Journal of
COMMUNITY SAFETY & WELL-BEING

Special issue: Updating global efforts to promote and secure first responder wellness

Norman E. Taylor, Editor-in-Chief*

> *When I was a boy and I would see scary things in the news, my mother would say to me, "Look for the helpers. You will always find people who are helping."*
>
> *Fred Rogers*

But what if the helpers aren't there? The past few years have shown us that this has now become much, much more than a rhetorical question.

In communities around the world, citizens have had to learn to adapt to staffing shortages in some of the most heretofore reliable and presumptively available essential services. We have seen emergency rooms and operating rooms close their doors to intake. We have seen school classrooms literally closed for business. We have seen correctional facilities at a breaking point. We have seen the publicly funded and community-based services that attend to the needs of our most marginalized people overwhelmed and besieged, as unhoused and complex-needs populations continue to grow on our streets and in our parks. And we have watched as police, fire, and emergency medical resources are both strained and maligned, sometimes unable to respond sufficiently to planned events, and wholly overwhelmed by unplanned incidents of high consequence.

For most of us, all of this has largely been experienced as inconvenience, with perhaps yet unmeasured impacts on our sense of security and social stability. However, make no mistake. For those professionals who dedicate their careers to the human services, these unrelenting conditions have been experienced as life-altering, disorienting, anxiety-producing, and traumatic. All of these recent conditions pile onto the emotional strain and compassion fatigue that already accompany many of these vital lines of work.

About two years into the overlapping issues of 2020 and 2021, with some glimmers of hope beginning to point towards recovery for society in general, it was apparent to us at the *Journal of Community Safety and Well-Being* that helping the helpers was becoming an urgent imperative. The world was delivering a new baseline upon which such help must be conceived and understood. What we may have thought we knew in 2019, and what programming had already been achieved, must now make way for new knowledge, reset possibilities, and scaled-up wellness practices to meet the still-emerging collateral damage from these unprecedented times. When we floated this observation with our friends at Deloitte, they agreed and generously stepped up to support this special wellness issue, dedicated to all CSWB professionals who have taken the rest of us through the early storms of a new decade.

Please see the opening Editorial from Lauren Jackson and Michelle Theroux, representing Deloitte, our Supplement Sponsor, and the Editorial from Linna Tam-Seto and Jeff Thompson, our two guest editors who have curated an outstanding and diverse selection of papers. These two editorials will set the stage for your journey through the featured papers, contributed by an impressive collection of global authors.

We thank our guest editors for their tireless work in a short space of time. We thank all of the contributing authors for their patience, flexibility, and cooperation throughout all stages of this production. We extend similar thanks to the wide array of peer reviewers for their work in supporting these aims, while ensuring high standards of editorial quality in all of the papers.

Finally, the combined special issue team looks forward to the upcoming Canadian Association of Chiefs of Police (CACP) Canadian Policing Wellness Check conference, scheduled for March 6–8 in Ottawa. See cacp.ca for details, and we encourage everyone working across CSWB sectors to register and get involved in this event. This special issue of the journal has helped to shape an "updating the evidence" panel session as a flagship component of that conference program.

CONFLICT OF INTEREST DISCLOSURES

The author has continuing business interests that include providing advisory services to communities, police services and related human service agencies.

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EDITORIAL

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Resetting and informing a new baseline for wellness in policing

Linna Tam-Seto, Ph.D., O.T.Reg.(Ont.)* and Jeff Thompson, Ph.D.†

Since the emergence of organized policing, its success has relied on the work of the people wearing the uniforms, alongside other professionals also serving as dedicated public servants, in rural areas, towns, and cities across the world. At times admired, at other times justly criticized, policing remains an unquestionably noble profession because of those people who have dedicated their lives to the protection of others.

As modern policing continues to evolve, it must include, in every aspect, the well-being of its number one asset: the people. If those serving in the agencies are legitimately the priority, as so often casually stated, then their resilience, mental health, and well-being should always be leading the path forward. Unfortunately, we know that this is still too often not the case. Suicide rates in policing are alarmingly high, as are the rates of mental health conditions such as depression, anxiety, alcohol and substance abuse, and post-traumatic stress disorder, with significant effects on police employees, their loved ones, and ultimately the communities they serve.

In order for the policing profession to address these concerns in a meaningful manner, an important first step is to acknowledge the mental health challenges that face its members. Mental health stigma in policing remains rampant. Although addressing stigma is ostensibly easy and a logical first step, in reality, doing so is much more complicated. Good intentions do not always result in meaningful and appropriate actions. Expectations to address mental health stigma are not always pursued with accuracy, and the temptation for a "quick fix" can lead to "check the box" training that can often do more harm. Remember too, our police officers are human beings first. They are also spouses, life partners, children, siblings, and friends and neighbours. Understanding that police officers are more than just their jobs underscores that the challenges that they themselves face in their own mental health and well-being will also affect many others in their circles of support.

Addressing police mental health is complicated. Similar to there being no single cause to suicide or declining mental health and well-being, protecting those who protect us does not have an instant or straightforward solution. The responsibility of protecting the protectors lies beyond individuals and their families, requiring the ongoing support of organizations, leaders, policy makers, health-care providers, and communities.

Something as important as the well-being of police employees needs to have leaders doing just that—leading—with innovation, courage, compassion, and a forward-thinking approach that might ultimately challenge much of the current and established norms, rules, policies, and structures in place.

These reasons have inspired both of us to join this special issue as guest editors. This timely issue is about leadership, first and foremost. The *Journal of Community Safety and Well-Being* invites, represents and gives voice to true leaders in many ways, and this is reflected in the support coming directly from Deloitte to ensure this special issue could become a reality. *JCSWB* is constantly and perhaps uniquely working towards bridging the gap between academia and practitioners so that rigorous police and related multi-sectoral research and commentary have a credible place to be published, while also ensuring the focus remains human-centered. The studies featured in this issue can impact how policing is conducted to support the police, both internally and in their interfaces with the public. Because of this Journal's established tradition of translating research to audiences who strive for excellence in policing, neither of us hesitated when we were invited to team together to be part of this special issue.

As your guest editors, we come from two diverse backgrounds. One of us is a former New York City Police Department detective who was a hostage negotiator and the department's first-ever mental health and wellness coordinator, and is currently a research scientist at Columbia University Medical Center. The other is an occupational therapist and researcher exploring the experiences of military, veteran, public safety personnel, and their families, as well as being a spouse of a Toronto Police officer in Canada. Although our career paths have been different, we share similarities in that our work, research, and importantly, our passion are supporting people who constantly look after the safety and well-being of others. This extends to these professionals in their personal lives and in their home and family environments.

Despite our varied professional and personal experiences, for this issue we have embraced our differences to form the lens through which we identified select articles for this special edition, with the express goal of exposing readers to a variety of perspectives. Our approach to diversity is demonstrated in many ways: our authors are from multiple countries, they

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include both academic researchers and professionals, and they have an array of titles ranging from a former police commissioner, to a professor, to a mental health clinician, and a family member.

In order to forge onward, researchers, police leaders, and those who are in positions of influencing police policy and procedures must all be aware of the importance of wellness in policing and must remain knowledgeable about what has been done, what is being done, and what still needs to happen. Importantly, these reflections, explorations, and analyses must be done in a rigorous and evidence-based manner in order for there to be meaningful conclusions and applicability to policing on a global scale.

The authors generously contributing to this special issue, while each offering individual value, are also serving collectively to help others achieve these goals. Through this special issue, and by giving our selected authors this platform to share their important research and perspectives, we hope to contribute to moving modern policing further in a direction that genuinely is addressing individual and organizational resilience, mental health, and police workers' overall well-being.

If the people working in police agencies truly are the number one asset, we hope these articles will help to motivate, guide, and influence those responsible for demonstrating this every day through well-informed actions that prioritize the well-being of all police employees. Everyone deserves to have positive mental health, and that certainly includes our everyday heroes.

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EDITORIAL

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Police need wellness checks too: Embedding a culture of wellness and resilience in policing

Lauren Jackson* and Michelle Theroux†

The policing profession is in the midst of a global mental health and wellness crisis (Edwards, 2023). The police workforce (including police officers and non-uniform members) serves as the backbone to maintaining community safety and well-being; however, sentiments across the profession point to an overwhelming sense of stress, burnout, and mental health–related issues. Anxiety, depression, alcohol and substance abuse, suicide, and post-traumatic stress disorder are being reported at alarming rates among police service members (Tam-Seto & Thompson, 2023). A Canadian study showed that 37% of police officers at the municipal and provincial level and 50% of police officers at the federal level reported having a mental health disorder (Carleton et al., 2017, as cited in Grupe, 2023). These are just disclosed statistics. The mental health and wellness of the workforce is not a sector-specific issue; it is a human issue—one facing every single police service in Canada and, indeed, globally.

We sponsored the first special edition of the *Journal of Community Safety & Well-Being* focused on "Envisaging the Future," because we recognize that you cannot have safe, healthy, and resilient communities without a safe, healthy, and resilient police workforce. Full stop. Wellness, focused on health promotion and disease prevention, is foundational to a sustainable model of policing that supports the health and safety of our communities. Recognizing this is a complex issue that will not be solved with simple solutions, our Security and Justice and Health Care practices have come together to co-sponsor this second special edition focused on wellness and resilience in policing.

A Holistic Approach to Health and Wellness

The mental health and wellness crisis facing police services today calls for a new approach to how we build and maintain the health and wellness of the police workforce. Like other shifts in policing, wellness needs to be approached holistically, with a shift to preventive approaches and away from reactive approaches rooted in "sick care" or treatment. Research has demonstrated that social drivers—such as socioeconomic status, neighbourhood and physical environment, and social community—play an important role in the health and well-being of people. From an external service delivery perspective, the policing sector knows this, with formal integrated planning frameworks developed to cultivate more integrated approaches to resolving complex human issues that create or perpetuate vulnerability in communities (Government of Ontario, 2021). It is no different when looking inward. Policing mental health and wellness programs need to consider the holistic needs of the individual while at work and home.

One way we can better support the health and wellness of the police workforce is through community. When a new member joins the police service, they join a community of like-minded professionals who serve and protect others, as well as each other. The question remains: how can police organizations and leaders leverage this embedded community to support common goals, address health and wellness issues, and take a proactive approach to maintain wellness within the police workforce? As described in Deloitte's *Smart Health Communities and the Future of Health* report, we need to empower individuals to proactively manage their health and well-being, foster a sense of community and belonging and use digital technologies to improve health and wellness (Dhar et al., 2019). Thanks to digital technologies, communities no longer need to be physically together to be connected. With police officers and non-uniform members working across diverse geographies and communities, digital technologies can play an impactful role in opening up channels to engage with others in their community facing common challenges—such as parents in the service, or those returning to work following an injury or traumatic event. Once the sole domain of hospitals and clinicians, health and wellness is now inexorably intertwined with every part of our lives, demanding a holistic approach that takes into account the interplay of individual and community, enabled through digital technologies that connect the police workforce with information and each other.

A Resilient and Empowered Police Service

In our recent article, *In Pursuit of Next-era Community Safety and Well-Being*, we documented the need for police and social services to collaborate more closely to create safe and resilient communities (Jackson & Hjartarson, 2022). Connected communities are resilient communities. Fostering a sense of community within the police service can improve wellness and build resiliency—two facets of policing that are mutually dependent on one another to realize their full potential.

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Building a resilient workforce means we can't wait until mental health challenges arise to provide support; we need to empower members of the policing community to proactively manage their own health and wellness. This in turn means cultivating a policing culture where the benefits of this empowerment can be fully realized and barriers to help-seeking are minimized.

We need to provide support through dedicated policies and programs that encourage help-seeking behaviours and tools to empower police services to actively access and participate in these programs. How does speaking about a resilient and empowered police workforce shift the narrative around police health and wellness? It opens the door to breaking down barriers and addressing the traditional stigma associated with help-seeking behaviour to focus on the concept of resiliency as a springboard to authentic wellness. We believe that being empowered goes hand in hand with being resilient.

An Authentic Culture of Wellness

If you build it, will they come? An age-old question. Empowering the police workforce to proactively manage their own health and wellness doesn't stop with wellness-related policies and procedures, and tools and resources. It requires building an authentic culture of wellness in which the promotion of mental health and wellness is embedded in the values and principles underpinning the operation of the police service. Addressing the known barriers to help-seeking behaviours among police officers is critical to building such a culture.

Significant research, including the research in this special edition of the Journal, has documented concerns regarding police culture, where seeking help is often stigmatized for fear of being perceived as weak or lacking the capacity to do one's job. There is a longstanding traditional culture of needing to convey having "everything under control all the time." Given this, it is no surprise that in a study of 4,020 currently serving public safety personnel (including police service members), 43% to 60% stated they would never, or only as a last resort, seek professional mental health services (Carleton et al., 2020, as cited in Drew & Martin, 2023). Reframing "strength" and "courage" in policing to embrace vulnerability must be the first step on the journey to addressing the crisis. Deloitte's *Diversity and Inclusion Revolution* report puts it simply—creating an inclusive and diverse organizational culture has an immense impact on people's lives. They feel included when they are respected, are able to show up as their authentic selves, feel safe to speak up, and feel empowered to do their best work (Bourke & Dillon, 2018). We cannot solve for wellness in policing without this side of the equation and this is a pivotal moment to cultivate a culture that mirrors this, a culture where reaching out and asking for help is recognized as a sign of strength, not weakness.

Call to Action

Addressing the policing mental health and wellness crisis is a complex challenge—one that we must solve together. Like other big problems facing society, we need to break the existing silos between policing, justice, and health and wellness–related organizations. While the specific stresses and challenges police service members face are unique to their profession, as we highlighted at the start of this piece, these professionals are not alone in facing this crisis. Given there are over 150 police services in Canada (Statistics Canada, 2020), any strategies looking to address common challenges should consider scalability and economies of scale as part of design and planning efforts. This includes for example, screening programs to identify mental health challenges, driving adoption of employee assistance programs (EAPs), expanding benefits coverage, and creating communities of wellness and social connection.

Initiatives from beyond the security and justice sector have shown great success in adapting proven mental health and wellness strategies to realize economies of scale. For example, Bell Canada implemented an enhanced return-to-work program that increases support for employees facing mental illness and their leaders through early intervention and communication and uses an online accommodation tool to improve the employee experience (Chapman et al., 2019). As a result, Bell has seen its employees' mental health–related short-term disability relapse and recurrence decrease by over 50% from 2010 baseline levels.

In adapting and developing mental health and wellness strategies, it will be critical for police organizations to focus on outcomes measurement as a driver for planning. We need to understand what works well, what doesn't, and why in the context of police mental health and wellness to repeat and scale successes. Because this is a universal issue, there is immense value in the research and findings that go into this topic. They can be learned from, replicated, and scaled across jurisdictions. If solutions are developed on an agency-by-agency basis, we run the risk of having an impact that is siloed, costly, and inefficient. Policing and public safety agencies have an unparalleled ability to rally around and support one another in times of shared need and crisis; the wellness and resilience crisis facing the police workforce presents both an imperative and an opportunity for scaled collaboration and support that poses too real a risk not to recognize and seize. Collaboration at this scale presents a major opportunity to accelerate and maximize impact by exploring solutions driven locally but applied at a sector or regional level.

We would like to thank the numerous researchers and authors across the world who have contributed to this exceptionally important topic. Through your work, you are highlighting that, just like the communities they serve, police officers need wellness checks too. Who's checking in on police to make sure they are ok?

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COMMENTARY

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NYPD Pathways to Wellness: "R U OK"

Bill Bratton* and Cathleen Perez†

Policing in the United States and around the world has never been an easy task. In 1970, when a young Bill Bratton walked a beat on the streets of Boston, cops would carry a six-shot revolver, handcuffs, a summons book, and a pocket full of dimes for the pay phones in case they needed to call for assistance with an arrest. As times change rapidly, policing practices and equipment often lag behind. Often lagging along with them is the morale and wellness of the men and women who serve our communities.

In 2014, when we returned to the New York Police Department (NYPD) for a second time, crime had been significantly decreased over the two decades since we had left, thanks to the initiatives we had put in place in the 1990s, but there was a new threat that New York's Finest was up against—terrorism. Our predecessors did a good job of creating one of the most cutting-edge counterterrorism units in the world. But with it came more responsibilities for the officers, more equipment to carry on patrol, and more deployments that were often in addition to their regular scheduled duties. What had been left behind during the continued 20-year success story were the needs of the cops.

For any agency, the importance of inclusion cannot be overstated. Leaders must seek to draw on all the strengths of all their members as they strive for improvement. Think of it as a guiding principle of leadership—even the greatest among us can improve.

We spent much of 2014 in a reengineering process that helped define our goals. It included a cultural diagnostic of the department. We began by forming teams to design and implement change. We held focus groups and conducted surveys across the NYPD. We, as the leadership team, wanted to ensure the membership that we see them. And we found that the members of the department willingly stepped forward with ideas. We had hundreds of both sworn and professional staff working in dozens of groups that generated more than 800 recommendations, the significant majority of which were implemented. It has been said that cops hate two things: change and the way things are. But what they really want is for their voices to be heard.

We learned that many of our officers felt alienated and forgotten about, often due to an overly punitive discipline system. Officers also told us that equipment needed replacing or repair, everything from vehicles that were broken down with no air conditioning to their locker rooms that would flood in the rain. It was clear that the relationship between the NYPD leadership team and the men and women in blue across the city was frayed. The challenge was to win back the trust of our officers and civilian employees and their enthusiasm for the profession we all love.

As important as upgrading equipment and repairing facilities were, we knew that change must begin at the core of what drives not only officers, but every person. Wellness was a major priority as we righted the ship and asked so much of our members. Our process for feedback identified the dire need for a truly confidential way in which officers could ask for and receive help with their mental health.

The existing structure was not working. Officers felt there was no avenue to reach out without being stigmatized and being subjected to what felt like a disciplinary process. In fact, the resources at the time were provided by the unit that oversaw discipline in many instances. Often, in the past, an officer seeking help would face being transferred, and while the reason for the transfer was not made public, it was often well known by colleagues. It dissuaded officers from getting the help they needed and added an extra worry to an already very stressful career.

We had to act quickly to create an avenue of trusted resources that met the needs of the 52,000 members of the NYPD. Also needed was the proper messaging to reach them. Our campaign became known as "R U OK?" (Are You OK?). It was partially inspired by a similarly named public campaign in Australia. We took a two-pronged approach to this important task of addressing both personnel wellness and suicide prevention. Our messaging directly reached out to any member of the NYPD who may have been in need of help and taught the entire workforce to look to their right and left to identify their fellow officers and professional colleagues who may have needed resources. We began to remove the stigma and had posters hung in every station house in the city —"R U OK?" The posters included practical tips on how to check in with someone as well as both resources within the NYPD and external options. We encouraged members of the department to seek help, ensuring it would be truly confidential. Importantly, we also empowered each and every member of our agency, regardless of title or rank, encouraging them to take action and check in with a co-worker by starting with a simple yet powerful question, "Are you okay?"

As important as the actual change was its sustainability. Our campaign for wellness needed to have the ability to advance under new, engaged leadership. For this, the department collaborated with outside agencies whose missions were mental health, resilience, and suicide prevention. For any successes we had, these partners deserve credit. We relied on the guidance of organizations like the New York City chapter and

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the national office of The American Foundation for Suicide Prevention (AFSP), the Psychiatry Department at Columbia University Irving Medical Center (CUMC), the Crisis Text Line, and the American Association of Suicidology, among others.

Their support was diverse, including ensuring our messaging was based on best practices. When it comes to suicide, we owe it to that fallen brother or sister who died by suicide to understand as much as we can about what happened. Working with these partners ensured we did it in a manner that was evidence-based. This cannot be stressed enough—external collaborations with organizations and researchers are necessary to make meaningful change in policing when it comes to wellness, resilience, and suicide prevention.

An example of how external partnerships led to direct action is one of the NYPD's most successful initiatives built on the "R U OK" campaign—the Peer Support Program. This program was developed in direct partnership with CUMC as well as with other partners like AFSP. In the NYPD model, Peer Support members, who are the rank and file themselves, receive an intensive, 4-day training. During the course, the peers learn about a variety of topics that will help them de-escalate a colleague in crisis. This includes crisis communication skills (adapted from our hostage negotiation training), understanding risk factors and warning signs of suicide, mental health conditions, and the neuroscience of resilience.

Importantly, peers come from a variety of ranks, both uniformed and civilian members. Fighting stigma must involve everyone, and this has to include the civilian workforce. Our peer program included only those members who genuinely volunteered (this is not a "volun-told" program), and part of the program's success was ostensibly counter to police culture—the peer members are 100% independent. There are no reports, meetings on statistical data, or benchmarks to achieve. Independence and confidentiality are the foundation of this program.

As the program grows, more than 400 of New York's Finest continue to be trained (in small groups of a maximum of 26 people)—and likely countless others helped by their colleagues. We proudly look back to a legacy of success, knowing the department continues to take the mission of health and wellness seriously, and share the experiences of what has been learned with other agencies. That too is worthy of mention—we are not operating in silos, nor are we the only ones doing this. The NYPD wellness team eventually became a permanent unit. The team includes a mental health and wellness coordinator for the agency. As we developed our peer program and other initiatives, we constantly engaged other police partners and organizations across the United States and internationally. The list includes the Police Executive Research Forum (PERF), the Fraternal Order of Police, Metro Nashville Police, the Los Angeles Police Department, Police Scotland, the Australian Federal Police, and the New Zealand Police.

We know that there is not a single cause of suicide and that mental health conditions arise from a variety of complex factors. Therefore, the work being done to prevent suicide and address mental health conditions while also supporting police members needs to be diverse—there is no one quick fix to this. It is complicated. And acknowledging those complications helps to guide our responses.

Much as we tell officers they do not have to take on challenging incidents by themselves while on patrol, addressing suicide prevention, resilience, and mental health should be no different. Reaching out for help is a true sign of strength, not weakness.

It's imperative to work with external experts. As already stated, the NYPD has been fortunate to work with AFSP, PERF, and Columbia, among others. As police agencies across the world continue to address these concerns, embracing genuine external collaborations while promoting an internal message that each individual can play a role is how real change will be made. Everyone deserves to have positive mental health and we need to make sure this message—and our actions—are felt and supported by the men and women in blue.

CONFLICT OF INTEREST DISCLOSURES

The authors declare that there are no conflicts of interest.

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COMMENTARY

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Addressing the mental health impacts of COVID-19 on Canada's frontline workers[1]

Alexandra Heber,*† Amber Schick,* and Elizabeth Bose*

On June 21, 2018, the *Federal Framework on Post-Traumatic Stress Disorder Act* became law, after receiving all-party support in the Parliament of Canada. This ground-breaking *Act* acknowledges that those in certain occupations, including public safety personnel (PSP) such as police, firefighters, paramedics, search and rescue personnel, Indigenous emergency managers, correctional employees, operational and intelligence personnel, border services personnel, and public safety communicators, along with healthcare professionals (HCPs) and military personnel, are at greater risk of exposure to potentially traumatic events, and therefore are more likely to develop posttraumatic stress disorder (PTSD) than the general population, just by doing their jobs (Public Health Agency of Canada [PHAC], 2019). The *Act* mandated PHAC to lead a coordinated, national approach to recognize PTSD among those within these occupational groups and, through this recognition, to help lay the groundwork for more timely access to mental health and well-being supports for those affected. As such, the *Federal Framework on PTSD* was created by PHAC in collaboration with multiple stakeholders. Through research, promotion, and implementation of best practices, education, awareness, and evidence-based treatments, this framework seeks to ensure the creation of solutions for those affected by occupation-related PTSD. The *Federal Framework on PTSD Act* was passed in 2018, and its relevance has only increased in significance during the COVID-19 pandemic.

According to preliminary data from a study on the mental health effects of working the frontlines of the COVID-19 pandemic, 35% of Canadian PSP scored above 33 on the PCL-5, a self-report psychological instrument that assesses for the diagnostic symptoms of PTSD. Scores above 33 on the PCL-5 are compatible with the presence of symptoms severe enough to require formal treatment for PTSD. Furthermore, when screened for symptoms of depression, anxiety, and stress using the Depression, Anxiety, and Stress Scale 21 (DASS-21), an alarming percentage of PSP scored within the moderate to extremely severe range for depression (41%), for anxiety (over 38%), and for stress (32%) (Ritchie et al., 2022). In addition to these findings in PSP, research indicates that 86.5% of HCPs reported feeling more stressed at work during the pandemic, and nearly 18% indicated that they intend to change jobs or leave their current job within the next 3 years, with job stress or burnout being the most common reason, followed by concerns about their mental health and well-being (Statistics Canada, 2022). Other Canadian-based studies reported similar findings (Brophy et al., 2020; D'Alessandro-Lowe et al., 2022; Wilbiks et al., 2021). These results shed light on the devastating effects of the pandemic on the mental health of Canadian PSP and HCPs, and on the urgent need for resources to help support and rebuild their mental health and well-being in the face of COVID-19.

In response to such findings, the Government of Canada, in its 2021 Budget, committed an investment of up to 50 million dollars over 2 years to support the creation of evidence-informed projects and resources to address PTSD symptoms and other mental health conditions in frontline and essential workers and their families, as well as caregivers, who have been most affected by the pandemic. As part of this commitment, in June 2022, the Honourable Carolyn Bennett, Minister of Mental Health and Addictions and Associate Minister of Health, announced a 28.2-million-dollar investment to create mental health supports for these workers (PHAC, 2022). During that announcement, Minister Bennett stated:

> Canada's frontline and essential workers have sacrificed much to keep us healthy and safe throughout the pandemic, and they deserve our support. With [this] investment, our government is helping create new tools to support those most at risk for PTSD, and is encouraging their healing process, all while reducing stigma and removing barriers to care. To all frontline workers – we are incredibly grateful for your continued dedication and commitment to caring for our communities. Thank you!

This funding supports the work being done by nine applied research projects to develop these resources for Canadian PSP, HCPs, military personnel, Veterans, their families and the people who support them. In addition, this funding is supporting the creation of a Knowledge Development and Exchange Hub, the Canadian Institute for Pandemic Health

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Education and Response (CIPHER), which will host, promote, and share the resources developed by the nine projects and will help to inform and enhance Canadian COVID-19-related mental health literacy, policy, and practices going forward. Following is a brief description of CIPHER and the nine research projects.

CIPHER curates and mobilizes the information and resources developed by the nine government-funded projects, supports evaluation and measurement of outcomes, and provides a space for knowledge exchange and collaboration among the projects. CIPHER activities encourage the creation of high-quality, evidence-informed, accessible, and practical interventions, training materials, and supports for Canadian PSP, HCPs, military personnel, Veterans, their families, and the service providers who care for them. CIPHER will serve as a template for networking with existing organizations to provide rapid responses that address significant mental health challenges for these "first-responders," now and into the future.

The *Advancing Peer Support Programming* project is working to provide a coordinated national approach to peer support for PSP and Veterans and enabling evidence-based improvements and standardization—ultimately leading to independent nationally recognized accreditations. This project is also developing and deploying a mobile health platform that provides private and secure access to peer support.

The *Beyond Silence* project is creating and testing a new and innovative peer support e-mental health app that improves opportunities for HCPs to build mental health literacy, reduces barriers to seeking support, and provides real-time access to confidential peer support. The app is designed to promote early intervention and mental health support for frontline HCPs to reduce their risk of PTSD and the mental health impacts of the COVID-19 pandemic.

The *Bringing Mental Health Resources to Long-Term Care* project equips long-term care staff with the capacity to deliver training that builds a common baseline of knowledge on what mental health is, why it matters, and what to do when mental health needs are identified in oneself or ones' peers. This program builds on the unique complexities in long-term care through a customized version of The Working Mind program and implements a train-the-trainer model, so staff can administer the customized course in their long-term care home.

The *Expansion and Evaluation of the Before Operational Stress* (BOS) project offers training to support Canadian PSP and HCPs who are regularly exposed to traumatic events and posttraumatic stress injuries in the context of the ongoing COVID-19 pandemic. The BOS program is being deployed by Wayfound Inc., and the Canadian Institute for Public Safety Research and Treatment (CIPSRT) is conducting an independent research study to evaluate the effectiveness of BOS across delivery modalities.

The *Healthcare Salute* project is designed to support the mental health and well-being needs of Canadian HCPs serving throughout the COVID-19 pandemic. This project is developing evidence-based resources for affected and at-risk healthcare populations using HCPs' own experiences and equipping healthcare support and allied organizations to recognize and support HCPs affected by trauma and PTSD during the COVID-19 pandemic.

The *Promoting Positive Mental Health and Well-being* project is adapting Canada's Department of National Defence's mental health literacy and resilience program, Road to Mental Readiness (R2MR), and tailoring it to meet the unique mental health and well-being needs of Canadian HCPs who have been impacted by the COVID-19 pandemic. This includes creating user-friendly tools that highlight elements such as moral distress, organizational structures, institutionalized practices, and leadership.

PSPNET Families serves the needs of PSP family members experiencing mental health challenges and stressors related to the occupational risks faced by their PSP loved ones. PSPNET Families is complementary to PSPNET, a federally funded online service that offers internet-delivered cognitive behavioural therapy to PSP.

Resilient Minds™ is a trauma-informed, peer-to-peer training program designed to enhance the personal resilience of fire services personnel. The Canadian Mental Health Association is adapting, translating, piloting, evaluating, and implementing Resilient Minds™ for both Francophone fire fighters and Indigenous fire fighters who have been affected by or are at higher risk of trauma-related psychological impacts due to their line of work and the COVID-19 pandemic.

The *Training and Development Program for Public Safety Personnel* project improves access to relevant and urgent training for PSP and stakeholders. It expands upon CIPSRT's existing training program, the R2MR Train the Trainer Program, provides new modalities and increased reach for existing training, such as an electronic R2MR, and pilots the testing and expansion of the CIPRST's newest training opportunities, such as "Treatment 101."

The important work being done through these projects is a crucial part of the larger pan-Canadian effort to support the mental health and well-being of PSP, HCPs, military personnel, Veterans, and their families to heal, recover, and thrive in the COVID-19 environment and aftermath. The team at CIPHER is honoured to support, highlight, and promote the resources being created by these nine projects, and to support the well-being of all those who have sacrificed so much to ensure the health and safety of all Canadians.

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CONFLICT OF INTEREST DISCLOSURES

The authors declare that they have no conflicts of interest to report.

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ORIGINAL RESEARCH

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Mental health and wellness initiatives supporting United States law enforcement personnel: The current state-of-play

Jacqueline M. Drew* and Sherri Martin†

ABSTRACT

The current research provides a national snapshot of availability, access, and perceived effectiveness of wellness services and help-seeking stigma. This study is based on a sample of 3,994 police officers across the United States. The current study found a substantial percentage of officers are accessing wellness services, whether agency-provided, external, or a combination of both. Among officers who were most in need of wellness services, those experiencing some level of psychological distress, over 90% accessed at least one agency-provided or external service. Employee assistance program (EAP) services, formal and informal debriefings with managers and colleagues, chaplaincy services, and peer support were identified as some of the most common types of wellness programs provided by agencies and were also among the most effective wellness services as identified by officers who had accessed them. However, the research did highlight the need to consider gender, years of service, and agency size to provide a more nuanced view of psychological distress, support, and help-seeking stigma. Stigma associated with help-seeking remains a concern that must be addressed in police populations.

Key Words Police; psychological distress; wellness services; help-seeking; stigma.

INTRODUCTION

In recent years, significant focus has been placed on developing and providing wellness services for first responders. As numbers of U.S. law enforcement officers who died by suicide surpassed those killed in the line of duty (Ruderman Family Foundation, 2018), law enforcement advocates and leaders sounded the alarm for examining and addressing this issue. This has been coupled with readily acknowledged high prevalence rates of depression, anxiety, and post-traumatic stress disorder within police populations (Carleton et al., 2020; Regehr et al., 2019). Underpinned by the *Law Enforcement and Mental Health and Wellness Act* (2017), police agencies and advocacy organizations across the United States are gaining increased funding and assembling wellness programs, offering an array of services aimed at increasing officer well-being and preventing law enforcement suicides.

With increasing resources and funding expended on service development, it is imperative to ensure that services are available to all of the law enforcement community, that they are being utilized, and that they are effective. Stigma around mental health concerns remains a significant barrier to help-seeking, reducing the likelihood that police will access support services (Drew & Martin, 2021). A review of the literature found that as many as one-third of all first responders experience mental health stigma (Haugen et al., 2017; Wheeler et al., 2021). Despite the apparent increased availability of wellness services, law enforcement populations still experience higher rates of mental health concerns than the general population (Carleton et al., 2020). As such, availability, access, and perceived effectiveness of wellness services and help-seeking stigma are the focus of the current study.

Wellness Services in the Policing Context

As noted, police organizations now increasingly offer an array of professional clinical and non-professional informal peer-based resources to their employees. Historically, the service offered most widely by law enforcement agencies has been employee assistance programs (EAPs). Despite broad access to EAPs, and the potential benefits EAPs present, they are generally underutilized. Asen and Colon (1995) found that within a New Jersey police department, 70.2% of officers were

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aware of the EAP program, but only 22% of those surveyed used EAP to assist with their mental health. Similarly, in a nationwide survey of law enforcement officers conducted by the National Fraternal Order of Police (2018), nearly 80% of respondents reported being aware of EAP services available to them, but barely 20% had accessed the service (Fraternal Order of Police (FOP), n.d.). Carleton et al. (2019) reported that most of the public safety personnel in their large Canadian sample (74%, $n = 2,975$) would first seek care from their spouse. This perhaps suggests that informal mental health services may be perceived as more desirable than more formal, clinical services.

Much emphasis has been placed on peer support programs. Horan and colleagues (2021) concluded that peer support interventions are effective at increasing self-efficacy and intention to communicate with peers regarding mental health, directly assessing intent to harm self or others, and encouraging treatment-seeking in first responders. Mental health education is also provided through peer support models in the military and has shown to enhance engagement in mental health services among veterans (Weir et al., 2017). Jeannette and Scoboria (2008) found that first responders preferred to debrief with a peer following a critical incident, but that, as the incidents increased in severity, they preferred a more formal intervention with a professional.

While we have some insight into specific types of wellness programs that are being used by U.S. police agencies, research tends to focus on specific programs in isolation, such as EAPs or peer support programs. Research that identifies and quantifies the full range and scope of wellness services that are available to police across the United States remains understudied (Taylor et al., 2022). We need to understand what types of services are available, whether they are available to all police personnel, regardless of the size of agency, and importantly, what types of services police officers are most likely to access. The Bureau of Justice Assistance (2022) has recently highlighted the challenges faced by smaller agencies where there may be a lack of mental health service providers with which to even partner. By studying the range of wellness services available across the United States, this study can provide valuable information as to the perceived comparative effectiveness of services through the lens of those officers who have used such services.

Barriers to Help-Seeking

Barriers to help-seeking among law enforcement have been identified in the literature. Newell et al. (2022) identified three main barriers to help-seeking among police staff: stigma, worries about confidentiality, and occupation-specific experience with people in the community who present with mental distress. Corrigan (2004) identified that among these, stigma is the greatest barrier. The primary concern cited by police officers is often fear of being seen as weak or unfit for duty if they were to ask for help (FOP, n.d.). Drew and Martin (2021) found that over 90% of officers, based on a national study of U.S. law enforcement, perceive stigma as negatively influencing help-seeking behaviour, and even when officers access services and find them effective, stigma levels remain extremely high. Others have taken a more nuanced view, examining stigma as a function of agency size. Some researchers have noted that less stigma is reported in larger agencies than in smaller ones (White et al., 2016). One possible explanation is tied to availability of services: smaller agencies are likely to have fewer resources available. There might also be heightened concerns about confidentiality in smaller agencies, with a perception that it is more difficult for officers to keep their help-seeking behaviour confidential. Larger police agencies are often better equipped to provide a range of wellness services due to both larger budgetary resources and greater availability of services in their communities. It seems likely that a greater number of available wellness resources fosters a culture which normalizes the use of services and in turn, stigma decreases.

A study by Carleton and colleagues (2020) indicated that 43% to 60% of public safety personnel (including correctional workers, communicators, firefighters, paramedics, and police officers) would never, or only as a last resort, seek professional mental health care. Similarly, Berg et al. (2006), examining help-seeking among police officers, found that only 10.3% of officers who experienced serious suicidal ideation and depressive symptoms sought care from a psychologist or a psychiatrist. Newell et al. (2022) identified strategies for overcoming barriers to accessing mental health resources, including: ensuring confidentiality, providing accessible, uncomplicated resources, and providing police-specific services. First responders appear to prefer a mental health professional with experience as a first responder or military veteran. Many also approve of a provider who "knows the job," having worked with multiple first responders in the past. It is also important that providers be trained in trauma-informed methods, which is currently not a requirement for EAP therapists and may shed light on low levels of engagement with that service (Jones et al., 2020).

Current Study

The current study provides a national snapshot of availability, access, and perceived effectiveness of wellness services. The study seeks to capture variances in availability of a range of services provided by police agencies across the United States, rather than focusing on one or a few programs. It provides data on which wellness services, both agency-provided and external, are being accessed by police personnel. Importantly, we examine the perceived effectiveness of various wellness services by those who have accessed these services. The current study explores how both availability and access to services are linked with psychological distress outcomes and seeks to increase understanding of how availability and access to services are connected to help-seeking stigma.

METHODS

Data Collection

The sample for this study was drawn from the membership of the National Fraternal Order of Police (FOP). The FOP is the largest organization of sworn law enforcement in the world, drawing members from across the United States. Current membership of the FOP totals approximately 364,000 law enforcement members across more than 2,200 local lodges (FOP, 2023). In August 2021, a survey was launched at the FOP Biennial National Conference, attended by over 2,000 of the organization's most influential leaders with representation from every state as well as the District of Columbia. An online quantitative survey was deployed via the Survey Monkey survey platform, and the survey access link was sent via

email to members of the FOP and other known members of law enforcement. The survey link remained open and accessible for approximately 3 months, with the survey closing in November 2021. Ethics approval for the research was obtained through the Griffith University Human Research Ethics Committee. A response to the online survey was received from over 5,840 active and retired law enforcement officers.

Sample

Following data screening for responses with significant missing data, outliers, and restricting the sample to active-duty officers only, the current study is based on a sample of 3,994 sworn law enforcement officers from across the United States. Key demographic information for the sample is provided in Table I, below.

Variables

Psychological Distress

The Kessler psychological distress scale (K10) was used to measure non-specific psychological distress, indicating symptoms associated with depression and anxiety, that had been experienced by respondents within the previous 4 weeks (Kessler et al., 2003). The scale includes 10 items, with each item rated from 1 (none of the time) to 5 (all of the time); thus, higher scores indicate greater psychological distress. Two methods of scale summing were undertaken for this study. The first involved a calculation of a mean score and the second used a methodology that was developed for use in the Victorian Population Health Survey (Department of Human Services, 2001). This method produces the following K10 diagnosis categories: well, mild distress, moderate distress, and severe distress.

TABLE I Key demographics of sample

	Number	Percentage
Gender		
Male	3,363	85.2
Female	585	14.8
Years of Service		
Fewer than 5 years	351	8.8
5 to 10 years	646	16.2
11 to 15 years	677	17.0
16 to 20 years	784	19.6
21+ years	1,536	38.5
Agency Size		
1 to 25	497	12.5
26 to 50	472	11.8
51 to 100	534	13.4
101 to 250	859	21.5
251 to 500	454	11.4
501 to 1,000	565	14.1
1,001 to 3,000	336	8.4
3,001 and over	268	6.7
Geographic Location		
Southeast	872	21.8
Southwest	675	16.9
Northeast	1,276	31.9
Midwest	797	20.0
Northwest and Territories	363	9.1
Federal Agencies	11	0.3

Availability and Access to Agency-Provided Services

A scale was constructed based on consultation with the FOP Wellness Committee and a review of relevant literature to identify services that are provided within law enforcement agencies across the United States. A list of 10 items was presented to respondents. A rating scale was provided that allowed respondents to indicate whether or not the service was available in their agency. If the service was available, respondents were asked to indicate whether they had accessed the service or not. If the respondent indicated that they had accessed the service, they were asked to rate how helpful the service had been using a 5-point rating scale, ranging from "not helpful at all" to "extremely helpful." A higher rating indicated greater effectiveness of the service for that individual.

Access to External Services

Using the same method as discussed above, a scale was constructed to identify external wellness services that are being accessed by U.S. law enforcement personnel. A list of 8 items was presented to respondents, who were asked to indicate whether they had accessed each of the listed services. If the respondent indicated that they had accessed the service, they were asked to rate how helpful the service was using a 5-point rating scale, ranging from "not helpful at all" to "extremely helpful." A higher rating indicated greater effectiveness of the service for that individual.

Mental Health Stigma

A 5-item version of the Perceptions of Stigmatization by Others for Seeking Help (PSOSH) originally developed by Vogel et al. (2009) was used to measure factors that are likely to inhibit individuals from seeking psychological services. An introductory question was presented, "how much would each of the things listed below influence the likelihood that you would seek support," and items such as, "people in the agenwcy would think bad things of me" were provided for response. Respondents rated each item using a 5-category response scale, ranging from "not at all" to "a great deal." An overall mean was calculated to give a total scale score, with higher scores indicating greater perceived stigma.

RESULTS

Psychological Distress

Figure 1 provides an overview of the levels of psychological distress of the officers in the current study. It was found that 44% of officers are experiencing some level of psychological distress. Of the officers surveyed, 23.8% are experiencing moderate or severe psychological distress.

It was found that male officers (M=1.98, SD=0.69) reported significantly lower levels of psychological distress than their female officer colleagues (M=2.11, SD=0.74), t(2642) = 3.55, p < .001. Significant differences were also found in the experience of psychological distress as a function of years of service, F(4,2673) = 9.345, p<.001. Those officers who had 21 and more years of service (M=1.91, SD=0.66) had lower levels of psychological distress than officers with 5 to 10 years of service (M=2.12, SD=0.72); 11 to 15 years of service (M=2.06, SD=0.74); and 16 to 20 years of service (M=2.02, SD=0.72) (Figure 2). No significant differences were found for psychological distress as a function of agency size.

Availability of Wellness Services

Table II indicates that the most commonly available agency-provided service was an EAP or similar specialist psychological or psychiatric service. Over 90% of officers reported having access to this type of program. Over 80% of officers had access to programs such as chaplaincy services, substance abuse programs, and peer support. The least commonly available, although still available to over half of the officers surveyed, was annual mental health or wellness check-ups.

Table III reports on the availability of the top five agency-provided services that were identified in the previous table according to agency size. A rating of one indicates that this agency-provided service was the most reported service by officers employed in that size agency. A rating of nine indicates that this is the least reported service by officers employed in that size agency. Consistent with previous findings, regardless of agency size, employee assistance programs (EAPs) or similar specialist psychological or psychiatric services were the most available programs. It is interesting to note that availability of peer support, while commonly reported by officers employed in larger agencies (agencies with greater than 251 sworn staff), was reported by very few officers employed in smaller agencies (agencies with fewer than 51 staff). The opposite trend was noted for formal or informal debriefings, with data indicating that smaller agencies, particularly those with fewer than 251 sworn staff, may rely more heavily on this type of service to support staff, compared with larger agencies.

It should be noted that 1.5% of our sample indicated that their agency provided none of the services listed in the survey. About half of the sample (47.72%), indicated that their agency provided all 10 of the services listed (Figure 3).

Accessing Services

Collecting information about access to services involved asking officers about access not only to agency-provided services

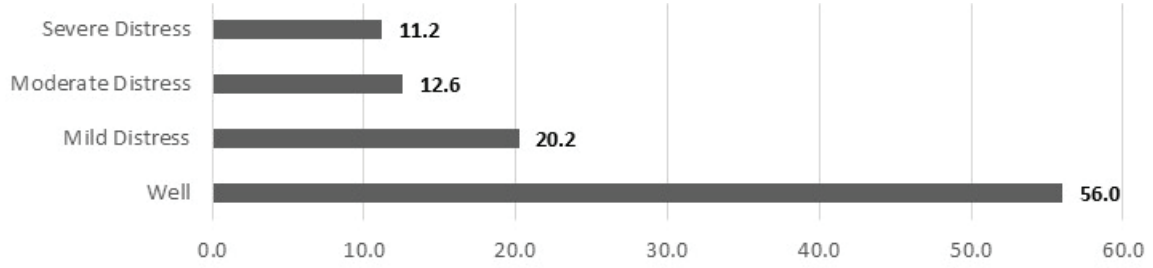

FIGURE 1 Psychological distress – K10 diagnosis categories

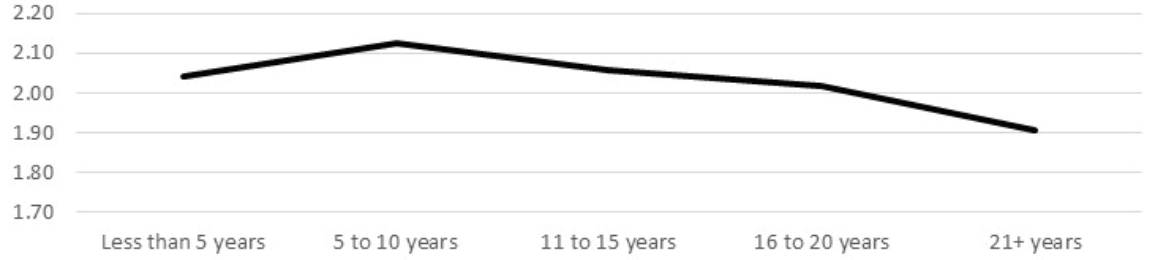

FIGURE 2 Psychological distress by years of service

TABLE III Availability of services (agency-provided) by agency size – top 5

Type of Program	1–25	26–50	51–100	101–250	251–500	501–1,000	1,001–3,000	3,001+
Employee assistance program (EAP)	1	1	1	1	1	1	1	1
Formal or informal debriefings	2	2	2	2	4	4	4	4
Chaplaincy services	6	4	3	3	2	2	2	3
Substance abuse program	4	3	4	5	5	5	5	5
Peer support	9	9	5	4	3	3	3	2

TABLE II Availability of services – agency-provided

Type of Program	Available
Employee assistance program (EAP) or similar specialist psychological or psychiatric services	92.92
Formal or informal debriefings with a manager or work colleagues	88.75
Chaplaincy services	84.77
Substance abuse program	82.19
Peer support	80.78
Online training/program for mental and physical self-care	78.52
Suicide awareness and prevention education/program	78.31
In person training/program for mental and physical self-care	76.53
Mental health first-aid (MHFA) training	71.79
Annual mental health or wellness check-ups	68.57

but also to external services. External services include services such as doctors, psychologists, and telephone counseling. Of the 2,678 officers who responded to questions about both agency-provided and external services, 10.87% of officers did not access any services. It may have been that they did not have any agency-provided services available to them, or that despite having services available (whether agency-provided or external), they did not access a service. Examining only those officers who did have services available to them (agency-provided or external) revealed that 9.9% of the sample did not access a service despite having the provision to do so.

Agency-Provided Services

Examining agency-provided services only (Figure 4), of those officers who had access to at least one agency-provided service, almost one half of officers accessed one to three services. Despite the almost universal availability of EAP services to officers, when examining engagement with this service, just over one-third of officers who had this service available to them engaged with it (Table IV). The most popular service was online training and programs for mental and physical self-care. This was followed by suicide awareness and prevention education/programs and peer support.

External Services

Just under 70% of respondents accesses some form of external services (Figure 5). The most accessed type of service was General Practitioners. This was followed by accessing internet resources for general wellness information and engaging with services provided by psychologists or psychiatrists (Table V).

Perceived Effectiveness of Wellness Services

The following two tables provide information about the perceived effectiveness of agency-provided and external services according to officers who have engaged with the service. Table VI indicates that the most effective agency-provided

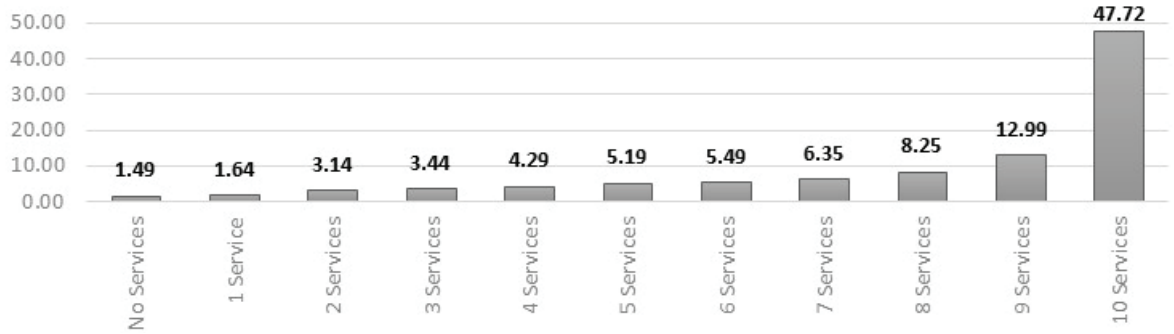

FIGURE 3 Number of services available – percentage of respondents who indicated availability of services (agency-provided)

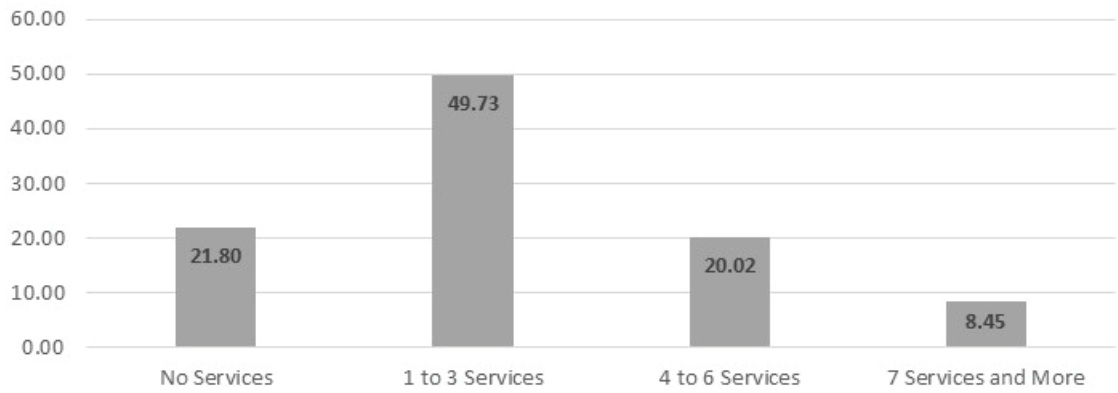

FIGURE 4 Available and accessed services (agency-provided) – percentage of respondents who accessed services

service is peer support, followed by chaplaincy services and EAPs. The most effective external service rated by those officers who had engaged with the service was other professional providers of mental health services, followed by psychologists and psychiatrists and general practitioners. The least effective external services were internet resources, either information around general wellness or internet support forums or support groups (Table VII). Across both agency-provided and external services, the type of services that received the highest effectiveness ratings (the top three rated as most effective) were all external services. This was then followed by the top three agency-provided services of peer support, chaplaincy services, and EAPs.

Demographic analysis revealed some interesting differences based on gender. For the top-rated agency-provided services, female officers (M=3.18; SD=1.43) rated peer support significantly more effective compared with their male colleagues (M=2.82; SD=1.14), $F(1,519)=7.74$, $p<.01$. Similarly, for the top-rated external services, female officers rated psychologists and psychiatrists ($F(1,467)=7.42$, $p<.01$; M=3.39; SD=1.21) and other professional providers of mental health services ($F(1,328)=5.91$, $p<.05$; M=3.48; SD=1.16), as being more effective than did male officers (M=3.00; SD=1.23 and M=3.10; SD=1.19, respectively).

Service Availability, Access, and Psychological Distress

The current research provides some insight into the potential impact of service availability and use of services on psychological distress. While the conclusions that can be drawn are far from conclusive or definitive, they do provide some guidance. It is encouraging that across both agency-provided and external services, around 93% of officers who were experiencing some type of psychological distress and who had access to services did use at least one service.

Agency-Provided Services

Of those officers who had a service available to them, around 80% of officers experiencing some level of psychological distress accessed at least one agency-provided service. Significant differences were found in the psychological distress being reported by officers as a function of whether or not they had agency-provided services available to them, $F(3,2674)=16.17$, $p<.001$. Those officers in agencies with 7 or more services available (M=1.94; SD=0.68) were significantly less likely to report psychological distress than officers in agencies that had no services available to them (M=2.26; SD=0.72); 1 to 3 services (M=2.17; SD=0.75); and 4 to 6 services (M=2.15; SD=0.73) (Figure 6).

Examining the proportion of officers who are accessing services as a function of their current level of psychological distress (Figure 7), around 80% of officers who report experiencing mild, moderate, or severe distress are accessing a

TABLE IV Accessed services – agency-provided

Type of Program	Available and Accessed (%)	Ranking
Employee assistance program (EAP)	33.40	5
Formal or informal debriefings	24.44	6
Chaplaincy services	20.09	8
Substance abuse program	14.97	9
Peer support	39.40	3
Online training/program for mental and physical self-care	58.11	1
Suicide awareness and prevention education/program	40.21	2
In person training/program for mental and physical self-care	37.45	4
Mental health first-aid (MHFA) training	22.03	7
Annual mental health or wellness check-ups	12.26	10

TABLE V Accessed services – external services

Services	Accessed (%)	Ranking
General Practitioner (GP)	61.00	1
Psychologist/Psychiatrist	17.80	3
Other professional provider of mental health services	12.50	4
Telephone/virtual (online) counselling	8.80	5
Complementary/alternative therapist	4.80	7
Alcohol or drug counsellor or support service	2.80	8
Internet, for general wellness information	29.20	2
Internet based (online) support forums or support groups	6.60	6

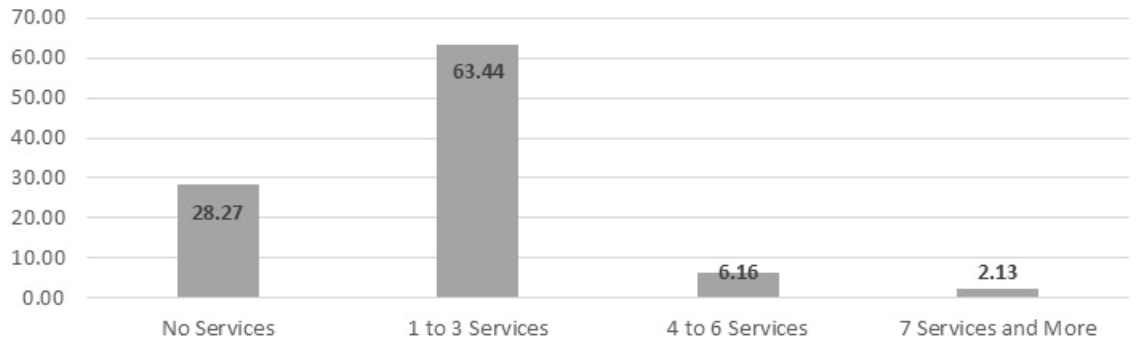

FIGURE 5 Accessed services (external) – number of services accessed

TABLE VI Effectiveness ratings of services (agency-provided)

Type of Program	Mean	Rank
Employee assistance program (EAP)	2.76	3
Formal or informal debriefings	2.63	6
Chaplaincy services	2.81	2
Substance abuse program	2.64	5
Peer support	2.89	1
Online training/program for mental and physical self-care	2.01	10
Suicide awareness and prevention education/ program	2.36	9
In person training/program for mental and physical self-care	2.41	7
Mental health first-aid (MHFA) training	2.40	8
Annual mental health check-ups or wellness check-ups	2.65	4

service when it is available to them. A significant percentage of officers who report being well (76.5%) are also accessing services. Officers experiencing mild, moderate, or severe distress are for the most part accessing one to three services (Figure 8).

External Services

Similar to the proportion of officers who report experiencing some level of psychological distress and accessing agency-provided services, almost 80% of officers experiencing some level of psychological distress accessed at least one external service. Also similar to the data reported in reference to agency-provided services, officers who are experiencing mild, moderate, or severe distress are generally accessing one to three external services (Figure 9).

TABLE VII Effectiveness ratings of external services

Services	Mean	Rank
General Practitioner (GP)	2.97	3
Psychologist/Psychiatrist	3.08	2
Other professional provider of mental health services	3.18	1
Telephone/virtual (online) counselling	2.67	5
Complementary/alternative therapist	2.91	4
Alcohol or drug counsellor or support service	2.42	6
Internet, for general wellness information	2.37	8
Internet based (online) support forums or support groups	2.38	7

Help-Seeking Stigma

An important aspect of understanding the use and effectiveness of mental health and well-being services in police populations is the stigma associated with help-seeking. In terms of demographics, significant differences were found on mental health stigma as a function of years of service

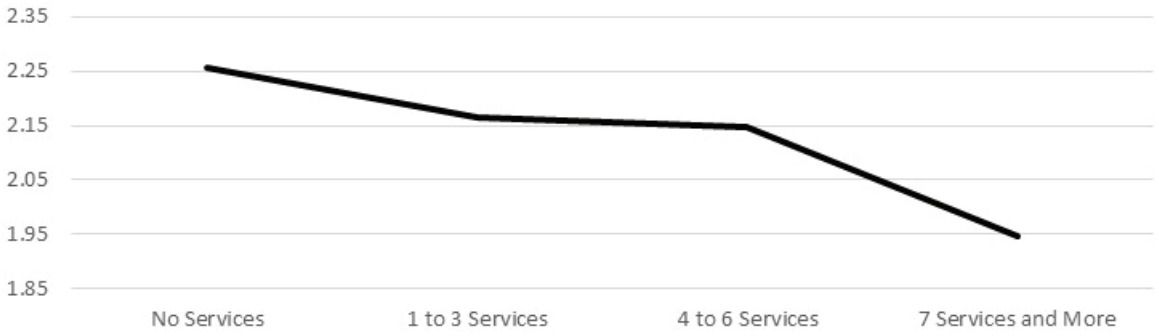

FIGURE 6 Reported psychological distress by number of available services (agency-provided)

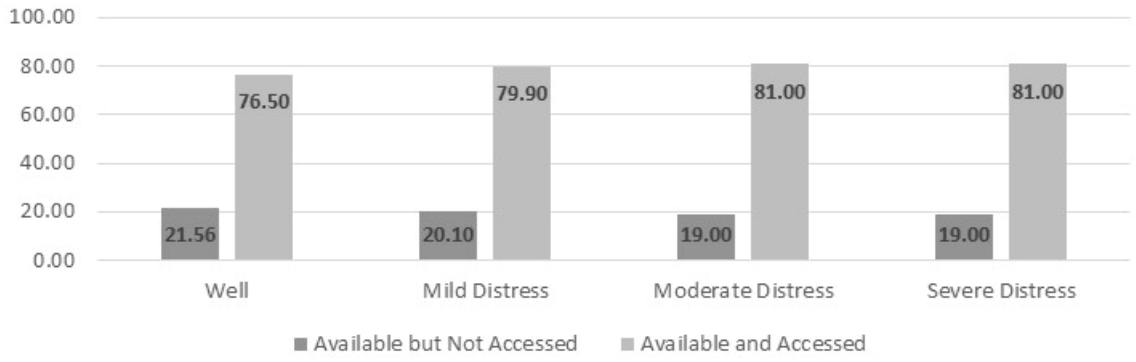

FIGURE 7 Percentage of respondents accessing available services (agency-provided) by level of psychological distress

F(4,3068)=4.166, $p<.01$. Those with fewer than 5 years of service (M=1.89; SD=1.07) compared with those with 5 to 10 years of service (M=2.24; SD=1.74); 11 to 15 years of service (M=2.14; SD=1.16); and 21 and more years of service (M=2.13; SD=1.11) had lower perceptions of mental health stigma (Figure 10). No significant differences were found on mental health stigma by gender or agency size.

We also considered the potential impact of the availability of services on help-seeking. Significant differences were found on perceptions of help-seeking stigma according to the number of services available in agencies, F(3,2673)=39.90, $p<.001$. Officers in agencies with seven or more services available (M=1.99; SD=1.05) were significantly less likely to hold perceptions of help-seeking stigma compared with officers in agencies that had one to three services (M=2.58; SD=1.24) and four to six services (M=2.52; SD=1.27) (Figure 11).

The study further revealed significant differences on help-seeking stigma according to whether officers had or had not accessed a service provided by the agency, F(1,2635) = 8.79, $p<.01$. Officers who had accessed at least one service (M=2.09; SD=1.10) had lower perceptions of help-seeking stigma than those in agencies where a service was available but who did not access it (M=2.25; SD=1.22) (Figure 12).

We were interested in the potential barriers that help-seeking stigma might pose to those officers who are most in need of services—those experiencing some level of psychological distress. Significant differences were found on perceptions of mental health help-seeking stigma between officers experiencing different levels of psychological distress, F(3,2672)=55.00, $p<.001$. Compared with officers who were well (M=1.91; SD=1.02), perceptions of mental health stigma were significantly higher for those who were experiencing mild (M=2.23; SD=1.12), moderate (M=2.40; SD=1.22), and severe (M=2.70; SD=1.27) psychological distress. Significant differences were likewise found between those experiencing mild and moderate psychological distress and those experiencing severe psychological distress (Figure 13).

DISCUSSION

The overarching aim of the current study was to provide a national snapshot of availability, access, and perceived effectiveness of wellness services. We have provided insights into whether wellness services are equally available across police agencies and the numbers of police officers who have access to services. Availability is important, but this research also focused on understanding what services officers choose to access. Our research examined what officers perceive to be most effective and how service availability and use is linked to help-seeking stigma and the overall rates of psychological distress in the police population.

The research confirms that developing wellness services must remain an urgent priority for police agencies, as we found that almost one-quarter of officers who responded to the survey were experiencing concerning levels of psychological distress, regardless of the size of the agency in which they worked. Further, elevated rates of psychological distress are present across the span of policing careers. The study

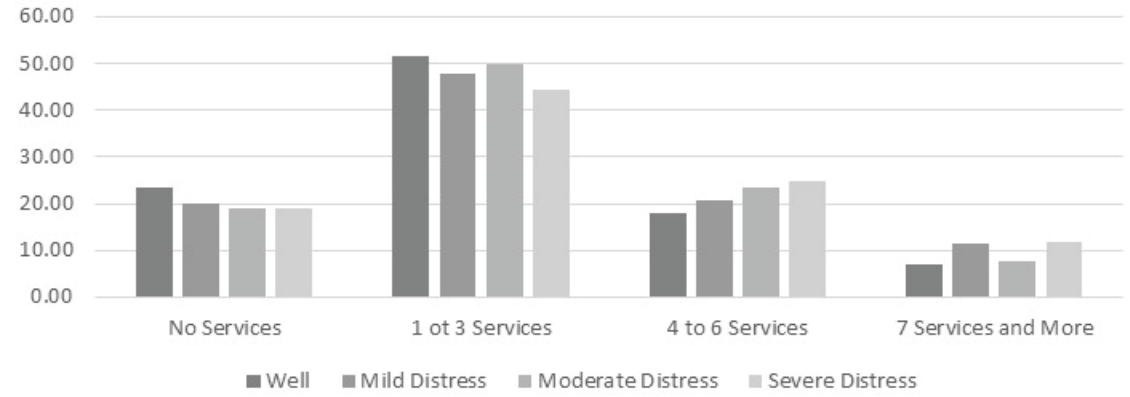

FIGURE 8 Available and accessed services (agency services) by psychological distress

FIGURE 9 Accessed services (external services) by psychological distress

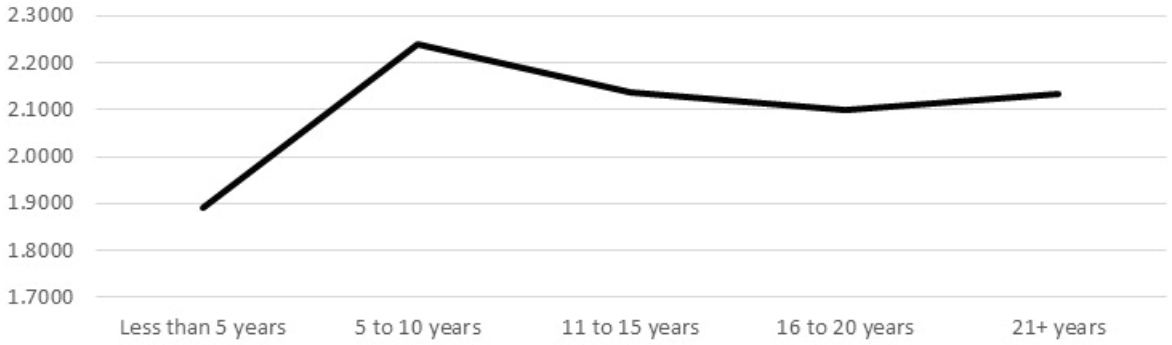

FIGURE 10 Perception of stigma associated with help-seeking according to years of service

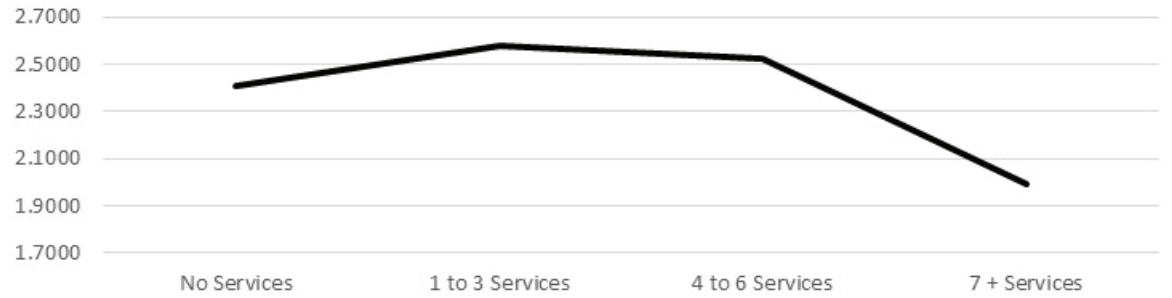

FIGURE 11 Stigma associated with help-seeking by services available (agency-provided)

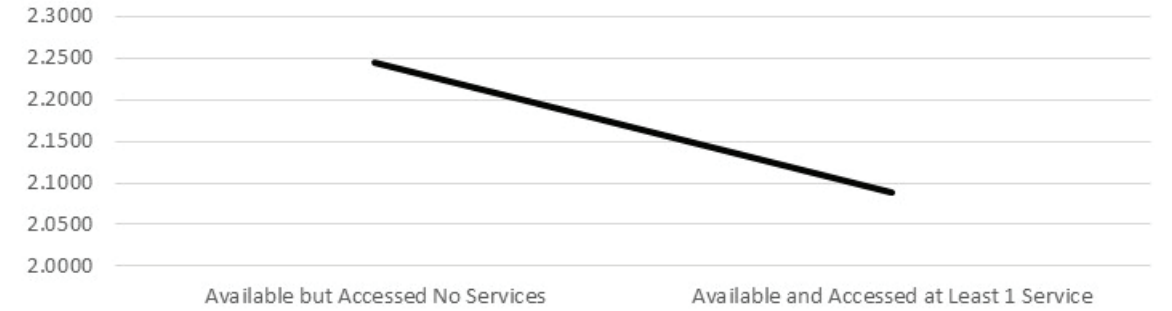

FIGURE 12 Stigma associated with help-seeking by services available and accessed (agency-provided)

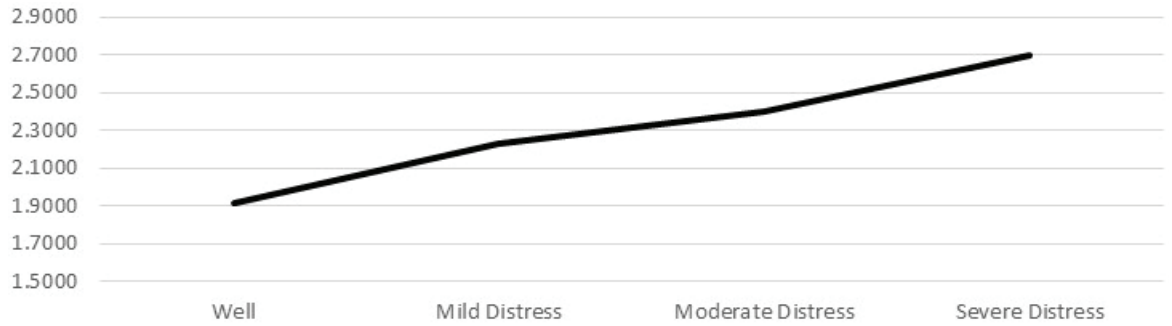

FIGURE 13 Stigma associated with help-seeking according to level of psychological distress

highlighted the need to focus increased attention on female officers given their rates of psychological distress. However, what was encouraging was that when female police did access wellness services (particularly, peer support and mental health professionals), they were more likely than their male colleagues to find them effective. The challenge will be to ensure that female officers, who might be most in need of support, have access to services and actively engage with them.

It was likewise encouraging that a very large percentage of officers in this sample indicated that they had accessed a wellness service, whether agency-provided, external, or a combination of both. When considering officers who were most in need of wellness services, those experiencing some level of psychological distress, over 90% of officers accessed at least one agency-provided or external service. For those officers in agencies where services were available, compared with agencies where there were no services, overall rates of psychological distress were lower. Whether agency-provided or external, officers experiencing psychological distress were accessing between one and three services. It should be acknowledged that recent research undertaken by Taylor et al. (2022) using agency level analysis found that 62% of U.S. agencies did not offer wellness services. The findings of both the current research and Taylor et al. (2022) point to the importance of understanding availability at the agency level. In addition, the present research highlights the importance of the proportion of officers in the law enforcement population who have services available to them.

The current research indicates that it is important for police agencies to offer a range of wellness services. Coupled with the findings provided above, we found that greater numbers of services offered by agencies was associated with lower overall reported rates of psychological distress. This points to the critical importance of agency-provided services alongside external services. It is important for police officers to be able to not only choose from a suite of options, but to also simultaneously engage with multiple channels of support. Our findings reveal that agencies have potentially begun to better promote the availability of services, addressing earlier research which found that officers often were unaware of where to access help (Karaffa & Tochkov, 2013). We also found preliminary evidence that greater availability of services may be beneficial in reducing help-seeking stigma.

Echoing previous conclusions, we found that EAP services and peer support are common types of wellness programs provided by agencies. Aligned with formal peer support programs, formal and informal debriefings with managers and colleagues and chaplaincy services were widely available. Peer support, EAP, and chaplaincy services were also among the most effective wellness services, as identified by officers who had accessed them. From this, it appears that agencies are on the right track in the types of programs they are offering; however, the issue of which services officers are accessing needs to be addressed. There is congruency between the availability, access, and effectiveness of peer support, but despite EAP and chaplaincy services being available and rated as effective, officers seem less likely to access these services. It may be that some EAP services are being provided by external providers who are not culturally competent with law enforcement. An often cited criticism of EAP services is that support is being provided by those who have no understanding of police work, yet it is important that police feel comfortable with the service and perceive that it is effective (Newell et al., 2022). Barriers to engagement with services that have been found to be effective, at least in the eyes of officers themselves, need to be further explored.

It should be noted that agency size did have some impact on the availability of services, particularly peer support. These differences are consistent with the findings of previous research (Taylor et al., 2022). It seems that in most agencies, regardless of size, EAP is provided. However, smaller agencies may be more reliant on formal and informal debriefings with managers and colleagues, rather than having access to a formal peer support program. Given the perceived effectiveness of peer support, further research is needed in smaller agencies to determine whether formal and informal debriefings with managers and colleagues are an adequate substitute for formal peer support programs or whether more investment is needed to ensure that all officers, regardless of agency size, have access to this service.

Our research found that, regardless of agency size or officer gender, help-seeking stigma is persistent across most of an officer's career. Those who are the most in need of wellness services had greater perceptions of stigma than those who were well. Further, those in severe distress had significantly greater perceptions of stigma than those whose levels of distress were lower. Help-seeking stigma is clearly something that still needs to be tackled within police populations. However, this research, in contrast to the findings of Drew and Martin (2021), indicates that encouraging access to services may have a positive impact on help-seeking stigma. Drew and Martin's (2021) research found that stigma perceptions continued to persist even when officers accessed services and found them helpful. Given these contradictory findings, more research is needed to explore how and why access to services might affect help-seeking stigma and how to increase the willingness of police to seek support.

The current study has provided an important contribution to the literature; however, the research has some limitations. Despite the study including police from across the United States to provide a national overview, the officers involved in the survey were recruited from the FOP membership. Future research should seek to diversify the sample population and include officers outside of the FOP. The current study did rely on officer perceptions. This is potentially advantageous in terms of understanding wellness service effectiveness as it provides a view through the eyes of police themselves; however, future research should be triangulated with more objective effectiveness measures. We have provided an important contribution to better understanding the effectiveness of wellness services and programs for police (Stelnicki et al., 2021), but research on this issue should continue.

CONCLUSIONS

The current research has provided a national snapshot of availability, access, perceived effectiveness of wellness services, and help-seeking stigma. We found encouraging results in terms of current availability and access of services by police officers across the country. However, our research highlighted the need to further explore how gender, years of service, and agency size must be considered if we are to gain

a more nuanced view of psychological distress, support, and help-seeking stigma.

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CONFLICT OF INTEREST DISCLOSURES

The authors have no conflicts of interest to declare.

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ORIGINAL RESEARCH

Journal of
COMMUNITY SAFETY & WELL-BEING

Stakeholder experiences of a public safety personnel work reintegration program

Chelsea Jones, PhD,* Shaylee Spencer, MSW,* Brenda Juby, MN,* Elly O'Greysik, BScN,* Lorraine Smith-MacDonald, PhD,* Michelle Vincent, PhD,* and Suzette Brémault-Phillips, PhD*

ABSTRACT

Public safety personnel (PSP) are at risk of experiencing operational stress injuries (OSIs). The functional impairments caused by OSIs can contribute to challenges with returning to pre-injury operational requirements. A Canadian municipal policing agency developed a peer-led workplace reintegration program (RP) to assist PSP in their workplace reintegration after an illness or injury. Although this RP has been used internationally, there is a paucity of research on this program and its implementation by PSP organizations. The perspectives of key stakeholders are important for capturing the current state of RPs and future directions for the advocacy, implementation, sustainability, and spread of the RP, and to set the stage for future research. The purpose of this study was to explore the experiences and perspectives of key stakeholders engaged in the creation, implementation, facilitation, and execution of RPs in Alberta, Canada. This will help identify strengths, barriers, facilitators, needs, processes, and attitudes associated with the RPs and direction for future research. A qualitative thematic analysis of focus groups (N=8) involving key stakeholders (N=30) from five PSP organizations with RPs was conducted using a community-engaged research approach as part of a larger mixed-methods study. Four key themes emerged from the participants: (1) Integral elements of success, (2) Integral needs, (3) Key areas of growth, and (4) Evolution of the Program. While RPs are highly regarded by the key stakeholders, it is essential that evidence-based research guide the evaluation, modification, implementation, spread, and scale of RPs globally.

Key Words First responders; return to work; workplace reintegration; operational stress injuries; mental health; post-traumatic stress; mental illness; return to duty.

INTRODUCTION

Public safety personnel (PSP) is an evolving term that encompasses personnel who ensure the safety and security of Canadians (e.g., border services officers, public safety communications officials, correctional workers, firefighters, Indigenous emergency managers, operational intelligence personnel, paramedics, police, search and rescue personnel, etc.; CIPSRT, 2019). PSP are at an elevated risk of experiencing operational stress injuries (OSIs), which are work-related psychological distress, mental illness, and workplace injuries that result from exposure to events and tasks that can be unpredictable, traumatic, and high-risk (CIPSRT, 2019). OSIs include a broad range of conditions, including post-traumatic stress disorder (PTSD), depression, anxiety, and other mental health disorders, that interfere with daily functioning (CIPSRT, 2019) as well as moral injury (Lentz et al., 2022). Operational stressors such as shift work, media involvement, and culture also contribute to the experience of OSIs (Carleton et al., 2019).

A Canadian study surveying 5813 PSP in Canada found that 36.7% of municipal police, 34.1% of firefighters, 50.2% of Royal Canadian Mounted Police (RCMP), and 49.1% of paramedical staff screened positive for a mental health condition such as PTSD, depression, anxiety, or substance abuse (Carleton et al., 2018). These conditions have the potential to impact an individual's quality of life and can result in decreased community integration, diminished cognitive functioning, increased social isolation, greater difficulty forming and maintaining meaningful relationships, increased workplace absenteeism, and increased prevalence of substance use disorders (Bisson et al., 2021; Edgelow et al., 2019). After a PSP has taken leave from their position due to illness or injury, functional impairments can contribute to challenges with returning to work in a present, meaningful, and engaged manner. A recent study found that PSP diagnosed with a psychological injury were less likely to return to pre-indicent work levels, and taking a longer time to do so, compare to PSP and civilians with only musculoskeletal injury (Gross et al., 2021).

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Peer support programs have been recognized by some PSP organizations as a component of an overall work reintegration strategy that may help PSP return to work following injury. Peer support refers to a variety of mental health supports and resources implemented via programs or services and offered by a peer who provides social or emotional assistance to a peer (Price et al., 2022). Higher quality effectiveness studies that incorporate stronger study designs, rigour, validity, and reliability are still needed to determine both the short- and long-term effectiveness of such initiatives (Price et al., 2022; Beshai & Carleton, 2016). A 2022 paper by Sutton and Polaschek reviewed the literature on initiatives that have been designed to support PSP in their workplace reintegration or continuation after critical incidents. They identified the incorporation of peer support, with a strong focus on stress and well-being outcomes and education, across all types of studies, but noted "a dearth of research into the influence of critical incident interventions on work performance, attitudes or experiences" (Sutton & Polaschek, 2022).

EDMONTON POLICE SERVICE REINTEGRATION PROGRAM

In 2009, the Edmonton Police Service (EPS) identified a need to assist police officers who were off work following a critical incident (e.g., officer-involved shootings). In response, they formalized workplace reintegration efforts by providing officers with peer support to process their critical incident and regain confidence with operational skills. Over time, the EPS Reintegration Program (RP) evolved, and it has spread to several other PSP organizations across Canada, the United States, and New Zealand. Although RPs may include elements specific to each PSP organization and profession, the goal of the programs remains to assist PSP to return to work as soon as possible following a critical incident, illness, or injury, while diminishing the potential for long-term psychological injury (Edmonton Police Service, 2018).

The RP incorporates both a short- and long-term critical incident RP stream (Edmonton Police Service, 2018). Detailed descriptions of the RP have previously been published (Klose et al., 2017). The RP includes relationship building, reintroduction to equipment, skill building, and exposure to operational scenarios; the participating PSP is guided by a trained peer RP Facilitator through a step-by-step process that addresses the unique stressors that the PSP may experience (Edmonton Police Service, 2018). Support offered by RPs is complementary to clinical interventions but outside the scope of what officers receive from their healthcare professionals (i.e., psychologists, occupational therapists, etc.; Edmonton Police Services, 2018). RPs may assist worker's compensation organizations to facilitate positive outcomes for officers attempting reintegration after developing an OSI. To date, however, information regarding the potential success of the program has been largely anecdotal. Although there has been preliminary research regarding the effect of the RP Facilitator Training Program developed by EPS on the mental health knowledge, attitudes (Jones et al., 2022), and perspectives of attendees (Jones et al., 2021), the RP itself has not been formally studied.

The experiences and perspectives of RP key stakeholders can facilitate a better understanding of the current state of the RPs and provide future direction for the advocacy, implementation, feasibility, sustainability, and spread of the RP. They may also set the stage for future research that would more rigorously analyze the effectiveness of the RP, as recommended in previous publications (Beshai & Carleton, 2016; Sutton & Polaschek, 2022).

Purpose

The purpose of this qualitative study was to explore the experiences and perspectives of key stakeholders engaged in the creation, implementation, facilitation, and execution of RPs within the province of Alberta, Canada. We aimed to gather information regarding the strengths, barriers, facilitators, needs, processes, and attitudes that contribute to the current RPs within five Alberta PSP organizations. Through this study, we hope to set the stage for future research regarding the effectiveness, safety, efficacy, and feasibility of RPs in various jurisdictions.

Methods

This qualitative study utilized a community-engaged research approach to collect data from key stakeholders of the RP in Alberta (Barkin, et al., 2013; Esmail et al., 2015). Ethical approval was received from the Research Ethics Board at the University of Alberta (Pro00118357).

Participants and Recruitment

Study participants included RP facilitators as well as health, wellness, human resources, and mental health services personnel, organizational leaders, and policy-makers within participating PSP organizations. Key stakeholders were engaged if they were able to offer insights into practice, policy, or practical considerations regarding the RP, or had experience and involvement with the implementation of the RP within their organizations.

Study participants were recruited through snowball and purposeful sampling. Key contacts within PSP organizations helped disseminate recruitment emails through their networks. Potential participants were asked to contact the research team directly and were screened for inclusion before consenting to study participation.

Data Collection

Data was collected between September and November 2022. Consent and demographic questionnaires were administered via REDCap (Research Electronic Data Capture), which is a secure, web-based software platform (Harris et al., 2019). A semi-structured focus group script was designed by the research team, which contributed to deductive data collection. 60-minute focus groups (n=8) were conducted and recorded via videoconferencing with Zoom according to existing literature and guidelines (Stewart et al., 2007). Each focus group was specific to a single PSP organization, but heterogeneous with respect to professional representation and experience. This allowed for broad discussion and the collection of rich, comprehensive data. Data collection continued until information power was reached based on the process outlined by Malterud et al. (2016). Information power considers study aim, sample specificity, established theory, quality of dialogue, and analysis strategy, which would ideally also correlate with data saturation.

Data Analysis

Quantitative data was analyzed descriptively with Microsoft Excel software. Audio or video-recorded focus groups and interviews were transcribed and thematically analyzed deductively and inductively following an iterative process (Braun & Clarke, 2006). Through an inductive process, initial codes were developed by identifying themes that presented from the data. Three researchers independently conducted open coding for each focus group, after which an arm's length researcher reviewed and provided feedback on the codes. An analysis of the preliminary themes followed, with discussion around any conflicting ideas. Once the final themes were determined, key quotes were isolated to illustrate the themes and the final presentation of the thematic analysis was prepared.

Results

Demographic details of study participants (N=30) are presented in Table I. Study participants belonged to one of five participating PSP organizations and had varying levels of experience and involvement within their respective RPs. It was noted that three of the five organizations had implemented both the short-term critical incident and long-term RP streams. Although not explicitly captured through the questionnaires, it was observed that some stakeholders had also engaged in the RP as a PSP participant and utilized this in their own return to work following an illness or injury.

The data exhibited dense sample specificity, and strong, focused dialogue, which allowed the perceived information power to be reached with fewer participants than originally anticipated (Malterud et al., 2016). The research team

TABLE I Demographic information of the key stakeholder participants

Demographic Category	Participants n (%)
Gender	
Man or masculine	15 (50%)
Woman or feminine	15 (50%)
Transgender man, male, or masculine	0 (0%)
Transgender woman, female, or feminine	0 (0%)
Gender nonconforming, genderqueer, or gender questioning	0 (0%)
Two-spirit	0 (0%)
Not listed	0 (0%)
Prefer not to specify	0 (0%)
Sex	
Female	15 (50%)
Male	15 (50%)
Intersex	0 (0%)
Prefer not to specify	0 (0%)
Ethnicity[a]	
White	25 (83%)
South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)	1 (3%)
Chinese	1 (3%)
Black	0 (0%)
Filipino	0 (0%)
Latin American	0 (0%)
Arab	0 (0%)
Southeast Asian (e.g., Vietnamese, Cambodian, Laotian, Thai, etc.)	0 (0%)
West Asian (e.g., Iranian, Afghan, etc.)	0 (0%)
Korean	0 (0%)
Japanese	0 (0%)
Indigenous (First Nations, Metis, Inuit)	1 (3%)
Other/Unknown	3 (10%)
Prefer not to say	0 (0%)
Education Level[a]	
Some high school	0 (0%)
High School diploma	4 (13%)
Vocational or technical college	3 (10%)
College diploma	11 (37%)
Some undergraduate	3 (10%)
Undergraduate degree	7 (23%)
Graduate degree	4 (13%)
Unknown	2 (7%)
Professional Role Related to RP	
Senior leadership	5 (17%)
Manager	2 (7%)
Administrative support	3 (10%)
Licensed healthcare provider (medical doctor, psychiatrist, nurse, psychologist, occupational therapist, social worker, mental health therapist, etc.)	1 (3%)
Reintegration program coordinator/facilitator	0 (0%)
Peer support provider	9 (30%)
Other[f]	3 (10%)
PSP Organizations	7 (23%)
Edmonton Police Services[b]	5 (17%)
Calgary Police Services[b]	5 (17%)
Alberta Health Services[c]	6 (20%)
Royal Canadian Mounted Police – K Division[d]	7 (23%)
St. Albert Fire Services[e]	
Number of Years in Role Related to RP	
<1	0 (0%)
1–3	13 (43%)
4–6	6 (20%)
7–10	3 (10%)
10+	6 (20%)
Unknown	2 (6%)
Number of Years in Profession	
<1	1 (3%)
2–5	0 (0%)
6–10	4 (13%)
11–15	4 (13%)
16–20	8 (27%)
21–25	8 (27%)
25+	3 (10%)
Unknown	2 (6%)

RP = reintegration program; PSP = public safety personnel.

[a]Totals greater than N=30 as participants could select more than a single option; [b]Municipal policing organization; [c]Emergency medical services; [d]National policing organization; [e]Fire and rescue services; [f]Other professions included positions within human resources and disabilities management departments.

experienced saturation, where no new patterns emerged from the data thereafter, after four focus groups and 12 participants. Through the thematic analysis, four main themes were identified: (1) Integral elements of success, (2) Integral needs, (3) Key areas of growth, and (4) Evolution of the program (Figure 1). The themes are summarized below, with detailed descriptions and supporting quotes within Tables II to V.

Theme 1: Integral Elements of Success

Overall, two key elements to the success of the RP were identified by stakeholder participants. Credibility and buy-in were identified as the most integral elements, followed by collaboration between internal and external stakeholders at varying levels within and outside the respective PSP organization (Table II).

Theme 2: Integral Needs

Key stakeholder participants identified integral needs of the RP centering around staffing challenges. RP facilitator positions were observed to have substantive workload demands while being emotionally demanding. Such a tempo creates potential for staff to experience their own psychological injury. Also highlighted was the imperative to have the "right person for the job," and the challenges in assuring the best candidate for the RP is selected to support the program. Participants further identified the need for a diverse team with RP facilitators who are respected and knowledgeable in their field (Table III).

Theme 3: Key Areas of Growth

Participants identified several means of strengthening the RP, including enhanced communication, education, and training processes. They credited education and communication stemming from the RP as components of recent growth in organizational acknowledgement and acceptance of mental health challenges. Participants celebrated this growth while also acknowledging that additional short- and long-term goals and initiatives are needed to facilitate continued forward movement and improved organizational culture (Table IV).

Theme 4: Evolution of the Program

Key stakeholder participants were enthusiastic to share the history of implementation of their respective RPs, as well as describe the current state of their program. Although there are differences between the RPs, such as engagement with rural versus urban areas, resource and staffing allocations, program size, and stage of implementation, there were multiple similarities in both the origins, present state, and future vision of the RPs (Table V).

FIGURE 1 Results of thematic analysis: Four themes

TABLE II Integral elements of success

Subtheme	Description and Quotes
1.1 Credibility and Buy-In	Participants noted that the credibility of the RP internally, externally and at all levels of the organization was integral to its implementation and sustainability. Belief in the program allowed for autonomy and resource allocation. Credibility and buy-in also contributed to outside stakeholders, such as Workers Compensation Boards (WCBs) and healthcare professionals, referring to the program and regarding it as an effective step in the recovery for PSP affected by mental health challenges. External stakeholder buy-in, such as WCBs, healthcare professionals, and unions, was identified by participants as an integral piece of the RP's success. At the program level, participants identified that factors such as being client-centered, trauma-informed, and providing the client with control, choice, and autonomy in their recovery contributed to the buy-in and credibility of the program within the organization. Dedicated and trained RP facilitators, who strongly believed in the effectiveness of the program, also built credibility through peer support. *"...organizational credibility is absolutely paramount as well. So that the members that are coming to you in a time of need have that trust and that ability to build rapport with you and understand kind of where you're coming from and the things that you've done within the organization so far beyond that."* (FG3)
1.2 Widespread Collaboration	Widespread collaboration internally and externally and at all levels of the organization was noted as being a critical element of the RP's success. RP facilitators collaborated with other facilitators, departments, and units, such as Disability Management, Human Resources, or specialty units, within the organization to facilitate understanding of the reintegration process and create specific exposure experiences. Outside the organization, collaboration with WCBs, healthcare professionals, and other community partners was needed to ensure a seamless process for PSP from clinical care to workplace reintegration. *"I think the biggest improvement we've seen is when we decided we're not on an island, and that we can collaborate with other people and solve things together. So, as we move towards that, I think we're going to see the successes grow."* (FG8)

RP = reintegration program.

TABLE III Integral needs

Subtheme	Description and Quotes
2.1 Workload Demands	Participants widely agreed that increased demand for RP services is a significant stressor for the RP staff and program as a whole. This demand was intensified due to limited resources. Participants recognized that this left RP staff themselves at risk for developing an OSI, including burnout. *"you are exposed to, you know my psychologist says, cumulative stress and…vicarious trauma. You know, that's the big piece, and we have to be aware of that and when we develop these types of programs that we are putting our facilitators in positions where they may, based upon their lived experience, activate themselves into a trauma response."* (FG5) *"But without the stability of committed financial support, this program will always be on shaky ground. And I say that from just a numbers game, but also the vicarious trauma of our staff, getting too overworked so it will go to full crisis collapse. And we're going to have nothing. And that's falling on deaf ears a little bit. Because the rest of the service isn't people-centered like this."* (FG7)
2.2 "The right people for the job."	Participants identified the need for appropriate training for facilitators to ensure they were engaging with RP participants through a trauma-informed lens. They also advocated for RP facilitators to exhibit adequate mental health literacy, individual resilience, coping strategies and skills, and insight into their own mental and emotional health. They observed challenges finding the right people for RP facilitator positions, noting that seniority and hiring guidelines did not always allow for passionate candidates who had the aforementioned knowledge and skill to be successful. *"I think having a really strong dedicated self-care practice is fundamental. Like we've got to practice what we preach, because then that authenticity comes through and I think it's easier for people to receive that. I know that. I mean, most of us that are already on this team, do it because we want to be helpful and we are supportive, but we've got to make sure that we set healthy boundaries and we have that good self-care place so that we don't get hurt through the process."* (FG2)
2.3 Diverse Staffing Positions	Participants identified the need for integrative and multifaceted teams to support the facilitation of the program and recommended specific administrative and clinical roles to assist the RP facilitators. *"to have a mental health professional within the program, not only to support our coordinators, but you know, having ensured there's no…vicarious trauma or compassion fatigue, but also being able to answer questions that our coordinators may have on, on what…their members are going through and whatnot."* (FG6). *"So, having that administrator, that dedicated administrative support, you can't put a value on it with words. I mean, it's just so important… *name* ensures a seamless process from referral to…a completed reintegration. That's a very important job."* (FG6)

RP = reintegration program; OSI = operational stress injury.

TABLE IV Key areas of growth

Subtheme	Description and Quotes
3.1 Communication	Participants emphasized the importance of communication among stakeholders. Good communication policy and processes were observed to break down organizational silos, facilitate an interdisciplinary approach to service delivery, mitigate duplication of services, and assist with advocating for program support and resources. Participants identified a need to hone current communication practices to assist in collaborating with internal departments, organization administrators, and external stakeholders, such as referring clinicians, Worker's Compensation Boards (WCBs), community partners, or other PSP organizations. *"*name* keeps the leadership team totally informed about stages, and where they are at, maintaining confidentiality, but just in terms of what they need to know. And so, what's critical is just keeping people informed. And then also, I think, just the overall communication in the organization about the program. So, lots of discussion about it, lots of promotion and discussion at the highest levels; like our chief, he looks for opportunities where he can have…somebody talk about (it).* (FG3)
3.2 Education and Training	Participants reiterated the importance of thorough training for RP facilitators through a set curriculum on topics related to mental health and wellness, trauma-informed approaches, and facilitation of RP activities such as workplace exposures. Additionally, education was identified as important amongst the wider PSP organizations. This might assist with identifying mental health challenges among PSP, mitigating the effects of real and perceived mental health stigma, and enhancing engagement in, not only RPs, but other support and services. Externally, there was a strongly expressed need for stakeholders, such as WCB and healthcare professionals, to understand the RP program, organizational and profession-specific culture, job expectations, and operational demands of PSP. Finally, there was discussion regarding the need for implementation and organization of widespread education and training to other organizations that plan to implement RPs across Canada. *"I think going forward, the education piece…educating our members as to…what the reintegration program's going to be looking like, …is it going to be something that's developed over time with, you know, what resources we have, and everything else that goes around that…especially with new recruits and our own members, I think that it goes a long way. And I guess, giving people comfort that they do have those resources available if they find themselves kind of going astray. … the best answer is just the communication piece and the boots on the ground – people seeing that people are actually doing something.* (FG8)
3.3 Organizational Culture: Shift in Mental Health Knowledge and Stigma	It was noted that organizational culture and stigma regarding mental health knowledge and acceptance has evolved positively within PSP organizations. Participants expressed that this is likely due to a multitude of factors, one of which included the RP itself as well as the education provided by the RP staff to the wider organizations on other mental health-related topics. This was perceived as assisting with improving overall mental health knowledge and reducing stigma. *"…having the peer support over the last five years has been huge in changing just the culture around *organization*. I think more people see that that support is there. Right? And if it's needed, that they have something to lean on. I also…think that…them seeing that there's…so many stakeholders kind of stepping together to try to get this reintegration established, I think it naturally does start to kind of change a culture around the hall to see that…a member is supported, right. They do have resources and somewhere where they can go.* (FG8)

RP = reintegration program; PSP = public safety personnel.

TABLE V Evolution of the program

Subtheme	Description and Quotes
4.1 Past Implementation	It was noted that, in some cases, there was a traumatic loss for the PSP organizations which may have spurred interest in a formalized RP. Participants reported that there was a gap in the process of PSP returning to work after a critical incident or illness/injury. It was noted that some PSP were having challenges returning to work which led to the identified need for more assistance with workplace reintegration. Participants identified that programs often started, "off the side of the desk," and buy-in at micro, meso, and macro levels was noted to be swift. Policy and procedure evolution and development, however, was slower, and continues to evolve. *"the gap was just that members were left wanting a bit more, as before we would work with members after a shooting through the integration program; members would get a gun and they would just go back to work. And there wasn't that acknowledgement by the organization that they had been through something traumatic…members just felt like they needed something more after a shooting, but no one knew what that would really look like."* (FG4)
4.2 Present State	As the RP grows, a focus on wellness and confidence building emerged rather than simply a return-to-work program involving workplace exposures. This evolution continues, with the engagement and collaboration of internal departments, such as human resources, disability management, and wellness units, internal and external healthcare providers, and external entities such as workers' compensation organizations. As some organizations have province-wide jurisdiction, the range and scope of the RP has spread to accommodate rural areas of the province. Despite some organizations trialing virtual methods of RP delivery, in-person delivery was still widely preferred. *"I think the reintegration program has been able to expand the scope of not just building comfort and confidence in their skill sets, again, but also advocating for members outside of the reintegration parameters in a number of different areas."* (FG6)
4.3 Envisioning the Future	Looking forward, participants envisioned evolution that involved implementation of the RP for other PSP, healthcare providers, and other civilians. Additionally, some advocated for the expansion of the program to provide services and support to the family members of the PSP engaged in the RP. Participants also acknowledged the demand for the program and the current/eventual need for growth that could involve additional infrastructure, space, and staffing. *"I think it [need for workplace reintegration] lands mainly in PSP. And what I mean by that is, if we're going to rebuild confidence, and we're going to do it through shooting, driving, control tactics… same thing with firefighters, paramedics, nurses, correctional officers, CBSA [Canadian Border Services Agency]…I think it can be any industry truly, I could be an office worker who witnesses a co-worker have a medical event."* (FG4) *"dedicated training facilities for the facilitator courses, and maybe hub areas where we can base those full-time teams out of and then have everybody travel down if they want to – better, better refer to the program to the major centers where we'd have access to maybe the occupational therapist or a firing range or scenario-based training venue, things like that, to make it just maybe a little bit easier."* (FG6)

RP = reintegration program; PSP = public safety personnel.

DISCUSSION

The purpose of this qualitative study was to explore the experiences and perspectives of key stakeholders engaged in RPs within Alberta. We uncovered perspectives regarding the current state of the RPs across PSP organizations to better understand the unique strengths, barriers, facilitators, needs and processes, as well as cultural aspects and attitudes associated with the RP. The themes that emerged from the data are reflected in the existing literature regarding the mental health and wellbeing of PSP and their respective organizations.

In the first theme, widespread credibility and buy-in throughout the organization was noted to be paramount to the program's implementation and sustainability. This is consistent with existing literature demonstrating that programs valued by PSP organizations and stakeholders will encourage greater participation and engagement (Sutton & Polaschek, 2022). Conversely, a negative reception of a program may indicate that participants regard the content as irrelevant or may perhaps point to deeper problems with organizational culture (Lennie et al., 2020). Peer-led programs are also generally regarded favourably by PSP (Sutton & Polaschek, 2022). The key stakeholder participants regarded their respective RPs highly. They believed the RPs contributed to better return-to-work outcomes and had a high economic return on investment. They also noted that collaboration, both internal and external to their respective organization, was another key to the success of the RP.

Within Theme 2, high workload demands for RP facilitators was the most notable challenge identified. Participants noted that a lack of attention to the evolving staffing needs and operational demands within the RP could be a major threat to the programs and potentially contribute to OSIs among RP staff themselves. A recent literature review addressing the impact of organizational factors on the mental health of PSP organizations found that high workload and limited resources were negative organizational factors frequently cited by paramedics and firefighters that contribute to negative mental health outcomes (Edgelow et al., 2022). This was reflected in the data among the PSP stakeholders, as it pertained to PSP's role in operating the respective RPs. Adequate staffing levels, along with co-worker and supervisor support, are positive organizational factors that facilitate better mental health among PSP organizations (Edgelow et al., 2022). Additionally, the sub-theme of, "the right people for the job," has been found in previous literature regarding the RP Facilitator Training Program (Jones et al., 2021).

Future planning, development, organization, implementation, and spread of education, training, and communication policies and processes internal to the respective PSP

organizations as well as to external stakeholders was identified in the third theme as an area of growth. Further, education, training, and communication among PSP regarding mental health topics has been shown to improve organizational wellness among PSP (Edgelow et al., 2022). For police, workplace culture was the most frequently encountered negative organizational factor that affected the mental health of staff (Edgelow et al., 2022). Efforts to improve workplace culture, reduce stigma, and provide organizational support could contribute to better mental health among PSP. The RP, through promotion and education, has been shown to play a role in these efforts. Furthering engagement internal and external to PSP organizations through educational efforts as well as expanding resources to help more PSP with workplace reintegration across Canada was envisioned by participants, all of whom were positive about the future direction of the RPs as noted in Theme 4.

Recommendations

Based on the existing evidence-based literature and the results of the current study, the authors have provided key recommendations for future implementation, sustainability, and spread of the RP. As one participant expressed, recommendations include access to, "the right people, right budget, and appropriate sphere of influence:"

- Buy-in must be facilitated, communicated, and modeled from the top down to influence sustainable cultural change throughout all levels of the organization (Jones et al., 2021).
- Stable and rewarding RP facilitator positions must be created with designated full-time equivalents as opposed to voluntary positions or work done in addition to regular duties (Jones et al., 2021).
- Strong communication policies, plans, and practices must be developed that allow for increased awareness and understanding of the RP as well as the process, information, and referral flow for internal and external stakeholders alike.
- Hiring policies and practices must be delineated that allow candidates to be vetted for RP positions to ensure they are a good fit for RP work and exhibit authenticity, motivation, mental health knowledge, resilience, and insight into their own mental and emotional well-being.
- Integration of support initiatives and access to services must be facilitated in the event RP staff are experiencing mental health distress as a result of their reintegration work. This may include integration of other allied health professionals into the program to support staff directly.
- High-quality RP effectiveness studies that incorporate stronger study designs, rigour, validity, and reliability are needed (Beshai & Carleton, 2016). A determination of long-term effects of the RP is also required, together with an assessment of potential risk of harm to the participants and facilitators (Jones et al., 2022).
- As the goal of the RP is to enhance workers' effective return to work, future research should incorporate constructs and conditions which may correlate with success in sustained return to work such as measures of absenteeism, presenteeism, organizational injustice, work function and performance, perceived stigma, as well as mental health knowledge and attitudes (Sutton & Polaschek, 2022).
- If research is favourable, use of effective implementation science approaches would best facilitate sustainable spread and scale of the RP, enabling more PSP and civilian professions to receive support in their return to work (Jones et al., 2022).

Limitations

Several limitations are associated with the study. First, a convenience sample which drew on pre-existing relationships with a small number of PSP organizations was used. Second, significant work demands, related and unrelated to the RPs, limited the ability of many key stakeholders to engage in the study. Third, focus groups were used, which does not allow for complete anonymity of participants. As a result, some participants may not have been as open with their responses with their peers present. Finally, as with all PSP research, the hierarchical nature of PSP organizations may affect a participant's ability to discuss these topics openly.

CONCLUSION

Engagement with key stakeholders of the RP over the course of this study provides additional insights into the elements of success, needs, areas of growth, and evolution of the RP. While this RP holds promise, a strong standardized evidence base is essential to guide the implementation, evaluation, modification, spread, and scale of it globally. Continued research, collaboration, and evaluation of the RP may allow for the development of a best practice model. Such a model may assist PSP with workplace reintegration after illness and injury while contributing to continued growth in PSP organizational cultures with respect to mental health knowledge, stigma, and support.

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CONFLICT OF INTEREST DISCLOSURES

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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ORIGINAL RESEARCH

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Mental health stigma and help-seeking intentions in police employees

Daniel W. Grupe*

ABSTRACT

Mental health problems among police employees are exacerbated by negative attitudes and beliefs around mental health help-seeking that are perpetuated by police culture. We collected anonymous survey data from 257 civilian and commissioned police employees in a mid-sized, Midwestern U.S. city to test hypothesized relationships among help-seeking stigma, help-seeking attitudes, and intended help-seeking behaviour. Results demonstrated that mental health help-seeking stigma was negatively associated with help-seeking attitudes, and in turn with reduced mental health help-seeking intentions. Structural equation modeling provided support for a model linking help-seeking stigma, help-seeking attitudes, and intentions to seek help. This path model was moderated by psychological distress and previous participation in mindfulness training, which had opposing effects on help-seeking stigma and (indirectly) on intended help-seeking. Results provide insight into policies, practices, and interventions that police agencies may enact to combat stigma, positively influence mental health help-seeking, and improve the mental health and well-being of police employees and the broader community.

Key Words Perceived stigma; self-stigma; mindfulness; psychological distress.

INTRODUCTION

High rates of mental health difficulties among police professionals are well documented and have widespread negative consequences. A national Canadian survey found that 37% of municipal and provincial police officers and 50% of federal officers screened positive for a mental health disorder (Carleton et al., 2017). A separate meta-analysis reported rates of 15% for posttraumatic stress disorder (PTSD), 14% for depression, 11% for generalized anxiety disorder, and 25% for hazardous drinking (Syed et al., 2020). Psychological distress is accompanied by restricted attention, self-regulatory difficulties, fatigue, and increased anger and aggression, all of which impede officers' ability to bring clear thinking, careful attention, and empathic, non-discriminatory responses to community members in need (Goff & Rau, 2020; Ma et al., 2013; Rajaratnam et al., 2011). Enhancing police mental health is essential for the well-being of those in the profession and the broader community.

Police culture plays a key role in this mental health crisis (Tuckey et al., 2012). Police officers are socialized to maintain control over emotions lest they interfere with decision-making, performance, or career advancements (Karaffa & Koch, 2016; Karaffa & Tochkov, 2013; Tuckey et al., 2012). Acknowledging emotional difficulties or offering emotional support runs counter to traditional ideals of masculinity, leading to shame or ridicule by one's peers (Pasciak & Kelley, 2013). Seeking help for mental health challenges may raise questions about one's fitness for duty (Drew & Martin, 2021). As a result, police officers often avoid or suppress emotions that are a natural response to the stress and trauma of their work, often coping with these emotions by abusing alcohol or other drugs or engaging in other destructive behaviours (Karaffa & Tochkov, 2013; Pasciak & Kelley, 2013; Rees & Smith, 2008).

Previous research (Vogel et al., 2007) suggests a pathway that discourages individuals experiencing psychological distress from seeking out mental health support (Figure 1). "Public stigma"—or culturally transmitted messages that mental health help-seeking is undesirable or unacceptable—can become internalized as "self-stigma," or one's *personally held* beliefs about the social unacceptability of seeking help and the negative impact of help-seeking on one's self-worth. Self-stigma is proposed to negatively affect specific attitudes about seeking help, which in turn discourages help-seeking behaviour. Research utilizing qualitative (Marin, 2012; Newell et al., 2022; Ricciardelli et al., 2020) and quantitative (Drew & Martin, 2021; Wester et al., 2010) methods has demonstrated that public stigma and self-stigma are powerful barriers to help-seeking intentions among police officers. Further, research

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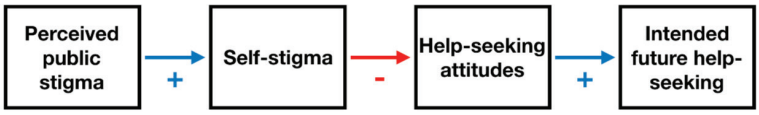

FIGURE 1 Theoretical path model. Theoretical model linking perceived public stigma, self-stigma, help-seeking attitudes and intended future help-seeking (based on Vogel et al., 2007).

with police officers validated portions of the Vogel et al. (2007) model initially validated in undergraduate students, demonstrating that self-stigma mediated the relationship between perceived public stigma and treatment-seeking attitudes (Karaffa & Koch, 2016). This suggests that stigma-reducing interventions may improve police officers' attitudes about seeking help, but the researchers did not investigate the impact of negative help-seeking attitudes on help-seeking intentions, as has been demonstrated in non-police populations (Li et al., 2014).

The primary goal of this study was to validate this model of mental health help-seeking intentions (Vogel et al., 2007) in a law enforcement population. By replicating previous findings relating stigma to help-seeking attitudes (Karaffa & Koch, 2016), and extending results to encompass intentions to seek help, this research may indicate proximal targets for interventions with the long-term goal of increased help-seeking and improved mental health outcomes. In contrast to prior research (Karaffa & Koch, 2016), the current study includes civilian employees, who are often overlooked in police mental health research despite reporting similar or higher rates of burnout, anxiety, and depression as commissioned personnel (McCarty & Skogan, 2013; Carleton et al., 2017; Lentz et al., 2020). The secondary goal was to investigate moderators of help-seeking intentions, including demographic characteristics, self-reported psychological distress, and past exposure to mindfulness training. Mounting evidence suggests mindfulness training has broad physical and mental health benefits for policing (Christopher et al., 2018; Grupe, Stoller, et al., 2021), and it may be less stigmatizing than interventions focused on symptom reduction due to its preventive, strength-based approach to promoting well-being. Moderator analyses highlight individual differences that may influence the pathway linking stigma, attitudes, and help-seeking intentions, thus facilitating the development of tailored help-seeking interventions among police employees.

METHODS

Pre-Registration

Hypotheses and data collection and analysis plans were pre-registered prior to data collection in May 2020 on the Open Science Framework (https://osf.io/zyk9d). The pre-registration included analyses investigating the impact of mandatory wellness checks on variables of interest, but this paper focuses on data from a single time point (due to the elimination of wellness checks following departmental budget cuts).

Participants and Recruitment

Study procedures were approved by the University of Wisconsin-Madison Minimal Risk Institutional Review Board. All employees of the Madison Police Department, Fitchburg Police Department, and University of Wisconsin-Madison Police Department (all in Dane County, WI, USA) were invited to participate in this research (the Fitchburg Department was added after pre-registration to increase sample size). The study was advertised across shift changes and in e-mails distributed to all employees over a 2-week period in May 2020. Notably, this research took place as agencies were adapting to rapidly changing operational conditions in the early months of the COVID-19 pandemic. Additionally, the end of data collection took place in the days following the murder of George Floyd by former Minneapolis police officer Derek Chauvin on May 25 (only 7/257 responses were obtained after May 25).

Data Collection

Recruitment e-mails included a link to a description of study procedures, informed consent language, and survey questions using the Qualtrics platform. Complete information on survey measures is provided in Supplemental Methods. Briefly, surveys included:

- Demographics and job information.
- Patient-Reported Outcomes Measurement Information System, 29-item version (PROMIS-29; Hays et al., 2018), from which we analyzed anxiety and depression subscales.
- Perceived Stress Scale, 10-item version (PSS-10; Cohen & Williamson, 1988).
- Perceived Stigma and Barriers to Care for Psychological Problems (Britt & Cox, 2008), which includes a measure of perceived public stigma of help-seeking.
- Self-Stigma of Seeking Help Scale (Vogel et al., 2006), which reflects the internalization of perceived public stigma.
- Mental Help Seeking Attitudes Scale (Hammer et al., 2018), which reflects one's general perceptions (positive or negative) of mental health counseling.
- Past and future utilization of mental health resources. This in-house measure, adapted from previous research with Canadian public safety personnel (Carleton et al., 2020), lists 14 resources for mental health support and asks how many participants had previously utilized or would consider utilizing them in the future.
- Previous mindfulness training. Participants indicated whether they had participated in an 8-week mindfulness training offered to commissioned personnel as part of prior research (Grupe, Smith, et al., 2021; Grupe, Stoller, et al., 2021).

We also included questions about agency culture and climate, and experiences related to COVID-19, which were not analyzed here (see Supplemental Methods).

Data Analysis

Statistical analysis was conducted using RStudio (version 1.2.5042; RStudio Team, 2020) in the R programming environment (version 3.6.3; R Core Team, 2020). Linear regression

analyses using the lm() library were used to test pre-registered hypotheses regarding factors associated with help-seeking attitudes, previous utilization of mental health resources, and help-seeking intentions. Regression analyses included covariates of agency, civilian/commissioned status, gender, and years of experience. In addition to regression models for individual dependent variables, we used the lavaan() library (Rosseel, 2011) to conduct a path analysis testing the fit of a model linking perceived help-seeking stigma, self-stigma, help-seeking attitudes, and help-seeking intentions (Lin, 2021; Figure 1). To test hypothesized moderators, we constructed a model with exogenous variables corresponding to prior mindfulness training and psychological distress symptoms. Psychological distress was operationalized as the standardized sum score of the PSS-10 and PROMIS anxiety/depression scores. See Supplemental Methods for full data analysis details.

RESULTS

Table I includes information on demographics and work. Across all agencies, 257 individuals provided informed consent, including 189 commissioned and 68 civilian staff. This represents approximately 20 to 30% of employees from each of these agencies, and generally reflects the ratio of civilian/commissioned staff in these departments. Table II contains descriptive information for self-report measures. Notably, civilian staff reported higher levels of perceived stress ($t(250) = 2.27$, $p = 0.024$, 95% confidence interval [CI] [0.28, 3.89]), anxiety ($t(250) = 3.66$, $p < 0.001$, 95% CI [1.78, 5.87]), and depression than commissioned staff ($t(250) = 3.95$, $p < 0.001$, 95% CI [2.26, 6.75]). See Supplemental Results for other commissioned/civilian differences.

Mental Health Stigma and Help-Seeking Attitudes

Controlling for agency, civilian/commissioned status, gender, and years of experience, perceived public help-seeking stigma was negatively associated with help-seeking attitudes ($r_{partial}(249) = -0.36$, 95% CI [-0.46, -0.25], $p < 0.001$; Figure 2A). A more robust relationship was observed for self-stigma and attitudes toward mental health help-seeking ($r_{partial}(249) = -0.63$, 95% CI [-0.70, -0.55], $p < 0.001$; Figure 2B). A mediation analysis using lavaan demonstrated the relationship between perceived public stigma and help-seeking attitudes was fully mediated by self-stigma (total effect estimate = -0.053, $p < 0.001$, 95% CI [-0.069, -0.037]; direct effect estimate = 0.00, $p = 0.99$, 95% CI [-0.017, 0.018]; indirect effect estimate = -0.053, $p < 0.001$, 95% CI [-0.070, -0.040]; Figure 2C). Generally consistent with hypotheses, prior mindfulness training was associated (at trend-level) with reduced perceived public stigma and more positive help-seeking attitudes (but not self-stigma), and greater psychological distress was associated with greater perceived public stigma, greater self-stigma, and more negative help-seeking attitudes (see Supplemental Results for details).

Help-Seeking Attitudes and Intended Help-Seeking Behaviour

A novel questionnaire created for this study listed 14 resources police employees might seek out for mental health support. On average, participants reported utilizing 6.3 of these resources in their lifetime (range = 0–13) and 4.1 of these resources over the past 12 months (range = 0–10; Table III and Supplemental Results). To operationalize past and future (intended) mental health help-seeking, we tallied how many resources participants utilized in the past 12 months, and those they "might" or "would definitely" consider utilizing in the future.

TABLE I Participant demographics and job characteristics*

	Civilian Employees	Sworn Employees	All Employees
Gender			
Woman	47 (69%)	76 (40%)	123 (48%)
Man	21 (31%)	113 (60%)	134 (52%)
Age Range			
18–24	3 (4%)	11 (6%)	14 (5%)
25–34	21 (31%)	55 (29%)	76 (30%)
35–44	15 (22%)	62 (33%)	77 (30%)
45–54	17 (25%)	53 (28%)	70 (27%)
55 or older	11 (16%)	6 (3%)	17 (7%)
Prefer not to say	1 (1%)	2 (1%)	3 (1%)
Race			
Asian/Pacific Islander	2 (3%)	2 (1%)	4 (2%)
Black	0 (0%)	4 (2%)	4 (2%)
Native American	0 (0%)	1 (1%)	1 (0%)
White	63 (93%)	170 (90%)	233 (91%)
More than one	1 (1%)	5 (3%)	6 (2%)
Prefer not to say	2 (3%)	7 (4%)	9 (4%)
Ethnicity			
Hispanic or Latinx	2 (3%)	15 (8%)	17 (7%)
Not Hispanic or Latinx	65 (96%)	169 (89%)	234 (91%)
Prefer not to say	1 (1%)	5 (3%)	6 (2%)
Years of Work Experience			
0–4	27 (39%)	45 (24%)	72 (28%)
5–9	15 (22%)	27 (14%)	42 (16%)
10–14	13 (18%)	37 (20%)	50 (19%)
15–19	5 (7%)	32 (17%)	37 (14%)
20 or more	8 (12%)	47 (25%)	55 (21%)
Prefer not to say	0 (0%)	1 (0%)	1 (0%)
Job Classification			
Civilian non-supervisor	57 (84%)	–	–
Civilian supervisor	10 (15%)	–	–
Police officer	–	112 (59%)	–
Detective/investigator	–	32 (17%)	–
Sergeant	–	20 (11%)	–
Management	–	21 (11%)	–
Prefer not to say	1 (1%)	4 (2%)	–

*Percentages may not add up to 100% due to rounding.

Controlling for agency, civilian/commissioned status, age, and years of police service, help-seeking attitudes were positively associated with utilization of mental health support in the past 12 months ($r_{partial}(248) = 0.28$, 95% CI [0.16, 0.39], $p < 0.001$; Figure 3A). A statistically stronger relationship was observed between help-seeking attitudes and *future* help-seeking

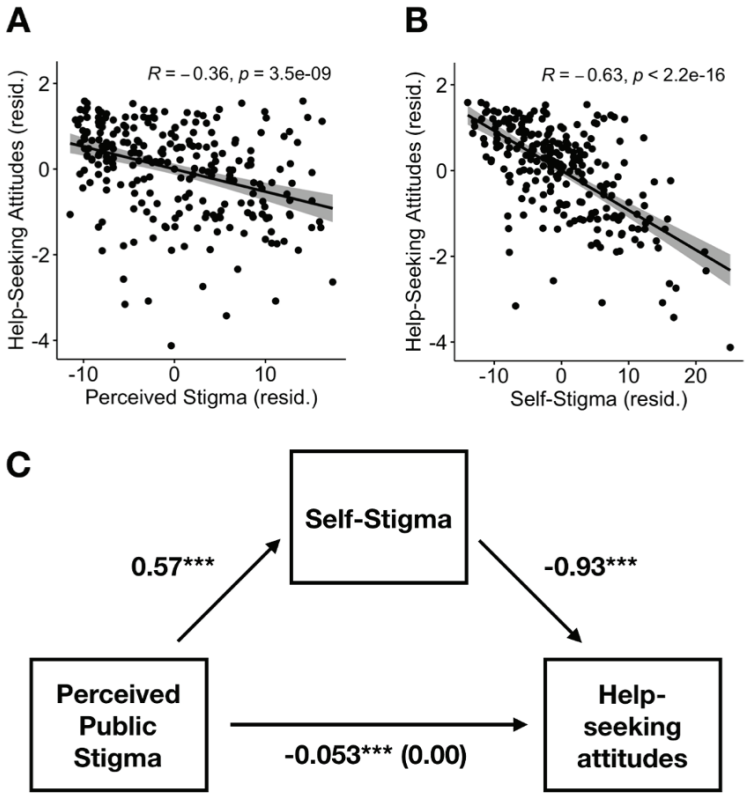

FIGURE 2 Perceived stigma, self-stigma, and help-seeking attitudes. Increased perceived public stigma (A) and self-stigma of help-seeking (B) were each associated with more negative help-seeking attitudes, controlling for police agency, civilian/commissioned status, gender, and years of work experience. (C) The relationship between perceived public stigma and more negative help-seeking attitudes was fully mediated by self-stigma of help-seeking. *** = p<0.001.

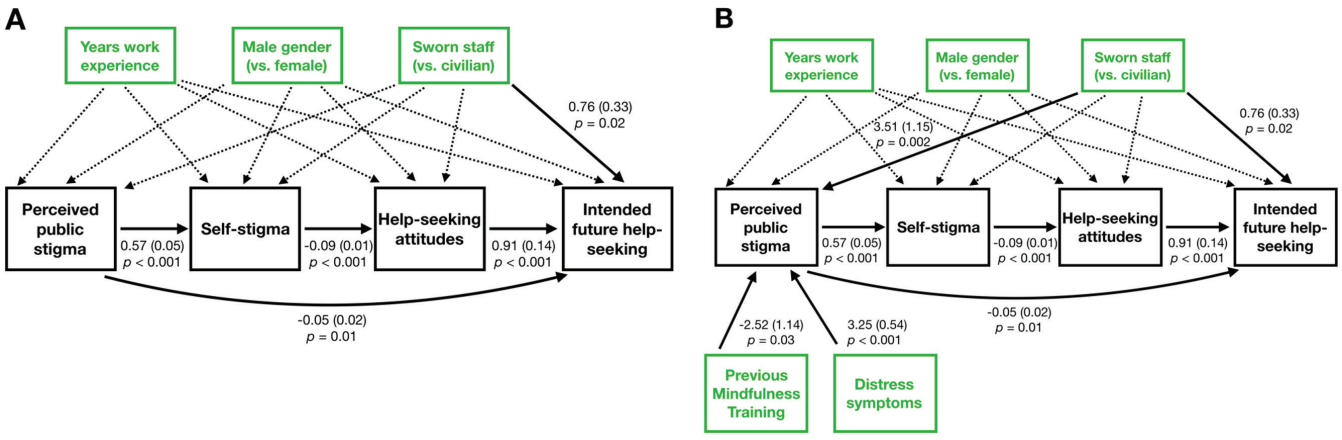

FIGURE 3 Final path analyses. (A) Structural equation modeling provided evidence of a good fit for a path model linking increased perceived public stigma, increased self-stigma, more negative help-seeking attitudes, and decreased future intended help-seeking. There was a significant direct path from job classification to help-seeking intentions, with increased intended utilization of resources among sworn relative to civilian staff. (B) The inclusion of moderating variables indicated an indirect effect of greater psychological distress symptoms on decreased intended help-seeking via increased perceived public stigma. In contrast, previous mindfulness training contributed indirectly to greater future help-seeking via decreased perceived public stigma. The inclusion of moderators also resulted in a significant path between job classification and perceived public stigma, with sworn vs. civilian staff reporting greater stigma that resulted indirectly in decreased intended help-seeking.

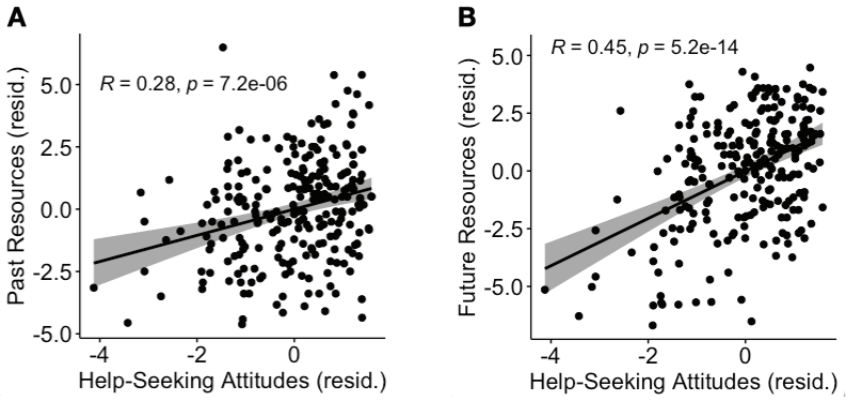

FIGURE 4 Help-seeking attitudes and utilization of help-seeking resources. Controlling for police agency, civilian/commissioned status, gender, and years of work experience, more positive attitudes towards seeking help were associated with greater past utilization of mental health resources (A) and increased intentions to utilize mental health resources in the future (B).

TABLE II Descriptive information for self-report questionnaires*

	Civilian Employees	Sworn Employees	All Employees
Perceived Stress Scale	15.7 (7.2)	13.6 (6.1)	14.2 (6.5)
PROMIS Depression	52.5 (8.4)	48.0 (7.8)	49.1 (8.2)
PROMIS Anxiety	57.3 (7.3)	53.5 (7.3)	54.5 (7.5)
Distress Composite	0.34 (0.96)	-0.11 (0.82)	0.0 (0.9)
Perceived Stigma	15.2 (7.7)	16.4 (7.6)	16.1 (7.7)
Self-Stigma	22.1 (7.6)	23.6 (7.6)	23.2 (7.6)
Help-Seeking Attitudes	5.7 (1.1)	5.7 (1.1)	5.7 (1.1)
Number of Mental Health Resources Used			
Lifetime	5.7 (2.7)	6.5 (2.6)	6.3 (2.7)
Past 12 Months	3.7 (2.3)	4.2 (2.1)	4.1 (2.2)
May Consider in Future	10.2 (2.9)	10.8 (2.3)	10.6 (2.5)

*All values reflect means (standard deviations in parentheses).

intentions ($r_{partial}(247) = 0.45$, 95% CI [0.35, 0.55], $p < 0.001$; difference between correlations: William's $t(246) = 2.48$, $p = 0.01$; Figure 3B). Consistent with hypotheses, prior mindfulness training was associated with greater past and intended utilization of mental health resources. Greater psychological distress was associated with greater past resource utilization but *lower* intended future resource utilization (see Supplemental Results for details).

Path Analysis of Mental Health Help-Seeking Stigma, Attitudes, and Intentions

Using lavaan, we modeled the path analysis depicted in Figure 1, with exogenous variables of civilian/commissioned status, age, and years of police service (police agency was weakly associated with all endogenous variables, all p values > 0.4, and was excluded from the model). Fit indices suggested this model fit the data well ($\chi^2(3) = 6.420$, $p = 0.093$; comparative fit index [CFI] = 0.988; Tucker-Lewis Index [TLI] = 0.927; root mean square error of approximation [RMSEA] = 0.068, $p = 0.268$; Akaike Information Criterion [AIC] = 5059). We added a direct path from perceived public stigma to intended mental health help-seeking, as suggested by a high modification index using the modindices() function. The resulting model had improved fit indices ($\chi^2(2) = 0.086$, $p = 0.958$; CFI = 1.000; TLI = 1.000; RMSEA = 0.000, $p = 0.977$; AIC = 5054), and is shown in Figure 4A.

An additional model included prior mindfulness training and psychological distress as potential moderators. This model fit the data excellently ($\chi^2(8) = 4.563$, $p = 0.803$; CFI = 1.000; TLI = 1.000; RMSEA = 0.000, $p = 0.957$; AIC = 5021; Figure 4B). Examination of individual pathways showed significant direct effects of psychological distress ($Z = 6.07$, $b = 3.25$, $p < 0.001$) and prior mindfulness training on perceived public stigma ($Z = -2.21$, $b = -2.52$, $p = 0.03$). Psychological distress was indirectly associated with *lower* intended help-seeking through *increased* perceived public stigma, whereas prior mindfulness training was indirectly associated with *higher* intended help-seeking through *decreased* perceived public stigma.

DISCUSSION

Results of this cross-sectional study in 257 commissioned and civilian police employees provide support for a pathway in which perceived public help-seeking stigma becomes internalized as self-stigma, leading to negative help-seeking attitudes and reduced intentions to seek mental health support. These findings underscore the importance of perceived public stigma—police employees' beliefs about what others might think if they sought out mental health support—for help-seeking intentions. In previous research, police officers underestimated the extent to which coworkers wanted to seek help for mental health concerns (Karaffa & Koch, 2016) and believed that *others* were less interested in seeking help than they were *themselves* (Karaffa & Tochkov, 2013). Individuals may not recognize that coworkers' behaviours and attitudes around help-seeking reflect a desire to fit in with the group, as opposed to personally held beliefs and values. By highlighting this discrepancy between *perceptions* and *realities* of attitudes about help-seeking, police organizations may

TABLE III Percentage of all staff, civilian staff, and sworn staff who indicated that they had utilized specific mental health resources*

	Percent Who Utilized Resource in Past				Percent Willing to Utilize Resource in Future			
Resource	**All Employees**	**Civilian Employees**	**Sworn Employees**	**Fisher's Exact *P***	**All Employees**	**Civilian Employees**	**Sworn Employees**	**Fisher's Exact *P***
Chaplain	1.6%	4.5%	0.5%	0.06	13.5%	12.1%	14.1%	0.83
Critical Incident Stress Debriefing	64.9%	**25.8%**	**78.9%**	**<0.001**	52.6%	**30.3%**	**60.5%**	**<0.001**
Counseling (Inside Law Enforcement)	38.2%	39.4%	37.8%	0.88	40.2%	43.9%	38.9%	0.56
Counseling (Outside Law Enforcement)	47.8%	54.5%	45.4%	0.25	49.4%	51.5%	48.6%	0.77
Crisis Hotline	2%	3%	1.6%	0.61	10%	13.6%	8.6%	0.24
Family Therapy	31.9%	34.8%	30.8%	0.12	34.3%	36.4%	33.5%	0.76
Friend (Inside Law Enforcement)	78.9%	**57.6%**	**86.5%**	**<0.001**	68.1%	**53%**	**73.5%**	**0.003**
Friend (Outside Law Enforcement)	81.7%	80.3%	82.2%	0.71	70.9%	69.7%	71.4%	0.87
Medications	27.5%	34.8%	24.9%	0.15	24.3%	22.7%	24.9%	0.87
Mindfulness/ Meditation	68.1%	66.7%	68.6%	0.76	55.4%	53%	56.2%	0.67
Minister/Faith Leader	13.5%	15.2%	13%	0.68	17.9%	15.2%	18.9%	0.58
Partner/Family Member	87.3%	81.8%	89.2%	0.14	77.3%	72.7%	78.9%	0.31
Peer Support	29.5%	**13.6%**	**35.1%**	**<0.001**	31.1%	**16.7%**	**36.2%**	**0.003**
Supervisor	53.8%	56.1%	53%	0.77	30.7%	39.4%	27.6%	0.09

*Percentage of use in their lifetime (left columns) or in the future (right columns). Significant group differences between civilian and sworn staff as calculated using Fisher's exact test are bolded.

be able to correct erroneous beliefs of "what everybody else thinks" and shift both group norms and individual attitudes about seeking help (Karaffa & Koch, 2016). This combination of group norms and individual attitudes is posited to influence intentions to engage in behaviour change (Azjen & Fishbein, 1980), and our finding that help-seeking attitudes were associated with increased help-seeking intentions suggests that correcting erroneous attitudes and beliefs about help-seeking may encourage greater help-seeking behaviour across the organization.

Stigma, Help-Seeking, and Policing

Moving the needle on perceived help-seeking stigma is challenging in a culture that strongly values stoicism and views emotional difficulties as a sign of weakness (Drew & Martin, 2021; Tuckey et al., 2012). Fortunately, our results suggest that changing beliefs about help-seeking may not require changes in widespread cultural beliefs. Our finding that the negative impact of perceived public stigma on help-seeking attitudes was fully mediated by self-stigma—replicating previous research in undergraduate (Vogel et al., 2007) and police samples (Karaffa & Koch, 2016)—suggests that interventions targeting *self-stigma* around help-seeking can change help-seeking attitudes, which represent the most proximal factor for intended behaviour change (Azjen & Fishbein, 1980). A report commissioned through the 2017 Law Enforcement Mental Health and Wellness Act (Spence et al., 2019) suggested regular mental health check-ins could help destigmatize the help-seeking experience and encourage additional help-seeking behaviour, particularly if made mandatory for all employees and not just those perceived as having "a problem." The same report, however, also noted the absence of empirical support for the impact of these check-ins.

Opposing Influences of Mindfulness and Distress on Help-Seeking Intentions

A "foundational step" for increasing mental health help-seeking, argue Drew and Martin (2021), is normalizing the negative emotions that arise in an environment full of trauma, loss, and human suffering. Acknowledging and talking about these natural emotional responses, rather than avoiding or suppressing emotions to project a façade of strength and control, may encourage help-seeking when the impact of occupational stress and trauma becomes overwhelming. Engaging in these conversations in a supportive group setting with one's peers may be especially helpful in normalizing these experiences and reducing help-seeking stigma. Indeed, we found that previous participation in an 8-week, group-based mindfulness training was a significant moderator of the path proceeding from perceived public stigma to help-seeking intentions. Mindfulness practices support greater awareness of internal sensations, emotions, and thoughts and encourage curiosity and acceptance of challenging experiences, rather than avoidance or suppression. These data are correlational, and mindfulness participants may have entered the training with lower levels of stigma or more positive help-seeking attitudes than their peers; prospective designs are needed to establish a causal role of mindfulness for promoting mental health help-seeking.

In contrast to relationships with mindfulness training, greater psychological distress was associated with greater perceived stigma and reduced help-seeking intentions. Elevated stigma among those with more mental health symptoms presents a paradox for encouraging help-seeking. Mental health interventions may need to be framed in terms of skill-building or as addressing less stigmatized needs (e.g., improving sleep or strengthening relationships) to effectively

engage these individuals. Notably, participants generally reported greater interest in seeking support from family, friends, and peers as opposed to mental health professionals (Table III). Providing members of these networks with resources or knowledge about how to effectively provide mental health support could be a valuable intervention strategy that circumvents the barrier of help-seeking stigma.

Civilian Police Employees and Help-Seeking

Civilian employees, representing 25% of our sample, reported significantly greater levels of psychological distress than commissioned staff, consistent with previous results from the few studies that have included civilian personnel (Carleton et al., 2017; Lentz et al., 2020; McCarty & Skogan, 2013). Civilian employees also endorsed fewer mental health resources they would seek out in the future (Table III and Supplemental Results), but it is also the case that some resources are only available to commissioned staff in these agencies (e.g., peer support, critical incident debriefing). This snapshot of group differences highlights the importance of including both civilian and commissioned staff in future mental health research to shed light on the unique and shared needs of all members of the organization.

Limitations

This study included multiple police departments and civilian as well as commissioned staff, yet generalizability is limited by the constrained geographical representation of the sample and self-selection bias. The sample's relative racial and ethnic homogeneity—representative of the agencies invited to participate—limits generalizability to non-white police employees. Another limitation is the use of a novel, unvalidated help-seeking measure that quantifies the *number and type* of resources participants would seek out rather than their *likelihood* of seeking help using a validated help-seeking scale (e.g., Cash et al., 1975). This decision increases external validity and relevance to our collaborating agencies but reduces internal validity. Finally, a prospective design is needed to establish a causal relationship between mindfulness training and help-seeking intentions, and the specificity of this relationship is unknown; perhaps officers engaging in *any* kind of wellness initiative might report increased help-seeking intentions.

CONCLUSION

One implication of these results for police agencies is the value of multi-level interventions for increasing mental health help-seeking. Individually focused interventions to reduce self-stigma must be paired with organizational messaging about the importance of acknowledging difficulties and seeking help, which can reduce perceived public stigma. Stigma-reducing interventions are most effective when based on social contact and first-person narratives and supported by a long-term organizational commitment (Thornicroft et al., 2016). For meaningful organizational and cultural changes to occur, management and direct supervisors must provide clear, consistent, and personal communication that normalizes conversations about mental health and makes clear the protections in place for employees who seek help.

More broadly, interventions to increase help-seeking behaviour should be considered a core element of police reform, as police mental health is inextricable from the mental health, well-being, and physical safety of the entire community. As the author and therapist Resmaa Menakem writes, "It's hard to keep the peace when your own body is constricted, unsettled, stressed, and traumatized" (Menakem, 2017, p. 125). Community safety and well-being necessitates the development of novel strategies to reduce help-seeking stigma, promote individualized and culturally appropriate mental health supports, and help police professionals address the unresolved and unmetabolized trauma that too often results in tragedy. This work affects community members and police practitioners alike, and identifying creative solutions necessitates collaboration among these groups to ensure these solutions are of mutual benefit.

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CONFLICT OF INTEREST DISCLOSURES

The author has no conflict of interest to report. This is an original report that has not previously been published in part or in full elsewhere. A pre-print version of this article has been posted to PsyArXiv (https://psyarxiv.com/xsey9/).

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SUPPLEMENTAL MATERIAL

Supplemental material linked to the online version of the paper at journacswb.ca:

- Supplemental Methods
- Supplemental Results

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ORIGINAL RESEARCH

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Mindful of authority: A snapshot of the meditation and contemplative practices of some Canadian Commissioned Police Officers

Les Sylven*

ABSTRACT

Research into the benefits of mindfulness training, meditation, and other contemplative practices for the workplace has grown dramatically. Within the context of Canadian policing, the wellness benefits of these mental practices are beginning to be understood. However, little is known about Canadian police officers' current use of these practices. This information is important for future research exploring the effects of these practices over time, and for police agencies considering introducing mindfulness or meditation training programs into their organizations. This article shares initial findings from a broader, yet unpublished, qualitative study of a cohort of Commissioned Officers from a large Canadian police service who self-identified as having regular meditation practices. Invitations to participate in a study exploring the perceived influence of meditation on leadership were e-mailed to all 605 Commissioned Officers. Of the 13 individuals who responded, 11 met the study criteria. Qualitative content analysis of the data yielded the following results: Commissioned Officers in a wide variety of roles in this police service are engaged in a broad spectrum of contemplative practices; each participant engaged in multiple practices; and the most common reason for beginning to practice meditation was to assist in recovery from a psychological or physical injury. These findings suggest that police organizations introduce a variety of mental training practices early in officers' service to ensure their career is more positive, resilient, and rewarding.

Key Words Mindfulness meditation in policing; contemplative practice; reasons for beginning meditation; Canadian police officer wellness.

INTRODUCTION

Research on the potential benefits of mindfulness, meditation, and other forms of contemplative practice for the workplace has grown exponentially in the last decade (Donaldson-Feilder et al., 2019; Good et al., 2016; Shahbaz & Parker, 2021). In Canada, where calls have been made to do more to understand and support the mental wellness of first responders (Carleton et al., 2018; Ricciardelli et al., 2018; Krakauer et al., 2020; Rinkoff, 2022; Tam-Seto, 2022), the benefits of meditation and mindfulness training for enhancing the well-being of police officers is beginning to be understood (Stevenson, 2022). However, little is known about Canadian police officers' current use of meditation and other related contemplative practices.

This information is important for at least two reasons. First, establishing an initial understanding of the varieties of meditation currently used by some Canadian police personnel is needed for any future research that explores changes in the use of these mental practices over time. Second, if police organizations intend to effectively introduce mindfulness and meditation training programs into their own agencies it would be valuable to understand why some police officers begin to practice meditation.

The purpose of this article is to contribute to this baseline of understanding by sharing preliminary findings from a larger exploratory qualitative leadership study of Commissioned Officers in a large Canadian police service who self-identified as having regular meditation practices. For clarity, Commissioned Officers are comprised of the six most senior ranks in the police agency, from Inspector to the head of the police service.

While the broader, yet unpublished, study explores perceptions of how meditation might influence the practice of leadership in this police agency, this report provides an early

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snapshot of the study's participants, the varieties of meditation and contemplative practices they employ, and the reasons they began to meditate. We begin by providing the conceptualizations of mindfulness, meditation, and contemplative practice that were used to guide this study, as well as a brief background on some of the primary research involving mindfulness-based interventions within the context of policing.

Study Definitions of Mindfulness, Meditation, and Contemplative Practices

As is the case with the terms "leadership," "management," and "organizational culture," there are multiple definitions of the terms "mindfulness," "meditation," and "contemplative practice." To this end, researchers have argued that the lack of clarity around mindfulness definitions is problematic, leading to ubiquitous usage and potential misinformation around the topic (van Dam et al., 2018). While an analysis of these multiple definitions is beyond the scope of this article, for clarity, the following conceptualizations of mindfulness, meditation, and contemplative practice informed this study.

Mindfulness has been defined as a state of consciousness characterized by "an enhanced attention to and awareness of current experience or present reality" (Brown & Ryan, 2003, p. 822). It is understood that everyone possesses a basic ability to be mindful, and that mindfulness as both a mental state and an enduring dispositional trait can be enhanced by regularly engaging in mindfulness training such as meditation and related contemplative practices (Brown & Ryan, 2003; Jamieson & Tuckey, 2017).

Meditation as defined by Walsh and Shapiro (2006) is frequently used in psychological research and guided this study. They propose that meditation is "a family of self-regulation practices that focus on training attention and awareness in order to bring mental processes under greater voluntary control and thereby foster general mental well-being and development and/or specific capacities such as calm, clarity, and concentration" (pp. 228–229).

Contemplative practice is often characterized more broadly than meditation practice. In this study, we drew upon Edwards et al.'s (2017) understanding of contemplative practice as "any activity undertaken regularly with the intention of quieting the mind and developing deep concentration, calm, and awareness of the present moment" (p. 1).

Finally, with respect to what constitutes a regular meditation practice, the definition from a study exploring the influence of meditation practice on the leadership development of managers was adopted (Frizzel et al., 2017). These researchers defined regular meditation practice as training at least three times per week, for at least 3 months. In this article, the terms mindfulness practice and meditation practice are used interchangeably. As will be outlined in the methods sections, these definitions were specifically used by the researcher to aid in the selection of study participants and to categorize the various practices and reasons given for beginning a meditation practice.

Mindfulness-Based Interventions and Policing Research

A valuable research method for exploring the outcomes of mindfulness and meditation practice is to exawmine any changes that may occur in individuals following a defined mindfulness-based training program or intervention (MBI). The first established mindfulness-based intervention program was mindfulness-based stress reduction (MBSR), created by Kabat-Zin et al. (1985) for the treatment of chronic pain. This 8-week group training program includes meditation, gentle yoga, sensory awareness, and psychoeducation training and has been considered the gold standard for MBI research (Bartlett et al., 2019).

MBSR and other variant MBIs appear to be effective in enhancing the health and well-being of participants as diverse as teachers, nurses, bio-tech employees, and service centre employees (Jamieson & Tuckey, 2017). Beyond individual professions, MBIs are also extensively used in the interdisciplinary field of leadership studies, demonstrating similar results, while the authors caution that further research is still necessary (Bartlett et al., 2019; Donaldson-Feilder et al., 2019; Urrila, 2022).

Interest in MBIs in the context of Canadian policing has recently begun to grow (Stevenson, 2022). In the United States, initial pilot and feasibility studies using mindfulness-based resiliency training (MBRT) reported benefits for high-risk professionals, including police, particularly related to reduced aggression, burnout, and sleep disturbance, and increased dispositional mindfulness, resilience, and emotional regulation (Bergman et al., 2016; Christopher et al., 2016; 2018; Eddy et al., 2021; Kaplan et al., 2017).

More recently, international research on MBIs within the context of high-risk professions has advanced to include several randomized controlled trials (RCTs). In Brazil, Trombka et al. (2018) are examining the outcomes of mindfulness-based health promotion (MBHP) training with active Brazilian police officers (n=160), exploring the differences in burnout and quality-of-life measures between program participants and a waitlist control group.

In Australia, Joyce et al. (2019) examined the wellness outcomes of Australian fire and hazardous material workers who participated in the Resilience@Work [RAW] Mindfulness Program. Comparing co-workers who did not participate in the online program with those who did, the intervention group scored higher on measures of adaptive resilience over time.

In the United Kingdom, Fitzhugh et al. (2019) contrasted well-being outcomes of police professionals who used the online MBIs Headspace and Mindfit Cop against those of a waitlist control group. Measures related to well-being, life satisfaction, resilience, and performance showed improvement for the MBI participants over the waitlisted group.

Finally, in the United States, Grupe et al. (2021) conducted an RCT involving police officers (n=114) from three Midwestern U.S. agencies that examined changes in psychological and biological measures after a modified MBRT intervention. Combining the measurement of psychometric instruments and distress-related biomarkers, researchers found greater improvements in mental health symptoms and sleep quality, as well as a lower cortisol awakening response among the MBI participants than in the waitlist control group.

Although this study is not based on intervention methodology, this evidence suggests mindfulness, meditation, and other contemplative practices are important areas of exploration within the context of police professional well-being.

METHODS

On March 18, 2021, following formal institutional approval from the University of Victoria Human Research Ethics Board

and the police service's Human Resources Research Board, an "Invitation to Participate" was sent to all 605 Commissioned Officers via their work e-mail fan out list. After reviewing the study details and informed consent information, e-mail recipients were instructed to contact the researcher directly if they were interested in participating in a telephone screening interview, followed by confidentially discussing their meditation and leadership practices in a semi-structured interview and focus group.

Screening Interviews and Participant Selection

Inclusion criteria for the study included holding the rank of a Commissioned Officer, having a regular meditation practice (Frizzel et al., 2017), and being willing to participate in an individual interview and follow-up focus group. When individuals contacted the researcher, a date and time to conduct a brief initial telephone screening was established. During these confidential screening interviews, the researcher read from a script which repeated the study details, informed consent information, and confirmed the respondents' willingness to continue.

Screening included a series of questions related to the participant's demographics and meditation practices. These scripted questions included: "How long have you practiced meditation?"; "What types of meditation do you practice?"; and "How often do you practice meditation each week?" Respondents who met the inclusion criteria were invited to take part in an online recorded semi-structured interview with the researcher.

It is important to note that, prior to beginning the screening interviews, one respondent e-mailed the researcher asking for additional information. She asked whether her regular practice of yoga fit this study's definition of a mindfulness practice. In response, she was provided with the study's definitions of mindfulness (Brown & Ryan, 2003) and meditation (Walsh & Shapiro, 2006) and was invited to continue with a screening interview. None of the other respondents asked for additional clarity or information, nor were they provided with the study's definitions in advance. This was done intentionally to capture the respondents' unique understandings of what they believe constitutes meditation practice, without any prior suggestions from the researcher.

Semi-Structured Interviews and Focus Group Interviews

Participants were e-mailed copies of the potential interview questions in advance, and all interviews were conducted using the Microsoft Teams video conferencing platform. During each interview, the specific prompt related to their meditation practice was simply "Tell me about your practice of meditation." If participants had difficulty answering this request, follow-up prompts included: "When did you begin meditation and why?"; "What type(s) of meditation do you practice?"; "How did you learn meditation?"; and "How often do you practice meditation and for how long?"

Each interview was later transcribed and reviewed by the researcher. Participants received a copy of their transcript and were asked to contact the researcher if they felt any corrections were required. Two participants suggested minor changes, including correcting the abbreviations of educational programs and specialized police units, and correcting dates for specific events in their careers. These changes were made by the researcher.

After the interview stage, participants were invited to join an online follow-up focus group interview at a later date to discuss the full study's preliminary findings. This final data collection phase was undertaken to determine whether any additional data could be gleaned collectively from the participants. A total of three focus groups were hosted, which included eight of the eleven study participants.

Participants

Of the 605 Commissioned Officers who were sent an invitation, 13 individuals contacted the researcher and asked to participate. After preliminary screening phone calls, two individuals did not meet the basic study inclusion criteria. One of these individuals had received a copy of the invitation from a Commissioned Officer but was not yet at that rank, while a second initial respondent did not meet the study definition of regular meditation practice (Frizzel et al., 2017). Accordingly, the final number of study participants was 11 for a response rate of approximately 2% of the total population of Commissioned Officers. A descriptive summary of the demographics of the study participants follows.

Demographics of Study Participants (n=11)

The age range of the participants was 45 to 57 years, with a mean age of 49.6 years. Participants self-identified their gender as either male (6) or female (5). Race or ethnicity were reported as White (8), Metis (1), South Asian (1) and Black (1).

Length of service in the police agency varied between 19 and 30 years, with a mean of 24.5 years. Participants reported they had been in formal leadership roles (defined as their first promotion in rank) between 10 and 21 years, with a mean of 15.5 years. The ranks of participants were almost exclusively Inspectors (10), with one Superintendent.

Finally, participants were serving in a wide variety of roles including: Unit Commander (2), District Commander (2), Operational Support (2), Major Crimes Section (1), Workplace Health and Wellness (1), Integrated Proceeds of Crime Unit (1), Integrated National Security Enforcement Team (1), and Executive Officer to a senior executive (1).

Data Analysis Methods

Data was analyzed using conventional qualitative content analysis (Hseih & Shannon, 2005). Specifically, information gathered during the screening interviews and semi-structured interviews concerning the types of meditation practiced and reasons for beginning meditation were analyzed and organized by the researcher into codes, categories, and frequencies. Preliminary findings are presented below.

RESULTS

Varieties of Meditation Practiced

A broad spectrum of contemplative practices was identified, with each study participant engaging in at least two different types of practice. The most commonly cited categories of practices were breath awareness exercises (8) and yoga classes (8). The use of trademarked technology or app-based meditations such as Headspace, Oura Ring, or Insight Meditation were also frequently reported (5). Several participants (4) reported using a mantra (either sound or word) during their meditation practice, while the same number reported engaging in positive visualization practices (4).

Additional practices mentioned by at least two participants included gratitude practice, martial arts practice, gardening, nature walking, dog walking and using meta-cognitive processing techniques to gain awareness of problematic thought patterns. Finally, practices described by one participant included listening to music, long distance running, and religious prayer (see Table I).

Reasons for Beginning Meditation Practice

Much like the varieties of practice, participants' reasons for originally starting to meditate were varied, and often more than one reason was given. These responses were organized into categories. The most frequent explanation was that participants were introduced to meditation while receiving treatment for an operational stress injury, post-traumatic stress disorder, or other work-related psychological trauma (5). Several officers indicated they were introduced to meditation during a yoga class (4). Recovering from a physical injury was also identified as a reason for starting a meditation practice (2).

Less common reasons provided included learning meditation through martial arts (2), being encouraged by a partner or spouse to try it (2), and simply hearing about meditation and wanting to formally give it a try (2). Starting meditation as part of a religious upbringing was mentioned by one participant.

DISCUSSION

Responses

With respect to the response rate, analysis of a recent U.S. online national study (n=1861) suggested that 23% of the public engaged in some type of contemplative practice (Lekhak et al., 2022). With this statistic in mind, the response rate of approximately 2 % of all Commissioned Officers was very low. Potential limitations to this study that may have influenced willingness to participate include: a request from a researcher outside of the police service; a single recruitment e-mail; and a research design that required far greater engagement than simply anonymously completing an online survey.

TABLE I Varieties of meditation and contemplative practices employed by study participants (n=11)

Category of Practice	Number of Participants
Breath Awareness	8
Yoga Classes	8
App or Technology	5
Mantra (Sound or Word)	4
Visualization	4
Gratitude	2
Martial Arts	2
Gardening	2
Dog Walking	2
Meta-Cognitive Processing	2
Listening to Music	1
Long-Distance Running	1
Religious Prayer	1

Accordingly, due to the low response rate and the nature of qualitative research (Hays & McKibben, 2021), these results cannot be generalized beyond the 11 participants who contacted the researcher to discuss their meditation practices. Based on previously described findings by Lekhak et al. (2022) that 23% of the public engage in some type of contemplative practice, we can broadly speculate that among the Commissioned Officers who did not reply, there may be others who engage in some type of contemplative practice. A recommendation for future research is to disseminate an anonymous online survey inquiring about mindfulness, meditation, and contemplative practices to all Commissioned Officers in order to better understand prevalence and interest.

However, based on those who did participate, Commissioned Officers working in a variety of operational and administrative assignments indicated they practice meditation. The representation of five women (45.4%) in this study was higher than the overall gender distribution of approximately 25% women within the police service. Although participants were predominantly White, the voices of individuals from other racial backgrounds were heard in the study. The remaining demographics relating to age, years of police service, and years of formal leadership experience were consistent with those in the Commissioned Officers ranks.

Varieties of Practice

The participants' understanding of what constitutes meditation was another interesting result of the study. The wide variety of responses provided, such as dog walking, gardening, martial arts, running, and prayer, indicates that many of the participants interpret meditation practice broadly. Although meditation in this study was defined as self-regulation training that brings mental processes under greater voluntary control (Walsh & Shapiro, 2006), contemplative practice, as more broadly defined by Edwards et al. (2017), could be a more accurate description of how the Commissioned Officers who participated in this study understood meditation.

The finding that each participant did more than one type of practice was also interesting. Using the analogy of physical exercise, just as individuals may do a variety of exercises to stay physically well (i.e., cardiovascular, strength, and flexibility training), each of these participants did a variety of practices to stay mentally well (i.e., breathing, gratitude, and yoga). Accordingly, a suggestion from these results is that police organizations offer their employees a wide variety of contemplative practices when introducing mindfulness or meditation training programs.

Reasons for Beginning a Meditation Practice

What led these participants to start meditating was also varied, with respondents often providing several reasons. However, the finding that most study participants reported being introduced to meditation while recovering from psychological or physical injury is a significant finding concerning the wellness of police officers. Continuing with the exercise analogy, this is akin to starting to exercise only after experiencing a significant injury or disease.

Fortunately, information on the preventive benefits of meditation and mindfulness for police well-being is gaining

traction in Canada (Stevenson, 2022). With this in mind, another suggestion from the results of this study is that police organizations incorporate these training programs early in an employee's service. This proactive introduction may go a long way in ensuring officers enjoy a long, resilient, and rewarding career.

CONCLUSION

This article provided a snapshot of the use of mindfulness meditation and related contemplative practices by some Commissioned Officers in a large Canadian police organization in March 2021. Although based on a small number of participants, and therefore not generalizable to all Commissioned Officers in the police service, it is valuable information regarding the characteristics of some Canadian Commissioned Officers who practice meditation, how they practice, and why they began. In addition to assisting future police wellness researchers, this information could be useful for police agencies to consider when proactively introducing mindfulness or meditation training programs into their organizations. Unlike the experiences of many of this study's participants, it is hoped this introduction takes place long before a diagnosis of mental or physical injury occurs.

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CONFLICT OF INTEREST DISCLOSURES

The author has no conflicts of interest to declare.

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REVIEW

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Prevalence, pattern, and a leader's intervention—The impact of alcohol abuse in police and public safety organizations

Dr. Paul B. Rinkoff*

ABSTRACT

Excessive alcohol consumption among police officers and public safety professionals continues to be an organizational challenge. Alcohol abuse brings about considerable mental, physiological, and behavioural consequences for employees and their families. The severity and impact of this problem is particularly pronounced for police officers. The intent of this paper is to bring greater attention to workplace performance and health issues caused by excessive alcohol consumption. To address this challenge, leaders are encouraged to develop evidence-based policies and interventions, break down barriers caused by stigma, and prioritize the health and recovery of affected employees.

Key Words Leadership; excessive alcohol consumption; law enforcement.

Alcohol consumption is often a factor when police officers and employees of public safety organizations respond to community complaints, disturbances, or medical emergencies. However, the harmful effects of alcohol consumption are not solely limited to the recipients of emergency services. Concerningly, alcohol abuse has a very real and adverse presence inside of police services, potentially affecting employees of all areas and ranks. The research demonstrates that excessive alcohol consumption among officers remains a difficult issue and one that continues to challenge police leaders. While the factors that cause alcohol abuse in police services remain a subject of debate, leaders continue to strategize and develop evidence-based methods to curb behaviours that promote excessive alcohol consumption, both on and off the job. Without appropriate intervention, the reputations of police services, the safety of the public, and the health and well-being of police officers remain problematic and at risk.

Excessive alcohol consumption can mean different things to different people. However, in public health terms, it is characterised by drinking large quantities daily, repeated occurrences of drinking to intoxication, drinking that causes mental and or physical harm, and drinking leading to alcohol dependency. Researchers have provided estimates of the prevalence of excessive alcohol consumption among police officers, reporting that up to one-third of police officers abuse alcohol (Davey et al., 2000a). A similar inquiry revealed that police officers' consumption of alcohol is double that of employees of non-policing professions (Kirschman, 2006). Equally discomposing is the finding that both male and female police officers engage in binge drinking more frequently when compared with professionals of other industries (Davey et al., 2000a; Weir et al., 2012). Alternative findings (Lindsay, 2008; Weir et al., 2012), suggesting that police officers do not consume alcohol at greater rates or in greater amounts than the general population, still encountered participants warranting administrative intervention. Admittedly, the consumption of alcohol even in the smallest quantities prior to work or while on duty can have serious safety consequences for police officers and members of the public. Therefore, it is imperative that police leaders continue to grow their understanding of the prevalence, patterns, and causes of alcohol abuse—those included in the literature, and those derived from one's own occupational experience.

Research provides insight into observed patterns of excessive alcohol consumption attributed to police officers. For instance, both marital status and years on the job are identified variables that correlate with levels of alcohol consumption. One study confirmed that over half of its sample of police officers was at risk of abusing alcohol after completing 4 years of policing (Beutler et al., 1988). Additional research revealed that police officers with 4 to 10 years of service, and those who reported being unmarried, were more likely to

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consume alcohol at excessive levels than officers with over 10 years of service and those who reported being married (Davey et al., 2000a). Rank was an additional variable found to correlate with alcohol consumption. The research suggests that lower-ranked police officers consumed alcohol at more harmful levels than higher-ranked officers (Davey et al., 2000a). A recent study, however, found that harmful alcohol use was twice as likely among those officers in the highest income brackets (Irizar et al., 2021). Additional research demonstrated that officers diagnosed with post-traumatic stress disorder (PTSD) were associated with higher rates of addictive disorders, including alcohol use disorder (Brunault et al., 2019). These findings, and the very public domain in which the behaviour occurs, have caused both researchers and police leaders to increase their efforts, as they attempt to understand why it is that police officers reportedly consume more alcohol than the average working professional. To answer this question, a significant amount of attention in the literature has been aimed at two unique elements of the profession: occupational stress and police subculture.

It is well accepted that occupational stressors have the ability to influence the alcohol consumption patterns of police officers. Factors that increase occupational stress for police officers include an unconventional working climate that necessitates adaptive skills and officers' willingness to expose themselves to danger. On a regular basis, police officers face horrific experiences that may result in severe physical, psychological, and emotional outcomes (Cross & Ashley, 2004; Leino et al., 2012; Hartley et al., 2013). These experiences can include sudden or critical events, violence, physical injury, or death. Additional contributions to on-the-job stress include work overload, irregular and extended shifts, on-call assignments, and the constant interruption to one's personal and family life (Elliot & Shanahan, 1994). Interestingly, and perhaps unexpectedly, police officers have long identified their paramount stressors as those that originate from within the police organization, such as low participation in decision-making, conflicting messages from administration, various inequities, and organizational rules and policies (Alkus & Padesky, 1983).

For many years, criminologists have recognized the unique subculture of police officers (see Banton, 1964; Cain, 1973; Rubinstein, 1973; Skolnick, 1966; Westley, 1970; Cochran & Bromley, 2003). The body of literature suggests that police subculture, which embodies the shared norms and behaviours of officers, has been cultivated internally to afford protection from external stressors and threats. Additionally, it is proposed that the attributes of police subculture, such as the promotion of loyalty, and its unique customs and bonding agents promote the safeguarding of police officers from risks that persist within and outside the organization (Kingshott et al., 2004). In line with the literature, subculture may also promote higher rates of alcohol consumption in policing. It is theorized that this behaviour is tied to the unique working environment of officers and the many social happenings and traditions that are believed to aid with stress reduction (Dietrich & Smith, 1986; Fillmore, 1990; Davey et al., 2000b). This includes high teamwork and low visibility settings, assignments that permit relaxed access to alcohol while working, and traditions that encourage socializing after work. Also acknowledged is that these subcultural patterns can be handed down from senior to junior officers as part of a shared learning process (Kappeler et al., 1998).

While not all research may agree with the causes of excessive alcohol consumption among police officers (Lindsay et al., 2008), the undeniable consequence of this problem is the impact on reported performance outcomes. Alcohol abuse diminishes an employee's task performance and accumulation of human capital and increases the likelihood of physical impairments such as disability or injury (Hodgkins et al., 2009; French et al., 2011). The hangovers caused by excessive alcohol consumption are also reported to reduce employee performance (Ames et al., 1997). Further, alcohol intoxication and withdrawal symptoms are linked to increases in employee impairment, absenteeism, misconduct, and drunk driving (Hodgins et al., 2009; Rushton & Lynch, 2019).

The impact of alcohol consumption on the health and well-being of police officers is equally distressing. The medical community has long recognized that prolonged alcohol use negatively impacts brain activity, cognitive performance, neurotransmitter levels within the body, cellular membrane structures, and nerve pathways (Glenn et al., 1989). Alcohol has the ability to permeate all bodily organs and is able to affect the efficacy of all physiological components of the human body (Rachdaoui & Sarkar, 2017). From a mental health perspective, the literature confirms that a range of mental health illnesses, which include depression, anxiety disorders, and bipolar disorder, coexist with, and can worsen as a result of excessive alcohol consumption (Shivani et al., 2002; Boden and Fergusson, 2011).

The above consequences of alcohol abuse provide measurable challenges for leaders, who have the inherent responsibility of identifying and preventing this behaviour within their organizations. From a regulatory standpoint, police services have established a wide range of internal policies and disciplinary measures to control alcohol abuse (Stinson et al., 2012). For instance, some police services have instilled zero-tolerance policies with respect to alcohol consumption while on duty. Others have taken the additional measures of enacting alcohol consumption policies during off-duty hours and consumption limits when in public view. Notwithstanding, the knowledge of patterns and the prevalence of alcohol consumption in police services provide leaders with valuable information and the opportunity to strategize and implement alcohol-reduction programs and interventions when and where it counts.

For interventions to be successful, police leaders should consider implementing proactive and reactive programs that focus on prevention and treatment (Waters & Ussery, 2007). Proactive interventions promote awareness and identification, supporting resources, and well-being programming offered by clinicians, mental health experts, and medical advisors. Reactive interventions may include reducing factors in the police environment that are responsible for, or encourage, alcohol consumption. This may mean, for instance, increasing the amount of supervision for groups of officers who have a greater ability to access alcohol at work. It may also include adjusting work locations and schedules so that they become less accommodating to social gatherings that promote alcohol consumption.

One form of intervention preferred by police services is enlisting Employee Assistance Programs. By taking a supportive

approach, these programs are able to connect officers with health professionals who are able to help with a wide range of issues, including substance abuse, mental health, and addiction. However, leaders should be aware of the barriers experienced by officers when seeking this form of intervention. Complicated shift schedules and overtime requirements often hinder officers' ability to attend appointments (Davey et al., 2000b). An additional obstacle cited by officers is their reluctance to participate in any type of intervention program due to strong subcultural norms and stigmas that serve to deter seeking help over fear of their problem being exposed to colleagues and management (Waters & Ussery, 2007). Similarly, the research tells us that officers are unlikely to report to management that their colleagues may have drinking problems (Violanti et al., 2011). Clearly, occupational stigma continues to represent a sizeable obstacle for officers, preventing access to appropriate support and treatment for alcohol abuse and mental health problems (Velasquez & Hernandez, 2019).

Evidence-based interventions and alcohol awareness programs designed to address excessive alcohol consumption should be administered strategically—at career intervals of susceptibility and based on the data. Appropriate screening tools can help leaders accomplish this task. The Alcohol Use Disorders Identification Test (AUDIT), developed by the World Health Organization, was designed specifically to help practitioners target patients who identify as excessive alcohol consumers (Babor et al., 2001). With decades of evaluation and validation completed, the 10-question screening test can be administered across a variety of at-risk subpopulations (Allen et al., 1997). Further, the test's short length and ease of application provides leaders of public safety organizations and police services, the opportunity to collaborate with trained healthcare professionals and integrate this screening tool into planned interventions. Notwithstanding the above findings, one recent examination of the relevant literature suggests that the evidence supporting the effectiveness of workplace alcohol abuse intervention is weak (Yuvaraj et al., 2019). However, the same study confirmed intervention effectiveness for the heaviest alcohol consumers. This latter finding may be significant for leaders who have limited resources and scope or who find themselves primarily dealing with issues caused by employees who have serious alcohol dependencies.

Progress in the application of alcohol screening in a complementary workplace has been documented in a recent study of military personnel. The research outlines a coordinated and integrated alcohol care pathway designed to manage excessive alcohol consumption in consistent ways across the organization (Rushton & Lynch, 2019). A key approach of this evidence-based intervention includes the participation of specially trained health practitioners, who conduct screening assessments and deliver misuse treatments. This collaborative and phased approach also employs motivational methods and flexible treatment options. For example, a treatment pathway for an employee may include an alcohol brief intervention (ABI) (World Health Organization, 2017). This can be a short conversation, face-to-face or over-the-phone, or an electronic communication that is non-confrontational and motivates employees to make changes to their drinking behaviours. An ABI also assists in determining the appropriate treatment based on the severity of the alcohol problem. Brief interventions may be more conducive to the complex and fast-paced occupational environment associated with public safety and policing, providing officers with ease of access to learn about the results of their screening and the steps required to make a more permanent lifestyle change.

Whether the causes of excessive alcohol consumption are occupational stress, police subculture, or otherwise, police leaders can challenge organizational norms and stigma and introduce evidence-based policies and interventions designed to reduce and treat excessive alcohol consumption. Alcohol-related incidents involving officers undermine the public's confidence in the police and weaken the public's faith in the justice system. In cases where problematic behaviours are identified, an evidence-based intervention implemented by leaders, provides the greatest likelihood that the health and well-being of the affected officer is prioritized, reducing the current and future impact of alcohol abuse on the officer, as well as on their workplace, family, and community.

CONFLICT OF INTEREST DISCLOSURES

The author has no conflicts of interest to declare.

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I'm not faking being sick, I'm faking being well: The need for leadership in mental health for policing

Grant Edwards*

ABSTRACT

The prevalence of mental illness amongst law enforcement officers is increasing despite genuine intent by leaders, policy makers and practitioners to combat this public health epidemic. Significant gaps exist in understanding mental health leadership, governance, education, and training, and the influence police culture has on help-seeking behaviours. This paper argues that introducing constructive and actionable processes to address these gaps will benefit greater productivity, lower levels of absenteeism, lower insurance premiums, reduce risk factors for illnesses, improve quality of life and sense of well-being, elevate cognitive performance, and reduce levels of stress. This will encourage investment in mental health, strengthen police employee–employer relationships, and save many relationships and lives.

Key Words Police Culture; investment in mental health; mindfulness; psychological distress; path analysis.

INTRODUCTION

Good mental health is without a doubt important for everyone, and leaders can play an important role in safeguarding the mental health of people in the workplace. While more leaders and their employees can now talk about mental health without much of the stigma from the past, we still have a ways to go in terms of leaders properly supporting the mental health of their team. The prevalence of mental illness amongst law enforcement officers is increasing despite genuine intent by leaders, policy makers and practitioners to combat this public health epidemic (Kamkar et al., 2019).

The aim of this paper is to address the still too-evident lack of leadership action within the profession. It articulates measures that might help overcome these gaps and identifies practical mechanisms to advance better mental health for police. Finally, this paper will offer leaders a complimentary suite of actionable tools that may help shape, form, and provide a structure for leaders in supporting the development of an all-inclusive approach to implementing better mental health procedures in the policing workplace.

Leadership—It Is Better to Be Supportive than to Be Superior

Leadership has perhaps the biggest influence over the law enforcement workforce and its organization. Any change in the perceptions of mental healthcare and attitudes towards people with mental illness among the workforce can only take place when the leadership drives the intention for this change throughout the organization. It is leadership that is required to understand the need for this shift in mindset among the entire workforce, both from the perspective of an organization's functioning and its social responsibility.

Many police executives around the world are struggling with how best to develop and implement appropriate mental health programs within their organizations. An extensive literature search has highlighted a noticeable lack of leadership development and training in police mental health. Leadership in policing is an essential element of the profession (Whitley, 2020). To date, much of leadership development and training has failed to focus on police well-being, especially mental health. It is highly likely that a police leader will supervise at least one team member with a mental illness, at some point in their career, whether or not they are aware of it. Many leaders, though, will struggle with identifying, acknowledging, and dealing with staff who might be suffering. This is totally understandable. Having to deal with mental health in the workplace can be highly confrontational and problematic for a leader and, without proper education and training in such matters, could lead to a devastating outcome (Martin et al., 2018).

Police leaders can no longer afford to be passive participants in the declining mental health of those men and

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women who put service before self, and the profession is amid a global mental health crisis. Leaders have a moral and legal obligation to ensure the health and safety of those they supervise, and, consciously or not, they play a pivotal role in creating the type of environment that either promotes or erodes mental and emotional safety (Heyman et al., 2018; Edwards & Kotera, 2021).

It has been well documented that policing is a stressful and hazardous occupation that can impair an officer's physical and mental health (Victoria Police Mental Health Review, 2017; Queirós et al., 2020; Axelrod, 2019; Burke, 2016; Deschamps et al., 2003; Tuckey et al., 2012). The policing community suffers a higher prevalence of stress-related illnesses than the general public (Soomro & Yanos, 2018). Research has shown repeatedly that exposure to occupational stress and trauma is directly related to higher rates of heart disease, divorce, sick days taken, alcohol abuse, and major psychological illnesses such as acute stress disorder, post-traumatic stress disorder, depression, and anxiety disorder (Waters, & Ussery, 2007; Zimmerman, 2012; Violanti et al., 2017; Gilmartin, 2002).

Evidence also exists that routine occupational stressors can be even more stressful to police officers than exposure to danger and critical incidents. Such routine occupational stressors can include an exclusionary or toxic workplace culture, ineffective management practices, real and perceived inequities in promotions and assignments, and moral injuries often resulting from declining internal and public trust. Continuing exposure to such environments can produce conditions that can easily compound those more commonly attributed to the traumatic aspects of police work (Lieberman et al., 2002). General Strain Theory (GST) is used to explain certain general effects upon police populations that may also affect how police might react to a situation in the workplace, at home, or in the field. Such reactions can lead a person to display behaviour associated with alleviating the pressure, such as anger, frustration, depression, isolation, and burnout (Bishopp, 2013; Ontario, 2019).

Some symptoms may include (Shim et al., 2015; Hoffart et al., 2022):

- Substance abuse: Consumption of excessive amounts of alcohol and taking legal and illegal drugs.
- Rumination: Extreme and ongoing focus on "depressive symptoms and on the implications of those symptoms."
- Emotional numbing: Shutting down feelings to provide relief from stress and anxiety.
- Intrusive thoughts: Unwelcome or involuntary ideas and thoughts that may be upsetting and difficult to manage.
- Procrastination: Procrastination, like rumination, can lead to the conscious or unconscious avoidance of difficult issues or tasks that require completion.
- Behavioural disengagement: Under challenging situations, individuals may disengage or reduce the effort in a task or social situation.
- Risk-taking behaviour: Another form of behavioural disengagement used to alleviate the adverse effects of a situation.

To develop police leaders in mental health, several core capabilities ought to be considered, including the following:

Communication

Leaders need to be excellent communicators, and the ability to communicate as a formal leader comes down to mastering several skills (Eades, 2020). They include:

- Learning to listen properly. It is easy for persons in power positions to listen to respond instead of actively listening. If our focus is constantly on developing a response, it is likely that we will miss essential pieces of information.
- Considering body language. Non-verbal communication plays a large role in the way a message can be taken and/or delivered.
- Storytelling. Police love a great "war story." Good stories engage, provide focus, and stick in the minds of those listening. They help to remember ideas and concepts in a way that a PowerPoint presentation or simply being "spoken at" cannot.
- Remaining calm—breathe and relax. Yes, it is amazing what stress can do to communication. The science behind breathwork has gained importance recently (Dispensa, 2011). By regularly using breathing techniques we can activate our "rest and digest" nervous system, supporting free-flowing communication and calming our thought processes.

Emotional Intelligence

Emotional intelligence is commonly defined as the ability to understand one's emotions and the emotions of others. It is a personal skill set that focuses on interpersonal abilities, helps understand our emotions and develop self-awareness, and improves the ability to relate with others to promote emotional and intellectual growth (Goleman, 1995).

Emotional intelligence (or EQ) can be developed throughout one's lifetime. It is a seemingly simple and attainable attribute one would almost expect most police leaders to possess. Emotional intelligence affects leadership in organizational culture and may come to define the skill set of the most exceptional leaders. Leadership is most effective when conducted through a lens of several emotional intelligence attributes (McCutcheon, 2018; Turner, 2009):

- Intrapersonal (self-regard/emotional self-awareness/assertiveness/independence/self-actualization)
- Interpersonal (empathy/social responsibility/interpersonal relationships)
- Stress management (impulse control)
- Adaptability (reality testing/flexibility/problem solving)
- General mood (happiness/optimism)

Vulnerability

Vulnerability in the workplace means admitting that you can make mistakes and acknowledging that you are, yourself, constantly learning and growing. As a leader, it can feel uncomfortable to do this. However, being honest and vulnerable in front of your staff will make you more relatable, can increase trust within a team, and shows that you are open to new information and creative solutions.

Unfortunately, for those with the most organizational power to exhibit vulnerability has historically been seen as an oxymoron in the policing environment. Police training and culture have resisted showing vulnerability, as it can

be perceived as being weak and lacking intestinal fortitude.

Three core skills that all leaders should possess include (Lofgren, 2019):

- Being open to exploring tough conversations. Embracing vulnerability starts by having open and honest conversations, even when it's uncomfortable.
- Letting go of your ego.
- Acknowledging your own triggers to lead from a courageous place.

Authenticity

Authenticity is the healthy alignment between internal values and beliefs and external behaviour. Authenticity comes from finding your style and your own way of leading—and making life decisions that reflect your ethics, values, and personality. Authentic leaders have the integrity and skills to make the right choices when necessary. Being self-aware will allow you to understand yourself and your relationship to those being supervised. Modesty, humility, and being genuine will foster trust in the workplace. Showing authenticity will provide you with the ability to make necessary decisions with integrity and in a manner that is more consistently supportive of your team (Ackerman, 2021).

Growth Mindset

Growth mindset is the belief that abilities can be developed. The continuing desire to embrace learning, and to recognize challenges and setbacks as sources of growth, creates and feeds drive and resilience for a leader and for those around them. A growth mindset will play an essential role in successful leadership. Leaders with a growth mindset embrace challenges, understand that long-term effort is a requirement, embrace criticism, and take inspiration from others (Dweck, 2006).

Empathy

Empathy has always been a critical skill for leaders. According to Miller (2011), three specific elements of empathy are critical to good leaders:

- Cognitive empathy—includes understanding an employee's unique experiences and the obligations they have outside of work.
- Emotional empathy—also known as affective empathy, is the ability to respond with an appropriate emotion to another's mental states.
- Empathic concern—is the ability to sense another's needs, and often respond with compassion and tender feelings, and a desire to want to spontaneously help.

Accountability

Accountability is one of the most valuable skills a police leader can master. Leadership accountability lays the foundation for an organization's culture, productivity, and overall success. Accountability is a skill that requires leaders to own up to their actions, decisions, and their mistakes. It's also the ability to follow up on the commitments they have made and not just dismiss them.

Leaders must regard their employees' health as an essential and necessary condition for organizational success (Relojo-Howell, 2022). Being educated, empathetic, and understanding will help create a compassionate, caring and safe workplace where everyone can succeed while keeping their mental health intact (Davenport et al., 2016).

Understanding Stressors and Trauma in the Workplace—It's Not Stress That Kills Us, It's Our Reaction to It

Life is stressful enough for everyone. However, it can reach new and hazardous levels when we add into the mix the unique stressors associated with being a police officer. The dynamic and often problematic environment, exposure to trauma, and organizational injustices create a potent cocktail of situations leading to poor mental health within the workplace (Rousseau, 2022).

As a leader, understanding the potential organizational, internal, and external stressors that can affect police staff and potentially generate a negative psychological response is important. They include (Subošić, et al., 2018):

- *External stressors*—jurisdictional isolation, seemingly ineffective legal and court systems, adverse media accounts, impact of negative and venomous social media.
- Internal stressors—poor supervision and leadership, absence of career development opportunities, inadequate reward system, unpleasant policies, over-reporting, mountains of paperwork and budgetary constraints.
- *Performance stressors*—role ambiguity and conflict, adverse work and roster schedules, inherent fear and danger, sense of uselessness, and absence of closure.
- *Individual stressors*—feeling overcome by fear and danger, pressures to conform, gender disparity, bullying, sexual harassment, ethnicity and cultural differences, lack of unique understanding such as LGBQTI.
- *Life-threatening stressors*—ever present potential for injury or death to the individual, fellow police, or members of the public.
- *Social isolation stressors*—cynicism, isolation, and alienation from the community; prejudice and discrimination.
- *Organizational stressors*—administrative philosophy, changing policies and procedures, morale, job satisfaction, and misdirected performance measures.
- *Functional stressors*—role conflict/confusion, use of discretion, and legal mandates/obligations.
- *Personal stressors*—home life, including person issues, spousal, illness, problems with children and aging parents, marital distress, and financial constraints.
- *Physiological stressors*—fatigue, medical conditions, comorbid health issues, poor sleep, poor nutrition.
- *Psychological stressors*—all the above and the exposure to shocking situations.

The ability to recognize and respond to a range of mental health and stress injuries that regularly confront police, including acute trauma, cumulative trauma, compassion fatigue, vicarious trauma, operational stress, burnout, and moral injury, is an important capability to understand (US Center for Substance Abuse Treatment, 2014). Police leaders need to recognize that trauma cannot be wished away. It needs to be managed, worked through, and monitored by leaders and organizational support elements alike. Trauma does not simply disappear when police finish their shift. It can leave a

residual presence that can contribute to a long-term cumulative reaction if not identified, and if intervention strategies are not properly deployed early on (Louth et al., 2019).

Some police leaders may simply become stuck and immobilized in understanding the problems facing the occupation. Many leaders may be understandably concerned about how to balance compassion for an employee going through a mental health challenge with accountability for that individual's responsibilities and performance within the workplace. Many leaders will struggle with this concept, as they are reluctant to delve into dealing with mental health. After all, the topic can be vague, subjective, and awkward to engage in. It can be uncomfortable, complicated, and highly demanding.

Sometimes it is easy to tell that a colleague is going through a rough time, at other times it is not. There are many things to consider. Are they struggling with relationship issues, family issues like sick children or parents, a chronic illness, or having troubles with others in the workplace? Perhaps they have been exposed to a traumatic event or are engaged in units that deal with sexual assault, homicide, or crimes against children? Are there noticeable changes in their demeanour, appearance, or mannerisms, for instance where they have withdrawn and are not keeping in touch with co-workers or friends? Or perhaps, are they looking more dishevelled and tired than usual? These sorts of indicators may reflect an undue exposure to stress and may be an indication that they are simply "not in a good place" (Liu et al., 2022). If so, it is a good idea to check in.

The Impact of Police Culture on Mental Health

Workplace culture is a collection of attitudes, beliefs, and behaviours that make up the regular atmosphere in a work environment. Culture is the character and personality of your organization. It is what makes the profession unique and is the sum of its values, traditions, beliefs, interactions, behaviours, and attitudes (RMIT, 2020).

Within policing, culture can be a major obstacle that impedes psychological health. There is a paucity of literature on professional police culture as it relates to mental health, especially literature examining predictors of officers' attitudes towards help-seeking behaviours for mental health (Lane et al., 2022). Research, education, and training tools are all but non-existent (O'Hagan, 2009), but what is widely acknowledged within police culture is that admitting to possessing a mental health condition is a potential career killer (Subošić et al., 2018).

Police culture values strength, fearlessness, integrity, stoicism, scepticism, distrust, self-reliance, controlled demeanours and emotions, strength of body, and competency in handling complex problems (Olson & Wasilewski, 2016). An unintended consequence of this culture is that it discourages help-seeking behaviour. If these values are held too rigidly, an officer can feel weak, embarrassed, and a failure for seeking help from others. This generates concern for those officers who unconditionally conform to the traditional values of law enforcement culture and who may, as a result, be more likely to avoid seeking help, even when distressed, potentially paying the price of detrimental health effects (Dimoff & Kelloway, 2016). Fearful of being perceived as weak and untrustworthy, those who are suffering in silence may ultimately face even more potential sanctions, loss of professional opportunities, and discrimination that lead to greater isolation and alienation. (Gutschmidt & Vera, 2020; Afful, 2018; Hitch et al., 2020).

In a recent study of police in the United Kingdom, researchers analyzed responses from 16,857 serving officers and operational staff who took part in "The Job, The Life," a major survey carried out across England, Wales, Scotland, and Northern Ireland. Their work revealed that two-thirds of all respondents said they had a mental health issue directly resulting from police work. Yet almost all of the survey's respondents—some 93%—said they would go to work as usual if suffering from psychological issues such as stress or depression. Many indicated they would do so without seeking treatment because of the associated negative organizational cultural effects (Hargreaves et al., 2018; Brewin et al., 2022).

When leaders fail to influence culture through collaboration, listening and empathizing, honesty, trust, commitment and engagement, an opportunity to shape a more healthy and positive culture is lost. According to Bikos (2021), staff retreat into a *"numbness mode"* and any actions by police leadership to superficially address issues are considered just "window dressing."

Why Governance Is Vital: We Cannot Be Mere Consumers of Good Governance, We Must Be Active Participants; We Must Be Co-Creators

Governance in the policing sector is concerned with the systems and processes that ensure the overall direction, effectiveness, supervision, and accountability of an organization (Francis & Armstrong, 2022). Governance structures for mental health are essential elements that support police in managing their workforce. Introducing well-defined mental health policies is critical to good governance and leadership for mental health in law enforcement (Lund et al., 2013). Effective governance structures allow organizations to create value through innovation, development, and exploration, and to provide accountability and control systems commensurate with the risks that police face daily (Francis & Armstrong, 2022).

A workplace mental health policy is useful in addressing police cultural impediments such as stigma, scepticism, and distrust. A sound policy framework may encourage help-seeking behaviours and encourage staff buy-in and engagement (Rosenberg, 2012). In establishing a mental health policy across all organizational factors at the strategic, tactical, and operational levels, plans will set out departmental intent. Including such policy across mission statements, operational risk assessments, recruitment and leadership syllabus, anti-discrimination and harassment strategies, and performance management structures (Stanley-Clarke et al., 2016) emphasizes to staff that their organization is serious and committed to embedding mental health in its language and DNA (Kruk, 2012).

However, the ability to establish a mental health program carries costs, whether funding comes from within existing allocated budgets or is supplementally allocated. Police departmental forecasts are the foundation of their budgets. Forecasts are discussed by police executives, and when the most productive and impactful combinations of forecasts are selected, they become budgets. The more sound the forecasts are, the better the results will be in what ultimately comes out of the budgeting.

Most police departments survive on minimal year-over-year budget allocations. The money for policing comes from local governments, state or provincial governments, and federal programs directly, or through grant applications. Figures from the U.S. Census of Governments show, that taken together, state and local governments in that country spent $123 billion on police in 2019. They spent another $132 billion on courts and corrections (Mollenkamp, 2022). However, there and across the globe, mental health remains a neglected priority, low on the agenda of many policy makers and funders at the national and international levels (Mahomed, 2020). Investing in police mental health includes financing education, promotion, prevention, early intervention, treatment, and recovery systems (Davenport et al., 2016).

Highlighting the return on investment (ROI) is one way to reduce the reluctance of many police departments to allocate funds. Research has found that workplace mental health initiatives reap many benefits (Friedli & Parsonage, 2007) for individuals, families, leaders, the community, the organization, and the investors (elected officials and governments). A positive ROI reveals that every dollar spent on mental health initiatives will return on average $2.50 to $4 in organizational and community benefit. Staff are more likely to be engaged if they have a positive work environment and their performance and work quality have been shows to improved and their productivity increase in the workplace (Deloitte research paper, 2019).

It is one thing to implement a mental health initiative, but it is equally important to show that it is working. Measurement and evaluation (M&E) are critical tools in any ongoing initiative that attracts financial allocation. Without M&E, how do you know if a program or initiative works well? How can you continue to shape and develop a program if it is immeasurable (Gilkerson et al., 2019)?

As the famous Peter Drucker business maxim goes, "If you can't measure it, you can't improve it" (Drucker, 2006). Measuring the value of mental health benefits has long been a puzzling notion for employers. Police executives and elected officials will always ask: How do we know if it's worth it? Leaders who prioritize mental health understand the importance of measuring and tracking improvements in programs. Using metrics can not only guide revisions and adjustments that make initiatives more effective, it can also send a powerful signal to employees that achieving mental health goals is every bit as important as hitting other operational targets (Kilbourne et al., 2017).

The All-Inclusive Approach

Mental health ecosystems research is an emerging discipline which takes a whole-systems approach to mental healthcare, facilitating analysis of the complex environment and context of mental health systems, and translation of this knowledge into policy and practice (Furst et al., 2019; 2020).

The socio-ecological framework can be an ideal tool for addressing these broad issues and implementing new mental health programs through integrating behavioural, leadership, and cultural and environmental changes. Such a model is typically used to explain an approach, program, governance, or policy that will achieve greater acceptance and participation in conceptualizing an implementable and deliverable strategy. A comprehensive strategic framework should identify and develop agency-specific needs for creating and enhancing a mental health program (Reupert, 2017; Frawley et al., 2018).

All facets of the socio-ecological framework require simultaneous attention. They are symbiotically reliant on each other, such as governments or elected officials' financial and policy support; governance, capability, and organizational relationship enhancement; social and cultural reform; enhanced leadership understanding and training; social connectedness strategies; and individual knowledge and literacy extension (Kilanowski, 2017).

CONCLUSION

This article has attempted to identify significant gaps in mental health leadership, governance, education, and training, and the dysfunctional influence that police culture can have on help-seeking behaviours. It has attempted to introduce constructive and actionable suggestions to encourage police executives to commit to ensuring the psychological health and well-being of their people. Such a commitment is paramount and must be infused into all facets of the policing environment. Doing so will allow departments to benefit through greater productivity, lower levels of absenteeism, lower insurance premiums, reduced risk factors for illnesses, improved quality of life and sense of well-being, greater staff recruitment and retention, better cognitive performance, and reduced levels of stress. Such an approach will encourage and support stronger employee–employer relationships. It will also, no doubt, save and strengthen many personal relationships inside and outside of work. And it will save lives.

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CONFLICT OF INTEREST DISCLOSURES

The author declares that there are no conflicts of interest.

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SOCIAL INNOVATION NARRATIVES

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Employee support: Where have we come from, and where are we going?

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ABSTRACT

Peer involvement has been supporting people experiencing mental health and other psychosocial problems for over a hundred years. As the influence of peers increases in primary and secondary health care as well as within organisations, there is a need to evaluate the effectiveness of using peers to deliver support for a range of psychosocial conditions. This paper reviews the emergence of peer support from the United Kingdom's social welfare and the American social justice movements. There are some well-established benefits to taking support as close as possible to those in need through peers provide clinical support without adequate training and assistance. Whilst this paper was written with policing in mind, the principles would apply to any organisation considering introducing a peer support program.

Key Words Police peer support; well-being; evaluation.

INTRODUCTION

During the 21st century, there has been a dramatic increase in employees seeking to become involved in improving their colleagues' and peers' health and well-being. Many, after a few days of training, have become Mental Health First Aiders (Kitchener & Jorm, 2002), Wellbeing Ambassadors (Goldman et al., 2017), Wellbeing Coaches (IAFPD, 2020), Critical Incident Stress Debriefers (Mitchell & Everely, 2001), Trauma Incident Management Assessors (Jones et al., 2017), and Psychological First Aiders (Shultz & Forbes, 2014). Organisations have spent significant sums of money training workers in one or more of these approaches to address rapidly rising levels of psychosocial problems in the workplace when access to psychological interventions through the National Health Service (NHS) is restricted (Punton et al., 2022). Despite the high expectations and glowing reports on peer models, most evaluations (e.g., Price et al., 2022; Chinman et al., 2014; Repper & Carter, 2011; Dieltjens et al., 2014) have found a lack of evidence to demonstrate the effectiveness of peer-delivered support. This paper will explore the origins and development of peer-led support programs from their roots in the early 19th century to the establishment of the approaches found uneasily cohabiting in today's organisations.

The interest in this area of study stems from the wish to develop a suitable Peer Support program for the National Police Wellbeing Service (NPWS) in the United Kingdom (UK) that is context sensitive, scalable and attractive to those implementing the programme. Police services in many other jurisdictions continue to seek ways to better support the wellness and recovery of their own members, and peer support programs will often form an important part of those services. A thorough understanding of the history of these programs, the variations among them, and the experience people have had with them, along with many of the important considerations arising from that experience, will help to inform decision-makers and practitioners alike.

Peer Support for Mental Health

For centuries, people with mental health problems were incarcerated in lunatic asylums, where their treatment was harsh and inhumane; patients were neglected, abused, and viewed as objects of ridicule (Ruggeri, 2016). In 1792, William Tuke, a Quaker, built the Retreat in York, pioneering a "moral treatment" of mental health based on humane conditions, sound, caring medical treatment, and a minimum of physical restraint (Pearce, 2020). Five years later, Philippe Pinel, a physician at a mental asylum for men in Paris, described the principles of a humane method for treating mental health problems. Pinel believed mental illness could be cured and required his physicians to make diagnoses by observing behaviour and listening to and recording their stories. Pinel emphasised the importance of understanding the natural history of the disease and precipitating events. One of Pinel's patients, Jean

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Baptiste Pussin, treated for scrofula (a form of tuberculosis), was appointed as an assistant to Pinel. Under Pussin's influence, other recovering inmates were used to support their fellow asylum inmates; chains were removed and replaced with strait jackets. Pinel's records provide the first recorded evidence of recovering patients being used to support mental health patients' clinical treatment (Weiner, 1992).

Today, one of the most influential peer-based movements is Alcoholics Anonymous (AA), which began in 1935 in the United States based on the experiences of two alcoholics whom a clergyman helped to become sober and maintain sobriety by working with other alcoholics (Alcoholics Anonymous, 2022). Early in 1939, an introductory textbook called *Alcoholics Anonymous* explained the philosophy and methods, the core of which was the now well-known Twelve Steps of recovery. Central to the AA model is the use of peers who have been through the Twelve Steps model to support peers starting the process. Other groups have followed this approach to respond to addictive behaviours, including gambling and drug abuse. Other self-help and peer support models were established, including in 1967 a community mental health care model involving non-professional peers employed to help with the development, implementation, and evaluation of the approach (Cowan et al., 1967).

Occupational Welfare Support and Social Well-Being

The origins of peer support within organisations also have a long history. In the nineteenth century, workers faced dangerous and harsh conditions and treatment. In response to this situation, in 1802, Sir Robert Peel introduced the regulation of working conditions and the appointment of factory inspectors to protect the health and welfare of workers (Blayney-Thomas, 1949). Some far-sighted industrialists, including the Salt, Cadbury, and Lever families, were concerned for the well-being of their workers and created Saltaire, Bourneville, and Port Sunlight villages in the mid-nineteenth century. Together with housing and health care, social welfare services were provided for workers. The first employee welfare service was created in 1886 by the chocolate manufacturer Rowntree's in its York factory; this idea spread, and by 1913, the Welfare Workers Association was formed (Edmonds, 1991). Welfare officers were selected from the workforce based on their skills and aptitude for helping others. They were required to adhere to a code of ethics which included a responsibility to respect the dignity of their clients, to enhance the quality of life of those they helped, to act without prejudice on the grounds of origin, sex, age, nationality, colour, religion or status, to maintain confidentiality, and not to abuse their position for personal gain. Founded at the end of the nineteenth century, welfare officers were the first peer supporters in the workplace.

In 1946, strains appeared in the Welfare Workers Association, and those concerned with the efficiency and effectiveness of the workforce formed the Institute of Personnel Management, leaving the welfare officers providing help, advice, and guidance to their colleagues to create an occupational welfare service (Martin, 1967). The Institute of Welfare flourished for many years, providing training, standards, and accreditation for welfare officers. Many private and public organisations, including the emergency services, military, manufacturing, retail, and civil service, recruited welfare officers internally and organised training through the Institute of Welfare to give them essential welfare qualifications and skills (Martin, 1967).

Twenty-five years ago, concerns were raised about the future of welfare services (Tehrani, 1997) due to the lack of product definition and the inability of the service to adapt to changing needs. In response to these concerns, the Post Office launched an Employee Support Service (Tehrani, 1998). The framework was developed to introduce a more effective method of service delivery, clearly designed and promoted products and services to meet the needs of the organisation and its employees, regular assessments of the competence of the employee supporters, and tools to monitor and evaluate services. Seven core services were defined: Well-Being Information, Problem Assessments, Short-Term Interventions, Employee Education, Manager Training, Specialist Trauma, and Counselling Interventions. A peer listening scheme was introduced to respond to bullying and harassment, where the peer listeners listened to their colleagues and provided information on the choices available to them to resolve their problems (Rains, 2001).

During the past 25 years, the principles established in Welfare Services and refined in Employee Support have continued to adapt and respond to changing organisational and employee needs. Peer welfare services have been delivered in many settings, including retail (Tehrani et al., 2001), insurance and banking (Tehrani et al., 2007), emergency services (Hesketh & Tehrani, 2018; Tehrani, 2017), prison service (Ruck et al., 2013), civil service (Tehrani & Welch, 1992), and many more. With the growth of trauma-informed care and trauma-informed organisations (Bloom, 1997), peer-delivered evidence-based interventions have been clearly defined and supported by professionally qualified and registered psychology, occupational health, and counselling professionals to ensure that supervisors and peer supporters were able to undertake their role without risk to themselves or those they wish to support.

Peer Support Movement

Peer Support Movement emerged in the United States in the 1960s as a response to pressures from consumer and social justice activists. The social justice movement views mental illness in terms of human rights, claiming that the "medical model" created a suppression of difference where expressions of personal experiences were medicalised and individual rights removed (Mead et al., 2001). In its extreme form, the social justice model rejects the validity of research methodologies and hypothesis testing. Its adherents claim that such methodologies are founded on the belief that people cannot recover from mental illness and are only capable of functional healing (Curtis, 2000). The social justice belief is that the medicalisation of human experience fails to recognise opportunities for wellness, growth, and the achievement of personal goals. The social justice view rejects assessments and evidence-based interventions, proposing that recovery is achieved by engaging with recovering peers' experiences, awareness, and understanding to bring about positive outcomes and healing for others (Segal et al., 1993). This approach has been widely adopted in the United States with the development of the Substance Abuse and Mental Health Services Administration (SAMHSA), the US-led body, to reduce the impact of substance

abuse and mental illness. SAMHSA has promoted a range of peer-delivered services, including Critical Incident Stress Management and Alcoholics Anonymous (SAMHSA, 2022). Peer support is beginning to be adopted in the UK and supported by the NHS, where mental health peer support workers are employed (Health Education England, 2020).

Who Are Peer Supporters?

There are two main groups of peer supporters: first, those who come from a social justice framework, with their belief that it is essential for peers to have experienced mental ill-health and to be in or have achieved recovery. In their role, social justice peers (SJP) use their personal experiences to facilitate, guide, and mentor another person's recovery. The second type of peer supporter emerged from the social well-being movement, where social welfare and well-being peers are recruited based on their knowledge, aptitude, and interest in supporting others. Social well-being peers (SWP) recognise the need for peers to work with and respect practitioners from various disciplines and are willing to adhere to best-practice principles in delivering evidence-based support and interventions. Despite the differences between the two groups, their espoused values are similar (Statford et al., 2019; Sunderland et al., 2013; Health Education England, 2020). Table I provides a summary of the key peer values.

The stance of the SJP movement is that "if it is a role that can be done without lived experience of mental health issues, it cannot be peer support" (Beales & Wilson, 2015). The alternative position of the SWP group is that, to become a peer supporter, one must demonstrate personal skills, background, and aptitude for the work (Martin, 1967). For SWPs, there is no requirement to have experienced the same adversity or condition as the person they support; for example, it is not necessary to have been raped to help someone who has experienced rape. However, it is recognised that experience of working within a similar role or industry is essential.

A Canadian review of the types of peer support available in that country (Price et al., 2022) identified three models: 1) peer-led, where the peers lead and deliver support without the involvement of others, 2) peer-enabled, where peers are led by professional mental health practitioners and supported by other peers, and 3) a peer partnership, where an external organisation, such as the International Critical Incident Stress Foundation, provides training for a peer-delivered Critical Incident Stress Management program. Price and colleagues reviewed 11 training manuals and found no recognised definition of a peer. A peer could have one or more of the following characteristics:

- Shared life experience or condition: e.g., substance abuse or mental health problem
- Similar working role: e.g., emergency responder, nurse, or teacher
- Same job: e.g., train driver, bank clerk
- Working in the same organisation: e.g., the NHS or Local Authority
- Similar demographic characteristics: e.g., age, sexual orientation, cultural background.

Price and colleagues (2022) noted the absence of research into the effectiveness of peer support and the lack of consistency and fidelity in the delivery, accountability, and adherence to training and suggested that there should be national regulation, standards, and accreditation of peer support.

Effectiveness of Peer Support Programs

To assess the efficacy of peer support programs, it is essential to identify the tools to measure any changes, determine the nature of the changes, and establish whether they are due to peer support. Without evidence, it is impossible to understand any support program's effectiveness. Some attempts have been made to evaluate the effectiveness of peer-delivered support; however, the results have been inconclusive, with randomised controlled trials reporting no difference or, in one case, a negative outcome (van Vugt et al., 2012). Researchers have highlighted several common concerns (Price et al., 2022; Chinman et al., 2014; Repper & Carter, 2011), including the need to be more rigorous in adhering to practice standards and the lack of a defined peer support model. It was also recommended that training should be improved with the introduction of competency standards and regular personal supervision.

It is perhaps not surprising that, given the rejection of evidence-based practice by the SJP adherents, there is a reluctance to seek symptom-based evidence of effectiveness. However, this leaves other non-symptom-related measures such as sickness absence, work engagement, and job satisfaction as proxies for clinical significance. Davidson et al. (2012) provided the following questions as consistent with the SJP approach:

1) Do interventions provided by peers differ from services provided by non-peers?
2) Are there any interventions that peers cannot provide without lived experience?
3) What critical features of peer support produce positive outcomes?

TABLE I Values of peer support

Inclusivity	Acknowledging the worth of all people regardless of background, preferences or situation	Mutuality	Understanding a person's experience from their perspective. Feeling a sense of solidarity
Respect	Building an accepting respectful relationship. Respecting background, culture or group	Self-Determination	Recognising that people know the best path to recovery, and that they have a choice
Reciprocity	Sharing experiences to learn from each other. Contributions are of equal value	Strengths-Based	Helping people to learn from their experiences. Focusing on strengths
Safety	Ensuring a safe, non-judgmental environment. Safety in sharing difficult experiences	Self-Defined Recovery	Helping to make sense of experience in the context of their life. Creating hope and empowerment

Many peer-delivered approaches, including critical incident stress debriefing, psychological debriefing, trauma risk management (TrIM), and psychological first aid, fall within an SWP approach where it is not essential for peers delivering services to have lived experience to support others. The designers of these interventions are willing to use clinical measures for evaluation. It has been shown that the results from these interventions are generally positive and well regarded by users (Richins et al., 2020). Still, high-quality evidence is lacking (Dieltjens et al., 2014).

Concerns for Peers Supporters

Surveys of peer supporters show that most are satisfied with their roles and benefit personally from working with others with similar mental health conditions (Brooks et al., 2022). However, there are challenges, including problems with boundaries, particularly for peers who have experienced mental health problems that are the same as or similar to those of the person they are supporting. The problem of re-triggering unresolved trauma increases as the SJPs are encouraged to self-disclose and share intimate stories from their own experiences of mental health difficulties. Repper and Carter (2011) expressed concerns over peers becoming friends with the people they were supporting; they found evidence of peer supporters socialising, drinking, dancing, and forming romantic relationships; however, Mead et al. (2001) regarded this kind of social interaction as an opportunity for both peers to develop meaningful and reciprocal relationships, failing to recognise the ethical issues involved. (It needs to be remembered that this behaviour is explicitly forbidden in the ethical standards of most professional regulating bodies, with severe sanctions, including the removal of the right to practice.)

Concerns were also expressed regarding the stress and reactivation of personal traumas (Chinman et al., 2006); some peers reported being shocked by the level of disturbance experienced by the people with whom they worked and becoming distressed by the stories they heard. The impact of these experiences, often accompanied by feelings of incompetence and failure, is understood by counsellors and therapists, for whom the principles of secondary trauma, parallel process, transference, and countertransference are significant elements of training (Sedgewick, 1994; Page, 1999).

There needs to be some recognition by the SJP movement of the considerable body of evidence that psychological injuries can be caused to anyone fulfilling a supportive role (Morrissette, 2004); where peers are selected based on having experienced or recovering from a mental health problem, the danger of developing compassion fatigue and secondary trauma is dramatically increased (Figley, 1995). In organisations, the use of peers with previous mental health problems in delivering services to colleagues with similar issues creates an organisational duty of care and legal responsibility should these vulnerable peers find themselves being harmed by the role in which they have been placed.

Training

Training and evaluation are essential for all learning, particularly where the training exposes the trainees to information and experiences that could be harmful if not handled appropriately. The level and depth of training are determined by the trainees' existing skills, aptitude, and preparedness, plus the complexity and challenges of the learning.

Training for Peers with Lived Experience of Mental Health Problems

Where peers use their lived experiences as the basis for the support they provide, this will require significant self-awareness and ongoing personal supervision due to their increased vulnerability (Hawkins & Shohet, 2006).

Two guidance documents on training for peer supporters who use their personal life experiences to support others were identified, one Canadian and one British. The Mental Health Commission of Canada guidance was developed based on the practice and training of peer supporters (Sutherland et al., 2013). The guide has 17 learning units arranged within three blocks. This model has been adopted by several organisations in Canada, including the Ottawa Police:

1) Fundamental principles: lived experience, self-determination, values, ethics, and principles of practice, trauma-informed practice, and applying principles in diverse environments
2) Social and historical context: historical context, prejudice, discrimination and stigma, diversity and social inclusion, social determinants of health
3) Concepts and methods that promote effective peer-to-peer support: interpersonal communication principles and methods, building supportive relationships, the process of recovery and change, building resilience through self-care, limits and boundaries, crises and strategies, connecting with community resources, awareness of possible symptoms and side effects of medication

The second framework was developed at University College London for the National Health Service (Health Education England, 2020). The competency framework is more comprehensive than the Canadian version, with seven blocks and 28 units:

1) Understanding the values of peer support and principles which underpin its implementation: values of peer support workers, principles of peer support
2) Knowledge for peer support workers: mental health, trauma-informed care, local services, professional, legal, and ethical frameworks, confidentiality, consent, and data protection, safeguarding and suicide prevention
3) Core relational skills: recovery focus, drawing on and sharing lived experience, maintaining a reciprocal relationship, active listening and working with difference
4) Supporting people as peer supporters: personal recovery, engaging in meaningful activities, coping and problem-solving, support options, recovery plans, access to care, transitions
5) Working with teams and protecting rights: working as part of a team, working with organisations and systems, personalised recovery, promoting rights
6) Self-care and support: reflection on work, effective use of supervision
7) Meta-competencies for peer support workers: ability to reflect on one's own thinking processes (theory of mind)

Neither framework gives a timescale for the training, but it seems unlikely to take less than 6 months to achieve a basic level of competence.

Training for Specialist Welfare Peers

Some organisations have retained specialist welfare peers. The United Kingdom's Ministry of Defence (2017) outlined a diploma level qualification made up of five mandatory units; this assessed course is open to peers. The units include:

1) Analysing a welfare case
2) Communications and principles of practice in welfare work
3) Concepts and theories to support welfare work
4) Presenting issues
5) Professional practice in welfare work

This qualification in specialist welfare work creates the opportunity to progress into research degrees, such as a master's degree.

Training for Peers Operating within a Stress and Trauma-Informed Framework

An alternative peer support model is based on a stress and trauma-informed care and treatment (STRICT) approach (Bloom, 1997). Organisations need to develop stress and trauma-informed employees, cultures and interventions to achieve STRICT status. There are three levels of stress and trauma training:

1. **Informed:** all employees to be given a basic knowledge of the signs and symptoms of stress and trauma
2. **Skilled:** training modules for well-being peers and supervisors in problem assessment, organisational and personal well-being assessment, demobilisation, defusing and post-incident support
3. **Enhanced:** training for occupational health practitioners in assessment and structured interviewing

Each skilled module for peers builds on the previous module, with opportunities to choose which intervention is most suited to the peer's skills and interests. Although some of the knowledge is similar to that found in the Canadian and NHS peer training, the role of the peers is placed under the clinical guidance of mental health professionals, and the interventions are restricted. In the STRICT approach, peers are trained to deliver specific intervention models with clear guidelines, competencies, and monitoring to prevent peers from straying into areas that could harm them and those they are trying to help.

DISCUSSION

The use of peer support in working with employees with psychosocial problems is important. Taking support as close as possible to those in need has significant benefits in terms of accessibility of help, understanding personal and organisational settings, and creating stress- and trauma-informed culture. There is mounting evidence that when peers engage with stress and trauma, the oxytocin system is stimulated through the creation of social systems of support (Olff, 2012). As described, there have been two routes leading to the introduction of peer supporters into the workplace, the first and oldest being the development of the Social Welfare model, with its roots in the activities of the enlightened industrialists of the eighteenth century, which gave rise to the Welfare Services prominent in the delivery of employee well-being and support in the UK and other countries. The second route emerged from social justice, where sympathetic recovering and recovered survivors of severe mental health conditions were recruited to support those at an earlier stage of recovery.

For organisations considering introducing a peer support approach, there is a need to fully assess the potential risks and benefits of using peers with lived experience of a severe social or mental health condition to support others with the same or similar condition. Having experienced and recovered from alcoholism, suicide attempts, eating disorders, gambling, domestic violence, or non-recent child abuse may give insight into the plight of others, and this may be reassuring, as has been found in some self-help groups (Watkins, 2017). Still, there is a risk that unresolved issues and trauma may be transferred, which can increase the exposure to traumatising thoughts and images by the recipient of support and the reactivation of unresolved trauma and secondary traumatisation of the peer providing the support.

Having decided to introduce "peers by experience" within an organisation, determining the organisation's responsibility to ensure that the peer support program "does no harm" (General Medical Council | Medical Schools Council, 2015) is the guiding principle behind all bio-psychosocial interventions. To reduce, as far as is reasonably possible, all risks of increasing mental health problems in "peers by experience," the level of training, support, screening, and monitoring required to prevent injury to themselves and the people they support would be significant. This burden would be more manageable in clinical settings such as the program developed within the NHS (Health Education England, 2020), where the mental health peers would be working full time in the role and well supported by a range of clinically qualified colleagues.

As described earlier in this paper, a significant problem with the peer support programs in operation today is the lack of definition of the role, the intervention, and the evaluation. Consideration needs to be given to screening, training, monitoring, and deployment of peers to ensure they are resilient and able to work safely. Where the peer role is an additional responsibility to an existing job, working within a clearly defined intervention model with training to determine the range and limits of activities is effective in terms of the resources required in the training and management of the support program. Adopting a more closely defined and monitored approach can eliminate many of the identified problems, and the benefits of peer support can then be fully achieved and demonstrated.

As more police services consider, further develop, or expand their use of peer support, more confidence can be achieved by placing greater emphasis on the key learnings and important considerations highlighted by the experiences in other sectors, and the growing body of work and literature that presents both cautions and encouragement. At the same time, understanding and giving the required attention to the many unique aspects of policing culture and the lived experiences of police members must form a core part of all such considerations.

CONFLICT OF INTEREST DISCLOSURES

The authors have no conflicts of interest to declare.

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Mental Health Secretariat: Collaboration for public safety personnel (PSP) mental health in Ontario

Beth Milliard, PhD*, and Robert Chrismas, PhD†

ABSTRACT

Mental health issues, and more specifically suicide, within the policing community have been a growing concern in recent years. In 2018 alone, there were nine suicides among active and retired police officers in the province of Ontario. At the time, nine suicides in one year were shocking and began to raise focused awareness of mental health challenges facing the profession. In 2021, the Ontario Ministry of the Solicitor General created Mental Health Collaborative Tables comprised of key stakeholders, subject matter experts, public safety personnel (PSP) with lived experience, mental health clinicians, and researchers. The Mental Health Secretariat (MHS) is responsible for supporting the tables. The MHS is accountable to the Deputy Solicitor General and has a mandate to provide a provincial action plan to address mental health issues among PSP. This article explains key observations regarding Ontario's innovative approach to improving mental health supports for PSP and describes the perspective offered by Karen Prokopec, Manager, MHS at Ontario Ministry of the Solicitor General, and her colleague, Zarsanga Popal, Senior Performance Measurement and Evaluation Specialist with the MHS, on the establishment of the MHS.

Key Words Innovation; collective accountability; diversity; inclusion.

INTRODUCTION

It is no secret that mental health issues among public safety personnel (PSP) are greater than in the general public (Carleton et al., 2018). As recognized in recent research, PSP are not just affected by exposure to trauma and human suffering in their work, they also report significant levels of organizational stress (Milliard, 2020). The Mental Health Secretariat of Ontario (MHS) was established in part because of the growing recognition of the stresses that impact PSP in contemporary Canada. The authors interviewed Karen Prokopec, MHS Manager, and her colleague, Zarsanga Popal, Senior Performance Measurement and Evaluation Specialist with the MHS. They offered perspectives on lessons learned in establishing the MHS.

Milliard's (2020) research on peer support found that organizational stressors, including promotional processes, police culture, and unsupportive supervisors, are more prevalent and ongoing compared with the traumatic incidents PSP are routinely exposed to (see also Chrismas, 2013). Furthermore, it is up to each PSP leader to decide what types of mental health initiatives, programs, and resources their organization should adopt, which is problematic for many reasons. While many organizations work with with clinicians and researchers to ensure resources are available, other organizations operate without mental health programming. Some may not fully understand the mental health needs of PSP. Any sustainable solution requires a unique approach that accounts for the underlying issues of PSP organizations as well as collaborative approaches based on accountability at the provincial level.

In 2012, the Ombudsman of Ontario conducted an in-depth systematic investigation into how the Ontario Provincial Police (OPP) were addressing operational stress injuries affecting police officers (Marin, 2012). The report revealed that more officers had died by suicide over the previous 23 years than were killed doing police work (Marin, 2012). The Ombudsman's Report was instrumental as it was the first time a governing body had taken an interest in investigating and reporting on the mental health issues of police officers. The report was also an "eye opener" to all PSP who faced similar challenges. It created awareness of systemic barriers in the policing culture, such as stigma for those reporting having problems, and leadership that had historically prevented

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sustainable change. Fast forward to 2020, and the province of Ontario was seeing an overwhelming number of PSP who were absent from work on Workplace Safety Insurance Board (WSIB) claims for traumatic or chronic mental stress, mostly due to the presumptive legislation passed in 2016. In addition, the notable number of police suicides in 2018 sparked the need not only for change, but also for evidence-based, sustainable solutions to address the myriad of challenges faced by PSP.

There was a realization that we could not expect change through efforts only at the individual level for PSP but also required change at the cultural and leadership levels. There needed to be change at all levels—we needed to make systemic change (Popal, 2022).

Creation of the Mental Health Secretariat (MHS)

In 2019, the Office of the Chief Coroner of Ontario initiated an expert panel review to understand risk patterns and create intervention processes for vulnerable police personnel. The report (*Staying Visible, Staying Connected, for Life*) introduced seven pathways for the prevention and treatment of mental health challenges for police. One of the main themes highlighted throughout the report was the need to create a culture that is open to supporting mental health through sustained access to care, treatment, and recovery for policing. The report concluded with 14 main recommendations, outlining a total of 36 actions and specifications, which reflect a continuing theme of collaboration across the policing community. As a result, in 2020, under the mandate of Ontario's Chief Coroner Dr. Dirk Huyer, the Ministry of the Solicitor General created the MHS.

Although the original idea and recommendations from the expert panel's report revealed a much-needed change within the policing realm (Ontario Chief Coroner's Report, 2019), after further consultation, it was quickly recognized that other public safety sectors, namely corrections, emergency health services, and fire, should also be included. The COVID-19 pandemic initially slowed the government's response to many of the recommendations of the expert panel's report and the creation of the MHS, but it also provided an opportunity to be methodical and ensure voices from all public safety sectors were included in the early stages of its work. The idea was to bring together a team that could align the work of many previously disconnected efforts and build greater stability and sustainability in this space by bringing experts to the table. Further, it was critical that the work balance the needs of stakeholders, ensuring equitability across services and public safety sectors. In the words of the manager of the MHS, "Like making soup, there were many ingredients that needed to be blended together. Bringing diverse perspectives from stakeholders and the experts in the field together was important, but remaining open to adding other ingredients to make the soup better was critical" (Prokopec, 2022).

Among the first actions from *Staying Visible Staying Connected for Life* taken by Ontario was to implement the recommendation for the formation of an Ontario Police Members Mental Health Collaborative (OPMMHC) to serve as a standing body that would initiate, guide, monitor, and report on an urgent and comprehensive plan of action in Ontario. In February 2021, recognizing that the mental health challenges faced by police are also more prevalent across other public safety sectors, Ontario announced the creation of concurrent tables for corrections, emergency health services, fire, as well as police, leveraging the report's recommendation on structure and governance. The Mental Health Collaborative Tables (MHCT) are comprised of key stakeholders, subject matter experts, public safety personnel (PSP) with lived experience, mental health clinicians, and researchers.

Greeno et al. (2022) explained through their Global Studies 2020–2022 research that "wellness" was identified as an immediate priority for sector-wide unification under the Canadian Policing Initiative. They questioned who would be tasked to further develop parameters, priorities, and opportunities. The MHS provides an example of an approach that can begin to tackle some of the mental health issues faced by PSP through initiatives such as addressing access to trauma-informed mental health professionals; developing comprehensive mental health and wellness strategies and best practice guidelines; promoting knowledge mobilization; and addressing stigma in organizational culture.

The priorities of the MHS's 5-year strategic plan start with building a common understanding of the issues facing PSP, building a coalition amongst partners in the field, taking tangible action, building a stronger evidence base to support decision-making, and then ensuring sustainable implementation of programs and services. There were several documents that guided the work of the MHS, with the first step being alignment with Ontario's broader mental health and addictions strategy: Roadmap to Wellness. It emphasized that PSP have unique needs, and that service-specific supports are effective given the unique culture of each occupation (Ontario Minister of Health, 2020). Second, the Ontario Chief Coroner's Report (2019) identified gaps, overlaps, and service deficiencies that, if addressed, would improve the effectiveness, efficiency, and universal accessibility of mental health supports to police service members across the province. Third, the creation of MHCTs brought together key partners across the sectors to identify gaps, barriers, and opportunities in accessing currently available mental health programs as well as identifying priorities for the way forward. Fourth, a Joint Knowledge Sub-Committee, Key Government Partners, and an Inclusion Advisory Table were created to offer a lens through which priorities can be reviewed and considered to ensure the implementation meets the needs of PSP. In addition, programs are coordinated and integrated to reflect the broad diversity of the sector and emerging best practices. Fifth, a budget initiative sought approval for funding to support proposed initiatives. Sixth, an Executive Mental Health Steering Committee was created.

MHS Manager Karen Prokopec commented that great care was taken to ensure the MHS was established with collaboration and representative voices from each public safety sector. Prokopec advised, "We developed a very robust, some might say overly robust governance structure, but every time I look at it, I don't see any components we could remove from that structure without missing something" (Prokopec, 2022).

Mental Health Collaborative Tables (MHCTs)

The MHCTs for corrections, emergency health services, fire, and police meet a minimum of four times per year. They are comprised of unions/associations, employers, municipal representatives, other key stakeholders, PSP with lived experience, mental health clinicians, and researchers. The tables advise on strategies, initiatives, and innovations to improve

mental health supports for PSP in Ontario. The MHCTs inform and support the development and implementation of Ontario's Mental Health Action Plan (MHS, 2021).

Executive Mental Health Steering Committee (EMHSC)

As a decision-making body, the EMHSC addresses the priorities stemming from the MHCTs and the Mental Health Action Plan (MHS, 2021) to support the mental health and wellness needs of PSP across Ontario. The committee is made up of executives from across the Ministry of the Solicitor General, Ministry of Health, Ministry of Children, Community and Social Services, and Treasury Board Secretariat. The Deputy Minister, the Commissioner of the OPP, and the Chief Coroner regularly attend these meetings and recognize their priority, thereby creating trust with the other sectors and stakeholders.

Joint Knowledge Sub-Committee (JKSC)

Primarily a collaborative body comprised of mental health clinicians, researchers, and active PSP, the JKSC shares information to support key priorities identified by the MHCTs. They assess, interpret, and adapt best practices in mental health for PSP that align with identified priorities. The sub-committee gathers and consolidates research findings to better understand gaps, priorities, and opportunities, synthesizes available evidence to generate recommendations, and ensures the delivery of effective knowledge mobilization techniques. The JKSC informs the creation of program-specific task teams and meets every 6 weeks. To date, task teams to study peer support, family programs, and stigma, and to develop an Ontario.ca resource portal, have been convened.

Inclusion Advisory Table (IAT)

The IAT provides leadership and guidance on anti-racism, diversity, and equity in public safety sectors with the goal of ensuring that the mental health needs of racialized and minoritized PSP are met. Co-chaired by the MHS and executive leaders who represent racialized and minoritized groups, this table meets bi-monthly to hear from real experiences of PSP which they use as a platform to encourage discussion and identify key points for change.

Key Government Partners Tables (KGPTs)

The KGPTs support system-wide implementation of priorities stemming from the MHCTs and the Mental Health Action Plan (MHS, 2021) to ensure the delivery of coordinated and integrated mental health and wellness supports for PSP across Ontario. Members at this table include decision-makers from the Ministry of the Solicitor General, the Ministry of Health, the Workplace Safety and Insurance Board, the Association of Municipalities of Ontario, and the Ministry of Labour, Immigration, Training and Skills Development Prevention Office.

PSP Mental Health Working Group (PSP MHWG)

The PSP MHWG provides a platform for a broad range of public safety sectors to discuss how to enhance and support existing mental health programs and supports for PSP across the Ontario Public Service. This working group meets bi-monthly and includes corrections, emergency health services, fire, and police but also youth justice employees, animal welfare investigators, coroners, emergency management personnel, and forensic scientists and pathologists. A key focus of the working group is to share best practices, gaps, possible collaborative initiatives, and steps to culture change in an effort to reduce the stigma associated with mental health and help-seeking. The group has created an internal-to-government intranet page to support knowledge mobilization across public safety sectors in the Ontario Public Service.

Early Success and Learnings of MHS

Although the work of the MHS continues, some noteworthy milestones have been reached.

Diversity and Inclusivity

First and foremost, the MHS has created spaces where the collective mental health needs of PSP are being discussed and addressed. There is a recognition of diversity and inclusivity. The MHS created the IAT based on research and conversations with organizations such as the Association for Black Law Enforcement (ABLE). As the work of the MHS and MHCTs has evolved, there is growing (anecdotal) recognition that racialized and minoritized PSP face a greater likelihood of mental injury.

Through the membership of the IAT, it was acknowledged that this was the first time that diverse and marginalized PSP had a platform to discuss their experiences—experiences that often put them in positions where they needed to consider their roles both in the community and in their public safety organization. In 2022, the first author had the honour of being asked to speak at the IAT on "Gender in the PSP Context" alongside women from police, corrections, and fire. Being in a space of shared similar experiences solidified awareness and understanding of the complex needs of PSP when it comes to mental health.

The work of the MHS has been innovative and fluid. Not everything is laid out line-by-line. There was nothing in the expert panel's report that addresses the needs of marginalized and diverse PSP, but we felt it was important to explore. We realized that although the profession is the same, marginalized and diverse groups have very different experiences within it—these experiences can affect one's mental health (Popal, 2022).

Utilization of Technology

The MHS has had a unique opportunity to operate across public safety sectors, other provincial ministries, and municipal and First Nations public safety services because of its mandate to better align and build equity in mental health supports for PSP. An example of significant progress in this area came from the introduction of the PeerConnect application across Ontario. Originally the Peer Connect app was to be implemented for Corrections to support the roll out of their Peer Support Program. However, through COVID-19, an opportunity for funding to support a one-year pilot allowed for the expansion of the PeerConnect app to also include police, fire, and paramedics. The MHS is demonstrating its ability to work to address the mental health and wellness of PSP by working across various groups to deliver much-needed programming.

Most recently, the MHS launched a portal for members and families to access mental health resources within the Ontario.ca website. The information on the portal can be service-specific for larger services and/or general access for

all provincial services. The portal was launched following the work of a task team that included communications leads from public safety sectors, persons with lived experience, and psychologists who work with PSP in their practice. The MHS' role in facilitating discussions with subject matter experts is leading to many of their successes.

Stigma Reduction

Work is currently underway to design and execute a broad campaign aimed at normalizing mental health challenges to reduce stigmatizing behaviours. The goal is to achieve a healthier identity and work–life balance, building awareness of supports, treatments, and recovery outcomes in all PSP sectors. The MHS recognizes that great work is happening across the country. For this initiative, the MHS connected with representatives from the provinces of British Columbia, Saskatchewan, and Nova Scotia to learn from their experiences, and build on them to support a "made in Ontario" program.

Peer Support

The MHS has also organized focus groups for peer support. These groups consisted of PSP that represent front-line, leadership, and the organization. The purpose of the focus groups was to gather evidence to support the creation of a best practice guideline for PSP organizations.

Building a Strong Foundation: Implications for the Rest of Canada

As one of its major projects, the MHS is working towards an evaluation process for mental health programming, training, and resources. The Evaluation Advisory Table (EAT) will create an evaluation process that will provide credible and independent evaluation and implementation advice to inform government and the broader public sector. The goals of EAT are to support the development of evaluation criteria for programs and ensure consistency in evaluation across mental health initiatives, support informed decision-making, and increase understanding of return-on-investments for mental health services and supports. Members selected for the EAT will be representative of all public safety sectors, possess a wide range of skills and experience (including areas of evaluation, research, academia, performance measurement, program planning, budget, and costing), and include members of racialized and minority communities.

In collaboration with the Canadian Institute for Public Safety Research and Treatment (CIPSRT), the MHS is working to create a "Mental Health Needs Framework." The JKSC recognized that no framework currently exists to identify best-in-class mental health services and supports along the career pathway (new hire to retirement) for PSP and their families. The JKSC proposed an investment in developing a framework. The committee acknowledged that while various services and supports are available, there is a notable lack of awareness of the specialized and tailored services that are most effective for this population. Consequently, public safety organizations often use anecdotal data to fund various mental health services and supports due to the lack of existing evidence to validate appropriate services and supports.

Through the establishment of a Mental Health Needs Framework, the MHS and local public safety services will be better positioned to implement effective programming that addresses the unique and diverse needs of PSP. In addition to addressing the most needed programming, the framework will support value-for-money investments across a continuum of needed services. Karen Prokopec described the initiative as follows:

> We're working on a Mental Health Needs framework. I believe it will be important for supporting services by providing public safety organizations with the type of programming they should invest in to best support their PSP. The journey of PSP through their careers is not ubiquitous, so what they might need at the recruitment stage versus the retirement stage is quite different, and we believe this framework will set that out. (Prokopec, 2022)

Going forward, Prokopec and Popal described the constellation of services and programs supported by the MHS as having momentum in a positive direction and fulfilling the goal of collective accountability. Notably, Prokopec described how she is continually impressed by the commitment of senior leaders from all the sectors, showing up at meetings, engaging and supporting development of these resources for PSP. She also acknowledged that there is a long way to go, stating, "There's a lot of table setting that still needs to happen and I think foundational elements like evaluation and needs assessment are really important" (Prokopec, 2022).

CONCLUSION

The power and efficacy of collaboration have become conventional wisdom in public governance. Achieving it, however, is another matter. Many initiatives have failed, due to territorialism and the challenge of sharing information. Ontario's MHS seems to be overcoming many of these obstacles, perhaps because the end-goal of improving the mental health and wellness of PSP is so critical. Some factors that seem to clearly play into its success thus far include support at the highest levels, a focus on inclusiveness and equity, and a strong emphasis on the front line. Zarsanga Popal of the MHS described the high engagement at all levels, which likely accounts for the team's successes to date: "There is great expectation across the province because it's the first time a model like this, where everybody is getting together to talk about PSP mental health collectively, has been created—people want something positive to come out of this" (Popal, 2022).

Police and the broader PSP community are part of Canada's social fabric and play a critical role in protecting our communities. A significantly high suicide rate has become a call to action. We owe it to PSP to do what we can to support them. Ontario is taking a positive step to increase awareness and acknowledge the cost of mental injuries to PSP, their families, and the organizations in which they work. Ontario's MHS is advancing approaches and innovative practices that can be a template for the rest of Canada.

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CONFLICT OF INTEREST DISCLOSURES

The authors have no conflicts of interest to declare.

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