



A Descriptive Study of Police Officer Access to Mental Health Services

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Abstract

The culture of policing is thought to emphasize maladaptive methods of coping with stress, such as the use of alcohol, rather than seeking out mental health services. The current paper seeks to better understand police officers' knowledge about mental health services offered by their department and their willingness to engage in and utilize such services. Pen and paper surveys were administered at daily briefings with 134 members of a Southwestern police department. This descriptive study indicates that while only 34% of officers were explicitly aware that their department provided services to alleviate stress or mental health issues, and 38% of officers were unsure of exactly what those services were, over 60% of officers were willing to participate in an annual mental health checkup or mental health class. Ultimately, officers may now be more willing to participate in and take advantage of mental health and wellness opportunities, but the knowledge of what those services are often acts as one barrier, among others, to accessing those services. Knowledge dissemination of mental health and wellness opportunities represents one way to engage more officers in preventative health options.

Keywords Police officer · Mental health · Stress · Mental health services

Since 2020, COVID-19 has stunned the world, hitting those who work as frontline employees particularly hard. Indeed, of the 1335 total officer deaths from 2020 to 2022, COVID-19 was responsible for 829 of those, with gunfire (intentional and inadvertent) accounting for the next highest portion of officer deaths, at 179 (ODMP 2020, 2021, 2022). In addition to those deaths, termed “Line of Duty Deaths” (ODMP 2020, 2021, 2022), an additional 504 officers died by suicide (Blue H.E.L.P. 2020, 2021, 2022). Unfortunately, these years were not anomalies; rather, the fact that more officers died by suicide than as a result of homicides or accidents reflects a trend that has been occurring since officer suicides began being officially recorded in 2016 (LEOKA 2016–2019; Blue HELP 2020). Furthermore, as the climate surrounding law enforcement has grown more contentious amid a surge in protests in urban environments, the Black Lives Matter movement, and numerous U.S. Department of Justice investigations (Day 2015; USDOJ Civil Rights Division 2015), police are working in an environment that is perceived to be ripe with public apathy (Marier and

Moule 2019) and the stress and risks associated with being a member of this occupation have arguably increased (i.e., the 2016 shooting of five Dallas police officers; Fernandez et al. 2016).

In 2015, President Obama convened a task force that was charged with developing proposals to strengthen community policing and improve overall levels of trust between the police and the communities they served. Of the six pillars they proposed, one explicitly called for police departments to improve police officer wellness and safety. Since the disbursement of the final report, research has continued to examine aspects of policing such as community policing (Leroux and McShane 2017; Peyton and Sierra-Arévalo 2019), officer use of force (Ariel et al. 2015; Terrill and Paoline 2013), and the use of technology (Ready and Young 2015; White et al. 2017). Furthermore, scholars have focused substantial attention on police officers' *perceptions* of some of these concepts (e.g., Gaub et al. 2016; Padilla et al. 2022; Wolfe and Nix 2016). However, given the current contentious climate of law enforcement—what some have termed a “legitimacy crisis” (Gest 2016; Todak 2017)—examining police officers' overall health and wellness, and what officers perceive their departments are doing to help them, is critical, as police officers themselves should be included in the police reform process.

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Stress in Policing

Phrases such as “stress” and “stress management” have become buzzwords in policing—akin to “community policing” or even “de-escalation.” The impact and importance of stress and stress management are understood, yet there is a lack of consensus on what exactly stress is, how it should be measured, and how it is best addressed. Research demonstrates that a police officer’s level of stress is likely to be affected by the characteristics of the individual officer (Padilla 2020; Zhao et al. 1999), as well as their working group and their department (Maguire et al. 2020; Peterson and Uhnoo 2012). What is more, police officer stress typically stems from one of two sources: organizational and occupational (sometimes discussed as operational or environmental; McCraty et al. 1999). Organizational sources of stress are those that are found across many types of occupations and can include having to deal with excessive paperwork or unsupportive supervisors (Purba and Demou 2019; Violanti et al. 2019). These stressors are often deemed more problematic in the lives of police officers as compared to occupational sources of stress, due to their repeated exposure to these situations (Joseph and Nagarajamurthy 2014; Shane 2010). Occupational sources of stress, on the other hand, are those that are unique to a particular occupation—in this case, policing. Occupational stress in policing is generated by having to write traffic tickets, deliver death notifications, or being exposed to potentially dangerous or life-threatening incidents (Lieberman et al. 2002; Violanti and Aron 1993).

The consequences of stress can manifest in a variety of dimensions of a police officer’s life. Physiologically, police officers have high rates of cardiovascular disease and high blood pressure (Wirth et al. 2017), as well as exacerbated spinal issues (Maguire et al. 2020). Psychologically, officers have relatively high rates of depression and suicidal ideation, as well as high rates of suicide itself (Milner et al. 2013; Violanti et al. 2016). Behaviorally, there are often high alcohol-use rates (Chopko et al. 2013), as well as marital issues, such as high rates of divorce and domestic violence (Blumenstein et al. 2012; Burke 2019). Additionally, the failure to cope appropriately can result in a higher rate of use of force in interactions between officers and citizens (McCarty et al. 1999), resulting in an increase in lawsuits that will have to be managed by the department and their legal team (Schwartz 2011, 2016). These consequences can be further felt and seen by the organization itself. Officers who are under immense stress without the proper channels or ability to cope with that stress may experience decreased job satisfaction (Maurya and Agarwal 2015), higher turnover rates (Yun et al. 2015), or increased use of sick days (Devonish et al. 2012), resulting in lost productivity (Fox

et al. 2012). It then behooves police department administrators to be able to identify stress in the workplace, implement programs or services designed to ameliorate such stress, and encourage their officers to engage in those services.

Services and Barriers to Accessing Services

The first experience an individual will have with psychological services in law enforcement comes with their pre-employment psychological screening, which is designed to identify and select candidates who are well-adjusted and possess coping skills that will help them navigate the stress associated with the job (Dantzker 2011). After the pre-employment screening, departments generally offer in-house training or seminars, though often not mandatory to attend, as well as a staff psychologist. Indeed, Employee Assistance Programs (EAPs) allow officers and their families to access mental health care without out-of-pocket costs (Burke 2019; Donnelly et al. 2015). Nevertheless, officers report that they are reluctant to utilize EAPs due to the perception that EAPs are intrinsically “linked” to the department (Burke 2019; Fox et al. 2012).

Resiliency training, or training to improve “the ability to withstand, recover, and grow in the face of stressors and changing demands” (Deuster and Silverman 2013, p. 24), and peer support groups designed to combat the stigma associated with seeking help for mental health issues (Creamer et al. 2012) have grown more common in police departments. After exposure to potentially life-threatening or traumatic incidents, peer support groups have proven beneficial in alleviating poor mental health issues such as anxiety or depression (Evans et al. 2013; Waters and Ussery 2006). Other resources that departments have provided for officers include fitness programs (National Law Enforcement Memorial Fund 2020), staff psychologists (Brewster et al. 2016), critical incident stress debriefings (Burke 2019; Pasciak and Kelley 2013), in-house chaplains (Padilla 2016), and trauma risk management (TRiM; Watson and Andrews 2018).

One of the most prominent and, perhaps, daunting encounters between law enforcement officers and psychiatrists and psychologists is the fitness for duty evaluation (FFDE; Mayer and Corey 2017). Typically performed after exposure to a critical incident, an FFDE is designed to ensure that an officer is capable of safely and effectively performing their job functions (Mayer and Corey 2017; IACP 2013). The stigma of the potential for termination of employment that is associated with FFDEs often acts as a barrier for officers to seek out mental health care support more generally (Fox et al. 2012; Padilla 2016).

There are a number of additional barriers to seeking out mental health care services in policing (Burke 2019; Fox

et al. 2012; Price 2017; Haugen et al. 2017), including the fear of employment termination (as discussed above), fear of judgment from peers/supervisors, as well as a self-imposed stigma that admitting to needing help is a sign of weakness (Haugen et al. 2017; Karaffa and Tochov 2013), and feeling ostracized (Stuart 2017). Additionally, there often are inadequate resources provided by departments (Karaffa and Koch 2016), insufficient knowledge of services, ease of access issues (Burke 2019; Donnelley et al. 2015; Haugen et al. 2017; Padilla 2020), a perceived lack of support (Webster 2013), and general negative perceptions about mental health services from the department (Terpstra and Schaap 2013; Cordner 2017; Blumenstein et al. 2012).

Current Study

Given the increasingly contentious environments in which police officers work, it becomes imperative to better ascertain the types of services that departments offer and understand why officers may or may not be willing to access mental healthcare services. As such, the current study seeks to address three research questions: (1) How knowledgeable are police officers of departmentally provided mental healthcare services? (2) How likely are officers to participate in any type of mental healthcare services? (3) What are some of the barriers officers may identify regarding participation in mental healthcare services? As this study is descriptive and exploratory in nature, no a priori hypotheses are included, and all statistics presented are descriptive.

Methods

Procedure and Design

In June 2019, day (6:00 am), swing (3:00 pm), and graveyard (9:00 pm) shift patrol briefings were attended each day for 7 days. Separate briefings were held for school resource officers (SROs), officers assigned to criminal investigations (CIS), and individuals instructing at the academy. Prior to the administration of the surveys, respondents were read a university IRB-approved informed consent. Survey administration took between 12 and 30 min, averaging approximately 15 min to complete. While the department employed approximately 190 sworn officers at the time of the study, due to officers being on leave, conducting business off premises, or otherwise unavailable, 145 officers were asked to take the survey, and 134 agreed, resulting in a 93% response rate.

While the survey administered included a modified version of Spielberger et al. (1981) Police Stress Survey, Cohen et al.'s (1983) Perceived Stress Scale, and Reising and Mesko's (2009) procedural justice scale, of interest in the

current study is respondents' knowledge of, willingness to participate in, and barriers to accessing mental healthcare services in their department. The full survey is available upon request. Pen and paper surveys were entered verbatim into Qualtrics and all data were analyzed using Stata 15. As this study was exploratory in nature, all results provided are descriptive.

Sample

The current study is part of a larger series of projects with the sample department, which was selected due to the author's proximity to the organization. Importantly, this department falls below the national average in terms of female representation, so meaningful comparisons between male and female officers could not be ascertained and results presented are reflective of the entire department.

The modal respondent in the current study was a White Hispanic/Latinx male patrol officer with approximately 1 decade of law enforcement experience. Males accounted for 89% of the sample. Approximately 89% of the sample indicated they were White, 2% indicated they were Black/African American, less than 1% indicated they were Native Hawaiian/Other Pacific Islander, and 6% identified as a member of another racial/ethnic group. Approximately 63% reported their ethnicity as Hispanic/Latinx. Tenure or years an individual had served in law enforcement (to include other policing agencies) ranged from less than 12 to 358 months, with an average of 126 months, or approximately 10.5 years (SD = 82.04 months or 6.8 years) in law enforcement. Fifty-six percent of the sample worked in a patrol role. Thirty-five percent of the sample had "some college" experience, but with no degree, and 36% of the sample had at least a bachelor's degree.

Measures

Two questions were asked regarding *knowledge of services*: (1) "Please rate your level of agreement to the following statement: Your agency provides services that help manage stress or mental health" (with responses ranging from "strongly agree" to "strongly disagree") and (2) "If you know your agency provides services to manage stress or mental health, who performs these functions (select all that apply)" (options including a private provider, contract provider, department provider, city provider, EAP, or unsure). Three questions were asked related to *willingness to access services*: (1) "How likely are you to participate in any type of services to manage your stress or mental health?" (with responses ranging from "not likely at all" to "very likely"); (2) "Would you consider taking part in a voluntary annual mental health checkup, similar to an annual physical checkup?" (Yes/No); and (3) "Would you consider taking

part in an annual or bi-annual class on the importance of good mental and emotional health?” (Yes/No).

Finally, one question was asked regarding *barriers to accessing services*: “What are some reasons you might choose to not participate in any type of mental health services (select all that apply)?” Responses to this question were divided into “resource-based” and “fear-based” categories. Resource-based barriers included “didn’t have time/the process is too cumbersome,” “don’t know the process to activate services,” and “don’t believe in these types of services.” Fear-based barriers included “fear of peers finding out,” “fear of supervisor(s) finding out,” “fear of subordinate(s) finding out,” “fear of retaliation,” and “macho subculture—don’t want to appear weak.” This question was analyzed for frequency of response and resource-based and fear-based barriers were compared against each other.

Results

Knowledge and Types of Services

Table 1 provides the results for the first research question, which focuses on officers’ knowledge of departmentally offered services, as well as provides context on the types of services officers perceive their department offered. Thirty-four percent of police officers in this department ($n = 46$) either agreed or strongly agreed to the statement “Your agency provides services that help manage stress or mental health.” Furthermore, when asked about potential services offered by the department, 38% ($n = 51$) responded that they were unsure. One respondent wrote in, “I HAVE NO CLUE WHAT’S PROVIDED” (all caps included in initial response), although it is important to note that the police department provides an EAP and departmental psychologist.

Table 1 Knowledge of services and types of services offered

	N	%
Department offers mental health services		
<i>Strongly disagree</i>	19	14%
<i>Disagree</i>	21	16%
<i>Neither agree nor disagree</i>	48	36%
<i>Agree</i>	42	31%
<i>Strongly agree</i>	4	3%
Type of departmentally provided mental health services (select all that apply)		
<i>Private provider</i>	6	4%
<i>Contract provider</i>	7	5%
<i>Department provider</i>	38	28%
<i>City provider</i>	45	33%
<i>Employee assistance program</i>	46	34%
<i>Unsure</i>	51	38%

Table 2 Willingness to access services

	N	%
Likelihood of participation in any mental health services		
<i>Not likely at all</i>	35	26%
<i>Somewhat unlikely</i>	38	29%
<i>Somewhat likely</i>	50	38%
<i>Very likely</i>	10	7%
Willingness to participate in...		
<i>Annual/bi-annual mental health class</i>		
<i>Yes</i>	87	65%
<i>No</i>	47	35%
<i>Annual mental health checkup</i>		
<i>Yes</i>	82	61%
<i>No</i>	52	39%

This provides crucial evidence that officers are not aware of what is being provided under their own roof, and if they are unaware of services offered, they cannot take advantage of those services.

Willingness to Access Services

Table 2 provides the results for the second research question, regarding the likelihood of accessing mental healthcare services. Respondents were asked about general mental health services, with no clearly articulated type of services, as well as about two specific types of mental healthcare services, including an annual/bi-annual class on the importance of good mental health, and/or an annual mental health checkup, similar to a physical checkup.

Forty-five percent ($n = 60$) of respondents indicated they were “somewhat likely” or “very likely” to participate in general mental healthcare services. However, when asked about specific types of mental healthcare services, such as a class or checkup, those who were willing to participate jumped to 65% ($n = 85$) and 61% ($n = 80$), respectively. This may be indicative of the stigma surrounding the term “mental healthcare services.” Conversely, discussing the specifics of the intervention (e.g., a class or checkup) may lead officers to feel more comfortable, indicating a willingness to participate. This is examined further in the “[Discussion](#)” section.

Barriers to Accessing Services

Table 3 provides the results for the final research question, related to barriers to accessing mental healthcare services. Generally, these results could be separated into one of two groups: resource-based barriers or fear-based barriers. Responses related to resource-based barriers included: “didn’t have time/the process is too cumbersome,” “don’t know the process to activate services,” or “don’t believe in these types of services.”

Table 3 Barriers to accessing mental healthcare services (select all that apply)

	N	%
Resource-based	83	43%
<i>Don't have time/the process is too cumbersome</i>	50	60%
<i>Don't know the process to activate services</i>	17	21%
<i>Don't believe in these types of services</i>	16	19%
Fear-based	111	57%
<i>Fear of peers finding out</i>	31	28%
<i>Fear of supervisor(s) finding out</i>	30	27%
<i>Macho subculture—Don't want to appear weak</i>	20	18%
<i>Fear of retaliation</i>	16	14%
<i>Fear of subordinate(s) finding out</i>	14	13%

Responses related to fear-based barriers included: “fear of peers finding out,” “fear of supervisor(s) finding out,” “fear of subordinate(s) finding out,” “fear of retaliation,” or “macho subculture—don’t want to appear weak.” Barriers related to fear accounted for 57% of the responses, while barriers related to resources accounted for 43%. The most commonly reported barriers to accessing mental healthcare services included not having time ($n=50$), fear of peers finding out ($n=31$), and fear of supervisor(s) finding out ($n=30$).

Discussion

Scholars have increasingly focused their attention on police officer health and wellness, and with good reason. As President Obama’s Task Force on Twenty-First Century Policing (2015) indicated, improving the ways in which police officers manage their mental health is one of a myriad of ways that policing can be improved. This study provided evidence that largely the cultural mindset and stigma of seeking out mental health assistance in policing may be starting to shift. Though these data were collected in 2019, approximately 1 year prior to the death of George Floyd and the resulting demands for change and accountability in policing, they still are indicative of the current climate surrounding law enforcement. This is evidenced by the finding that barriers to accessing mental healthcare services reportedly stemmed largely from resources and knowledge of accessing resources, rather than solely from a fear of how others may perceive the choice to participate in mental healthcare services.

What is more, police officers are expressing a willingness to participate in departmentally provided services—with a catch. The wording of these services appears to play a particular role in their decision to participate. That is, while less than half of all respondents indicated they would participate in “any” type of mental healthcare services, those numbers jumped to approximately two-thirds indicating they *would* take part in annual/bi-annual classes/

checkups on the importance of maintaining good mental health. This could be related to a perceived reactive, punitive connotation that may be attached to the phrase “mental health services,” rather than a proactive, educational connotation that may be attached to “classes/checkups.” It is important that future research further parses out not just *what* services are offered, but *how* they are advertised and phrased to those they aim to impact.

While these findings shed additional light on mental healthcare services and barriers to accessing those services, it is important to be cognizant of limitations in the study. First, these data were collected in one, cross-sectional survey administration. Current efforts are being made to examine these topics more longitudinally to better understand the causality and how socio-political contexts may impact perceptions of mental healthcare services. Second, the sole department engaging in research is a majority-minority department, in a majority-minority city. That is, both the department and the city in which it resides are predominately Hispanic/Latinx, so the results may not be generalizable to other departments with differing demographic make-ups. Relatedly, the present study is subject to the potential limitations associated with case studies more broadly (Yin 2009). That is, it was intended to more thoroughly understand knowledge of and willingness to access mental healthcare services in a single department. However, these findings can provide added clarity about these issues in other departments. Finally, this study was exploratory and descriptive in nature, and, as such, did not set out to understand predictors of participation in mental healthcare services. Rather, the goal was simply to examine frequencies of knowledge of services, participation in services, and barriers to participation in services. Future work will undoubtedly utilize more rigorous analytical techniques to examine this aspect.

Limitations aside, this study provides evidence that officers may be more willing to take part in mental healthcare services. This is crucial for departments and administrators to take notice of as now may be the time to be implementing mental health programs and services that will improve not just the individual officer, but the organization as a whole, in turn improving the relationships they have with the communities they are charged with serving.

Declarations

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the Arizona State University Institutional Review Board (IRB: STUDY00010063).

Informed Consent Informed consent was obtained from all individual participants included in the study.

Conflict of Interest The author declares no competing interests.

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