services are available, some also feel the support offer may doubted or cautiously considered (Thoen et al, 2020).

2.4.4 Masculine ideals

This theme was developed alongside but separately to the policing culture, although both themes overlap However much of what follows draws on research discussing the police culture's masculinised culture. In this literature review there were only two papers drawing on exclusively male participants: 178 men from USA and nine from Sweden (Wester et al, 2010 and Backteman-Erlanson et al, 2011 respectively). Wester et al (2010) draw on Gender Role Conflict theory to explore any association between stigma and counselling for male officers. They found the anticipated benefits of therapy did not outweigh the anticipated risks; stigma (their own and others), remains too high and engaging with services, shameful.

This “code of silence” is echoed by Backteman-Erlanson et al (2011, p94). Men in this study were found to be highly selective when sharing information, even amongst peers. Double crewed partners were preferred. Drawing on previous successful incident strategies and not attending alone, where possible, assisted any at scene helplessness and later unhelpful rumination when out of uniform which many found helped them ‘mask’ insecurities.

More recently Edwards and Kotera (2021) also report on the masculinised and macho culture prevalent in policing; all five of their participants noting this in interviews. They portray the impact of this as affecting all, including their two female participants. Alcohol was also cited to be an acceptable coping practice by all within policing and talking, although later helpful in their recovery from stress, less permissible and accessible to those requiring of support. Other research supports this continued machoism despite all equality drivers and the need for the “ideal/Heroic male” prevails (Bell & Eski, 2016; Bell & Palmer-Conn, 2018; Soomro & Yanos, 2018; Turner & Jenkins, 2018; Van Hulst, 2013b; Wester et al., 2014)

Aside from physicality there are other masculine ideals at play such as over working and enduring high stress (Cohen et al, 2019). To fit in, these ideals are deployed by men and women alike and tolerate an approach that although is deemed honourable, is unsustainable and open to psychological and physical health fractures. It is clear, from the literature to date, that weakness remains unacceptable within law enforcement and strongly discouraged, not coping is therefore ignored or minimalised at best (Edwards and Kotera, 2021). There are accounts of hypersexualised behaviours, relationship difficulties, alcohol use, competitive sports and aggression as acceptable stress discharge methods (Abdollahi, 2002). There are calls for further research to investigate this intersection of gender and police culture within the field of mental health stigma and help-seeking (Edwards and Kotero, 2021., Soomro & Yanos, 2018) so that concealment is less likely (Bell & Palmer-Conn, 2018).

2.4.5 Language

Discourse is very powerful within the policing environment. Not only does policing have its own language (radio codes, abbreviations etc) and hinges on effective communication to successfully undertake everyday tasks, it is also a powerful (and hegemonic) medium (Oliffe et al, 2016). Story telling is a key construct that facilitates debrief, destressing, team cohesion, assertion of male hierarchies and bravery and team excitement (Van Hulst, 2013; Loftus, 2010; Van Hulst, 2013b).

Mental health however is a more silent topic; being unwell misaligns with being a competent officer and is open to stigma, self-stigma and fears that disclosure will be career limiting (Bell & Palmer-Conn, 2018; Bullock & Garland, 2018; Karaffa & Koch, 2015; Turner & Jenkins, 2018; Wester et al., 2014). Similar to male mental health expression, mental ill-health within the police population is particularly difficult and is accompanied by a particular linguistic description; the term “sick, lame or lazy” (denoting those unable to carry out full duties on health grounds and almost insinuating choice in this) found in literature discussing stigma (Silvestri, 2017). In addition to the “sick, lame or lazy” construct, officers wish to avoid being “one of them”; a term referring to mentally ill people encountered in the line of duty such as those requiring taking into services under Section 136 of the Mental Health Act 1984 (Bullock & Garland, 2018; Royle, Keenan, & Farrell, 2009; Loftus, 2010) which ‘downgrades’ the Officer from a strong resilient presence to one of requiring help (Berg, Hem, Lau, & Ekeberg, 2006).

Police humour is also widely documented and tends to be dark and inappropriate (Holdaway, 1988; Loftus, 2010). On the surface, this 'gallows humour' may appear contentious but it can be invaluable in eliciting emotionally charged material to cope with atrocities (Rowe and Regehr, 2010), Charman, 2013). It also promotes teamwork within and across this emergency service (Bullock & Garland, 2018; Van Hulst, 2013b). Research by Rowe and Regehr (2010) details the multifaceted benefits of humour within blue light services in facilitating the discharge of autonomic nervous system stress, cognitive processing of otherwise traumatic/challenging information, emotional catharsis and eliciting care and support from colleagues. Humour may therefore be for many a protective strategy and a way of engaging with helpful non-clinical support.

Therapy presents a challenge within police mental health help-seeking. Not only does it openly 'admit defeat', but it is also a female construct that conflicts with gender roles and outweighs perceived benefits and risks of engaging in therapy? (Wester, Arndt, Sedivy, & Arndt, 2010). Police officers may not draw on their existing support networks as the nature of their roles can be sensitive and challenging and discussing this can be avoided outside of their policing groups (Kirshman et al, 2015). In fact, male officers tend to withdraw from their networks in times of struggle which causes ongoing inter-relational fractures and problems; "We're together at work but alone at heart" (Turner and Jenkins, 2018 p.8). Material to be discussed may be graphic and/or highly sensitive making the usual social interactions inappropriate settings and limiting avenues of support (Kirshman et al, 2015., Woody, 2005). Previously Officers had access to "safe spaces"; bars, canteens and gyms specific to police, often within the station or closely adjoining (Van Hulst, 2013). These environments facilitated dialogue informally "If you'd been to a horrible job.... you could go up there and chat...it was the best way to get things off your chest" (Turner & Jenkins, 2018 p.7). Talking is advocated in tackling ongoing stigma and normalising the impact policing has emotionally (Bell & Palmer-Conn, 2018; Hesketh & Tehrani, 2018; Soomro & Yanos, 2018; Turner & Jenkins, 2018), yet due to staffing reduction and changes in work practices it is less likely.

2.4.6 Accessibility of mental health support.

Research suggests that a barrier to mental health help- seeking for police officers is the need to remain “professional” at all costs (Berg, Hem, Lau, & Ekeberg, 2006., Edwards and Kotero, 2021). Mental health help-seeking is harder due to the stigma and self-stigma associated with this (Bell et al, 2022). Furthermore, it appears that mental health recognition within the police can be poor and mistaken as an effect of everyday duty “it's what we do” (Bell & Eski, 2016; Biggam, Power, Macdonald, Carcary, & Moodie, 1997b). For some, it is an ‘it won’t (can’t) happen to me’ attitude that serves as an obstacle; many officers acknowledge that others, including colleagues require psychiatric care but can dismiss their own infallibility (Bell & Eski, 2016; Bell & Palmer-Conn, 2018). Accessing professional help is therefore hindered due to a compromised inability to recognise difficulty and /or to adopt a ‘care needing’ position; “all of them (ambulance and fire) … come to us. There’s no one else to save the day. So, we always need to be superheroes if you like” (Turner & Jenkins, 2018 p.6). It appears that even if officers recognised their difficulties, support engagement would be unthinkable due to these cultural and wider societal constructs.

There are logistical barriers too. One of the biggest stressors for police is the lack of staffing (Biggam et al., 1997b) and the resultant impact on the remaining team. Workload and unsocial able/long working hours and shifts compromise the ability to engage with mainstream services. Even if help was to be sought, policing commitments render regular attendance almost impossible (Arjmand et al, 2024).

Adding to this is that cynicism regarding psychological therapies prevail (Bell & Palmer-Conn, 2018; Woody, 2005). This is multifaceted. There is a general distrust of external providers regarding the utility and efficacy of treatment (Bell & Palmer-Conn, 2018; Woody, 2005). There is also reticence and inability to disclose policing material to non-police related services, this can be due to highly sensitive and confidential material and not wanting to ‘burden’ the psychological professional with higher than average traumatic or graphic information (Woody, 2005., Wester et al, 2010). The clinician is also under scrutiny, there is a general distrust and therefore a ‘testing period’ ensues; can this individual cope with this information and are they credibly qualified (Kirschman, Kamena, & Fay, 2015). Internal providers do not fare any better. Much to do with this is occupational transparency and information sharing so for many help-seeking is career limiting (Bell & Eski, 2016; Bell & Palmer-Conn, 2018; Turner & Jenkins, 2018). This help is

not generally confidential but documented within occupational and psychological services (Bell & Eski, 2016; Bell & Palmer-Conn, 2018; Turner & Jenkins, 2018). Many UK forces provide some form of trauma support and/or peer support, this however also relies on officers self-referring, accepting the peer/non confidential level support and working with both party's respective shift patterns.

Recent work in Australia (Arjmand, O'Donnell, Sadler, Nursey, Peck & Varker, 2024) interviewed 13 police officers to explore their experiences of mental health service use and how this can be improved. Cultural competency was yet again highlighted as the biggest barrier to engaging with professionals, with many citing trusted word of mouth recommendations determining of service choice. Also important to these individuals was a sense of agency in their treatment choices and previous evidence of positive treatment outcomes within their peerage.

Furthermore, in some countries, officers attending in house provisions often come in uniform, including firearms which can spark strong reaction from the mental health professional, rupturing any therapeutic alliance and foundation for future work (Kirschman et al., 2015). The need for discreet external services is further supported by Arjmand et al, 2024 and may alleviate this concern. However, according to Woody (2005), psychological professionals need to understand this 'cop mentality' to engage effectively with the individual. Negating or not appreciating the police culture and that person's respective team subculture is akin to enforcing the practitioner's own views on the situation (Woody, 2005) and will greatly hinder any rapport. The officer needs to know that the practitioner can help (Kirshman et al 2015, Woody, 2005) and develop trust in this process. As discussed under "language", discourse shapes socially constructed cultures and mechanisms, this is something also discussed by Woody (2005); police may use often risk orientated or even aggressive discourse to describe events that bring them into therapy. This presentation however is to be worked with and appreciated as part of the population's make-up, way of coping and when in their peer group a strategy that enhances cohesion (Woody, 2005., Kirschman et al 2015).

Kirshman et al (2015) have very comprehensive guidance for prospective police psychologists/practitioners because "Cops are not eager clients. It takes a lot for them to seek help and very little to turn them off. Therapists who make mistakes with cops don't

get second chances" (p. 5). Key qualities include working sensitively but appropriately with affect and avoiding the 'touchy feely stuff', practitioner integrity, resilience and ability to deal with challenging and sensitive material, ability to use and accept humour given its widespread use within law enforcement (as discussed above) "if a cop doesn't kid you, he or she probably doesn't trust you" (Kirshman et al 2015, p.12). According to this literature, professionals working with police officers have adjustments to make to their usual/trained style to accommodate these additional needs and this may not be found in mainstream services.

Therefore, there is an inherent lack of help options deemed accessible; internal services are not neutral or confidential and thus disclosure may have an adverse effect on one's career (Bell and Palmer Conn, 2018) but external services are not police aware or 'safe' (Kirshman et al, 2015, Woody, 2005). Even within the last 12 months, the need for police culturally competent services continues to be highlighted (Arjmand et al, 2024). This shows that despite advancements in the (clinical and academic) field a disconnect between service and officer remains.

2.4.7 Police Wellbeing

During the literature review, which used the term 'mental health' in line with clinical and psychiatric terminology, it became clear that policing practice, and several policing authors, use the term 'wellbeing' instead. Clinically these terms are not synonymous, and wellbeing describes something broader and more generic. This difference highlights the clinical and policing gap even further.

In recognition of this, and the aforementioned sections on discourse and language nuances, the searches were repeated using 'wellbeing' in place of the mental health terms.

This yielded many overlapping papers already discussed, as well as work pertaining to physical health and quality of life enhancing practices. Systematic reviews of psychological wellbeing in policing (Purba & Demou, 2019., Kukucska et al 2023) show comparable concerns regarding culturally appropriate service access, confidentiality concerns and widespread mental health stigma as underpinning delayed help-use or avoidance and echo the previous sections of this chapter. After removing duplicates, 17 international primary studies remained: 8 from the United States, 6 from the UK, 1 from Hong Kong, 1 Canadian and 1 Australian. Of these 10 were quantitative, 3 qualitative, 1 mixed methods and 3 evaluative/conceptual in design.

These papers provide interesting additions regarding specific interventions, support availability and officer experience, with international contributions as well as consistencies on 'wellbeing' highlighting organisational stressors being equivocal health detractors to operational demands and that the credibility of campaigns promoting wellbeing are questioned (Oliver et al, 2022).

Large-scale survey work in the United States revealed that officers do use a range of supports, with employee assistance programmes, chaplaincy, peer support, and debriefings among the most accessed and perceived effective options, although stigma remains a persistent barrier that varies by gender, service length and agency size (Drew & Martin, 2023). Notably male officers often underreport symptoms, delay service use and rate service efficacy more negatively than female officers, likely due to masculinised scripts and expectations, although in their study Drew & Martin (2023) did not further explore this.

Among individual-level interventions, mindfulness is developing an evidence base in policing; a UK multi-force randomised controlled trial found that two app-based mindfulness programmes over 24 weeks improved wellbeing and performance and were cost-effective at the organisational level, offering a link between individual outcomes and force economic value (Fitzhugh et al., 2024). This work follows a separate RCT of an eight-week course undertaken in the US that reported sustained improvements in distress, sleep and a reduced cortisol awakening response at three-month follow-up, suggesting effects extend beyond self-report (Grupe et al., 2021). Earlier work shows that specific facets of mindfulness predict reductions in organisational stress, operational

stress, and anger, which are important for maintaining a healthy day-to-day functioning (Bergman et al., 2016).

Further to this, mental health destigmatisation needs active work at both cultural and skills levels; a path-model study with US police employees showed that help-seeking stigma reduces help-seeking attitudes and intentions, while prior participation in mindfulness training related to lower stigma, implying that skills programmes can shift culture indirectly (Grupe, 2023).

In Hong Kong, the use of "Mental health First Aid" (MHFA – a listening and signposting approach for those experiencing emotional distress) was used force-wide alongside scenarios adapted for policing, digital psychoeducation and visible champions (Chan et al, 2023). The findings reported officers had more favourable perceptions of support and better help-seeking, illustrating how culture can be changed if interventions are population-tailored and accepted (Chan et al, 2023). However, interventions in the workplace, although culturally competent, bring confidentiality concerns; research by Marshall et al, (2021) revealed that serving officers in Australia underreported their symptoms during workplace mental health screening versus the same tools being administered by an independent agency. Of particular note was that officers of lower rank and/or highest PTSD severity were associated with the greatest level of underreporting, suggesting concerns around power dynamics, organisational distrust and leaves those most in need of robust support, hidden. It is possible therefore, that signposting type interventions (MHFA) are more palatable for police personnel because they preserve a provider role and avoid the admission of personal need.

This is echoed by Ricciardelli et al, (2021)'s paper "I'm not sick!....Are you?!" and their explorative work on treatment seeking. Their 'groupthink' presented findings highlight collective negative beliefs around coping expectations, fears of disclosure and shared mental health silencing that extends to an organisational level meaning true recognition and appropriate service delivery is understandably hindered.

Indeed, any support offer that ignores these emotional 'rules' of the job will inevitably struggle, especially where emotions are the very issue. Here in the UK, a diary study of frontline UK officers found that depersonalisation (a term to describe a numbing of experience, feelings and almost dehumanising method of coping) was a widespread

coping function that extended into peer and family life, emotional experience and regulation needing to become understood and acceptable to restore personhood, occupational, social and familial wellbeing (Lennie et al, 2020). Asking officers therefore to engage with emotional wellbeing is asking officers to connect with something actively discouraged or potentially long-term alien and potentially heightened for male officers. Stepping stones to this may be exercise; a cross-sectional study from two British police forces found that physical activity can mediate some of the effects of perceived organisational stressors such as under resourcing, long hours, persistent administrative pressures and emotional distress, anxiety or depression (Oliver et al, 2023).

With regards to wellbeing strategy in England and Wales, the Blue Light Wellbeing Framework and the National Police Wellbeing Service (NPWS), also known as Oscar Kilo[1], provides forces with evidence-based strategies, tools, and resources to support healthy working environments and meet their duty of care. The NPWS annual survey offers a crucial national picture of workforce wellbeing, helping forces understand what's working and areas to improve. They also provide dedicated resources for officers, staff, and their families including practical wellbeing guidance, crisis support routes, and accessible tools designed to help people understand and manage the pressures of policing life. The Blue Light Wellbeing Framework provides forces a way to benchmark their progress and independent reviews of completed frameworks show development and also an enduring disconnect between organisational and individual reporting which reinforces the need for authentic delivery, supervisory capability, and credible change (Phythian et al., 2022; Phythian et al., 2023; Oscar Kilo, 2024). What is needed and what works, is therefore still misaligned and work needed to understand this gap further.

Researchers examining pathways into mental health care found that secondary traumatic stress was the primary driver of officers' past help-seeking, and no single provider type was preferred; officers entered through diverse doors and those who had sought help reported higher social engagement and social pressure to do so, which suggests forces should keep multiple confidential doors open, from EAP (Employment Assistance Programme) and external clinicians to chaplaincy, peer support, and digital tools, and make it straightforward to move between them (Daniel & Treece, 2022; Drew & Martin,

[1] The National Police Wellbeing Service | Oscar Kilo

2023; Crowe et al., 2022). Best practice may be approaches that combine peer and clinician level input (Uhl et al, 2023).

Even with the growth in police wellbeing understanding and promising developments in peer, clinical, and digital support, it is still unclear how male officers make sense of distress and access mental health treatment. The disconnect between what organisations implement and what officers report reveals an evidence gap that needs deeper examination, especially around male officers and the realities of accessing care in this hypermasculine culture.

2.5 Discussion

The quantitative papers within this review used surveys, questionnaires and statistical reports to provide tangible evidence regarding the prevalence, incidence, consequences and patterns of mental ill-health among police officers. However, these approaches are unable to offer deeper perspectives on lived experience. The qualitative studies included in the review generated some rich insights into the police culture itself (Hofer and Savel, 2021, Berg et al, 2006., Backteman-Erlanson, Jacobsson, Oster & Brulin,2010). With regards to mental health services, Arjmand et al (2024) has offered insights into the importance of specialist, confidential and police friendly facilities. Whilst useful, these papers are not of UK focus nor male specific. Nor do they offer thoughts on how these officers overcame these mental health barriers, nor their lived experiences of help-seeking and what contributed to their decisions to reach out.

Furthermore, despite some calls for gender-specific research (Arjmand et al, 2024., Edwards and Kotero, 2021) work pertaining to the specific needs of male officers is rare. The masculinised culture however is well reported and deserving of its own theme in this review, yet there is no research exploring the effects of this on and by those it applies to the most; police men. Whilst policing is proportionally more male and thus, they are represented in published works, it is not clear how the data supplied by their female colleagues may have occluded the findings, nor is it possible to segregate any of the data so to facilitate a secondary review.

There were only two papers (published in 2010 and 2011) that focused on men specifically and exclusively, despite much of the wider evidence highlighting the masculinised culture of this occupation and its potential impact on the workforce's mental wellbeing. It is thought that men are more likely to experience significant barriers to mental health support (Wester et al, 2010) yet no studies have explored this further since. Backteman-Erlansen et al (2011) focused on how 9 Swedish male officers experienced the stressors of caring for traffic victims. This is useful in understanding how these men experience this particular operational demand, especially on their emotional wellbeing and support needs. However, law, policing practice and cultural as well as societal influences differ between nations and this paper focuses on traffic officers only, therefore has little transferability to the UK and wider policing teams or disciplines. Wester et al (2010) considered gender role conflict in the context of counselling for police officers, the outcome being that stigma was such a barrier that anticipated therapeutic benefits could not mediate. This work, which helpful in understanding the depth of stigma in 178 Law Enforcement Officers, with its US origins again may not be transferable to UK officers 14 years later.

Some research is available regarding the gendered experiences in policing and of women's occupational presence and influence (Silvestri 2018). This work does deploy use of pertinent theory; hegemonic masculinities as per Connell (1987., 2006) but Silvestri (2018) does not connect this framework to review men's mental health needs or mental health care. Moreover, work using a hegemonic masculinities lens for men's health has also not extended its applicability to police officers general health, let alone mental health needs.

Much of the knowledge base in this review therefore presents a global disconnect between help needing and help uptake but with data from across the international police population. Policing in the UK is distinctly different; non-routine firearms carrying, national oversight, differing operational fitness requirements, policing by consent (the philosophy of British policing), public perception, legislation and prosecution differences. The needs sequelae to service are therefore not wholly comparable to those serving in other English-speaking countries, or even within the UK when considering Northern Ireland which has further unique cultural qualities and community tensions for example.

For further reliability, advice regarding this search was also sought via a colleague and author of several key UK papers in this specialist area, who now works within this academic field. Their feedback mirrored the experiences and challenges already outlined. Although there has been an increase in publications regarding police mental health, there remains little specific to help-seeking or service engagement of the officers themselves. The papers that have ensued since 2018 predominantly explore knowledge around mental health need and experience, for example pre-2018 the prevalence of occupational trauma was being uncovered, now in 2024 there is more around the contributory and exacerbating factors.

Research in help-seeking has been predominantly quantitative to which further experiential work could provide valuable depth. It is important to explore the experiences of male officers who sought and engaged in mental health treatment as this may offer key insights into how they accessed care, difficulties they experienced and areas of improvement. At present there are no studies that explore this within the UK male police population.

2.5.1 Strengths and limitations

The retention of non-empirical knowledge and discussion papers offered an inclusive approach to appreciate the expertise of others established in the field alongside peer-reviewed research. This review was of English-speaking international focus and therefore not reflect police mental health in non-English speaking countries. However, no other current review appraises global literature of this phenomenon pan-methodologies.

Some recent research has aggregated first responders as a population; as extracting specific data was not possible, these were excluded in the present review to focus on police officers (they were often a minority in these studies) but doing so negates the contribution they may have made.

Furthermore, thematic analysis of established, sometimes repetitive results of mental health service deterrents meant that coding unavoidably drew on the same linguistic descriptors. For example, “stigma” offers few synonyms and describes a particular

phenomenon making themes harder to develop. A strength of this however may be that the contributions of others in the field are more visible, and this review offers a clear aggregation of contemporary works.

2.6 Conclusion

Policing carries psychological occupational hazards that come in different guises (Abdollahi, 2002). Policing populations also harbour more stigma and service uptake reluctance than the general public (Bell and Palmer-Conn 2018., Soomro and Yanos, 2018) despite higher mental health incidence and vulnerability (Bell and Palmer-Conn, 2018., Brewin et al, 2022). Suicidality here is also significantly higher than the general population (Thoen et al, 2020., Dixon, 2021) and often publicised in national and social media. Ironically, they respond to those in psychological crisis to preserve life, yet the same officers struggle to speak out, irrespective of occupational health, force and national, charity-led provisions.

Much research points towards the police culture as a culpable factor in mental health help-seeking. This culture is portrayed as heavily masculinised and closed to outsiders (Bell, Palmer-Conn & Kealey, 2022). Due to prevailing stigma at individual and organisational level, help needing is often associated with an unfit and thus unreliable officer or even one whose work capability or progression is fundamentally undermined or doubted by. Officers therefore face a conundrum; seek help internally and blemish one's career or go private and risk an unvetted, police naïve practitioner, who may be unable to contain the material they bring (Woody, 2005, Wester et al, 2010., Kirschman et al, 2015, Arjmand et al, 2024). Stoicism and presenteeism can thus easily prevail (Bell and Palmer-Conn 2018., Soomro and Yanos, 2018). To avoid identification with illness or being "sick, lame or lazy", other behaviours are implemented or consequential; working harder, presenteeism, alcohol misuse, relationship strain, hypermasculinity and in the most extreme cases suicidality and/or self-harm (Tuttle & Papazoglou, 2018 and Fielding et al, 2017). Still Officers are reticent to seek and engage in professional help despite care availability.

There is much still to uncover in this area; appreciating the psychological risks the roles pose, it is understandable that mental health vulnerability exists. However, the perception

of mental health services or professional support that appears so repelling to officers is yet to be adequately discussed or implemented. The masculinised police culture and its discourses are clearly critical to this and warrant further exploration. With the higher incidence of men within policing and this wide acceptance of their service reticence there are calls for further research into the “intersection of police culture and gender” (Soomro & Yanos, 2018, p9). Utilising recognised male-specific theorem, could be valuable in uncovering how male officers with lived experience overcame these obstacles, what can be learnt and how services can better support them in their time of need.

The present study therefore will extend current knowledge by focusing on hegemonic practices, drawing on hegemonic masculinities' theory within the UK police culture and how these hinder mental health perception and help-seeking. Using a social constructionist approach to appreciate hegemonic masculinity theory, focus will be given to male officers who have attended a formal treatment setting with a view to better understanding these obstacles and how they negotiated them successfully.

Chapter 3 - Methodology

3.1 Introduction

This chapter describes the methodology, research ethics arising from the study, the recruitment process and data analysis methods. The chapter concludes with a brief reflection on the methods process itself before presenting the research findings in chapter 4.

To understand the disconnect between the need for mental health support and service use in the police population, further exploration of the experiences of male officers particularly is required. Therefore, this study aims:

To understand the ways in which hegemonic masculinities within the police culture influence male police officers accessing formal psychological support

- To explore how masculinities within police culture act as a barrier or facilitator to mental health help-seeking.
- To examine how hegemonies within this masculinised culture influence male officers' approach to their own mental and emotional wellbeing.
- To explore police officers' differing views and perspectives of mental health.
- To explore potential ways to improve officers' understanding of mental and emotional health
- To investigate ways of improving police officers' mental health help-seeking.

To do this the research questions for this study are:

1. How do hegemonic masculinities practised within the police culture influence officers' accessing formal psychological support?

2. How can police officers' mental health help-seeking be improved?

3.2 Methodology

For the first half of this section regarding theories of knowledge, I have chosen to interweave personal reflexivity for conceptual coherence. It felt impossible to extricate my epistemological and ontological decision-making from 'me'.

Embarking on a PhD for any researcher is one of personal choice and significant challenge, and therefore, I feel, mirrors a deep desire and dedication to a subject matter of personal interest. My very being as a woman in a study of male psychology, a clinician in the police wellbeing field, a police spouse juggling childcare around active policing and my visceral response to policing challenges and mainstream media means I cannot ever be detached or neutral in this work.

Given that qualitative research can be faulted if not undertaken with rigour (Bryman, 2012), therefore I am systematically and very deliberately situating myself throughout this chapter. In this thesis' chosen methodology of reflexive thematic analysis (Braun and Clarke, 2020), the researcher is not only inextricable from the study, they are a resource. Using this approach therefore requires the researcher to own, with transparency, their part (Braun and Clarke 2020). In aiming for high(er) quality I refer to two points from Braun and Clarke's "A tool for evaluating thematic analysis (TA) manuscripts for publication: Twenty questions to guide assessment of TA research quality" (2020, p345).

- "6. Is the specified type of TA consistently enacted throughout the paper?
- 10. Do the researchers strive to 'own their perspectives' (even if only very briefly), their personal and social standpoint and positioning? (This is especially important when the researchers are engaged in social justice-oriented research and when representing the 'voices' of marginal and vulnerable groups, and groups to which the researcher does not belong.)"

To this, reflexive TA requires acknowledgement from the outset of and consistently throughout the research. I am not drawing on a chosen research paradigm that simply best fits my research question, my thesis comes from a place of experience and desire to bring otherwise hidden, private accounts to a more formal space for the purposes of possible learning and improvement.

The chapter will again conclude with a brief reflection on the methods process itself before presenting the research findings in chapter 4.

3.3 Theories of knowledge: ontological and epistemological foundations

Much research in the field of police mental health relies on a quantitative paradigm. This is helpful in presenting a 'statement of fact' founded on a supporting measure of statistical significance and typically offers an accepted and reliable measure. Empirically, this positivist angle is the "taken for granted norm" (Darleston-Jones, 2007, p.20) within science. This practice is useful for highlighting the 'what' and guiding development and evaluations of interventions (Cruickshank, 2012). However, as Darleston-Jones (2007) also writes, quantitative research lacks a deeper appreciation of phenomenon.

Understanding human behaviour and experience therefore requires eliciting in a different way. Asking explanatory type questions can benefit from qualitative approach (Bryman, 2021). Drawing on the above police help-seeking example, there is a clear ongoing disconnect in service need and uptake where mental health experience warrants further exploration and requires a different epistemological viewpoint.

Utilising a Heideggerian lens, 'being' human is a dynamic experience subject to influence (Johnson, 2000). According to Healey (2012), Heidegger's non-reductionist ontological thinking offers access to sophisticated phenomenon such as health experience, which is similarly not static but changes over 'being and time' (Johnson, 2000). Johnson's (2000) work in understanding patient experience illustrates the detailed, delicate yet profound data depth and researcher-participant interaction possible within this perspective. What is also evident is that human health experience is reflective of subjective and objective (societal, temporal etc) influences. To this, the researcher is also an active participant. If, as Heidegger asserts 'being' (Dasein) is an innate human action (Healey, 2012) then 'being' with an other facilitates dialogue, understanding, and additional knowledge. Again, this is entirely epistemologically congruent; where researcher, research topic, design and wider societal context are effectively blended, ontic depth increases (Olsen, 2009).

The present study eschews positivism for a constructionist lens. Police help-seeking is patterned, indicating that help is accessed depending on illness and service type. Something therefore underlies their choices and/or makes help-seeking for psychological concerns less palatable.

Aligning with key masculinities research (Connell, 2001), the layers of hegemony around 'being' a man vary across time and space. 'Being' in this context describes not necessarily who a man is, but how he draws on a variety of constructs and practices to situate his 'being' in the world and are highly contextual. As identified in the introduction, policing is no exempt from this influence nor not gender neutral (Silvestri, 2017) but indeed an amplification of masculinised 'being' through the requirement for occupational action and competency. A constructionist approach may therefore offer an insight into how role, being, society and health introject.

Social constructionism asserts that meaning is (co)created through language, space and time (Burr, 2015). What it is to 'be' therefore adapts to, and is reflected by, current context. Understanding is via dialogue (interviews commonly) or narrative, word-based accounts. Key tenets of social constructions according to Burr (2015) include a deep appreciation of social and cultural influences not only regarding the surface information but also the connection with change and social action and active exploration of 'taken for granted' knowledge (p2).We have already moved from a time where police mental health needs were less reported/covered or even avoided to one of employee sickness rates of an all-time high, that advocates a 'deeper dive' of contextual and contemporary experience.

In my chosen profession, experience is never static; therapy is an inherently social process of (co)creation and (re)construction of learning, experience and perception. Its ontic core is one of (positive) change over being and time. Past difficult events cannot be undone but through psychological support the relationship with those experiences can become more tolerable. My "Dasein" as a woman, police spouse and practitioner in the field, is therefore unavoidably intertwined and combining all these methodologically offers quality and paradigmatic alignment.

Discourse analysis is frequently used within social constructionist research but is criticised for negating wider (non-lingual) reality (Burr, 2015). Thematic analysis, on the other hand is deemed largely theoretically flexible in its utility (Braun and Clarke, 2006) and appreciates wider factors. According to Braun and Clarke (2020), reflexive thematic analysis (reflexive TA) is very suited to qualitative inquiry rooted in a constructionist paradigm. Given the aims of this research, the latter was chosen for its 'bigger picture' possibilities. Specifically, as reflexive TA (per Braun and Clarke, 2018) accepts the inevitable influences of the researcher considering the sensitivity and private nature of the target population and needs to be transparent and systematic from the outset.

3.4 Hegemonic masculinity theory positionality

Given UK policing is a male dominated hierarchical and security service, hegemonic masculinities theory aligns at a paradigmatic level. Hegemonic masculinities theory, originally by Connell (1987, in Messerschmitt 2019) purports a pluralistic view of what it is to 'be' 'a man' and the powers of man, maleness and masculinities can exercise power over women and subordinated men. It seeks to offer a social psychological framework via which inequalities and differences may be explored and understood. Mental health experiences of male officers cannot be understood without consideration of their profession and its influences. These dynamic aspects of hegemonic masculinities theory and practice reveal a socially constructed reciprocity and in doing so align with the qualitative design and use of reflexive thematically analysed interviews.

3.5 Reflections on methodology

Working within a masculinity's lens in 2025, there is little published formally within policing regarding the needs of men. However, over the last few years the masculinised culture of policing has been subjected to much negative press. The media representations of 'male monsters in uniform' has further tainted the wider societal perception of policing. Whilst recent high-profile cases regarding abhorrent acts undertaken by male officers against women are never to be excused and negative opinion understandable, the disproportionate effect on the remaining male workforce is immeasurable. I have

experienced this first hand professionally, where at the time of Baroness Casey's review (an independent review into the culture of the Metropolitan police) whilst onsite at a station, many firearms officers were reluctant to speak with me and those that did over ensuant months started their stories by assuring me of their non-criminal and non-perverse backgrounds. Furthermore, with my clinical hat, I am concerned these perceptions will further limit male officers seeking support for psychological and emotional difficulties.

This observation also highlights the intricacies and interconnectedness of my professional work and research, and the challenges of their demarcation. The use therefore of reflexive thematic analysis is pertinent and essential in my understanding and owning of this in a disciplined manner. My knowledge of police and police wellbeing is not rudimentary, and suspending any existing knowledge would be impossible, and yet, also potentially helpful for this study. Logistically it offers me access to an otherwise harder to reach population whilst equipping me with an understanding from which this study can scaffold. Reflexive TA can assist here and offers guidance so that subjectivity is not a contaminant but something to be embraced and fully considered within the approach.

3.6 Research Methods

This section discusses the methods this study deployed.

3.6.1 The study setting

The Police Treatment Centre (PTC) provides residential psychological therapy and physiotherapy to serving and veteran police officers who subscribe to the charity. Subscription is minimal (around £2.30 week for serving and £0.70 week for veterans). The charity was established following the dedication and work of Catherine Gurney OBE who was an advocate for police wellbeing, and supporter of police children. Her work commenced in the 1880's, founding the International Christian Police Association and a convalescent home on the south coast. The inspiration for this came after she found a hospital bed for an injured officer, but he took early discharge after being on a ward next to a violent criminal he had previously arrested.

The site in Harrogate was opened in 1897 by Catherine to increase accessibility (The Police Treatment Centres, 2025). There are now three such sites in the U.K. Their aims are to provide intensive, timely treatment and promote the recovery of serving and veteran officers. More recently the charity has extended its support to eligible non-warranted/civilian police staff, police community support officers (PCSO's) and special constables.

The unit has the reputation for being a quality, police aware treatment centre with equipment and approaches to aid police back to recovery. The centre is detached from the patient's employer and treatment is protected and confidential. Usage and referral however are with employer's awareness to facilitate abstraction from duties. The Harrogate centre is a 77-bed unit and traditionally around 75% of these would be physio patients, however over the last number of years those requiring mental health support has substantially grown.

In April 2016, the PTC launched a psychological wellbeing programme (PWP) in line with demand for mild-moderate mental health (anxiety, burnout, depression). Mental health awareness within this population had to then, been less recognised but the same year, Mind started its "Bluelight campaign" highlighting the need for emergency service personnel bespoke support. I joined the PTC in March 2016 and assisted with the development and day to day therapeutic input for the PWP until October 2021. The PTC kindly hosted my research from November 2019 until I left in October 2021.

3.6.2 Participant selection

In their Reflexive Thematic Analysis Reporting Guidelines (RTARG) Braun and Clarke (2024a) ask reflexive TA researchers to avoid the term 'sample' due to positivist connotations, to follow that this section will refer to the selection or number of participants.

This study had broad inclusion criteria: men who had sought professional mental health support from the PTC. To access the PTC, the officer will have had to be referred by their

GP or occupational health provider and therefore forms part of the mental health help-seeking process. For those with mild-moderate symptoms this may be the beginning of their recovery or for those with more enduring presentations be adjunct with another service's care or at the end of a coordinated care pathway. Irrespective of timing, the officers will have had to consult a professional regarding their mental health concerns and been referred for treatment. As I was recruiting from within a treatment provider, gender was the only inclusion/exclusion specification.

Participant numbers can vary widely in qualitative research and should therefore be congruent to the approach design (Bryman, 2012). In reflexive thematic analysis, there is no ideal here, and the notion of saturation or coding completion rejected although Braun and Clarke (2019) do offer guidance to assist methods-related decision-making. They state that in other qualitative approaches, sample size is often gauged by 'saturation' (no new information is being generated, sometimes also termed 'information redundancy'). Whereas in reflexive TA, the fluidity of the data and ways that the themes are generated is not one where a destination is reached, as 'saturation' would imply (Braun and Clarke, 2024a).Instead, decisions on participant numbers ought best to be made through the researchers' situated judgement as part of their active role throughout the entire research process and review of conceptual depth (Braun and Clarke, 2024a). Following this, resulted in a selection of sixteen serving male officers who all had sought help for their mental health and were willing to share their experiences.

Specific demographics were not captured; this population can be hard to reach and very private and the work they do can be sensitive in nature. It was a privilege to have their accounts and maintaining their anonymity therefore key. Whilst the PTC is police-specific, patients are known by names, not rank, district, department or other police related term. It is about treating the officer as they present, and specifics hinged on their disclosure. Participants came from a variety of UK forces, predominately central or northern forces and ranged between 10 and 30 years in service.

3.6.3 Recruitment

Participants were, following referral from the GP or Occupational Health Department, residential at the Police Treatment Centres for the two-week psychological wellbeing programme. In line with the ethics application, they were recruited towards the latter days of their treatment. Recruitment drew on several different intake cohorts over a 13-month period. During a workshop at the beginning of their second week, a brief overview of the study was given and participant information sheet distributed (Appendix B). Interested participants were encouraged to ask questions and return later in the week to book in, so not to assert pressure or expectation. Participants then either approached the nursing team or me directly to arrange a time to talk.

Due to ethical considerations, those on the researcher's therapy caseload were not able to participate to avoid dual relationship with the participant as this offers additional considerations around power dynamics, confidentiality and purpose (The British Psychological Society – BPS 2021). Recognising how both therapy and interviews draw on talking may have made distinctions between the two processes harder to manage- for both parties. Furthermore, preexisting knowledge may have led the interview' s structure and/or blurred information given the active role of the researcher in reflexive thematic data analysis. The asking of pertinent questions regarding treatment provision could have also compromised participants' answers.

3.6.4 Data collection

Data collection was due to commence in early 2020 but was impacted by the global COVID-19 pandemic and resultant lockdowns. This incurred the temporary closure of the Police Treatment Centre. Whilst many healthcare consultations were made available in online formats, this was not possible here. As research shows, confidentiality is a regularly cited concern regarding mental health disclosure (Bell and Palmer-Conn, 2018., Turner and Jenkins 2018). From experience, police officers at the Centre had always expressed how in-person discussions were much preferred over other forms of therapy delivery and this is also supported in a pre-COVID-19 data gathered study by Sefotho and Seema (2020). Whilst this was for research purposes, the subject topic was highly

personal and therefore felt most appropriate in a confidential one to one space. Target population aside, in-person interviews offer a greater interpersonal sensitivity through the ability to read any non-verbal communication (NVC) (Bryman, 2012). This was important for both the researcher and interviewee; the former keen to understand a lived experience in those who typically display little affect but yet who are simultaneously attending to the NVC's of those around them to feel safe. Telephone interviews may have provided the ability to engage in a less visible manner but could have limited the rapport desired for this otherwise hidden population. The ability to interview whilst onsite also removed any further engagement barriers given the unpredictable nature of police work and shifts. This pre-identified importance of face-to-face data collection for this study meant that data collection briefly started in late 2020 but was paused again until late spring 2021 due to a further national lockdown.

Participants were briefed as to the interview's aim and purpose and invited to ask questions. Consent was then discussed, and the consent form signed (see Appendix C). This study used semi-structured, audio-recorded interviews which were transcribed. This structure offers a framework around key questions and also flexibility for new information (Bryman, 2012) The interviews were informed by an interview schedule (Appendix D). The interviews commenced with the same opening questions to elicit information regarding their perceptions of the policing culture and what denotes the 'ideal officer' but then offered some flexibility as to the sequencing and developing conversation. Question six, which enquired about types of illnesses that fulfil the 'sick lame and lazy construct', did not feature in several interviews as it was not conducive to the flow of the dialogue. It also appeared to be surplus to the discussion; mental illness presence was enough irrespective of type.

Most interviews were around 40-55 minutes long, and once concluded, each participant was then thanked and invited to ask any remaining questions. Consent was again clarified in case any participant had concerns following their discussion; no one withdrew at this point. The appointment time allowed discussion of any arising difficulties following their involvement with the research; again, this was not identified in any of the participants. The use of audio recording provided an opportunity to capture the interview but without sight of the interviewee, balancing confidentiality without compromising detail. The researcher kept anonymised notes of any pertinent observations not captured

in the recording (the holding of tears or other expressions during pauses or silent moments for example). The use of video recording may have felt less private or emotionally safe and increased concerns regarding ongoing confidentiality. After each interview, the audio file was uploaded to the university's server (Office 365) and deleted from the Dictaphone. The audio recordings were later transcribed; due to time constraints a Lancaster University approved transcriber was used for 11 of the interviews after signing the relevant confidentiality forms.

3.6.5 Data analysis

Interview data were analysed using reflexive thematic analysis, which through its structure and flexibility permits an engagement with the subject as it is experienced (Braun and Clarke, 2006). Not only is this illustrative of the participant's experience of the research topic, the bidirectionality of reflexive thematic analysis means that the researcher is actively involved in understanding and shaping the findings (Braun and Clarke, 2020) whilst adhering to method and methodological principles.

Thematic analysis offers a six-stepped structure (Braun and Clarke, 2024b). It is however not a rigid stepped process but requires an iterative and extensive engagement with the developing data reviewing not only the semantics but the underlying messages and constructs in line with the research questions and chosen theories. Therefore, transcripts were reviewed alongside the audio not only to familiarise more with the data, but also to note any salient points not evident in the text; intonation, expression of emotion. It was important to understand what each officer had shared verbally but in my role as a clinician within a police treatment setting, I understood the tendencies to underreport, contain emotional material and through this minimise noteworthy information. My role as the researcher meant that I wanted these sixteen men heard and understood so that their experiences may offer something useful and applicable within the field.

The data was viewed through a hegemonic masculinity theory informed lens. Coding entailed highlighting pertinent intra- and inter-transcript points with consideration of the aims and objectives of this study. For this a more traditional, long-hand method was used; coloured pens and/or highlighted sections, a dedicated notebook, an example of a coded transcript is in Appendix D. Computer-assisted qualitative data analysis software

(CAQDAS) was considered but not used due to researcher preference. Notably the authors of thematic analysis describe CAQDAS as “mechanical and less human” (Braun and Clarke 2018) which conflicted with the researcher's project design and ethos.

From the identified 29 codes across the whole data set, some were collapsed or omitted during the recursive reviewing and academic supervision. Knowing when to ‘let things go’ assists in the focusing on the most salient themes (Braun and Clarke, 2021). This resulted in 20 remaining codes from which four themes were generated. These themes, in line with reflexive thematic analysis centre around a central organising concept (Braun and Clarke, 2024). Themes seek to tell a story by providing an interconnected presentation of direct data, participant- researcher interaction and the researcher’s understanding of the subject matter (Braun and Clarke, 2024b), here policing culture and chosen theoretical frameworks.

Braun and Clarke (pg.96 2006) offer “A 15-point checklist of criteria for good thematic analysis process” which was referenced closely for best possible adherence to the approach. Although this checklist predated the development of reflexive thematic analysis, it remains compatible as “The 15-point checklist we developed in 2006 was always intended to support a reflexive approach to TA, even though we didn’t use that label at the time” (Braun & Clarke, 2021, p. 330).

Analysing the data was akin to plaiting participant and researcher contributions with theory. The theme titles therefore needed to reflect participants’ experience, semantic and latent coding, researcher interpretation (of data, dynamics in the interview and policing context), research design and overarching hegemonic masculinities and thematic analysis theories. This step took several (very reflective) months and the findings presented here seek to present the seemingly straightforward, yet sophisticated thematic analysis method.

3.7 Ethical considerations

Ethical approval was granted by the Lancaster University’s Faculty of Health and Medicine Research Ethics Committee and Lancaster University’s guidance on research ethics and Economic and Social Research Council’s framework for research ethics was followed throughout this work.

3.7.1 Recruitment and consent

The Police Treatment Centres is a charity external to all police forces that offers bespoke physio- and psychological therapies to police officers from 23 regional and 4 national police forces and the host setting for this research. Here, in my clinical role, I was active within the psychological wellbeing programme (PWP) and able to meet with officers who had sought support. The PWP intakes comprise risk and presenting needs assessments, undertaken by experienced nursing colleagues, therefore attendees are usually experiencing mild-moderate symptoms and not in crisis or acute ill health, although they may have experienced them previously and had specialist support. The PWP is designed to be an adjunct to mainstream services and a valuable space to recoup, learn wellbeing skills and access therapies cognisant of the policing lifestyle.

Recruitment utilised handouts and verbal information in the second week of the fortnight's intervention with interviews in the latter days of their stay, away from the bulk of any therapeutic input. Officers at this stage of the programme are generally looking at returning home, their next steps and ongoing recovery journeys. They are comfortable within the setting and familiar with the staffing present. Interested participants were able to get further information and an interview time from the nursing team, or with me directly.

At the interview, the purpose and process of the interview was again verbally discussed, and opportunity given to ask questions. Consent forms were signed and copies provided along with information on how to withdraw, raise concerns or contact the university.

As an accredited, experienced clinician working within the additional ethical and professional guidelines of the British Psychological Society (BPS), British Association of Counselling and Psychotherapy (BACP), Interpersonal Psychotherapy UK (IPT UK) and EMDR UK offered an additional layer of consideration to participant and interviewer wellbeing, alongside the British Psychological Society (BPS 2014) and Department of Health (DOH 2005) human participant guidelines.

To this, disclosure of imminent harm to self or others, had this occurred, would have been openly discussed with the participant, appropriately actioned and the recording omitted from the study in line with the ethical permissions of the study. Similarly, had any distress

or further support needs been identified these too would have been safeguarded and signposted appropriately. Clinical supervision would have also ensued to ensure research and clinical adherence to appropriate and best practice.

3.7.2 Confidentiality

Mental ill-health can be an emotive subject and may provoke difficult feelings, memories or experiences for those participating, whether they have first- or second-hand experiences. Similarly, police work by its very nature is often emotive, traumatic, sensitive and confidential. Details pertaining to the participants' work (especially personal or any identifiable data) were not overtly discussed and were anonymised in transcripts. This also meant that some direct citations were not possible as for some participants their specific role, rank or department could have been identified or at least speculated. Aside from the anonymity inherent to ethical research, police officers are typically private and their confidentiality requiring of reassurance. For these same reasons, demographic data was not gathered or reported here; many expressed relief at this, knowing they could speak freely. Since data gathering in 2020/21, public perception of policing has worsened, and internal professional investigations increased making it more critical that police officers feel comfortable partaking in research.

Interviews and their transcripts were stored on the Lancaster University server and dedicated platform, at first stored with numerical identifiers. At analysis and presentation here, I have replaced participants' names with pseudonyms. This is to recognise the human in the uniform; police are known by collar numbers, and this study seeks to understand the impact of their working culture on their mental health. Additionally, the Police Treatment Centres works on first names to delineate care-receiving and the hierarchical occupational structures.

3.8 Reflection on Methods

As someone who is clinically very familiar with police mental health stories, I underestimated the impact the participants' accounts would have. Many of their journeys

were astoundingly raw and I am humbled at their ability to speak so openly with me. The focus in therapy is symptom improvement, and this research interaction was one of data gathering without the ability to offer any relief. This forced me to bear witness in a different way and there have been (and still are) many moments where I feel overwhelmingly privileged to have been granted access to such sensitive and personal disclosures. This deep desire to share their journeys accurately, led me to take longer than expected processing and presenting the findings.

In contrast to quantitative literature on police mental health, (such as days off sick and number of suicides), working qualitatively feels like I have been to see 'behind the policing line'. This methodology permits review and presentation in a way that is distinctly human; derived from face-to-face interaction, constructed and processed long-hand (without technological assistance). Given the themes in the next chapter, this feels entirely congruent and necessary at a visceral level.

My role as a female researcher is also noteworthy. Whilst there is overt evidence in my data that women are generally seen as help providers and emotionally aware, what is striking is each participant's ability to quickly and (brutally) honestly engage in the interview. I surmise that the setting and previous successful professional input may be a contributing factor here. It is also confidential, external to policing and the hegemonies practiced within. This also supports that male officers do and are willing to seek help but only under certain conditions which is interesting to review theoretically.

In line with hegemonic masculinities theory however was the subtlety often present. On initial data review I had almost entirely missed the anger in many interviews. Admittedly this may be part my desensitisation (many officers express dissatisfaction with the workplace) but also my accessing a male population that has an in-group underpinning means I am an outsider. Barrett (200, pg. 84) writes "But with women you have to be a gentleman" and so the anger captured is one that is more polished and presented with decorum. I therefore wonder how the narrative would have been different, had I been a man, or indeed how this is discussed and differently constructed in spaces of shared lived experience.

Chapter 4 - Findings

4.1 Introduction

This chapter outlines the participants and the findings of the interviews. Following the initial 23 codes, four themes were developed. Each theme will be discussed, with accompanying examples, before a wider conclusion is presented.

4.2 Participants

Sixteen officers were interviewed. All had served over10 years and many were later in their careers or even on their second uniformed career. Many spoke of families, fatherhood and significant others.

The interview data revealed a variety of policing roles and role progression. Everyone spoke of uniformed (response) experience and service dedication. Others spoke of specialisms and transferring into (sometimes multiple) other disciplines in line with personal goal, skillset or even circumstance.

There was representation across ranks but in line with the percentages seen in policing, many were from constable or sergeant ranks. From my interactions and interviews I noted a handful of senior officers, two in particular, whose transcripts had to be more heavily anonymised as the detail provided could have left them identifiable. Whilst the PTC operates in a rank neutral way, these accounts referenced information pertaining to key occupational aspects only found in very senior positions. This information is critical to understanding what could otherwise pose as a potential blame culture of those in leadership positions and I am grateful to have their views. It was an honour to be trusted with all these accounts, knowing the potential repercussions had anonymity not been ensured.

This all adds quality to the data as it is reflective of the specialisms and hierarchy of policing. The fact that the whole participant base voiced similar frustrations therefore suggests that the obstacles to help-seeking within this population are not contained to particular teams, ranks, forces or role but appear endemic to the profession.

4.3 Themes

From the 23 codes, four core themes were developed; “The Rise and Fall of Robocop”, “Help-seeking … How you’re under control?”, “Raging against the machine” and “The Human/e solution”. Each will be presented and discussed below, before a short summary of how the themes hang together in a shared story.

4.3.1 The rise… and fall of Robocop[2]

This theme comprises six codes; ‘(hyper and hegemonic) masculinity’, ‘personal examples of great policing’, ‘dedication’, ‘policing; the machine’, ‘language use’ and ‘rock bottom’. The term robocop is taken from a film describing a high performing policing cyborg.

This theme also depicts a shared story; each interviewee describes their journeys from joining the police and notable service moments to their depths of poor mental health and recovery/ing. The rise describes their joining and service achievement. For all of these men, their core values are integral to their career choices and there is deep pride in their vocation and length of service - “it's a calling” (Mick).

These men speak of joining the police due to a “moral compass” (Gary) and innate desire to help; “Police put people first, strong, selfless and resourceful.” (Brian). Many report (often difficult) long careers or even multiple service experience (Fred - “I’ve almost done a full career here after my military one”) which suggests a type of helper persona as interestingly financial gain or (previously coveted) pension was not mentioned anywhere.

All participants report remarkable dedication to policing and public service:

> “You can literally go from locking up…for rape to dealing with… (a victim of) rape to dealing with a cot death. Everyone thinks CID do that, no you’re dealing with the Mum and baby all the time. I’ve been to numerous PM’s [postmortems] for babies. People don’t get that. So, the amount of resilience. You’ll have that then the pub

[2] Robocop is a fictional police-cyborg capable of extensive displays of strength.

> fight where there's ten people fighting, and its generally blokes. Ten blokes fighting and there's only two of you on scene…" (Rick)

> "A massive gas explosion…first on scene… I remember telling (a member of the public) if the house collapses to tell the fire service where we are. We dragged someone out literally as it was collapsing around us…it just progressed I then helped an elderly lady who had like an open fracture of both legs and half her skull missing. She was whisked off to hospital. She survived and then I…." (Nathan)

From this very brief sample so far, there are examples of everyday policing life that echo across every interview. These men are not flawed or weak but thrive on running towards human need. The notion therefore of weakness for these officers seems so far ironic.

Tying this into theory, there are clear connections with masculinised ideals of strength and commitment. These officers are saving lives, putting others before their own safety, wellbeing and striving for excellence.

> "I've gone home after a night shift with a plaster pot on my arm and been back the (next) night" (Fred)

> "…went back in a big bandage with blood on it…aren't I brave…" (Rob)

> "In 16yrs I have been off two weeks and 3 days. 3 days of odds and sods of food poisoning here and there and 2 weeks of viral meningitis" (Thomas)

Sometimes the reasons for needing time off are less visible and treated with less importance. Pete speaks of caring for his wife and taking some time off after her death. His return to work was initially well managed but he speaks of needing to be a dedicated officer for fear of being allocated a lesser role one that "…pretty much what I call deadman's shoes…" (p.2)

To avoid this, he returns to his substantive post which became unsustainable

"...work became so intense, busy and putting everything on me...I had to go off" (p.5)

Organisational support will be discussed later but within this theme, there is a sense of double standards. Physical injury is overtly displayed with honour, emotional wellbeing however is not. Caring responsibilities alongside policing and then losing a long-term life partner is not considered with gravitas or as worthy but Pete's narrative can only be considered as self-sacrificial as the others.

"The fall" describes (not) coping and crashing; as stress understandably takes its toll, several coping strategies are developed. Many of these are contemporaneously situated; the canteen culture was a place to vent, mostly self-governed but became contentious (Loftus, 2009) and were disbanded in conjunction with austerity measures. In line with masculinities theories, these coping strategies were those accessible and acceptable to masculinities practice. The "drinking culture" (Dan) is an acceptable outlet "...use alcohol and affairs to cope" (Jack). Other strategies include "tattoos" (Nathan) "alcohol, sloth and comfort eating.... don't show a chink in your armour..." (Frank) and a widespread acknowledgment of "banter".

"You have a lot of dark humour; bad jokes could get you sacked but that's a coping mechanism" (Keith). This is important given the widespread examples of inappropriate humour and WhatsApp messaging today within police professional conduct. Whilst offensive comments are not to be tolerated, in the absence of accessible coping it appears "humour is a gateway in" (Mick).

Spaces to safely explore, vent and process policing, with the closure of shared areas and restrictions on double crewing have limited what is available as acceptable decompression within this masculinised culture. Coupled with the reduction of collegial support is an organisational shift to key performance indicators (covered more in theme three). This was also highlighted by the majority (14) of officers as feeling mechanical and impersonal and thus coded as 'policing; the machine'

> "You're seen as a resource, a number and expected to do the job, no matter how traumatic, expected to get back on your feet and go out and do it again...it's essentially a machine". (Pete)

Some speak nostalgically of times of discretion, individual decision-making and human care before policing became more outcomes measured. “I loved it, it was very satisfying” (Jack)

Sadly, this capitalises on many adopting the masculinised practices of overachieving and silent coping. The descriptor “Robocop” is found within the interviews; “Robocop style” (Keith) to describe keeping going and unrealistic expectations held by those in the service; even the officers themselves.

Creating a vicious cycle, the threat of appearing weak, loss of reputation or performance is feared and perpetuates overachievement. Many participants speak of a disconnect between how they are struggling but feel unable not to rally on, or even that this is a welcome distraction away from how they are feeling. As Keith reported, “Police Culture is just keeping on. You're seen as a strong person who should be able to take anything.” This is echoed by Pete - “You’re not seen the one to break or suffer in any kind”. Indeed, there is a widespread expectation of infallibility place on the officers "...supposed to be super macho" (Dan).

This is inevitably unsustainable.

> "You fall on your sword...” (Brian)

This quote is illuminating. The language used offers a visceral insight into how this descent is experienced. The term itself is typically used to describe defeat whilst taking full responsibility, resulting in suicide or resignation. Looking at the descriptors of their individual breaking points it is nearly always seen as personal failure. “I always saw myself as a dependable character” Bill notably said in past tense, and Rob’s comment that “it's had a catastrophic effect on my life” suggests an enduring impact.

For many, rock bottom hits suddenly and dramatically.

> “It got to a breaking point where I was going to leave the [work] building from the fourth-floor window.” (Keith)

There are multiple other references to suicidality and self-harm attempts. For others they are incapacitated physically with references to heart attacks, losing the ability to verbalise, amnesia and loss of functioning:

> "I'd go into a trance and my wife had physically have to slap me across the face" (Nathan).

Operational memories also start to bleed into their experiences:

> "I was really struggling, having nightmares, would wake up in a sweat and some very dark thoughts" (Brian)

> "I was out in public but seeing that dead baby… (….) I was walking round the house looking for my police radio coz I could hear it. I was hearing noises, not voices" (Nathan)

From a clinical angle, many are (unsurprisingly) likely experiencing Post Traumatic Stress Disorder (PTSD) and dissociative symptoms which can affect 20% of the policing population at any one time (Brewin et al, 2022).

4.3.2 Help-seeking "How?… you're under control!"

This theme uses a direct quote from Frank and describes the challenges the interviewees had in help-seeking following their "rise and fall…". The theme incorporates the codes 'powerlessness', 'failed attempts', 'rock bottom', 'consequences', 'anger', 'pertinent she' and some overlap with 'control from the organisation/machine'.

The biggest message in this theme, which juxtaposes much of the literature in this field is these men did seek help, multiple times, but were unsuccessful and had to persevere.

Being off work, ill or compromised somehow was ego dystonic to these officers: “I felt so belittled” (Thomas), “I lost my pride” (Rob), “I was ex-communicated" (Bill) and in line with hegemonic masculinities theory (O’Brien, Hunt and Hart (2005) help uptake occurs to regain a higher positioning.

The obstacles to help engagement were multifaceted and culturally embedded. These ranged from non-existent care pathways to punitive measures. The systems and processes within the organisation appear inadequate in many ways, the responsibility being placed on the officers themselves.

> “I went to my inspector and said "look I'm not sleeping at night, I'm worried about my caseload. His response was I can give you some paid overtimes so you can do a bit before/after shift or on your day off… I said I work 6 in 7 and have a young family so I am doing too much already so that is not going to help. His response was I can give you an agile laptop so you can do some bits from home. …Sir, I don't think you're hearing me here" (Thomas)

> "What do you expect, you're going to sudden deaths and people fighting… and if you don't like it there's other departments” (Gary)

Within the interview data there are multiple references to being tasked to refer themselves to occupational health despite the force policy being of line management referral. Many spoke of long waiting lists - “It’s taken 7 months to be seen” (Eric) or even chasing their referrals whilst abroad “I rang occ health from Spain, a year on I still haven’t had the call back” (Keith). For Fred his treatment was delayed by his organisation “…because it didn’t ‘fit’ duties…”.

In a population that delayed help-seeking to start with, treatment delays are extremely unhelpful and further detrimental to their wellbeing and ideology of the organisation:

> “When someone (finally) says I want help, something should be in place. Not a back to work plan”. (Keith)

Sickness absence is “under a cloud” (Eric). The enduring construct commonly expressed in policing and the military, ‘sick, lame or lazy’ is acknowledged by almost every participant from early in their career, "the job allows that label because who wants to get tarred with that brush? I can't think of anyone with a physical injury who has been put in that box... not one" (Rob)

Given mental health-related absence is not perceived as an illness and does not equate to lameness, symptomatic participants are considered lazy.

> “He said ‘Are you telling me you can't cope with your workload?’” (David)

Consequences of ill-health reporting are widespread: many experienced career limitations, being taken ‘offline’ (a phrase mostly used to describe holding specialised duties such as firearms, advanced driving), removed from teams or departments or placed in a demoted perceived position (a civilian role for example) without consideration of actual ability and are often experienced forcibly. This is notable in linguistic descriptors; “sledgehammer to kill a fly” (Fred), “I was ripped away from all security” (Keith), “...under the cosh” (David), “hit with the shitty stick” (Nathan).

Loss of specialism and future options was also frequently reported, “they strip you of what you're worth and to get it back will be really hard” (Brian – note how he reports this as an ongoing struggle through present tense), career records are “blighted” (Rob), micromanagement and several mentions of coveted progressions being no longer viable; “my application never saw the light of day, it was rejected on sighting of the Inspector, you’re not going for that, you’re not having that” (Jack).

In attempts to keep individuals in the workplace or reduce sickness absence some forces have dedicated departments for less operational officers. This clearly does not help those who are already experiencing personal and professional failure “we're in the rubbish bin here” (Frank), “... in the broken biscuit barrel” (Thomas). These accounts indicate feeling discarded, useless and broken; akin to an object and the effects of these departments are astounding

> “I would be shit scared of going in there” (Brian)

To vocalise fear like this contrasts strongly with the heroic policing recounted earlier.

Faced with career ending and reputational consequences, coupled with a masculinised culture and reduced awareness of their psychological 'occupational hazards', it is inevitable that help-seeking is initially avoided. However, what we also see here is help not being available, accessible or appropriate. This includes psychotropic medication; often used by GPs as the first line of treatment.

> "When you bring someone into custody, and they say they got this and that. It's the association. You're booking them in and they're giving their tablets and you're thinking I'm on that...and therefore the same as them. You're blurring the picture between a police officer and a criminal" (Keith)

This process, known as 'othering' in hegemonic masculinities literature (Whitehead and Barrett 2001) describes the process often used to create distance and power between entities. 'Othering' situates an individual as higher/better, in Keith's example, it would be that police officers like (and need) to position themselves as distinctly different from criminals. Taking the same medications however is a sharing of experience and one that creates internal discord. This provides insight into some invisible barriers these officers experience.

"We are judged on a higher standard being in the police" (David)

Further barriers are created within the policing culture as 'othering' those considered 'weak'. Brian, having highlighted operational challenges such as being assaulted, stabbed, assisting burning people and a disembowelled child offers this in a discussion about wellbeing "You'll be alright because you're a big prop forward, good lad like you won't get shit like that". This response clearly requires Brian to consider how he would like to be perceived in the workplace; strong and good (masculinised ideals) or compromised, weak and thus a negative change in his personal and professional identity and positioning.

Two particular accounts stand out in the data as 'failed attempts' to access help and warrant explicit mention here as they illustrate the powerlessness experienced in this

theme. Fred reports having his treatment start rebooked by his superiors, more than once because staffing levels could not facilitate his absence; "...the super(indentent) said.... make a new date... it's too busy then...".

Fred then speaks of trying to circumvent this process with support from his GP but only to find that the treatment yet again is postponed. However, Fred's 'pertinent she' (a code that is explained shortly) comes to his aid "...taking it upon themselves to phone, they were put right on that, good. I think [Nurses name] spoke to them".

Nathan also experiences significant difficulties. Firstly, he reports his welfare contact phone calls were recorded by work, and his superiors disbelieved his illnesses (he was later diagnosed with anxiety, depression and PTSD). Nathan then spoke of one voicemail where his inspector didn't hang up properly and therefore his voicemail recorded an office conversation calling Nathan a liar who was off sick because he wanted an "easy ride". This was deleterious on his mental health "I'm not ashamed to say...that pushed me closer to the edge than I have ever been and as a result I nearly took some drastic action".

A few months later Nathan describes how he was struggling again, and his inspector rang him at home - "we found out you're not feeling good. We need to come to your house right now and see you, ok?" ... "Well I'm ok, I'm talking to you on the phone...it doesn't mean I am going to act on those feelings or try to kill myself, I'm not gonna take any action" ... "we can't take you at your word" "Ok... come to my house, but you won't get in, I'll stand at the door and wave".
"You need to meet us in public then" .... "You can hear I'm fine, I am home with my partner, and she can safeguard me, there are no issues" "You need to go to meet in a public place"
Nathan explains "I'm a bobby...I know the reason they want me out my house is that if I am in a public place they can use certain acts within the Mental Health Act (....) to drag me to the hospital and sit me in a room. I've sat outside those rooms, it would have been, well, absolutely the worst thing."

Having one's treatment dates altered or attempted Section 136 detentions are the ultimate examples of powerlessness. For police officers specifically, loss of personal or professional agency is a serious ramification of mental health help-seeking.

"...its career stopping..." (Rob)

Returning to Fred's reference to a nurse assisting his treatment access and this being coded under 'pertinent she's', thirteen of the men had women involved in their journeys as treatment/support facilitators. This code relates to this shared experience of having a female intervene at key moments in their journey or at times of need. Nathan spoke of his wife in the excerpt above and how her presence and understanding of his care needs safeguarded him from his colleagues attempts to section him. Whilst for many this was either their wife or other close female relative, other pertinent female influences include a female counsellor, and one cites a female colleague, and these women were **vital** to their recovery.

Examples of 'pertinent she' acts include arranging appointments (and accompanying if required), interrupting self-harm or suicide attempts, prompting medication, being early warning relapse detectors, advocating on the men's behalf, practical support and even tackling unhelpful management directly. These women provide significant connections to care providers and/or even the care directly but only tended to become involved after symptoms are established and apparent. Despite these 'pertinent she's' being close connections they do not appear here to offer or advocate prophylactic action but intervene to take control. In some cases, these women have been asked for their ongoing support which illustrates a further hegemonic dynamic about help-seeking ability. Finding these echoed across the data set reveals a hidden home responsibility where the occupational 'duty of care' fails. However, there were some failed attempts too; a couple of officers spoke of approaching a female colleague or supervisor to ill effect. It is therefore possible that the women within the policing culture are subscribing to the same masculinised ideologies as per Kronsell (2006). In any case, the role of women within and around male police help-seeking warrants further exploration.

4.3.3 Raging against the machine

This theme describes the anger felt by every one of these officers who having (over)achieved in public service, experience occupational-related mental ill-health and then are penalised and disempowered on help-seeking, they are disillusioned by their

callings and life sacrifices. This theme comprises the codes; anger, police as enemy, policing as a machine, poor support, powerlessness, playing the game, police as family.

The police service is frequently described by the men as a machine where only full robots can survive. Their attempts to be Robocop have understandably failed, and they are now realising that this was inevitable, yet the shame has already been internalised. These officers are not just annoyed, they are "fucking angry" (Dan) "I was more than pissed off with them" (Fred), thus raging against the machine. The language however is not always as strong, yet the anger clear "It took me to walk out the door…I've had enough" (Pete) "I withdrew when my fuse blew" (Eric). "I was flipping between nearly crying in the van to wanting to get out and punch someone, it wasn't right" (Keith)

Anger is not acceptable in policing and can lead to misconduct procedures. Some were disciplined following outbursts, and some went off sick to avoid this. David however quickly learns an alternative which bucks the masculinities trend.

"I'll cry…because it will either come out in anger or in crying… so the easier for me is the crying way because the anger way…don't get me wrong I don't go for people…but my size and height it can freak people out…"

David notes his stature was "great in uniform…just send the big fella in" but that this (hyper)masculinised ideal is risky in frustrating situations "I got called into the DI's office…I was fuming…instinctively I just started crying. Listen boss, I'm sorry I'm like this because if I'm not I'm going to be turning tables over and throwing things out of the window…(…) I knew I'm either going to go flip ding here or cry…I thought, you know what… just cry, because if I start… (…) I might as well just give my warrant card in and walk out the door anyway".

This example also highlights the powerlessness against the machine and his commitment to his job. Whilst leaving employment abruptly may carry consequences, these men appear to display ongoing dedication to policing; if this were just a job then they may have sought alternatives.

Every participant referenced government changes, a continued move away from (autonomous) decision-making models to a numbers game, hence policing being seen as a 'machine'. This shift to key performance indicators (KPI's) conflicts with their drive to serve. The data is littered with participant frustrations in this, austerity measures, crime recording, government changes and how these create a bullying like pressure that to them not only is professionally detrimental, but it can also have profound personal repercussions. To illustrate this, I will use a detailed example of Jack's:

> "It was the last day of the month…. I only had one fixed penalty ticket in. I was told that if I didn't come back in before the end of the shift that night with an endorsement fixed penalty ticket (..) that I would be the subject of a negative PDP and possibly an action plan for not performing properly. I started stressing… I could get sent to something that would tie me up the full shift and not have the opportunity.
> What happened then, I was on patrol and saw a young lad on a scooter with an L plate on… but he didn't have an L plate on the back. So (…) that's an offence. So I turned around and stopped him, and this was a thoroughly decent lad who is going to college….no way in a million years should he be subject to a fixed penalty ticket. It was totally against my ethos. We were turning members of the public against us, don't forget… we need their help (too)… What's he going to think in years to come? The police, look what they did to me. I was basically forced to give him that ticket because I was literally told on parade that if I didn't have one by the end of shift, I would be subject to a PDP or action plan. This young lad was crying in front of me, it made me feel like dirt, I felt awful. This was a young law-abiding lad, who due to recently passing now with a conviction lost his licence and had to take it all again at cost. It was minor and not worth it (but) I literally had no choice. It was destroying everything I believed the police was about"

Jack's scenario is shared to highlight the effects of this decision-making. Jack's story was very moving; the level of moral conflict and injury was palpable in the room. It raises the question of how many other such (forced) decisions have contributed to the public's poor perception of policing.

This scenario is not unique to Jack. Many others spoke of performance plans hinging on deliverables, underperforming incurring a threat of disciplinary action and fear of losing one's job/home and/or marriage (which again has financial consequences).

> “There was a joke when I worked in CID - You can have a second marriage, but you can't have a second career - we were encouraged to work longer hours" (Frank)

> “It was a case of piling a load of overtime, marriage didn't work out anyway" (David).

However, despite all these measurables, there are many references to these not being of actual use:

> “I’ve just been sent to the tenth child death this year, I’ve got a child of the same age, I needed time away and I asked the sergeant to stop sending me six months ago but he still kept….so if there was some kind of tangible audit trail that people could go and say…then they would not be in the lame and lazy” (Rob)

Interestingly, in Rob’s dialogue is an implicit reference to being ‘sick’ due to these call outs. Not being in the ‘lame and lazy’ tells us that this is how his wish to avoid further child fatalities is perceived at work.

Terms used by the participants to describe support from within the organisation include ‘lip service’, ‘Jekyll and Hyde like’ and ‘window dressing’. Eric describes it as “people don't truly understand mental health… (..)… the organisation talks about wellbeing; we have posters and screen savers” It appears the participants felt that the organisational support available is insufficient and lacks action. The language and tone of the interviews reveals a general distrust. These examples were coded under ‘playing the game’ as it felt that the officers' experiences were that support was disingenuous or to use Mick’s words “arse covering”.

In this machine “people crash cars, people get killed, we're never closed so we never stop taking work. Next Next Next. You go to a horrendous fatal and then deal with another the next day, no processing time. Thats what we signed up for and we can't have a week off in a

big job" (Brian). It's a non-stop world for these men who then get stuck in a perpetuating masculinities cycle of expectation at cultural and organisational level.

> "Policing now is so politically correct; we have lost sight of what was really important. People are frightened to step out of being that one-size fits all generic robot. We can't have our own free thought". (Rob)

Within this correctness comes societal change and need for regular training. David speaks of struggling with the introduction of pronouns and an inability to access his mandatory training on this due to continuous operational deployments. When he is called in, he is faced with the conundrum of how to address his supervisor:

> "Good morning, Sir, how can I help? ... "You just assumed my gender"... and they then make a complaint!"

In a world that hinges on hierarchy and respect David is in a no-win situation, he either risks negating rank (missing off the Sir/Ma'am) or misgendering the individual. I do not wish here to brush over the importance of diversity, equity and inclusion but raise the point on how challenging it is to access the much-needed training to equip individuals when they are being continually turned out to calls. It is also potentially unethical to then raise internal concerns or complaints when officers are unable to keep abreast of important training.

There is a stark contrast between the codes 'Police as family', describing previous strong collegiality, which is 'all but eradicated' (Jack) and talked of fondly by most participants and 'Police as enemy' which not only includes previously highlighted examples of stigma, powerlessness and inability to seek help. It permeates daily life leaving officers increasingly more hyper-vigilant:

> "You don't have the same freedoms...if I worked in Aldi, got drunk and arrested you would probably still have your job. Plus, there's mobile phones, auditors, public, YouTube...we're being watched constantly." (Gary)

> “There's a culture of paranoia in the police; you'll be sat in the office and say, "for the benefit of the tape” ... (...) being constantly scrutinised and recorded.” (David)

To conclude this theme officers, feel unable to fulfil their roles satisfactorily, feel lost, disempowered and disillusioned or as Franks sums up:

> "What the fucking hell are we here for?”

4.3.4 The human/e solution

This final theme describes more of the officers' internal worlds, reflections on their mental health journey and suggested improvements. For this, codes of illness, powerlessness, feminine traits, pertinent she, good examples and suggestions were utilised.

Robotic expectations and machine-like organisations leave little room to be human. Inevitably this high-level performance proves unsustainable, and help-needing ensues. Now the participants can reflect more on their recovery journeys they can share their learnings and recommendations.

To start this theme’s narrative from an impersonal place "you're seen as a resource and a number" (Pete) where the effects of the job left each of them feeling unwell “..I was absolutely shot” (Rick) and this all had “a catastrophic effect on my life” (Rob). Each sought help, mostly unsuccessfully to start with until a ‘pertinent she’ intervened. In the workplace some approached female colleagues unsuccessfully:

> “...women are generally seen as the caring gender and I thought, well if she can’t do it, if she’s not doing it then how are male supervisors going to do it? They’re never going to broach it are they?” (Rob)

Some however of these women did clearly step outside of the culture, offering solutions likely not found in a formal procedure - "My DS, she was the first to give me a hug –she was incredible” (Nathan). Gary also found one line manager integral to his recovery; she had

insisted on double crewing, asked after his GP appointments and how his medication was going. He notes this was not to offer additional medical help but felt supportive not restrictive. What is striking across the data is that these small acts were immensely appreciated. Rob speaks of a colleague who made a point of waving and smiling when they passed in patrol cars "it was just nice...and made me feel a bit better about myself and helped me deal with others".

What the interviews show is that simple humane acts were craved and where present, valued. Current day policing appears fractionated and the loss of connection evident; Rob told me he kept notes: "I wrote... all I want is someone to give me a hug and tell me it is going to be ok". This is echoed by Eric "I needed someone to hold my hand. I needed someone just to do it for me". These disconnects contrast to the police family code where individuals initially felt part of a wider supported group to now feeling ostracised and isolated; Bill "I was excommunicated", "I felt abandoned" (Nathan).

Every participant spoke of compassion and care. Not only with regards their public service delivery but also a desire to see this more informally and in house, between colleagues. In line with Bell and Eski (2016) there is a disconnect between the care provided to the general public in times of distress and that experienced between those within the police service. This says something not about their ability to provide care but their ability to do so within the overarching organisational culture and expectations. However, a few officers did have some 'good examples' to share; clear support procedures, or in the absence of, a manager who took the time to find out. There were mentions of 'safe spaces', often with a colleague where there was no agenda or expectation:

> "I used to have a great boss, a fantastic boss, every shift he would make me a brew and just sit for 10-15 and check in. It was perfect. This style was brilliant, and it defused everything." (Rob)

Shared experience was valuable, if handled correctly. Frank spoke of a high-ranking officer who openly shared his own lived experience and this being a facilitator to help-seeking. However, where 'mental health champions' existed in the workplace this is not always positive: "The email signature said, "I'm a mental health champion" and I thought I

wouldn't come to you if my life depended on it" (Rob) which contrasts with his quote in the paragraph above and raises questions about how support in house is delivered or the quality of existing relationships.

Across all of these men's accounts there is reference to mental health, yet each officer avoids use of specific medicalised terminology. 'Stress', 'breakdown', 'ill', 'blown a gasket' are referenced but not depression, PTSD, burnout or other more formal or medical label. Anti-depressants are commonly 'happy pills' or simply 'meds/tablets/pills'. This raises whether language is an implicit barrier to their help-seeking. Clinically, their ill health journeys, given the pressures and experiences they reported, should not come as a surprise and it raises the question whether this pathologisation is useful or if normalisation could assist better psychological care within policing.

Regarding improving the situation, many officers offered suggestions at individual and operational levels:

> "Be true to yourself, listen to yourself, listen to your body, for goodness sake, put your hand up and say I need help" (Eric)
>
> "We should be celebrating people and putting our arms around them" (Brian)
>
> "Can OH and GP share info? I had to repeat myself twice. [..] hot debrief style of other bluelight services. Be proactive, don't avoid. Talk. .... Attach collar number to jobs better to see wellbeing and saturation" (Gary)
>
> "If the organisation could learn anything - to remind themselves the reason people come to work to do a good job, look after the general public and keep them safe, we come to work to earn a living, go home and be with our loved ones". (Eric)

Help needs to be genuine, with longer term projects that are not just "tick box or promotion" (Frank) and "not glossy posters" (Keith). There are strong widespread echoes that the individual holding the wellbeing responsibility needs to have integrity and impartiality, possibly via a separate (external) provider.

Education was highlighted to further officers' insights into their own wellbeing. Two participants thought that offering an annual/biannual check-in (akin to their fitness tests) could normalise the strains of the roles. However, they also quickly added that this would need to actually happen as within pressures of the service these could lapse. One other officer indicated that his role required a six-monthly psychological screening but that this had never taken place. Waiting times are highlighted as an area of improvement; it was not uncommon for support to be delayed for considerable time frames, such as seven-eight months for therapy, a year for a response to an OH referral or even never hearing anything and needing to re-refer.

It appears from the data that many suggestions were around improving working conditions, sustained change, meeting basic needs and genuine human interaction as summed here:

> "Its results, stats, figures, graphs…I can't help but think we've lost grip on our resource's, making sure they're well, happy, had a break, something to eat, sleeping, not alcohol dependant" (Eric)

> "…just isolated, gotta work remotely out in your car, so you eat in your car, so separate" (Pete)

> "The … [senior officer] … said "we're going to look at how you have your meals, get your breaks and we'll get some healthy stuff in the canteen" …. but we didn't have a canteen anymore?! There were some changes to the vending machine…. so, you file it under B for Bullshit" (Brian)

Brian's last example is one of many highlighting how positive change is identified but not adequately followed through. Integrity is a core value within policing and his narrative an example of how officers can feel disheartened and disbelieving and situate those in seniority as out of touch with reality.

To summarise, "the human/e solution" making positive change for help-seeking and mental health experience in policing, these officers all felt that simple human acts of care, compassion and an ability to better meet their basic human needs (food, rest,

interpersonal connection) would be invaluable. These suggestions contrast with previous mechanical themes and acknowledge that being Robocop like is not sustainable, these men needed space to be human beings in order to return to their roles.

To do this, they had to drop their armour, feel vulnerable and find that drawing on support involved ways that are inherently human. Due to the mechanical policing culture, others 'stuck' within this system were not able to meet them at this humane level. This is not to partition blame because they themselves were likely as stuck in robot mode just as these participants previously were.

4.4 Discussion of presented themes

The officers interviewed joined the police due to a vocational calling and drive to be of public service. They excel in this, citing examples of high-quality policing and bravery.

Over time, and for many in conjunction with a drive for outcomes-focused policing, their ability to function effectively hinges on adopting a 'Robocop' persona and overriding basic human needs. This is encouraged by the mechanical ethos of the police service, the culture promoting success whilst diminishing (or abolishing) their previous (and sometimes contentious) stress outlets.

Each officer becomes more isolated, losing team cohesion, experiencing relationship discord or breakdowns. Procedural drives for efficiency advocate lone working, staying remote and further fractionates their ability to connect as humans. Inability to strive in these circumstances is frowned upon and those beginning to struggle are offered overtime or their capabilities questioned. Eventually they succumb to the pressures and experience this as a fall from grace, internalising the failure.

Help-seeking can be delayed due to reduced insight, stigma, perception and unavailability of support. When it does occur, it is not readily forthcoming or presented in a congruent or accessible way. These men often must repeatedly help seek and their therapeutic journey is multifaceted, understanding the contributory and perpetuating factors of their experiences, through and with support of others. They are then able to see that their experiences were inevitable and some of the basic human requirements required for

wellbeing were neglected or missing. They then feel angry, rejected and failed by a service that promised (and previously delivered) a family feel.

Where simple acts of care and compassion were noted, these are memorable highlights, and the officers are all able to offer thoughts given on how the situation may be improved for others who will likely succumb to the same. Key takeaways include changes at individual and organisational level that are delivered with simplicity, integrity and continuity.

4.5 Reflections

Hearing their respective journeys highlighted how these officers had been far from weak yet feared this perception greatly. As a clinician, I was left wondering how these officers could have ever not become unwell given the layers of extreme adversity and unwavering stressors they had experienced.

Needless to say, data analysis was emotive, the snippets provided here are selected to tell the story not because they are most shocking or raw. For me personally, it was extremely powerful to witness their strengths and depths in the interviews, the visual of these men freely expressing their emotions and difficulties was striking. Given these recorded interviews were not for therapeutic gain or a support session, their depth of engagement with me, a female police familiar researcher is maybe unusual. My gut instinct is that these officers, as helper personas wanted and needed to be heard. Jack concluded his interview with a summary paragraph “I’ve had a good vent!.....that’s my motive for coming in here”. After his account of a traffic stop to not face disciplinary action, he speaks of family life, financial pressures and fearing loss of his home. It feels confessional and one that has weighed on him for many years and I dearly wanted to give him airtime, acknowledging that in the face of such adversity and strict morally conflicting orders that police officers are humans in a uniform. Yet the public blame the human, not the uniform.

Where I have used quotes heavily it is because I feel that their direct words, when taken together with each person's previous quotes offer more meaning and depth than I could.

As a police spouse, I have insight into how the job's working patterns bleed into home-life but having these significant additional pressures and lack of support appear unlike any other. Much is being uncovered about policing families which strikes me threefold; as a researcher holding this data, a clinician that understands how pressures can manifest health wise and as a police family where I can see traits and nuances in my own family due to the policing lifestyle. Being so embroiled has meant this chapter was longer to produce than expected as I had to repeatedly disentangle myself from my roles and empathy with these officers and their families.

The third theme's use of a direct quote also mirrors the lyrics used by the band "Rage against the machine". As I have already outlined, suicidality in these participants' journeys is resultant of being forced into roles or corners (angered, disempowered and worthless). This is an area I personally feel warrants more research.

The solutions offered here are by those with lived experience and the officers were keen to offer options and contribute to a bettering of the situation. this indicates a continued 'service' driven mentality and wish to do-good.

Methodologically developing the themes was an iterative process and required a few different mind maps as per Braun and Clarke's (2020) six steps. This did draw on my knowledge for example, understanding the psychological impact of a threatened S136 detention on your own patch (especially) and coding it as 'powerlessness' and 'rock bottom' conjointly. Then noting that on reflection it feels 'policing as the enemy' both shame and anger inducing for the participant. Or looking for aspects of underreporting or more discreet descriptions to elicit their internal viewpoints, sometimes noting a nonverbal communicator less evident in a transcript. This assisted in understanding their reality and taking the semantics into latent meanings and thus a deeper understanding. These officers also clearly respected my level of shared understanding about their roles as the data is one where they do not explain police process or acronyms and the interviews flow.

Watching some of the men's distress was very humbling, to have an officer be able to show their vulnerability not for relief of symptoms but to contribute to the field of research

was moving (and in line with the literature), for a greater good/positioning. In writing I hope to have struck the required balance of sensitivity to their journeys with grace and dignity as it is clear this was often previously lacking for them.

What was also valuable was that I revisited my data set and analysis after leaving my previous role within a police charity during a break from clinical practice. This helped improve my impartiality as I was able to focus without other contributory police mental health distress. This facilitated a deeper immersion and ability to report from the data set and not my wider experience and expectations.

Chapter 5 - Discussion

The literature described a gap between service need and uptake in this population despite their disproportionate mental health vulnerability when contrasted to civilian males. The aim of this study therefore was to explore mental health help-seeking in male police officers and how their experiences affected engaging in support. This chapter will consider the findings in relation to previous research in this field and how the current study builds on this.

5.1 Introduction

Policing is a risk-based occupation where poor mental health in the workforce is widely documented. However mental health service uptake from police officers is chronically low. This research firstly undertook a literature review of police mental health help-seeking which highlighted six themes associated with this disconnect. Furthermore, policing tends to use 'wellbeing' as an umbrella term rather than more clinician-familiar language, which may be contributing to the officer-clinician gap. Wellbeing language may be softer but equally confusing lived experience and support avenues.

In sum, mental ill-health was experienced widely, but muted due to the surrounding social and police cultures. Service use was hindered with available services being deemed unsafe; breaches in confidentiality, career repercussions, clinician cultural (in)competency being the most cited. The unmet health needs of this population were linked to delayed help-seeking, reduced emotional literacy and increasing suicidality.

However, the review did not identify any studies on the lived experiences of UK male officers with regards to their mental health service choice or engagement. Literature in the UK has identified illness prevalence and contributors within this occupation but research has not yet focussed exclusively on the mental healthcare needs of men. The closest research in male officer help uptake, (Wester et al, 2010) is 15 years old and of US origin, so is neither contemporaneous nor transferable given the differences in policing culture and practices. The present study therefore thematically analysed interviews from 16

serving male officers regarding their journeys with poor mental health and service utilisation to explore this further.

Hegemonic masculinities (HM) theory has been applied to previous research on male mental health service use (Robertson, 2007) but not within the policing population. Work in this area has drawn on qualitative research to appreciate the lived realities of civilian men as constructed hegemonically and socially (Connell, 2001). The present study therefore sought to explore male officers' mental health experiences through a hegemonic masculinities lens and how male officers have circumvented these multiple obstacles to seek and use mental health services. It looks to offer some suggestions on how services may be designed to be more suitable to this population.

This chapter will therefore continue to explore the intersection of policing culture and hegemonic masculinities by reviewing the data through this theory: not only are the experiences of male officers considered using HM, but their HM experiences are then also considered within the workplace and the situational and organisational effects experienced by serving officers within the hegemony of policing. This is to offer further policy and practice suggestions making this work of additional value.

The seven original contributions that ensue will be discussed under separate subheadings, this separation is however for ease of presentation as they are intricately intertwined and although change in one area may incur positive change in another, a non-fractionated understanding and application of these contributions is encouraged. The offerings here reflect these individuals' experiences of, and within, their wider cultural and societal constructs and as per this research's methodological stance are to be appreciated as in flow, with change potential at micro and macro levels. In fact, due to the longevity of ideals at play here and the extent of their effect, the application of this knowledge may require multiple iterative steps that reconstruct ideologies and lived realities of males and masculinities practice in policing.

5.2 Original contributions

As an introduction to the next section, the topics that will be presented discuss the enmeshment of male officers' identities and how this facilitates both service performance

and yet a mental health vulnerability. The inseparable experiences of being a police man inform and perpetuate cultural and wider societal expectations in a bi-directional way that not only impacts the male officer at the epicentre, but those around him are also almost unavoidably implicated due to the power dynamics surrounding male practices. It is important to bear in mind that this is not reflective of who these men are but how society on many levels informs expectations. Nor should this work be read as blame; it merely seeks to highlight a set of processes and factors that warrant (re)consideration.

5.2.1 Policing as a live and embodied experience

Firstly, to understand the accounts of these male officers it is vital to appreciate their world. Cultural competence, or lack of, is seen as a barrier to engaging with professionals (Casas & Kegel, 2023) and whilst this infers a poor understanding of their occupational experiences, the lives of officers are much more complex and enmeshed.

These men spend their working lives in a socially constructed reality that differs from their civilian counterparts. Being a police officer, due to its sworn allegiance to the Crown requires an entire lifestyle commitment. These men do not have the right to strike, be ever fully off duty, or engage in life choices that policing may deem unacceptable; down to hygiene standards, grooming choices, hobbies, interests and interpersonal connections. Rest days can be cancelled, working hours, conditions and location changed without recourse. In being a warranted officer, one is to accept these terms and conditions and blur typical work-life distinctions, which many here did from a service calling perspective. The effects of joining were discussed by several interviewees and the social sacrifices required to sustain and fulfil their professional identities and expectations. Other professions have other considerations, and this is not to place occupations in competition or comparison but to illustrate that policing is a life choice that has its unique place. Upholding the law requires officer to be upstanding societal pillars and as these words already imply be strong and capable of these ideals and expectations. Therefore, this profession is one of inseparable, embodied lived experience. One does not *do* policing; one *is* a police officer.

Furthermore, employment choice and status are key components to male identity (Collinson and Hearn, 2001). Being a male police officer, loss of role (or threat of due to incapacity) could jeopardise their sense of self. This extends to their families who are vicariously signed up to policing, its unpredictable hours, relationship/marital strain and for some this ends in divorce as seen here. When an officer is vetted, this includes their contacts and immediate networks which is why many review their social circles on joining. This therefore requires those closely connected to become 'police standard compliant' or estranged. Very recent research undertaken by Lennie, Sondhi and Abinashi (2024) lays bare the all-encompassing impact of police service on families' from "single parenting" (due to the partner's unpredictable work patterns), social and psychological isolation, discrimination, disconnected lifestyles and even into the intergenerational trauma experienced by police children. Furthering this, the enmeshment of working and life on the officer and officer's family identities which means that help-needing or threat to occupational stance will run deeply, deeper than most other roles. This intricately woven strong sense of identity is multifaceted too; it is an embodiment of male, police and societal codes. Policing offers a double-edged sword; a distinct privilege to serve the community yet the high standards and conditions immense leave male officers under considerable pressure; infallibility therefore is highly incompatible and strikes to the core of their self and personal world.

Whilst comparisons between policing and military service are understandable, this is also not possible. Military families typically live together in bespoke accommodations and can support each other. There also remains a bond within military communities (Eldridge and Fraser, 2019) whereas the interviewees here report this to be no longer. Military deployment is often lengthy and abroad, policing however is daily and often within their local communities. Additionally, public perception of UK policing is markedly lower than the respect shown to our armed forces and where military personnel act in dishonourable ways this is dealt with internally 'behind the wire', not subjected to the same media scrutiny.

This profession therefore is not a choice made lightly or impartially. It is an entirely unique lifestyle with far reaching effects. This is not presented in the current literature; policing is viewed as a doing occupation suggestive of work-life distinction. Given this population

(and its wider family network) are therefore distinctly different, the data presented here must be viewed contextually.

5.2.2 Masculinity; policing's backbone and Achilles heel

Masculinised ideals and practice are widely reported to be unhelpful, negative or even toxic influences within police wellbeing (Edwards and Kotero, 2021., Silvestri, 2017., Backteman-Erlansen et al, 2011 and Wester et al, 2010). The present findings also reveal masculinised practices at play in help-seeking. However, when viewed via a hegemonic lens these practices can be seen as understandable, inevitable and to some degree protective to policing which extends current literature in the area.

According to HMT (Connell, 2001), institutions, including the state, are inherently masculine constructs. This does not mean run by men (although typically these can be male dominated spaces), but masculinised in their structure, policy development and routine. Policing is a similar institutionalised discipline and male heavy; around 68% of the UK workforce are men (Allen & Wong, 2024).

Policing thrives (if not survives) on portraying itself as a service of strength, integrity and honour that never closes. It is itself subject to review, investigation and continual service developments in line with changes in law and legislation. Policing therefore is a governed, dynamic and iterative entity. Considering this theoretically, identifying as a "male police officer" draws on specific gender and occupational social constructions (Burr, 2015) that are non-comparable to other males and other professions. Additionally, it could also be argued that the construct "male police officer" will differ depending on whether viewed by a member of the public or a police insider.

Attempting to appreciate the lived realities of my participants, their data situates policing certainly within the hyper masculinised setting described widely in the literature. Connell (2001) clearly situates gender within social practices reliant on hegemonic ideals, given policing's situation as a hierarchically organised power within and above other societal structures it is incomparable with other male experiences. This is furthered by Barrett (2001); groups create and sustain identity and power. Therefore, being a police officer is

an ensemble of non-civilian practices and ideals. With the lack of research into the configuration of hegemonic masculinities practice within police (especially mental health specific) there is much yet to explore.

Policing draws on practices of masculinities that are usually presented as problematic. Although it is questionable, and not evident in current publications, whether this study's male police officers (and indeed policing more generally) could have ever performed at such high levels if policing was constructed as any less. The social constructs of 'crime fighting', 'public servant' 'serve and protect' appear to be significant attractants to signing up, drive, performance, dedication and valour.

However, these constructs in their dichotomous nature do not readily facilitate the decompression required of such service. Those who require a slower pace, even if fleetingly, are quickly negatively labelled or have their capability questioned. These expectations are held at individual and organisational level; the interviewees spoke of breaching their internal codes; "falling on your sword" (Brian) and then experiencing barriers organisationally; "Our culture does not allow it" (Frank). These findings purport that policing (as doing) *and being* a male police officer creates a perpetuating cycle of masculinised honour and respect. It also suggests this is necessary (if not critical) in maintaining operational and thus organisational strength and not documented elsewhere. The organisation appears to need (and encourage) hyper-masculinity ("send the big lad in"- Brian) and whilst there are more techniques and tech available to officers, many of its processes still require displays of physical and emotional strength to the detriment of the unsupported individual. Masculinities practice in policing is therefore not wholly negative as current literature portrays; it is also its lifeline.

In sum, masculinised ideologies are the backbone to effective policing yet also its Achillies heel.

5.2.3. Illness; an indicator of strength?

Current literature presents mental ill-health in policing as heavily stigmatised and as an appearance of weakness (Bell and Eski, 2017., Bell, Palmer-Conn & Kealey, 2022., Wester

et al, 2010 and Karaffa and Koch, 2015). Disclosure is also feared due to the potential for disempowering occupational consequences (Bullock and Garland, 2018., Bell, Palmer-Conn and Kealey, 2022). This all results in an avoidance of-, or at best a delay in help-seeking (Bell & Palmer-Conn, 2018., Karaffa and Koch, 2015., Wester et al, 2010).

Masculinities theory however may offer an alternative perspective; one that situates these male officers as too strong, for too long. They did seek help, often unsuccessfully and thus repeatedly due to multiple barriers.

Interestingly, none of these officers' accounts suggest they experienced mental ill-health before joining the police and therefore a vulnerability to further mental health difficulties. Their reported drive to join is based on a deep desire to provide a public service. Originally Abdollahi (2002) suggested a policing personality and in the present dataset these traits are ones that facilitate remarkable acts of bravery and dedication, almost to a point of being self-sacrificial. This is inevitably unsustainable and culminates in stress induced levels of depression, PTSD or other psychological experiences. Becoming ill according to findings here therefore appears resultant of being too strong for too long.

This juxtaposes current literature that presents mental health being perceived as a sign of weakness and shrouded in stigma within the policing population (Edwards & Kotero, 2021., Bell & Eski 2016). These widespread mental health stigmas and masculinised ideologies (Edwards & Kotero, 2021., Bell, Palmer-Conn and Kealey, 2022) not only deter individuals' self-identification of mental health, but they also promote a masculinised ideal of overachieving and over-working (Collinson &Hearn, 2001). Although this level of commitment by officers is impressive, portraying it as honourable is only helpful (and possibly necessary) to the delivery of a 24/7 public service.

Trauma potential is a known occupational hazard (Brewin et al, 2022) and stress a commonly known wellbeing antagonist, however the role of police officers' duty perseverance in their ill-health development is unclear. Additionally, this may be a challenge to formalise or research, with wellbeing being a nuanced balance of individual differences. However, what the findings here suggest is some association between the officers' dedication to service and an increased illness vulnerability. The drawing on male ideals such as overperforming, acts of bravery, reduced emotional expression and help-

seeking delay appears connected with their ill-health development and thus could be contextualised as a side effect of their strength. Indeed, the physical injuries reported by these men were sustained through facing direct harm and are cited as more positively accepted, if not honoured as a sign of strength. Time away to recuperate, or the ability to remain in the workplace through adjustment of duties, are reported to be permitted whereas psychological injuries however are not afforded the same respect despite being clearly connected to facing similarly high levels of adversity. Emotional health practices are not only incongruent within masculinities practices, but they also stand in a misunderstood (op)position and therefore the 'sick, lame or lazy' has been perhaps used as an adage. Describing physical ill-health as 'sick' or 'lame' is antiquated and in current times inappropriate and the perception of those with invisible injuries as 'lazy' a wholly unacceptable, yet effective deterrent that subordinates those experiencing symptoms relating to enduring extreme stress, trauma and/or overwhelming pressures. This inequity could be challenged if the individual could be portrayed more as understandably floored, not flawed.

As mental health help-seeking is viewed so negatively, and the acceptable HM practices available to these men are the antithesis to what is needed then, this is detrimental to the individuals and the organisation alike. Current sickness levels are hard to deconstruct but given the reduction in the size of the police workforce, caps on wage increases and the service-driven personalities evident in these findings, it may be that poor mental health levels have increased as those remaining in role have 'stepped up' to cover deficits in their area. The policing environment with its masculinised construct facilitates the officers' desire to 'protect and serve' making it an attractive profession for those with caring, honourable traits. The culture however also creates, through its adherence to masculinised ideals, barriers to emotional flow, stress recovery and support. With changes to organisational deliverables, this culture also became more performance focused and 'machine like'. The only way these officers could contend with these changes was to 'step up' further and adopt a "Robocop" like approach. Due to their perceived positive (and HM congruent) ideologies associated with this character, this was all too easy to do. Becoming more 'superhuman' and doing a 'better job' unfortunately plays on hyper masculinised constructs within this already noted in this diligent population (Barrett, 2001) and exacerbating an already challenging situation.

“Falling on one's sword” (Brian) represents self-blame, and from the wider narratives here, the shame of failing. Counselling is often perceived as socially unacceptable for men in general (Seidler et al, 2018) but heightened in this population; even the perception of a successful therapy outcome cannot counteract the shame surrounding it (Wester et al, 2010). In help-seeking, not only is the officer owning their illness, but they are also outing its existence with another and bowing to a care provider. Keohane & Richardson, (2017 p.161) cite this as a “double jeopardy” however for male police officers this additionally requires a shift in role from helping to help-needing and loss of power which is incompatible with sustaining a hegemonic ideal.

Becoming unwell and needing support therefore is perceived by male officers as a double shaming and this is then perpetuated by negative and visible consequences at work, which incur a further and very public shaming. In these interviewees' accounts, the removal from substantive duties and peer group (or worry of) makes their perceived deficits public knowledge or open to speculation. The use of dedicated departments for non-operational staff is also misaligned; these spaces are highly visible and for these men highly deterring. For five interviewees removal from duties resulted in near catastrophic consequences; Nathan, Keith and Rob made attempts to end their lives citing irreparable loss of self-identity. Brian is seen in a Section 136 Suite and Nathan’s line management seek to section him too. For a police officer, this is “the ultimate” (Nathan) degradation; the use of police powers against an officer. This is mirrored in David’s experience; he elected to start crying as his anger placed him close to arrest on multiple occasions. These actions are a turning of the tables; one's closest colleagues treating you as an aberrant civilian, which in turn can result in losing your job. Given one *is* a police officer, this is not just loss of employment, it is status, life design and public outing of failure. This highlights a triad of shame related barriers; self-shame (the perception of personal failure), other-shame; help needing/disclosure (admission of failure to others) and public shame (absence or visible change in occupational role) that has previously not been so connected and extends current understanding. This is illustrated in diagram 2 and described further.

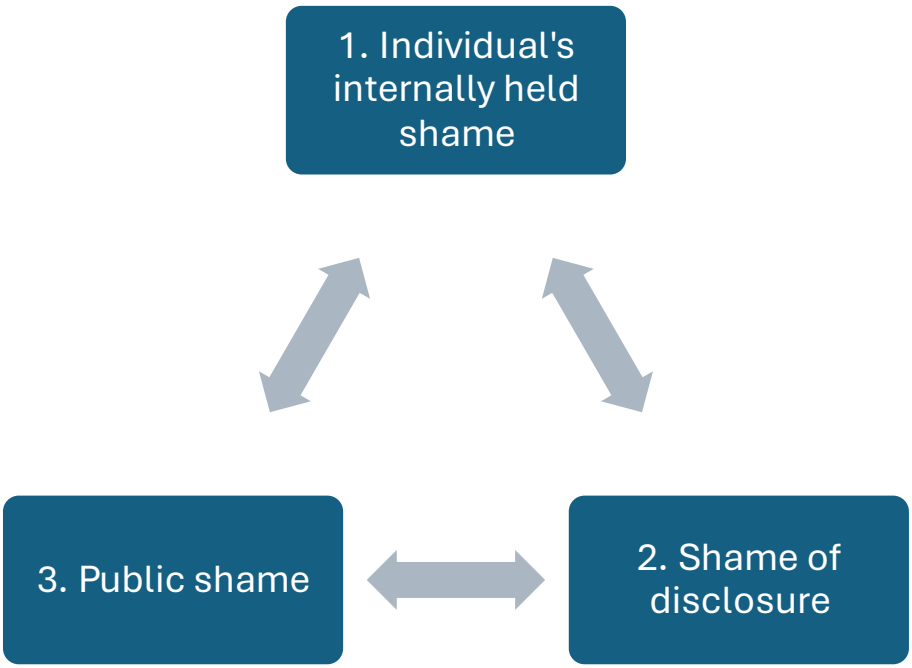

Diagram 2 "The triad of shame barriers to help-seeking"

To describe this process, male officer's enmeshed identities are ones constructed as capable and strong and strongly conflicted by experiencing poor mental health, for the individual this can be experienced as personal failure and self-shame. Where the male officer is unable to remedy this independently (and/or current culturally acceptable coping strategies such as overworking or alcohol use exacerbate this) they face external shame potential through disclosure and help-seeking (the 'double jeopardy' described by Keohane and Richards, 2017). Adding to this are the occupational expectations and requirements which can mean that the help-needing is not kept private or confidential but one where their 'failing' is outed to not only to their immediate community and marked here as the arrow between barrier two and three. This public experience of shame can be experienced potentially wider; multiple services may become involved or there may be family repercussions through role or wage changes. Similarly, life changes may incur further questions from their wider community or social networks. Changes at work level, particularly a removal of privilege reinforce unworthiness back at individual level meaning this is not a one-way process but one where the pendulum can swing between shame and blame, or perception thereof. Likewise, the experience of public shame can be connected to the help-needing disclosure not only for the individual in question but held by others as evidence that mental health disclosure is an unacceptable and risky process and contribute to the stigma found across the policing culture.

Intriguingly, Brewin et al (2022) found a higher male vulnerability to PTSD and CPTSD when compared to women, potentially due delayed help-seeking and/or increased trauma exposure. What they also noted was those incidents involving hostility, violence or aggression were less associated with male officers' trauma load, humiliation alternatively, was cited as traumatic. It would be interesting therefore, to further explore gender and shame within police mental health but what is already emerging highlights a tri-fold barrier to accessing help that is, to date, not otherwise documented. Therefore, services supporting this population will need to consider how this can be ameliorated. The men interviewed here all report getting to a breaking point or rock bottom. Where this coincided with suicidality it is portrayed as in desperation and/or exasperation at the systems and barriers to support; they have accepted self-shame, the shame of reaching out and the potential for career implications but to no avail. This could inevitably incur worthlessness and hopelessness, which are heavily associated with suicidality (Harrison et al, 2022).

What is interesting in this study is that these men repeatedly tried to seek mental health support, despite this myriad of barriers which itself required their ongoing determination and strength. This tenacity opposes the wider held notions of personal weakness or service avoidance otherwise reported.

5.2.4. Social connections/safe places

'Cultural competency' in this context is a term to describe a clinician's familiarity of policing and its officers, the lack of which is a barrier to engagement (Casas and Kegel, 2023). Due to the perceived ramifications, help-seeking is deemed unsafe by officers and to be avoided (Bell, Palmer-Conn and Kealey, 2022., Wester et al, 2010., Edwards and Kotero, 2021). Similarly, Turner and Jenkins (2018) revealed there are no safe places for police personnel to discuss, explore or learn ways to navigate their internal worlds leaving a void.

These officers' accounts referenced an ability to cope whilst they had ongoing connections to each other. However, the removal of social spaces; canteens, pubs,

double crewing impacted on this and is described as missed. Furthermore, as policing and societal constructs altered such as the introduction of pronouns example given by David, performance indicators (Jack, Fred) the remaining shared spaces (riot vans, offices etc) became increasingly unsafe areas to express emotive material or vent. This is particularly unhelpful for men specifically. This disconnect with colleagues however is not just subjectively physical or psychological. There is an objective disconnect in managerial mental health understanding and occupational support process. This extends to referral pathway, performance management, use of spaces and development of departments designed to encourage a return to work. However, for these men these spaces are seen as unsafe and the opposite of what is required. The required cultural competency (Casas and Kegel, 2023) appears therefore to be missing from within the organisation too.

According to masculinities theory, social connections are integral to male mental wellbeing (Oliffe et al, 2017) and their use missing from literature on police mental health. According to Oliffe et al (2017) where (civilian) men carry psychological injury, trauma particularly (both already noted to be prolific in policing) then further isolation or marginalisation increases introspection and mismanagement of ruminative, typically suicidal, cognition. Furthermore, in 2019 Oliffe and colleagues identified further social factors pertaining to poor male mental health. These included estrangement from family (real or internally constructed) and perceiving oneself as a misfit, or burden, in the workplace. Being disconnected therefore amplifies any underlying distress.

This evidence suggests that "normative influences of hegemonic masculinities are implicated in men's suicide" (Oliffe et al, 2017 pg.888). Given policing is hyper-masculinised then it would be reasonable to expect that these normative influences may be connected to the higher suicide rate in policing reported by Dixon (2021).

The sharing of experience within male groups shapes policing culture (Kurtz and Upton, 2017). These spaces, whilst not always positive hegemonic practice facilitators, are accessible outlets for male officers' post-incident (Kurtz and Upton, 2017). Drawing again on gender theory, the authors demonstrate how the sharing of war stories is a permissible masculine practice that enable the sense making of difficult experiences. The removal of these spaces has removed this outlet increasing isolation; an antagonist to male wellbeing (Oliffe et al, 2019). It is not possible to explore the impact of these now-

disbanded spaces on male officer mental health help-seeking, but the accounts provided here cite these spaces as helpful in the containing and venting of policing pressures and the inability to access these heavily connected to their subsequent ill-health episodes. What this adds to the literature is that safe places are not only important for civilian men's health, but they are also critical to male officers' wellbeing, and the removal of previously acceptable practices appear to be significant in increasing poor mental health here. Tying this in with recent US literature, early results from hybrid models that combine peer and clinician support are encouraging (Uhl et al., 2023). They appear to manage clinical severity and risk while still holding the preferred peer aspect. Part of this value lies in correcting the misrecognition of severity that often occurs when distress is framed only through peers or through broader wellbeing language. Hybrid approaches allow officers to feel understood culturally while ensuring that symptoms are recognised for what they are and responded to safely.

The specific pressures on male police officers amplifies the inadequacies of current mental health services in meeting the needs of men (Morison et al, 2014) undermining their effectiveness in terms of cultural competency. They are therefore disconnected from drawing on male accepted practices of supporting each other and they are additionally disconnected from professional services who may not recognise their unique needs as male officers. If services (or support in general) are to be successful in helping these male officers, then they will need to consider the conjoint needs of men *and* their policing identities. Gendered help-seeking may (and can) evolve but at present there is a significant and isolating double disconnect; officer-officer and officer - civilian male. Although some emergent changes in the civilian men's support spaces are encouraging, the differences and nuances for male officers render these positive initiatives inaccessible.

5.2.5. Under- or over-pathologising?

Linguistically, these officers refrained from drawing on mental health-specific descriptors. It is noted in wider literature that police lack emotional literacy and/or experience barriers to mental health due to their operational duties of responding to those

in distress (Casas & Kegel, 2023). When coupled with the processes of 'othering' (Barrett and Whitehead, 2001) it raises the question how mental health help-seeking can be achieved given these men's lived experience differs from what they are seeing professionally. Their antecedent triggers and journeys are different to those they assist with operationally.

In helping the public, officers can see unhelpful outcomes, such as (often unsuccessful) S136 detentions and mental health entwined criminality which here appears to add to a paucity of understanding how to respond to risk, symptom severity and medical professionals. If what they are seeing operationally is "mental health" then it is not surprising that experiencing overwhelm, burn out and nightmares for example is dismissed, underreported or misunderstood.

Furthermore, given the documented organisational response to mental health, actions with career-limiting effects (Bell and Palmer- Conn 2018) then it is understandable that this is experienced as 'punishment' and personal inadequacy and thus again is being mislabelled. Indeed, the present data shows this; every one of these men experienced multiple, performance and workplace measures; gross misconduct investigations, sickness absence-related poor performance management, denial of career progression, "taken offline" (Fred), "ripped from my team" (Keith), "ex-communicated" (Bill), withdrawn training opportunities or put in "dead man's shoes role" (Pete). Additionally, these men speak of witnessing similar around them either visibly through colleagues moving departments; some being known as "broken biscuit barrels" (Thomas) or via "...speculation, rumours.." (Rick) and "Chinese whispers" (Eric).

The words used by the interviewees offer some insight not only into how these are subjectively experienced but also show this may be universal across the workplace, given participants represented officers from multiple forces over many months. These experiences reinforce unhelpful stigmatising rhetoric and displace the need (initially at least) for mental health-based support. Indeed, where symptoms during in-house screenings are underreported (Marshall et al, 2021) and officers in leadership roles most likely to mask their difficulties (Edwards, 2023) there are few culturally aligned examples of stigma-challenging or successful help-seeking actions.

Adding to this is the clear lack of acknowledgement by those in policing regarding psychological "occupational hazards" that are otherwise so widely acknowledged in the clinical literature (Brewin et al, 2022). Indeed, why would one even seek mental health support if the affected officer cannot identify as such? There appears to be a gross distortion here; operational and organisational responses are a clear mismatch between the affected population's ideologies and those of medical professionals.
It may be therefore that their desire for culturally competent practitioners (Casas & Kegel, 2023., Grumley Traynor and Rydon-Grange, 2024) is multifaceted. Not only is it to facilitate easier conversation and exploration of their unique worlds with operational terminology, but it also appears that the psychological practitioner needs to be sensitive to police officers' distorted perception of mental health and how insight may require information sharing and psychoeducation. Words are a critical part of talking therapies but the available discourses regarding police mental health support equate mental health with punishment and not treatment. Those officers that suspect (or are informed of) psychological explanation for their changes delay help-seeking (Edwards and Kotero, 2021) and this was seen in the present study too, possibly due not to the lack of emotional literacy (Casas and Kegel, 2023) but instead due to the disconnect in how mental health is linguistically (and socially) constructed and how it is understood at an individual level by those in this profession.

Interestingly, the present study notes that previously emotional decompression methods have not always necessitated a health professional, many of the participants cite coping with informal layers of support. The interviewees spoke nostalgically of camaraderie, 'banter' and spaces that facilitated dialogue and support. These spaces were experienced in almost a familial like way that dealt with tensions and interpersonal dynamics. Moreover, many cited simple gestures such a taking a supportive coffee break as effective in their mental health management. The previous family/close knit team is reported as a way to talk things through and seek support from others.

This close collegial support appears to have offered protection against previous mental ill-health via an accessible way to express the inevitable distress consequential to their vocation. This in turn suggests that informal connections play an important preventative role in formal psychopathology development and improving male officer wellbeing may not costly or complicated. However, this would need consideration as to the sequencing

and education of this function. These simple acts, are 'wellbeing' conducive, however where clinically significant mental disorders are already in swing, conversations alone (although helpful) may not bring remission so a need for clinical resourcing remains. However, this may be complemented by increasing officers' ability to access their naturally occurring or personally favoured networks as suitable stress management could lessen their chances of a full psychiatric episode. This is seen in civilian spaces, where men connecting is overtly encouraged via national schemes such as Andy's Man Club, Men in Sheds and it is thought to promote male wellbeing. These spaces however are unlikely to be appropriate for police men due to the sensitive and often confidential nature of their work experiences.

Here we have two sides of the pathology coin: understandable (di)stress and serious psychiatric episode. The men interviewed report both in their journeys; an unremitting experience of the former that for most switched into the latter. Many interviewees spoke of only recognising and appreciating these signs retrospectively which questions the effectivity of awareness raising and health promotion in this population. However, were these officers overly cognisant of these psychological risks then this could have hindered their operational performance. It may therefore be helpful to have mental health, given the extremes of policing, (re)constructed on a normalised continuum of expected effects from emotional stress/expression and psychological fatigue to formal disorder potential with accompanying suggestions, indicators and strategies.

5.2.6. Calls for an industrial revolution

Following on from the above contribution, once these men have 'popped' the masculinities infused bubble, they become advocates of help-seeking. Anger is widespread in these men's accounts and directly predominately at the organisation; 'raging at the machine'. The previously internalised shame appears now externalised. Given policing is inherently masculinised, this anger may be at both the employer and unwittingly at the perpetuating hegemonies. This is not in the current police wellbeing literature but discussed within masculinities theory generically.

Messner (2001 p.261) reveals how men can alter their perceptions of unhelpful masculinised constructs "I call it garbage now, and I thought it was garbage then, but I felt compelled to go along with it because I wanted that image".

This suggests that there is a (deep down) understanding of alternatives and that societally created constraints can be reconstructed. The present data shows a strong desire to adopt the 'ideal' male officer identity and an inability to sustain this. These men, therefore, post-intervention similarly voice rejection of these norms and desire to assist future collegial help-seeking. Mindfulness apps have been a helpful stepping stone in this population; previous engagement with these have increased chances of further help-seeking (Fitzhugh et al, 2023) and Smith, Fix and Ferdik (2025) state that multiple service pathways ought to be available for this group. Indeed, Grumley-Traynor and Rydon Grange (2024) note that in policing generically, previous help seeking is a positive predictor for subsequent engagement. Perhaps, in men at least, this hinges on a post-intervention reconstruction of unhelpful ideologies. Policing has evolved and is a dynamic, not static entity. The men interviewed voice anger at its lack of substance ("window dressing and tick box" - Brian) despite a wide recognition of mental ill-health potential in the workplace; "it's on every email banner…" (Fred).

Their anger extends to force internal hegemonies which manifest as moving departments, loss of privileges and specialisms, and a bitterness at the lack of support. Given that organisational (not operational) stressors are the most widely cited contributors to ill health experiences (Abdollahi, 2002., Cohen et al, 2019) there is something about the workplace that is significant in employee wellbeing. It would be interesting to understand any connections with Post Traumatic Embitterment Disorder (PTED) as described by Carter (2021) given this strong sense of organisational injustice reported by these men.

Furthering this point and policing's cultural plasticity potential, addressing heteronormative ideologies and their ensuant barriers to health practices may be fruitful. These participants here see workplace-based mental health drives as lacking substance, not just due to inconsistent messaging but maybe because the options appear disingenuous amongst other messages. Police-wide discourses seen in the interviews such as "The broken biscuit barrel" and "Sick, Lame, Lazy" are stark contrasts and may be creating confusion and cognitive dissonance in this changing world of navigating gender,

police priorities, public perception, professional scrutiny and constant under resourcing. The oppression and lack of accessible option within these men's worlds is strongly disliked and adds to the disconnect between their experiences and expectations of the workplace. This however may not hinge on malice, it is expected that managers and seniors, are similarly entrenched in wider hegemonic practice as can occur in organisations (Collinson & Hearn, 2001).

Continuing these men's failed expectations is a notion that, on joining, policing felt like a family environment. Many cited examples of relational depth and trust, all now but lost, leaving feelings of disappointment and betrayal. This raises more questions around the organisational culture; given this is linguistically constructed (Burr, 2015) could the positioning of policing matter?

If policing is a 'public service', then it would attract 'public servants', who by very descriptor and nature would go over and above to deliver (like these participants). This is how policing was originally designed; the office of constable being traced back to the 12th Century and in this century still described as:

> "The Office of Constable works. It brings with it pride, unity and a commitment to serve. It is about integrity, impartiality, accountability and most importantly, political independence. Above all else it puts the safety and security of the public first." (The Police Federation, 2018 p1).

In contrast, if policing is an 'organisation', meeting deliverables, key performance indicators (KPI's) and agendas it will require 'employees'. This discourse denotes a different population; one that can go home at shift end, one that has a work-life balance and more personal life agency. This would also mean that the organisation would be unable to draw on certain practices or hegemonic ideals. Policing would then become a doing, not a being role with less recourse on employee's health status, off duty actions and in turn male officers may become men that sometimes wear a uniform and are able to balance their wellbeing better. Given policing is a societal hegemonic power, it is unclear how it could operate if its service giving attractants are removed and the role 'downgraded' to being 'just a job'.

Further to this, the College of Policing (p.1 2014) Code of Ethics states:

> "The policing profession has a duty to protect the public and prevent crime. The public expect every person within the profession to fulfil this duty by being fair and impartial and giving a selfless service"

Fulfilling these words, will require displays of self-sacrificial strength and bravery and the overriding of natural physical responses. The contributors to this study therefore became ill through overextension, dedication and adherence to their roles. This presents a mismatch between the servant and the organisation, understandably creating discord and a disconnect in expectation. For the policing machine, this is a definite spanner in the works and the future for men's health in policing could be contingent on a review and clear position statement.

5.2.7. Robocop[3] vs Baymax[4]; the fight for male appropriate services

Typically, according to O'Brien et al (2005) mental health service use by men is essentially a mechanism to regain status (the return to a role or function) after the perceived inadequacy of becoming unwell. What this does not explain is why at interview, these men did not display shame or regret at help-seeking, but they now promote it and are brimming with ideas on how to change a culture they now view as distinctly unhelpful. It may be reflective of this study's population but is however extremely important; in male psychology, hegemonic theorists strongly advocate the need to involve men in service design and delivery (Seidler et al, 2018) due to the "…dynamic triad of help-seeking/giving/taking behaviours that are embedded in the sociocultural context of men's lives" (Keohane and Richardson, 2017 p.160). There is much therefore still to explore for male officers, but some suggestions ensue.

These men's desire to change mental health perception and service uptake may be out of hope or wish to prevent others' suffering or because they have an innate level of care; hence their occupational choice (as per the 'police personality'; Abdollahi, 2002). This suggests that policing may be currently a little misunderstood and misrepresented. It may

[3] Robocop is a fictional police cyborg capable of extensive displays of strength.
[4] Baymax is a Marvel character who despite his superhero status has a softer caregiving side

not be made up of hyper-masculine (verging on toxic) police robots, as media outlets commonly purport, but of men with contextual and multidimensional experiences who feel deeply but are unable (or are not permitted) access to these discourses or display these traits without reprieve. They may appear (and aspire) to be Robocop on the outside, but present study's men are more Baymax on the inside. Although still based on Marvel superhero fiction, this character is perhaps a little more fitting.

To illustrate, Baymax is a caring, cuddly and affable superhero dedicated to the health and safety of others. His suit of armour and wings are for emergency situations, and his typical demeanour is somewhat softer. Baymax however cannot perform indefinitely. When he is tired, or his battery is low his behaviours change; he can act drunk or erratic until rested. The male officers interviewed here express desire to be accepted as they are and for support in forms of simple human gestures and connections. They are asking for hugs, compassion and understanding to be acceptable and available to them. Akin to Baymax, they are asking for permissible rest and that sometimes others will have to steer them to this if they have not seen the warning signs, each reporting the widespread benefits of being allowed the space to recharge themselves.

What this suggests is that police support needs to come from within; both within the male police population but also from within the men; their inherent needs. These are highly functioning, skilled individuals who desire and thrive on being healthy. Current solutions are described by them to be like an outside-in layering on of armour and skills (action, training, overtime, keep fit, dos and don'ts) whereas what helped them most was a reset, space, talking, connection and rest. In terms of masculinities, these helpful aspects may be deemed more 'feminine' (Barratt, 2001) and therefore not on the men's original radars but the current over-focusing on hyper-masculinised coping was also for these participants, ineffective. There is clear rationale from these participants to consider carefully interweaving these positive health practices into daily life; when they could take space previously, engage in shared meals and operational 'war stories' this offered some relief and is sorely missed. Arguably these spaces may have encouraged behaviours that are now socially less acceptable, however they were, and remain, accessible to the masculinities practices of these men. Their removal and lack of alternative has created a void. Given policing operates in an alternate social reality littered with aberrant and abhorrent experiences, it is unsurprising that traditional clinical spaces (that are already

not readily accessed by 'lesser' civilian men for 'lesser' problems) are not suited to their needs.

Connecting policing and HM literature; if for civilian males, services have been long labelled "inherently feminised" (Morison, Trigeorgis & John 2014) and help-seeking is experienced as emasculating (Keohane and Richardson, 2017) then it would follow that this is again amplified for male officers. Indeed, Wester et al (2010) discuss the negative impact of gender role conflicts on male officers' mental health service engagement. This is interesting because O'Brien, Hunt and Hart (2005) report how service uptake proceeded (civilian) men's realisation that support will restore their masculinity. Yet given the entwined, hyper-masculinised identities of 'man' and 'police officer' the need for services conflicts twice over and therefore the delay in help seeking may be due to needing an effect on both identities before reaching out. It could also be that this practice is configured in a police male inaccessible way, again there is little to confirm otherwise.

Amid the already highlighted masculinised barriers and shame triad, these 16 men were dedicated in their help- seeking but in most cases their successful service engagement was facilitated by a woman. Typically, this was steered by a female in their network, this pattern is also not documented in current policing research but is in civilian help seeking literature (Galdas, Cheater and Marshall, 2005) and explained through men's perceptions that women have help needing and emotional discourses available to them and therefore understand the process of accessing health care. The role of women around male officers could be a further future focus but also how and if women in policing experience similar illness and treatment trajectories.

5.2.8 Cross-cultural considerations

Across emergency and other first responder literature, similar barriers to mental health support are reported (Haugen et al, 2017) and it has become increasingly common for emergency professions to be aggregated in research around psychological wellbeing given their operational overlaps.

Here, findings also highlight the role of culture, team norms as influential in support engagement with echoes of cultural competency and confidentiality concerns (Auth et al, 2022). Whilst in these works, male gender is also not specifically reviewed, it may be that

the findings of this doctoral research offer some insights for males in other uniformed roles given the comparable working patterns and strong masculine ethos.

Direct transferability is to be considered cautiously given the nuances of each security and first responder function, but the understanding of mental health gendered patterning may offer a helpful start to those exploring it deeper within specific sectors.

Nevertheless, programmes that make confidentiality explicit and consider peer routes to bridge into clinician support may also show greater acceptability and clearer pathways into care in these settings (Fallon et al, 2023).

5.3 Summary

Whilst previous research has explored police officers' mental health help-seeking, it has not explored men's experiences, despite recognition of the masculinised culture. Viewing mental health help-seeking via a hegemonic masculinities theoretical lens reveals depth and knowledge that may better explain the lived experiences, barriers and conduits to accessing mental health support. The current study has hereby identified several patterns such as repeated help-seeking, the overcoming of multiple layers of shame, anger at cultural messaging and the need for consistent and uncomplicated care which are not explainable by either police or masculinities research forming the originality of its research.

There are multiple implications and suggestions that will be presented in the next sessions. In any case, given established advice in the field that men should be at the centre of service redesign (Lefkowitz, Richardson and Robertson 2017) and calls for male-orientated health care provisions (Seidler et al, 2018) the findings of this study could be imperative to creating, co-and re-constructing gender-sensitive police-friendly psychological support. These services will need to appreciate the fullness of male policing life to be considered culturally competent.

5.4 Strengths and Limitations

Strengths of this work include direct access to serving police officers within a bespoke police treatment centre; a setting widely accepted by police officers and not via the workplace. This removed concerns regarding 'speaking out' and enhanced confidentiality. The use of interviews enables a closer and more detailed examination of male officers' experience currently not found in this subject area.

The researcher's multi-faceted experience of policing (clinical, academic and relational) also facilitated a strong understanding and foundation from which to conduct this work and is openly recognised in a manner congruent with the chosen methodology. Her female sex may have also assisted in the discussion of this information in a hegemonic conducive way. Differences in data had this been elicited via a male researcher are however unknown.

The study was limited in its inability to discuss the lived experience of diverse populations; whilst the gathering of demographic information was limited to enhance confidentiality (and thus increase access to participants) it cannot report how experiences were shaped by ethnicity, sexual orientation, marital status or age.

5.5 Implications and recommendations for policy and practice

This study highlights how male officers experience their working identities within their mental health journeys and the need for a male officer-sensitive health care approach. Implications and recommendations are outlined here and will require a delicate balance to empower, support and steer change. However, these suggestions should not be taken in isolation as widespread change is needed. There are multiple fractures in relationships too, male officers feel disparaged and unsafe, yet many maintain their passions for policing. Systemic change and the rebuilding of trust or some level of workplace psychological safety is critical. Overarching masculine ideologies are unlikely to change quickly and it can be argued that if male police officers are to be effective in this milieu some otherwise problematic practices need to continue as they can empower and enable the enactment of effective policing.

5.5.1 Health messaging and education

Current workplace health campaigns appear to be unpalatable and/or inaccessible to this population and health care within the workplace occluded by overarching operational and HR processes and power dynamics. Needing treatment is experienced with expectation of punitive measures within the workplace and external services deemed unsafe due to their lack of familiarity with policing; work is needed therefore to bridge this gap through awareness raising and/or impartial specialist services. Where male officers are experiencing poor mental health in the workplace and adjustments to role are indicated then current processes require review.

Health education and messaging occurs and despite its criticality, officers may have become desensitised to its omnipresence. Changes here could consider the frequency and delivery of the material, although internal promotion processes and other awareness raising campaigns offer a valuable opportunity to bring in positive actions, mental health appears to have been used extensively but not in an applied or sustainable way which has left officers questioning the value and integrity of the messaging. Officers appear to have responded better to authentic, transferable and relatable examples and where wellbeing support is offered with consistency and clarity.

It may be helpful to normalise mental health practices; some effects of the job may incur normal human responses. The expression of these is natural and may even be helpful and adaptive. Policing requires officers to defer their emotional needs and remain professional. Similarly, being overly fearful of occupationally derived mental ill-health could be counterproductive to the profession and therefore accurate messaging is needed; one in five are thought to have trauma symptoms (Brewin et al, 2022) therefore four in five may not and what to do if this is a concern. Help seeking could be improved through this transparency, acceptance and above all framing health care access as acceptable and inherent to staying (or regaining) health.

5.5.2 Employers' responsibilities

From an employment perspective, it may be helpful for police employers to understand if it is a service or an organisation and position itself accordingly as there appear to be clear disconnects in expectations. Linguistically 'service' infers mission, assistance, public servant status and acts of duty and self-lessness which in turn set an expectation of receiving duty of care, collegial support and familial (ingroup) cohesion. On the other hand, 'organisation' infers an employed status, being a number, a typical job, with generic employment terms and conditions (some of which are not applicable in this occupation) and would set a different expectation regarding the organisational response to needing support. The officers in this study were clearly angered and disappointed when the support they expected did not materialise.

If policing has evolved from its service feel, then messages of familial support, hyper-masculinised drivers and putting others first may be outdated and the "Office of Constable" no longer fully reflective of modern policing. This may have significant repercussions for workforce recruitment and retention.

One way to balance this may be to consider accurate expectations of the role and underpinning support mechanisms to capture the inevitable strains of the job. Policing's Code of Ethics (College of Policing, 2014) could expand its "Fitness for work" professional standards with clearer guidance around sustaining good health in a proactive manner. This section currently prohibits the use of alcohol on duty, and all drug misuse and advises engagement with health professionals if off work sick or unwell. It however could include psychological wellbeing in a 'fitness to practice' manner comparable with clinician's guidance such as that of the Health and Care Professions Council (HCPC, 2023). This could legitimise positive health care practices and provide a clearer structure. This study's participants appear to have followed the Policing Code of Ethics section 8.2 - "If you believe you are unfit to undertake your role or you are somehow impaired for duty, you must immediately declare this to your line manager, Human Resources department or other relevant person." (College of Policing, 2014 p12). But declaring it alone did not trigger an appropriate response for the male officers in this study; the word 'declare' alone suggests an ensuant active response from the force. Building in a function recognising the importance for emotional health and successful care delivery could help, especially if underpinned by clear compassionate organisational processes to assist those responding to this declaration.

However, any terminology and linguistic descriptors used in these areas along with any new guidance will need careful consideration. As this study shows, language is nuanced and makes a big difference, those words used and perceived as mental health deterrents (sick, lame or lazy/broken biscuit barrel etc) to how male officers describe their own mental health are significant. This will need additional appreciation so that the material is designed in a meaningful and accessible manner.

It may be helpful to consider the current response to mental ill-health, especially in the use of adjusted duties or so that the affected officer feels they can sustain some value and dignity. Similarly remaining within a familiar support network or team may offer support. This will require a sensitive balance; forces have a layered duty of care to execute and understandably may need to remove someone from their substantive post to protect all involved. However overarching ideologies and dynamics are significant contributors to the (often intense) shame experienced currently by male officers and further complicated by any expected negative cognitive distortions present within their symptomology.

This study reflects participants from multiple forces; there were variances in force practices suggesting a post-code lottery of responses. Work may already be underway in some of these areas but the value of sharing effective working practices is clear.

5.5.3 Health care providers

For those providing mental health care to male police officers, awareness of their unique and complex aetiology is paramount. Their presentations, engagement and treatment trajectories may require an alternate formulation to their civilian counterparts. This study highlights the importance of accessibility and timely response; repeatedly asking for help left many of these men disillusioned and questioning of services. In many cases this resulted in an escalation of clinical risk and a more urgent response; typically, the very ones most feared by male officers, which reinforces the unhelpful stigmatising rhetoric.

Resourcing across policing, including within occupational health, is limited, and in some cases being further reduced. This makes it more important than ever to consider the care pathway and how these provisions may be best allocated. Long waiting lists however are incompatible with those male officers who delay reaching out, under-report, or under-recognise their mental ill-health. Service providers therefore need to be cognisant of these patterns and seek to offer assessments and treatment accordingly. Early intervention or the ability to engage in regular informal support in an appropriate way could also be considered and care given regarding available 'champions' to ensure any troublesome interpersonal dynamics can be limited.

Within the NHS, long waiting lists prevail and officers who seek help here are similarly likely to experience support delays. If there is potential to consider a process of expediting police personnel akin to the process for military veterans, then that may be a step forward. This may also require some information or training on the policing population's specific needs and the potential for adjustments in treatment offer; flexible appointments around shifts and policies around non-attendance to reflect the unpredictability of policing for example. However, NHS resources are similarly diminishing and therefore multi-agency collaboration and/or the outsourcing to appropriate police familiar service could also be considered.

Above all, mental health support specific to police men's needs may benefit from some specialist review. In the civilian sector the approach to male mental health appears to be moving in a positive direction through male accepted mental health awareness campaigns and specialist support groups (such as Andy's Man Club for example) and so there may be some transferability here. However, it may be unrealistic to expect male officers' engagement in these existing informal or community provisions due to the clear differences in their work and the need for psychological safety. This however is mutual; officers may need to speak openly and without alarming those unfamiliar with their jobs so to not compromise policing sensitivities or vicariously traumatise. Physical safety of officers is also not to be dismissed given current high assault rates and poor public relations. Male officer safe spaces are incredibly rare, if not obsolete which ignores the value of peer support and social connections otherwise acknowledged for civilian males.

5.5.4 Male officers

Mental health stigma is so engrained that beneficial and sustainable change can only occur if implemented across all relevant areas. Thus, there may be change requirements for male officers, but this is the last point purposely so to redirect the onus from 'failing male' to one situated in a much larger picture.

Open dialogue and the sharing of lived experience is invaluable and to be encouraged, but 'banter' can be contentious and misaligned so needs approaching with care. Wellbeing initiatives may feel perfunctory, so it would be helpful to have male officers' input and expertise shared in the collaborative shaping of services fitting for male officers, this includes speaking up for positive change and offering constructive feedback. Where officers may not feel able to share this openly due to difficult workplace dynamics then independent services or feedback mechanisms could be considered. Peer support, where offered, needs to be driven by officers already respected in this field and not necessarily chosen at random or by those unfamiliar with the team.

If male officers could feel that emotional health challenges were not perceived as malingering or inadequacy and were also able to discuss emotional regulation more openly then this would in turn challenge the status quo. An understanding that wider ideologies as contributors may re-situate some widely held beliefs and yet male officers will need to be open to the rebuilding of trust and iterative change. Better help provisions can be created but require a collaborative call to action.

5.6 Further research

It would be important to understand how acceptable talking spaces could help UK officers. Particularly whether some of the current contentious use of social media outlets (WhatsApp for example) is being driven by the lack of healthier alternatives and whether culturally aware social equivalents of "Andy's man club" or similar initiatives could help this population.

Further work around the psychological effects of help-seeking and its connections with shame, CPTSD and PTED could also be valuable. Equally the occurrence of suicidal ideation and exploration of how this may have connections to shame or power-based experiences could prove useful.

This study does not represent those who tried to seek help but didn't persevere or those who are not even attempting to and research here would be important, similarly consideration of earlier intervention options is also warranted.

A deeper exploration of how the policing identity is embodied and changes in, or loss of career, whether planned or unplanned is suggested, along with how the wider family network navigate this transition.

Chapter 6 - Conclusions

6.1 Conclusion

This study's aims and objectives were to understand the ways in which hegemonic masculinities within the police culture influence male police officers accessing formal psychological support. Using a qualitative approach to interview experts by experience, I was able to explore this in detail and at a level not reflected in the current literature. The findings reveal that masculinised practices prevail within policing to the benefit of service delivery but at a price for police men. The hegemonic ideals internal and external to the profession incur multidimensional effects on the practices of individual men, the male collective and the wider organisation. In response to, and conjoint with, these ideologies there can be logistical barriers to mental health help-seeking; health services and professionals although well-meaning, can be disconnected or unreachable without changes to hegemonic positioning, occupational role, duty or team.

Policing as a function requires supremacy; fitness, dedication and honour to serve and protect. It is therefore understandable that these male officers are required to embody their roles on and off duty and in doing so readily subscribe to a range of hyper-masculinised practices. This unavoidable enmeshment of role and self however hinders the distinction between man and police officer and results in a lifestyle change. However most do not join for economic reasons but a desire to serve; this is also a hegemonic conduit; protecting the vulnerable in service of a greater good and power. Workplace changes, particularly those negatively perceived, are therefore inevitably experienced at a personal level; being employed hinges on being capable. Occupational adjustments are therefore taken at a subordinating personal level as well as a livelihood threat. With these far-reaching effects, mental health identification is naturally avoided or at best minimised, yet the occupation poses high vulnerability to psychological stressors. This results in a mismatch; mental health experience is presented and experienced as a failing man and not as an occupational hazard.

For these men, previous management of mental health drew on masculinities congruent practices such as shared spaces, team sports and socialising but austerity measures and social unacceptance has resulted in their removal. Conversely, shared spaces and peer

support are widely promoted for civilian men and seen as protective of mental health. Hegemonic ideals, coupled with occupational sensitivities, however, render these spaces inaccessible. Therefore, male offers are expected to perform without appropriate decompression and stress-induced-ill health almost inevitable.

This study has also presented opportunities to improve the situation. The lived experience of these tenacious help-seeking male officers reveals a subsequent rejection or at least an adjustment of their hegemonic masculinities held ideals. They advocate a non-pathologising and empowering approach where basic human needs are respected, encouraged and yet protected within police culture familiar systems. They knew at an almost instinctual level what they needed, but occupational principles and practices restricted this and to a detrimental effect. Whilst police cultural ideals, and socially acceptable behaviours have evolved and deconstructed previous stress outlets, this creates potential. In identifying this void, the next steps would be to reconstruct a police male-acceptable alternative. Thankfully, due to the social constructionist underpinnings of hegemonic masculinities theory this is possible.

Systemic change could improve the situation in simple yet gender sensitive ways that do not emasculate both police and male tenets. Services equally need to consider how they preserve both male and police-based dignity and honour in offering occupationally sensitive support in a non-shame inducing manner. Positive examples of de/reconstruction can be found within other hyper-masculinised settings, such as elite sports, and whilst this may not offer a directly transferable solution, it offers hope.

Policing by nature as an enforcement agency will always require strength, dedication and diligence from all within. These male congruent and celebrated ideals may serve as an attractant and facilitator of remarkable acts of service; however, this also leaves male officers vulnerable to exploitation/overperformance and poor health.

Policing is important for a healthy society and may, due to its hegemonic function, remain predominantly male in dogma and workforce. Wellbeing in this field may therefore benefit from focusing on men's mental health needs; treat the Achilles heel to repair the backbone.

6.2 Final thoughts and reflections

It has been interesting to undertake this PhD whilst active within the police wellbeing field. In the seven years since my research proposal, I have worked with many men, and whilst some things have changed, I continue to be told of significant help-seeking obstacles. In contrast, civilian male mental health practice advocates speaking up, looking out for each other and prominent male figures (athletes, celebrities, professionals) more widely endorsing help-seeking and visible in mental health promotion. This PhD therefore sought to improve the equity in male police officer mental health.

I have highlighted my researcher influence throughout each section and wonder to what degree my police spouse status facilitated this. I would never, however assert comprehensive knowledge of the lived experienced of this study's male officers but feel that my personal and professional experiences may have assisted my accessing of their accounts. To this, I could not undertake this study without some thoughts to the wives, partners and families of these men. Being in the police family can be incredibly tough on a normal day and hearing these journeys I can only but imagine the enormity of their additional anguish and turmoil.

I am struck how openly and readily these men discussed such private information. Given that a woman typically facilitated their help access, I am aware that there is a potential that they were entrusting me with their hopes for change in a similar way. However, these men responded and consented to be interviewed and by such action are understood to want to share their journeys and develop our understanding and that feels like a privilege and honour to have been part of.

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Appendices

Appendix A - Worked example of a CASP reviewed paper

CASP Checklist:

For Qualitative Research

During critical appraisal, never make assumptions about what the researchers have done. If it is not possible to tell, use the "Can't tell" response box. If you can't tell, at best it means the researchers have not been explicit or transparent, but at worst it could mean the researchers have not undertaken a particular task or process. Once you've finished the critical appraisal, if there are a large number of "Can't tell" responses, consider whether the findings of the study are trustworthy and interpret the results with caution.

Section A Are the results valid?	
1. Was there a clear statement of the aims of the research?	☒Yes ☐ No ☐ Can't Tell Yes, they are purposely focusing on former officers so to not conflict/compromise any service identities and increase confidentiality. No specific research question however is identifiable Inclusion criteria is also very broad 'ex officer'- possibly to be inclusive.
CONSIDER: • *what was the goal of the research?* • *why was it thought important?* • *its relevance*	
2. Is a qualitative methodology appropriate?	☒Yes ☐ No ☐ Can't Tell Yes, it is to elicit open answers for coding. Semi structured interviews to offer parity and flex. Subjective accounts.
CONSIDER: • *If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants* • *Is qualitative research the right methodology for addressing the research goal?*	
3. Was the research design appropriate to address the aims of the research?	☒Yes ☐ No ☐ Can't Tell There is discussion of decision making regarding research design and at the end discussion around how F2F vs Zoom interviews may have differed.
CONSIDER: • *if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)*	
4. Was the recruitment strategy appropriate to the aims of the research?	☒Yes ☐ No ☐ Can't Tell

	Mostly, but the use of social media platforms would mean that they will have had to either follow police platforms (what about those who do not follow this?) or recruit from 'within networks' (those connected/following the researcher) this is less impartial. Appears to use interpersonal or connected networks and could be explained more
CONSIDER: • *If the researcher has explained how the participants were selected* • *If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study* • *If there are any discussions around recruitment (e.g. why some people chose not to take part)*	
5. Was the data collected in a way that addressed the research issue?	☒Yes ☐ No ☐ Can't Tell Unsure if video or audio recorded – used Zoom. If videoed how were these anonymised? What was put in place re sharing of information? The interviews followed 6 questions with scope to expand. Mean time was 33 mins with 2 parts - phase 1 (rapport building), phase 2 – the interview. Shortest interview was <25mins – is this long enough for both sufficiently? TA has been used, saturation not acknowledged. Nor choice of specific TA – presume therefore standard TA. Dual researcher coding/checking for inter-reliability little known about researcher 2. Is the psychologist referenced as the 'question designer' or is that a third person
CONSIDER: • *If the setting for the data collection was justified* • *If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)* • *If the researcher has justified the methods chosen* • *If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)* • *If methods were modified during the study. If so, has the researcher explained how and why* • *If the form of data is clear (e.g. tape recordings, video material, notes etc.)* • *If the researcher has discussed saturation of data*	
6. Has the relationship between researcher and participants been adequately considered?	☐Yes ☐ No ☒ Can't Tell Mostly and it is stated, however the main researcher is an aspiring police officer which may have incurred some bias.

	It is unclear if there were any events in the interview or how these were dealt with (ethics?) Possible bias on recruitment/use of social media?
CONSIDER: • *If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location* • *How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*	
Section B: What are the results?	
7. Have ethical issues been taken into consideration?	☐ Yes ☐ No ☒ Can't Tell Ethical approval stated was in place – it is unclear how any risks were supported or would have been if present. Some emotive topics and sharing – was this considered? Were any medically retired (mental health caused)? If so, was this considered if symptomatic? Debrief was done at the end – did they also signpost to support agencies if MH was present?
CONSIDER: • *If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained* • *If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)* • *If approval has been sought from the ethics committee*	
8. Was the data analysis sufficiently rigorous?	☒ Yes ☐ No ☐ Can't Tell There are a number of clear subthemes. Analysis used TA (B&C cited appropriately) Two coders Unsure of how many codes. They present 2 themes and multiple subthemes. How were codes integrated into subthemes?
CONSIDER: • *If there is an in-depth description of the analysis process* • *If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data* • *Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process* • *If sufficient data are presented to support the findings* • *To what extent contradictory data are taken into account* • *Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*	

9. Is there a clear statement of findings?	☒Yes ☐ No ☐ Can't Tell Findings are presented as subthemes with 2 overarching themes along with diagrams. It is an exploratory piece and does not answer a specific research Q but does draw some interesting points.
CONSIDER: • *If the findings are explicit* • *If there is adequate discussion of the evidence both for and against the researcher's arguments* • *If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)* • *If the findings are discussed in relation to the original research question*	
Section C: Will the results help locally?	
10. How valuable is the research?	☒Yes ☐ No ☐ Can't Tell The study does some key points around current and past views regarding mental health in policing. There are calls for further gender-based research. Participant input is clear – quotes used. Good connections to existing literature. offers sociocultural insight
CONSIDER: • *If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature* • *If they identify new areas where research is necessary* • *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*	

APPRAISAL SUMMARY: *List key points from your critical appraisal that need to be considered when assessing the validity of the results and their usefulness in decision-making.*		
Positive/Methodologically sound	**Negative/Relatively poor methodology**	**Unknowns**

Good themes and diagrams are helpful. **Depth through use of quotes and participant voices.** **Confidentiality was kept tight.** **TA fitting for methods – eliciting subjective experiences.** **Variety of service histories in participants appears to represent a cross section of policing** **Social media opt in – offers agency and some neutrality. Info sheets then circulated as an additional layer.**	**Unsure on impartiality of recruitment** **Were the interviews long enough to create the depth presented? Lots of subthemes but interviews are short.** **Unclear how were codes collapsed into sub/themes**	**Research Q if there is a specific one? How did this inform the interview schedule?** **Safeguarding processes – presume covered to get ethical approval but not stated.** **Relationship – what were any social connection overlaps?**

Appendix B– Participant information sheet

Participant Information Sheet

Police and mental health help seeking

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

My name is Rachel Rogers and I am conducting this research as a student in the PhD Mental health programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?
The purpose of this study is to understand how police officers access support for their emotional and psychological support. It is keen to understand more about the police culture, obstacles and facilitators to seeking help. It is hoped that knowing more about this will help us reach more Officers in a timely and appropriate manner.

Why have I been approached?
You have been approached because the study requires information from people who have engaged in psychological support for their wellbeing, such as attending the Psychological Wellbeing Programme run by The Police Treatment Centre.

Do I have to take part?
No. It's completely up to you to decide whether or not you take part. Similarly you can choose to cease the interview at any point should you wish.

What will I be asked to do if I take part?
If you decide you would like to take part, you would be asked to you engage in a semi structured interview with Rachel. This will take up to an hour and be recorded.

Will my data be Identifiable?

The information you provide is confidential. Only the researcher will have access to your recording. This will then be transcribed and any personally identifiable data will be anonymised. The wider research team/academic supervision may see this transcribed, anonymised data. The accumulated and combined findings will be used in my Thesis and may be published in the future. It may be that direct quotes are used from the recordings but these will not have any identifiable link back to the person providing this information.

The data collected for this study will be stored securely and only the researchers conducting this study will have access to this data

- Audio recordings will be destroyed and/or deleted once the project has been submitted for publication/examined.
- Hard copies of questionnaires will be kept in a locked cabinet.
- The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected.
- At the end of the study, hard copies of questionnaires will be kept securely in a locked cabinet for ten years. At the end of this period, they will be destroyed.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them.
- All your personal data will be confidential and will be kept separately from your interview responses.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff - Helen birks, Head Nurse about this. If possible, I will tell you if I have to do this.

What will happen to the results?

The results will be summarised and reported in a thesis and may be submitted for publication in an academic or professional journal.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher:
Rachel Rogers – Rachel.rogers@lancaster.ac.uk
The Division of Health Research
Lancaster University
Bailrigg
Lancaster
LA1 4YW

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor Catherine Walshe, Research Director for the Division of Health Research
Tel: (01524) 510124
Title; Email: c.walshe@lancaster.ac.uk
Division of Health Research
Lancaster University
Lancaster
LA1 1YW

If you wish to speak to someone outside of the PhD Doctorate Programme, you may also contact:

Professor Roger Pickup Tel: +44 (0)1524 593746
Associate Dean for Research Email: r.pickup@lancaster.ac.uk
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance.

- Your GP
- Occupational Health – available to support work and health needs. Access depends on specific Force protocol, some accept direct referrals, other require referrals from your supervision.
- The Police Federation www.polfed.org

- Mind – a national mental health charity that provides support, signposting and advice. Check your local area www.mind.org.uk
- The Samaritans, available 24/7 for a confidential chat and support – www.samaritans.org Tel 116123
- For private, accredited therapists and counsellors you can search in your areas via www.**counselling-directory**.org.uk/ or https://www.bacp.co.uk/search/Therapists

Appendix C – Participant Consent Form

Consent Form
Study Title: Police and mental health help seeking

We are asking if you would like to take part in a research project looking at how male police officers accessed psychological support. Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Rachel Rogers.I confirm that I have read the information sheet and fully understand what is expected of me within this study

1. I confirm that I have had the opportunity to ask any questions and to have them answered.
2. I understand that my interview will be audio recorded and then made into an anonymised written transcript.
3. I understand that audio recordings will be kept until the research project has been examined.
4. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
5. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication.
6. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published.
7. I consent to information and quotations from my interview being used in reports, conferences and training events.
8. I understand that the researcher will discuss data with their supervisor as needed
9. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with their research supervisor.
10. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.
11. I consent to taking part in this study

Name of Participant_____ Signature_____ Date

Name of Researcher _____Signature _____Date

Appendix D – Interview Schedule (semi-structured)

Welcome the participant, discuss the consent form and any questions they may have. It may be helpful to give a background to the study.

1) Can you briefly describe the police culture to me?
2) What do you think is the "ideal police officer"?
3) Have you seen a fellow male colleague struggling with their mental health? What happened/how were they treated?
4) Why do you think male police officers find it hard to seek professional help?
5) I've heard the term "sick lame and lazy" a lot in my clinical work and research. When did you first hear this term? What do you think of it?
6) Depending on their answer to 6) consider asking what types of illnesses are most considered sick lame and lazy/ are there any of these that fall in/outside this category?
    - Stress
    - Depression
    - Anxiety
    - Panic
    - Bipolar
    - Schizophrenia
    - PTSD

Or 7) what types of illnesses would you need to have to not be considered "sick, lame and lazy"

7) Given what you've already told me, as a male officer, could you please outline what helped you get help?
8) In your experience, what could help male police officers manage their mental health/what have you found helpful or seen to be good practice at work?
9) If you could offer advice to those early on in their mental health journey, what would it be?
10) If you could change one thing about mental health in policing, what would it be?

In all responses look for discourse around the reframing of material, the how's and consider pursuing these points further.

Appendix E – coded interview example

In your experience, what do you think would help male officers manage their mental health and those sorts of pressures, based on what you found helpful and unhelpful?

R: A culture in the police that allows you to talk about it and talk to your colleagues about it. I still think it's not quite there yet to talk to your colleagues about it. It's getting better but it's still not there because we've had a number of suicides in this side over the last 12-18 months and there are still people bottling it up and suppressing it. So they still don't feel confident enough to come out and talk to people about it. There's a colleague I know had wrote his suicide note and was about to throw himself under a train. It was only his wife came home early from work and saw the note and went down to the train station and stopped him. He'd bottled all this in for years and no one knew. I didn't know either and I was probably one of his better friends. I felt bad about it myself. So yes –

I: So is that still because of that stigma that you said existed in the early 2000s or why do you think people are scared to come out and talk about these things?

R: It could be career-wise as well, can't be? Stigma, you've got not wanting to appear weak, that's always a big one, especially with men, they don't want to appear weak, they don't want to appear that they're not in control because you're expected to be that way, aren't you? You are meant to be the hunter gatherer provider type thing.

I: And you're a hunter gatherer type of provider in a uniform.

R: Yes, and look after the family. That's one of the things I always remember feeling strongly about was the pressure of we'd moved house, we've moved up to another area, we were out of (location). Bot ourselves a nice little rural village to live in outside of (location) It was a nice lifestyle, bringing my daughter up in a nice school, but that came with a lot of pressure as well. It's like hang on a minute, they're basically telling me they want to sack me here, they want to sack me, how do we afford this lifestyle up here without this job, without the wages?

I: So you were saying the stigma, there's not wanting to appear weak.

R: That's a big one, not wanting to appear weak. Feeling belittled in front of your colleagues.

I: Being less of an officer?

R: You're less of an officer, you're not a roughty-toughty because you've disclosed, you're suffering with mental health issues. You think they start thinking to themselves he's not going to be able to help me out in public order situation or a crowd control situation –

I: So you have anxiety or depression but somehow if you need to get hands on, that's going to impair you.

R: Yes. That's literally it, they are the main ones.

I: So it kind of degrades your position, doesn't it?

R: Yes, it undermines you.

I: Does that still come under that sick, lame and lazy bucket or is that less of a thing these days?

R: Less of a thing these days, I'd say. It's not banded around as much as it used to be but I think nowadays it's more quietly done. Between themselves they'll,

"He's alright, he's okay." Sometimes you can just tell it by the way someone seems to go somewhere quicker than someone else but their ability isn't as good as the other person. You think, "Well, how have they got that and gone there quicker than he or she has and they're nowhere near as good as them?" If your face fits. They like people who give the right answers.

I: So has the culture almost got, like you said, back in the early 2000s, this sick, lame and lazy people were very vocal about it, it was a big thing whereas now –

R: Managers would say it on parade and things, he's this, he's a head worker, was another fantastic phrase, a lead swinger. He or she, head worker. He's just a head worker, he works his head more than he works his pocket notebook.

I: So there are lots of phrases that really capture –

R: Derogatory.

R: It was destroying everything I believed the police was about, the police family was getting eradicated. Like you touched on earlier in our discussion, the culture used to be then we would discuss things with end of shift briefings, go for a drink somewhere or things like that, things were going on at the end of shifts, the section together and thrash things out. But bit by bit, single crewing was coming in, fewer and fewer officers, they were deliberately trying to keep you away from all of that, sending you out to different things. So you weren't meeting up, you weren't spending your breaks together and stuff like that, you felt like you were just an individual, that's all. You weren't part of an organisation, part of a group, you're just an individual working within the service.

I: So was that fracture of the team, the breaking things down, single crewing etc., at the same time that these national changes came in so where everything was performance focused. And actually our performance was better perhaps as an organisation if we single crew because you can be getting tickets there and you can be arresting people there and you can be doing things there, but actually it really breaks up –

R: It was quite the opposite; the opposite was actually happening. When there was a time when you were doubled up and there was two in the car, what they used to do was turn around and say instead of having your professional break at the same time together, you'd have what they call alternate rests. So one of us would go off at four and the other would go off at five or whatever but what would happen is, while that person was out on their own between four and five, they'd get tied up with something, make an arrest or whatever, they'd be late getting back in or then go into a custody suite. So the other person was left high and dry, sat in the police station. They didn't have anything to do because there probably wasn't another car for them to go out in. If there was, fine, if there wasn't, then they were left high and dry. Then it was like well, can we find someone for you to go out with or can we get you another car. So it was all just wholly inefficient and counter to what they actually thought they were achieving as well. That's just one example of it.

I: Whereas I'm guessing, reading between the lines there, if people had had rests at the same time, they'd have rest and been back out there and they would have been more productive.

R: Yes, or if something came out as an emergency, you'd drop and go, go off together. If it was an emergency, generally it was something that you were going to need two to deal with anyway as it was probably going to be a domestic or public order situation, something like that. Turning up by yourself to one of them, then you're asking for backup, then you're asking, well, I'm on my own, is anyone…? Then other people are dropping what they're doing and flying from the other end of the subdivision to come and help you out down on (location) if they're in (location), it's a long distance to get to and from. That puts stress and strains on your driving then.

I: I know you said earlier that you really disliked it, that it really wasn't good for you, did you see other people struggling in the same way?

R: Yes. Mainly more with the experienced officers like me. The younger ones seemed to take it more in their stride. They didn't know any different; they had less experiences to compare it against. So yes, it was difficult and it was a case of how you went about it. If you could shut off from it and just go along with it easier than others could, yes, you could probably get along and get your quota in that month and keep your head down and get on. You may have wanted to go for the dog section or you may have wanted to go to CID or whatever, to get that you needed to have your nose clean, so to speak. It wouldn't do you right to have been not cooperating with the division and their system that they wanted.

I: By keeping your nose clean, does that also mean a clean mental health record?

R: Well, yes, not going off sick, yes. At that time, the culture was there were so many days off you're allowed to have, once you tipped over that – I can't remember what the figures were but 20 days a year or something like that – whatever the figure was, if you went over that quota, then you were kind of barred or not eligible for twelve months to go for promotion or a sideways step, going to the dog section or traffic or whatever.

I: So how do you think people balance that in terms of this way of working is really impacting on their wellbeing and their mental health, they've got to counterbalance it with not being performance planned because they've got insufficient activity and KPIs. But they've also got to balance it in terms of they can't have time off because that's going to be again a mark on their record. How did that work?

R: A lot of people were taking leave instead of going off sick, that's what people were doing. If you really felt unwell one day and not really up to coming in but would ring in and ask, can I have a day off, leave or a rest day in lieu or something like that, as opposed to going off sick, that was a common one.

I: So people got a little bit more inventive with the ways that they asked for the days off.

R: Out of work, I think people were turning to alcohol as well and drinking a lot more than maybe what was good for them. I can't vouch for that; it wasn't something I did but I knew other people who would do it that way. I also heard people had marital problems, relationships breaking up, people having affairs and things like that.

I: So there were real considerable impacts, wasn't there, in terms of what this did to people?

R: The vast majority of people kind of rubbed along with it, they might have disagreed with it, as is the case, isn't it? Even if you disagree with it, a lot of

people just keep their head down and, "Alright, it suits me because I want to go to the dog section and I want to go to here, let's just put up with this a little bit and then get out of it to a less intense strand of policing." People then as well, whereas when I joined it was we liked response, we like the frontline type of thing, let's hang around here and keep doing that because we enjoy it, we like doing it. Now it was like that looks better, that looks better, let's go there, let's go there, no one was hanging around, the experience drifted away. The experienced officers started drifting away going to various departments and other roles, leaving the more inexperienced ones behind, if that makes sense.

I: So it sounds like there was a lot of people leaving the department, so like you say, that experience was lost. A lot of people were having family and social health problems, did anyone ever put their hand up and say, "Do you know what, actually, this is starting to impact on my mental health"?

R: Yes, from time to time you would, so to speak. The phrase was 'this is really getting me down, it's really getting on top of me'. You'd never say, "I'm struggling with mental health issues." It's different phraseology because it was a different culture then, a different time. I think now everybody would go, "I've got mental health issues," but then, it was not phrased like that, it was not said.

I: Why was it not said like that, do you think? What was behind that?

R: Almost certainly the stigma and you don't want to be seen to be weak. You don't want to be seen to have succumbed to it and that it's got to you and got on top of you. It was okay to say you were struggling with it a little bit but not to say, "This is succumbing me now, (? 00.17.41)," it wasn't really –

I: So I'm a bit busy and I've got my head down is okay but man down, you wouldn't go that far?

R: No because there was still a little bit of a 'man up', just sort of 'grow a set' type of thing. 'Deal with it' was a phrase, 'just deal with it'.

I: So if someone was like, "This is getting to me," the response would be, "Just deal with it."

R: Just deal with it, do whatever you're doing and just deal with it, don't bring that problem to me. You'd often get that. Not so much from other colleagues but certainly from the managers, 'just deal with it'.

I: What would colleagues do then? If managers were very much 'oh well, move on'?

R: On an individual basis some were more helpful than what others were. You had some who were looking after their own interests and they were able to cope with it better. If they were a more selfish type of person, yes, "I'll just do what I've got to do to get on and get what I want out of it." Whereas, if you were not that way like I was, and you made your opinions more heard, then that's where it became more difficult and a few of us did do that.

I: Did that pose a problem?

R: Yes, you just got yourself into trouble.

I: So did it kind of fall into… because you're sort of saying well, if you did say something you were a bit of a troublemaker, a bit of a problem person, and that doesn't sound like it was a helpful position. But it sounds like if it was getting to you, that equally wasn't a good position and there are people in the middle who looked like they were getting on with it but –

R: They might have been struggling as well, I don't know –

I: But their marriages were falling apart or they were drinking far too much or there were other factors there so there were lots of examples. I've heard

the phrase sick, lame and lazy quite a lot in that, is that kind of where this, what you're referring to now or is that something different-

R: Yes, managers, if you weren't up to it, you were seen as sick, lame and lazy. Yes, that was a pot they would just happily label you with and put you in. Once you're in that, it's very hard to get out of it, there was a lot of pigeonholing and boxing of people, that's exactly what it was like.

I: What would happen if you were in that sick, lame and lazy pot?

R: You could be made examples of. You could be made examples of to teach other people because that's how it works, isn't? You make examples of the odd person, show everybody else what happens to someone if they don't toe the line, then everybody else will go, "God, I don't like what happened to him." It's age-old, isn't it? It's been going on since the Romans and probably before that and the Egyptians. You fall out of line, make an example of one or two and everybody else goes, they don't like that. Then, "Oh yes, I won't be doing that then, I'll keep my head down and I'll be a good boy or a good girl and I'll get on."

I: So is that as well or maybe some people said it's getting to me, they'd kind of be like well, this is getting to me, it's a bit much, but anything more than that they perhaps wouldn't risk it because they might end up in the sick, lame and lazy pot?

R: Yes.