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An overview of the current concerns regarding police officer mental health and interventions in place to address these

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Abstract

The mental health and well-being of police officers is of key concern in England and Wales currently, with substantial numbers of workdays lost every year as a result, and this number continues to rise. This article seeks to explore current levels of mental health concerns within policing in England and Wales and their root causes, breaking these down into categories. It then explores various interventions in place to address those, and whether or not there is sufficient evidence to assess their effectiveness. It finishes by offering potential new or amended means to tackle the epidemic of stress, depression, and anxiety currently facing British police officers.

Keywords: *Police Mental Health, Police Sickness, Oscar Kilo, Trauma Risk Management*

Introduction

This paper seeks to examine the pertinent issues in contemporary policing that affect the mental health and well-being of police officers and their causes. It aims to measure the effect of adverse mental health within policing, through critique and examination of what current research-based evidence suggests, alongside the wider current mental health status of police officers within the UK. It finally seeks to investigate what the potential causes or triggers of these effects are and offer insight and critical analysis of the interventions seeking to overcome them, alongside possible new ideas around how to stop or even prevent these negative effects.

Current research proposes a wide array of factors as being responsible for what could be described as an epidemic of mental ill-health within British policing, with just shy of 10% of police officers having taken time off for mental-health related concerns in the 2023-24 financial year alone (Police Federation, 2024; Home Office, 2025). In 2023, this equated to 571,000 officer days, or 1600 fewer officers nationally (Police Federation, 2023). Furthermore, 39% of those who take a first leave of absence due to mental ill health go on to take further absence from work due to their mental health-related issues (Cartwright & Roach, 2021). This stands in contrast to the general population, where sickness owing to mental health concerns is generally in decline from 10.9% in 2019 to 7.9% for the most recent published figures from 2022 (ONS, 2022). The most prevalent causes identified, however, are organisational stressors, which include shift length, long working hours, low resources, and heavy workload exposures. Traumatic events and emotional incidents, alongside empathy fatigue / secondary trauma, also contribute to the build-up, compounded by the lack of help and macho stigma in policing. These are all topics that shall be explored below, alongside what evidence from policing and wider disciplines suggests can help counter this widespread concern.

Organisational Stressors

The police working environment has many occupational stressors that can lead to increased risk of mental health illnesses, as academics, police practitioners, healthcare professionals and psychologists all consider policing to be one of the most stressful occupations (Purba & Demou, 2019), and it ranks in the top three occupations globally for stress and mental illness (COEH, 2000). Within the UK specifically, several studies within the last few years have seen police officers featured as the most stressful occupation (English, 2024). One study examining Health and Safety Executive data identified being a front-line police officer as the most stressful job in the country, with approximately 11,000 of 169,231 (6.5%) reporting their job created or exacerbated mental health concerns (Brand, 2024). This is two-and-a-half times the national average.

These organisational stressors include heavy workloads and time pressures of the job (Oliver et al., 2022), pressure from supervisors, inadequate resources, shift

work (Velazquez & Hernandez, 2019), and overly bureaucratic organisational systems (Purba & Demou, 2019). These organisational aspects, including officers lacking a voice, can come under the concept of ‘organisational justice’, which has further been identified as a key cause of frustration among the police workforce (Quinton et al., 2015), and the leading cause of officer resignations currently (Tyson & Charman, 2023).

Some literature does not conclude organisational stresses are a direct factor in mental health, but it does consistently argue that it is a prevalent factor in officer fatigue and burnout (Purba & Demou, 2019). Once again, this association to burnout in itself did not lead to mental health issues; however, it did lead to emotional exhaustion, which then had factors correlating to mental health. Due to this association, it was found that factors like team support, shared values, and perceived fairness were a good prediction of well-being and decreased emotional exhaustion (Karaca, Tanova & Gokmenoglu, 2023) and thus, the opposite applies when you take them away, and naturally, officer emotional exhaustion increases.

Porter & Gavin (2024), however, completed an online survey which concluded that organisational and operational pressures *were* the main factors in the decline in mental health. This is because it relates to things that cannot be changed by officers themselves, but only by those higher up the rank structure, linking this to the aspect of organisational justice. The College of Policing states that if a police workplace is not fair and respectful towards its staff, then this will have a negative impact towards its employees (Quinton et al. 2015). Nearly a decade later, Charman & Bennett (2023) found this to still be the case, suggesting that change is either not occurring, or worse – is getting worse. As a result, this would impact negatively on officers’ mental health due to their believing that they are not cared about or valued. This means that within the police, organisational justice should be viewed as vitally important, as if an officer does not feel that they are being treated fairly, their mental health will decline. This conclusion is further supported by the view that with the current politically driven short-termism under Police and Crime Commissioners (PCC) and short tenures of chief constables, means that the focus from police leadership is very much on “quantity over quality”, hindering staff development and support, and by extension welfare (Andrews, 2025).

At the end of the scale of mental health issues, specifically looking at suicide as the ultimate expression of mental health difficulties, two studies contrast this idea of occupational stressors as being a factor in mental health. One study from Cantor et al. (1995), in a screening research question, and Hemming (2001) in the literature review, both found no links to increased suicidal levels with evidence of organisational stresses as being a factor, when compared to the general population. However, Cantor's (1995) study is nearly 30 years old and did not directly measure organisational stressors, and Hemming had a very small sample size, and neither explored the less severe end of the scale, which leaves room for ambiguity in this area. However, their findings were then supported in new research by Bell & Eski (2016), in which they found police officers experienced the same combination of mental health issues as the general working population. Given, however, that these studies are now significantly dated, it supports the suggestion above that the mental health stressors on police officers, specifically from an organisational standpoint, have significantly increased over the preceding decade.

But it must be argued, however, that their work reaches this conclusion because of the frequent exposure officers experience to inherently stressful situations, which require different levels of physical and mental ability to respond to effectively. While this can predispose police officers to stress, it is instead suggested that it actually serves to embed individual coping mechanisms, which become part of the police officers' personalities. This then allows them to cope and accept stressful situations as a natural part of their job and become more resilient to stress than civilians, and this may explain why the rates differ. Janssens et al.'s (2021) systematic review found that officer resilience to stress does indeed increase over time, lending credence to this idea. However, when owing to record resignations and mass recruitment (Home Office, 2025), around a third of police officers have less than five years' service, and "inexperience [has] reached a peak" (HMICFRS, 2024: 5), officers have not had a chance to build up this mental tolerance thus contributing significantly to poor mental wellbeing owing to lack of experienced peer support within the service. It may well also be the case that inexperienced officers do not feel comfortable or have an awareness of raising concerns or suggesting improvements to organisational issues. These same young in-service officers are also experiencing increased stress through the new police entry routes, especially those earning a degree alongside their operational

requirements. The culture and attitude of forces towards the enhanced requirements thereof, as well as the general lack of understanding by supervisors and leaders regarding the enhanced workloads that they bring, is a significant cause of concern for those officers (Andrews, 2023).

There is one organisational stressor factor which stands out conclusively from the rest, and remains coherent throughout the research, which is shift working and long working hours. In one study by Houdmont & Randall (2016), a quarter of their sample of police officers reported long working hours, and these officers were significantly more likely to report common mental disorders due to that factor. This is supported by a similar study of Australian junior doctors, where they had the factor of long working hours and shift work, and this study also yielded the result that they reported more common mental disorders than the general population (Petrie et al., 2020).

Exposure to traumatic events and mental health illnesses

There has been substantial literature which shows a strong association between interpersonal trauma and simple mental health illnesses in the general population. Hartley (2013) explored traumatic experiences and mental health illnesses in police officers and concluded that there is a strong prevalence of increased risk of developing mental illnesses post seeing a traumatic event. As a result, it can be reasonably assumed that policing can be considered a high-risk profession for the development of mental health, probably due to increased risk of repeated exposure to trauma (Mauritz et al., 2013). Indeed, research by the Police Federation (2021) suggests that police officers experience 400-600 traumatic events in their careers, compared to the general public, who experience just 3 – 4 in their lifetimes.

However, this assumption lacks empirical evidence, and in fact, research points in the other direction. One study sampled rates of over 40,000 police officers, ranging from staff to senior ranks to call handlers, found that depression was the most frequently reported mental health concern in 9.8% of them; 8.5% reported anxiety; and 3.9% presented PTSD symptoms. These groups at risk of common mental disorders, including police staff, were also employees who reported heavy drinking. Police employees exposed to traumatic events in the past six months had doubled rates of

anxiety and depression and a sixfold increase of PTSD compared to those who had not experienced any sort of recent trauma. With all that, the study still concludes that there is no significant difference between the general population's mental health statistics and the police rate statistics. When compared, even though at face value it seems there are prevalent rates of common mental health disorders in police officers, it is actually still the same rate as the general population experiences.

Supporting this is a systematic review by Regehr et al. (2021), who synthesise the existing research on officers dealing with large-scale disasters as a form of trauma to further the understanding of how extreme events may impact the mental health of police officers. These results found variability in the reported cases of mental disorder, but there was a clear trend overall in which rates of PTSD among police officers were consistently lower than those of civilians affected by the same traumatic experience. In this case, disasters. It was also found that they were lower than other occupations, too. The impact and nature of the trauma, as well as the influence of police culture on an individual, which enables them to cope with trauma, are clearly significant. A glaring criticism of the studies, however, is that they are only conducted with serving police officers and staff and therefore fail to take into account officers who have experienced significant trauma resulting in medical retirement or resignation or indeed were off sick due to mental health conditions at the time of the research, which, as above equates to 10% of the police workforce.

Not all officers, however, are affected the same way and coping mechanisms, both at individual and an organisational level, can make a considerable difference to how someone processes and recovers both primary and secondary trauma. It must also be considered that a large number of these studies did not account for different policing roles or measure the difference between these roles and what they'd be exposed to, including the trauma and what incidents those officers are attending on a day-to-day basis. Nor did the studies account for the participants' gender, as it is known that men and women differ in their ability to control situations and how they would react to them (Matud, 2004). Nor did they equate for their ages or the experience of the officer, as an officer with more than twenty years in the service, compared to someone with one year, will have very different ideas and perspectives of trauma; and this doesn't even account for survivorship bias, where those who cannot or struggle to cope leave the job. All of these combined could affect the results of the studies. As

could the fact that those who choose to participate in these voluntary studies are the individuals who are comfortable speaking about their feelings, and therefore would create an unrepresentative view, as the ones who don't want to speak about their feelings would not be volunteering to participate.

Taken at face value, though, these studies would suggest there is minimal impact on officers when dealing with trauma. However, Walker (1997), in a study of officer outcomes when dealing with hard roles such as recovering bodies, seeing dead bodies, and general traumatic situations, found that officers struggled to admit how these roles affected them and that their mental health conditions remained undiagnosed and would not have surfaced in the data because of that. But this study, once again, is an old study and is nearly 30 years old, and by now, it could be expected that researchers or mental health support services should have found a way around this. But Civiliotti et al. (2021) in more recent research explored the coping mechanisms of police officers in response to trauma once again, and in this, they found that there was a prevalence of deactivation strategies, which were associated with suppressing feelings in a strong percentage of officers. This suggests there is an element of denial of trauma, which may impact results within the literature, skewing the factors. This possibly explains why there could be such a big contrast between different studies, but it's yet to be fully explored and concluded in the literature. It must be taken into account, though, that this study, for example, had a very small sample size, and the results must be interpreted with caution as his outcome might differ with an adequate sample size. The study was also only conducted in one location, with one team, following the same disaster, so there could be shared traumatic events, which may cause some bias due to shared emotion. It may also be that the researcher speaking to that team specifically has overcome cultures within policing that stigmatise mental health, as shall be covered below.

It must also be borne in mind that traumatic incidents can have a profound effect on human psychology and physiology, both at the time and afterwards. In stressful situations, humans have evolved for our ‘chimp’ or ‘system one’ part of the brain to take over, as opposed to our ‘system two’ brain, which is the conscious, slower thinking part used for more complex problems. Our ‘chimp’ brain has evolved over generations and dates back to when humans were hunter-gatherers running away from sabre-toothed tigers; it helps us make quick decisions to keep us safe (Seth & Bayne, 2022).

The average human heart has a resting heart rate of between 60 to 80 beats per minute, and research has shown that effective emergency responders have a heart rate of between 115 to 145 beats per minute when dealing with an incident. This increased heart rate is triggered by the body's sympathetic nervous system and affects all our physiological functions (Clay, 2001). Our complex motor skills deteriorate, for example, writing or opening bandages. Auditory exclusion becomes common, where responders may not hear everything around them. Vision becomes impaired, and tunnel vision takes over. Time also becomes distorted, and things seem to move in slow motion, and this remains, making recall of events particularly problematic. Respiration also increases, as does blood pressure and is accompanied by general sympathetic nervous system disruption. This all contributes to significant memory loss (Russell & Lightman, 2019), which is also important to consider when reviews are being undertaken post-incident, as well as studies seeking to examine the impact of cumulative trauma on police officers. Obviously, if heart rates exceed this operating range, the effects get even worse. It may well be, therefore, that whilst officers may appear no more or less prone to common mental health conditions during research studies, the cumulative psychological and physiological effects of repeated high-stress situations.

Police cultures and stigma around mental health

Within policing there exists a pronounced stigma surrounding presentation of a macho image, a need to present a strong face for the public, the nature of the job as expecting an ability to cope, and specifically of not wanting to seek mental health due to it being perceived as weak (Foley, Hasset & Williams, 2022; Jackman et al., 2020; Edwards & Kotera, 2020). It is a profession that Hochschild (1983) would identify as having “display rules” which must be followed to be accepted and fit in. Police culture has been studied extensively, with both negative and positive aspects of such being debated (Westmarland, 2011). The impact of police culture and stigmas surrounding policing studies are thought as probably the biggest factors to consider when conducting research in policing. Negative impacts such as not being able to show weakness alongside confidentiality concerns are likely to have a significant impact on accuracy of results (Parkes et al., 2019), and it has been found that there are mixed

views by officers toward both talking to others about their experiences and a cultural theme of talking about concerns being too risky (Evans, Pistrang & Billings, 2013; Newell et al., 2021).

Parkes et al. (2019) showed in a study of officers that participants were reluctant to seek help from colleagues and supervisors until reaching the breaking point. More than half of their respondents felt that they were not able to seek support from loved ones or friends, owing to a concern regards oversharing traumatic details or causing secondary trauma or distress by detailing the nature of their work. This supports the organisational impacts regarding lack of proactive support from supervisors as identified above (Purba & Demou, 2019). Indeed, Brunetto et al. (2022) identify that leadership and organisational support are paramount in helping police officers' mental health, but there is not sufficient training or support for managers to identify or start conversations on the topic.

Such stigmas regarding mental health then become normalised in newer police officers through a social learning (Bandura, 1977) or relational leadership (Uhl-Bien, 2006) approach, and they continue to do the job with that skewed perception. They continue to mimic their forebearers who already have PTSD and depression and other related mental health concerns, but which are not openly talked about amongst the police officers. So once again, the job itself, the perception that the police officers have a way of doing their job and these “display rules” of an outwardly portrayed persona that may not be how the officers are feeling inside (Velazquez & Hernandez, 2019).

These issues are compounded by various forms of media, which do not portray officers as ordinary humans but instead as a strong face, paired with a societally defined law enforcement agency through ideals of masculinity (Scharrer, 2001), placing a burden on officers to embody an unrealistic persona. This endorsement of negative stereotypes in turn suggests law enforcement and police personnel will have a more difficult time seeking mental health treatment. However, there is a flip side to this, which does correlate with them not being able to talk to people and that it may lead to ‘emotional numbing’ (Karaffa & Tochkov, 2013). So, during training and in early stages of a police career, some officers might take the view that those who show emotion may be viewed as weak by other officers, due to this perceived stigma. This form of depersonalisation is known as emotional numbing, and as a result of this

emotional numbing, recognition of emotions and feelings can be skewed (Parkes et al., 2019). This inability to recognise or apply emotional intelligence highlights further the possibility of the stigmas contributing to why police officers may not seek mental health support (Pasciak & Kelley, 2013).

From this, it is logical to conclude that this skews data collection regarding adverse mental health conditions within policing, throwing out any attempts at research. Because people are under-reporting, any study exploring mental health as a factor must account for this, and if it does not, then the research is potentially invalidated.

Outcomes to improve mental health and wellbeing

As has been shown, academic research data regarding mental health concerns is skewed due to the culture of policing leading to under-reporting and makes even the pure statistics about numbers of sick days taken unreliable, due to a culture of 'soldiering on'. Therefore, to get any viable solution to the problem, the stigma needs to be resolved first. This will not be simple, owing to the deeply entrenched nature of this stigma, and the social learning and relational leadership theories identified above. It may, however, be one benefit of having trainee officers educated outside of police training school environments (Andrews, 2024), allowing mental health to be discussed more openly, and not with police officers. It is only once this stigma is reduced that accurate studies can be undertaken, providing results that can be analysed to identify and measure coping strategies utilised by officers.

Some of these coping strategies, which could be assessed, are measures which are already in place but are not fully understood. Primary among these is debriefing, which, as discussed above, can take place when a person experiences a traumatic event which may lead to a strong emotional reaction (Brucia, Cordova, & Ruzek, 2019). This reaction may disturb a person's ability to function, leading to either normal stress responses or symptoms indicative of PTSD. Therefore, a psychological debriefing was implemented to be an immediate intervention following a traumatic experience that was supposedly meant to help individuals manage their normal stress reactions to the incident. However, although this method was widely used at the traumatic events, its effectiveness is being debated (Mitchell, Sakraida, & Kameg,

2003). Due to the lack of empirical evidence, some evidence suggests it may not be helpful, and it may even be harmful (Wessley, Rose & Bisson, 2000). Some organisations are even advising against this general use, as it is argued that, when it is a mandatory force-wide scheme, it does more bad than good for participants who are resistant and did not want to participate but were forced to. These studies were in a single standalone session, and they found that in this single standalone session, if a participant was forced to do it as part of the scheme, they came out with negative reactions and actually worsened symptoms (Mitchell, Sakraida, & Kameg, 2003).

However, research by Tuckey and Scott (2013) found that when in a group debriefing session, and over multiple sessions, it is actually linked to significantly greater post-intervention quality of life related to its control groups, which were just education and screening. Although this was found, no significant effects were found on post-traumatic stress or psychological stress, which could be anticipated would go hand in hand, but in this research, it did not.

De-briefs also need to be formal, structured affairs, as it was found that informal de-briefings with peers often took place in a pub with alcohol. Whilst in moderation, this was shown to be a good way of socialising and talking through a shared experience, it was found that it could also lead to negative impacts of significant harm, and some people went as far as demonstrating increased risk of suicidal ideation (Pienaar & Rothman, 2005). The training of peers and supervisors to facilitate this is exemplified as best practice, due to familiarity helping overcome some of the negative stigmas, as well as enabling those supervisors and peers to be more proactive in identifying mental health concerns. (Demou, Hale, & Hunt, 2020).

It is possible from the research, therefore, to demonstrate that when debriefing is used too little, it can be negative, and when used too much or forced on participants, it also yields negative impacts, but only in the Goldilocks zone in the middle did it have any sort of positive effects. With these results being so varied in the literature and the application of this to policing being sparse and only dating from around the early 2000s, it leads to ambiguity and with no newer research on other populations, this technique should be used with caution until future research designs with well-controlled research studies direct towards overcoming the old methodological limitations of the past.

The second intervention relates to trauma risk management or TRiM. This is the system, which was originally developed in the British Army, aimed to ensure that trauma-exposed staff were properly supported and to seek help if they should suffer from any sort of mental health problems or increased adverse emotions post-incident (Whybrow, Jones, & Greenberg, 2015). The TRiM process works by training members of a social group (in this case, police officers) to carry out a rapid risk assessment using a ten-point scale it scored from nought to three, shortly after traumatic episodes. It is used to identify those who may be suffering from adverse psychological effects. The outcome does differ with the score, so intermediate scores require monitoring and follow-up, whereas higher scores require rapid referrals for mental health professionals (Whybrow, Jones, & Greenberg, 2015).

The research into TRiM and its use within policing agrees with the research relating to its use in other fields, stating its effectiveness in educating staff about the dangers of stress, burnout, and PTSD, whilst encouraging a positive action to prevent these problems developing (Walsh, Taylor, & Hastings, 2013). Another benefit of TRiM is that it also tries to challenge the traditional stigma around police cultures, which was discussed above, where any sign of supposed weakness should not be disclosed.

Because the stigma is so wide and so prevalent within policing at the moment, this may cause issues for trauma risk management sessions being able to function, or for people signing up to participate who don’t want to be labelled with the stigma (Becker, 1963). This is especially the case in specialist roles in policing, such as firearms, where additional perceptions that admission to a lack of mental toughness would see an officer removed from the unit (Turner & Jenkins, 2018).

One place where the TRiM process does try to challenge these stereotypes is in its original military setting, where it was found that TRiM not only did no harm, but may have actually had a positive impact on organisational functioning. It was seen as acceptable to those personnel, within a hierarchical organisation such as the military (Whybrow, Jones, & Greenberg, 2015), which thus naturally implies the crossover to policing.

TRiM overall, however, remains a significantly under-researched area and the literature that does exist only seeks to explore the positives of it, but not many of the drawbacks. To make it more conclusive, the drawbacks would need to be identified

and longer-term monitoring of those who have undergone TRiM sessions compared to those who have not.

The third approach to addressing the current issues around mental health and wellbeing concerns within policing is the Oscar Kilo scheme (Oscar Kilo, 2024). It is an evidence-based sector-specific service which has been developed *for* policing *by* policing. It is intended to meet the unique needs of police forces, officers and staff, and its main aims are to help police forces build a world-class wellbeing support service for everyone who works for them. Its goals are for improved knowledge, understanding, and identification of the help and support available, to try and once again reduce the stigma around the support or help and encourage people to support themselves and realise their own potential (Phythian et al., 2022). Oscar Kilo grew out of the government-funded Mind Blue light programme, which over its four-year lifespan found that there was a significantly improved rate of officers seeking help for their mental health. 59% of the survey respondents in 2019 also felt that their police force encouraged them to talk openly about their mental health, compared with just 24.8% in 2015 (Mind, 2019). This demonstrates that by encouraging conversations around mental health, the stigmas can be broken down. Due to the comparative novelty of Oscar Kilo, however, there is not yet in-depth analysis regarding its effectiveness. Therefore, these may benefit from further research in years to come to demonstrate whether forces are still using them and whether they are impacting positively on mental health or whether more needs to be done.

A more specific idea to improve on and linked to the cultural issues around supervisors lacking knowledge of how to intervene was an idea of social support from individuals and leaders within the same work group (Frapsauce et al., 2022). Social support has been viewed as a satisfactory support network to prevent PTSD in police officers. This is a community support approach that places those within the same category of work together to discuss their emotions and feelings. This, as a more structured plan within the police, could benefit police officers' mental and physical well-being as they are given specific time to sit down and discuss with their peers what they are struggling with. Doing this with peers and colleagues allows them to relate to others and talk about the trauma rather than it playing on their minds. A lack of social support has been shown to increase an increased chance of experiencing PTSD, with Frapsauce et al.'s research showing that more social support leads to fewer PTSD

symptoms. It further showed that with more recognition of the topic at work, the lower the frequency of PTSD symptoms occurred. If higher ranks within the police, such as sergeants and inspectors, offered the time for officers to sit with their peers and leaders to complete this, it could reduce the stigma attached and allow officers to feel they can speak freely about it to their line managers because they are given that opportunity rather than feeling like they have to take time off work for it. This approach has also been tested by Bjørlykhaug et al. (2021), who identified several systematic reviews which have been done on the links between social support and mental health. These suggest that individuals with low social support systems (inside and outside of the workplace) are more susceptible to poor mental health, whereas those with adequate support receive informal help regarding their mental health. This is not without the difficulties outlined above, however, in teams at greater risk of experiencing trauma, regarding the lack of experience currently prevalent on the front-line of policing, and thus the lack of experienced peer support. It is also hampered by the perfect storm of politics over the preceding decade, with funding cuts, significantly reduced officer numbers, and short-term needs of PCC election cycles combining to prioritise organisational priorities over individual needs, resulting in the oversight of officers as people.

Conclusion

It has therefore been demonstrated that poor mental health remains a key concern within policing currently, although there is strong debate as to the true extent of the problem. This stems from the issues of officers not wanting to admit – or not even recognising – that they have adverse mental health issues, as well as a perceived stigma surrounding asking for help and support. It has been seen that mental health concerns within policing, statistically at least, broadly mirror that of the general population; however, the latter appears to be declining, whereas in policing it is increasing.

The true extent of the issue in policing, however, is not known, and it has also been shown that mental health concerns among officers are not necessarily treated, owing to the large number who take sick leave relating to mental health, especially additional occurrences after a first period. A stigma of seeking help and support has been identified and strongly evidenced, although there is evidence that this is being broken down by newer generations of officers; it continues through ideas such as social learning, where those new officers emulate

the attitudes and behaviours of their more experienced and more senior colleagues. This led to the identification that supervisors and managers should play a key role in helping to identify and support officers under them. They can then instigate peer-led support groups, which overcome concerns regarding speaking to ‘outsiders’ as well as perceived stigmas of being the only one suffering. This is the approach that TRiM takes, which remains relatively unassessed in a policing environment, but has shown some positives in the limited studies of it in a military environment. Other welfare interventions currently available, most notably the government-led Oscar Kilo service, also lack analysis of their efficacy. This could, and should, provide an area for further research, given that this service was launched in 2017 (Mason, 2017). At the very least, these services, along with their forebear, the Mind's Blue Light Programme, are encouraging conversations about mental health among police officers, which appears to be reducing the stigmas and encouraging more people to seek help. There remains, however, some significant additional ground to cover. This is especially true in the case of organisational stressors, particularly around concerns of organisational justice, wherein senior officers need to be seen to value their staff more, and respect and listen to those on the front line.

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