Vervolgonderzoek omtrent de psychosociale gesteldheid van politiepersoneel

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<h1 style="text-align:center">Summary</h1>

<h2 style="text-align:center">Follow-up study on the psychosocial health of Dutch police officers</h2>

In 2013 an extensive survey, commissioned by the WODC, was carried out on the psychosocial health of Dutch police officers (Van Beek, Taris & Schaufeli, 2013). Questionnaires were distributed among a sample of 1,535 police officers (response rate 41%). These officers were employed in six key task areas: (1) Leadership & Management ("Leiding"); (2) Enforcement & Emergency ("Handhaving & Noodhulp"); (3) Investigation ("Opsporing"); (4) Intake & Service ("Intake & Service"); (5) Support ("Ondersteuning"); and In Training ("In Opleiding"). Although this research did yield important information, there is a need for further deepening regarding some issues. This is the main concern of the current follow-up study that uses the original data of the 2013 survey, supplemented with some reference data from other sources.

Main question

The current follow-up study focuses on three issues that detail the original survey. Firstly, the follow-up study investigated to what extent the differences in psychosocial health between police officers and relevant referent groups – as observed in the original survey – are related to differences in demographical background, like age, gender, and level of education. Secondly, the follow-up study investigated to what extent the observed differences in psychosocial health between police officers from various task areas can be explained by differences in work characteristics and/or demographic characteristics. And thirdly, the most relevant work characteristics for taking measures to improve psychosocial health of police officers have been identified in the current study, controlling for demographics.

These three issues lead to the following research questions that will be answered in different sub-studies:

1. *How do police officers score on psychosocial health when (for each task area) a distinction is made according to gender, age, and level of education?*
2. *To what extent will differences in psychosocial health between various task areas remain to exist after controlling for work characteristics and demographics (separately and jointly)?*
3. *What are, for each task area, the most relevant work characteristics when it comes to improving psychosocial health?*

Design

The so-called Job Demands Resources (JD-R) model is used as a theoretical framework. This model stipulates two types of work characteristics: (1) job demands which refer to those aspects of the job that require effort and (2) job resources which refer to those aspects of the job that have motivational potential. According to the

JD-R model, job demands like red tape, role conflict and work-home conflict have a negative impact on psychosocial health, whereas job resources like autonomy, task variety, and social support have a positive impact.

Psychosocial health is a complex concept, therefore the current study includes various indicators: (1) burnout (emotional exhaustion and cynicism); (2) work engagement (vitality and dedication); (3) depressive symptoms; (4) anxiety; (5) posttraumatic stress symptoms (reliving and avoidance); (6) suicidality (thoughts about death, death wish, suicidal thoughts, and suicide attempt); (7) experienced health; (8) overweight (Body Mass Index); and (9) self-reported sickness absence.

Sub-study 1: Psychosocial heath in perspective

The first sub-study compares psychosocial health of police officers with that of the Dutch (working) population. If possible, a distinction is made per indicator of psychosocial health between men and women, various age categories, and levels of education. Better and more recent reference groups are used than in the previous study. More particularly, the 2013 LISS-panel (*N*=2,253) of Tilburg University is employed , which is based on a representative sample of the Dutch workforce, as well as the 2013 National Work Conditions Survey of TNO (*N*=23,303), which is based on a representative sample of the Dutch working population. Unfortunately, for burnout and posttraumatic stress symptoms no alternative reference group was available.

It appears that, generally speaking, the psychosocial health of police officers is quite good as compared to other Dutch employees. For instance, police officers are much more engaged than other Dutch employees; almost half of the police officers can be classified as highly engaged, against only 5% of the Dutch workforce. The fact that depression and anxiety are less prominent among police officers in comparison to the Dutch workforce also fits into this favorable picture. In contrast, though, police officers have more thoughts about death than other Dutch employees, but most likely this is related to the nature of their job rather than to suicidality per se. The most eye-catching negative aspect of health is that overweight is 12% more prevalent among police officers than among other Dutch employees (55% versus 42%). This finding refers to *moderate* overweight, the rate of *serious* overweight (obesity) among police officers is similar to that in the Dutch workforce (about 10%) with BMI > 30). Finally, self-reported sickness absence is also higher among police officers than among the general Dutch workforce.

Although *gender differences* in psychosocial health among police officers are generally small, it seems that female officers are somewhat more healthy than their male colleagues. For instance, they report less depression and anxiety, they are less preoccupied with suicide, and they have less overweight than their male colleagues. This is all the more striking because reversed gender differences are observed in the

Dutch workforce. Only sickness absence follows the national trend; female officers are more often on sick leave than male officers. Possibly a positive selection-effect is responsible for the superior health of female officers; those females who are most healthy choose for a career in policing, whereas this might not apply for male officers.

As far as *age* is concerned, the pattern for two health indicators is similar as in the Dutch workforce; experienced health of police officers decreases, whereas overweight increases with age. Tellingly, young police officers report higher sickness absence levels compared to their older colleagues, whilst the reverse is the case among older Dutch employees. This is remarkable because younger police officers do not *feel* less healthy than their older colleagues.

Unlike what is observed in the general working population, among police officers psychosocial health does not increase when the *level of education* increases. This only seems to be the case for subjectively experienced health, although the differences between educational levels are rather small. The most outspoken finding is that moderate overweight is more prevalent among police officers with lower education (MAVO/VMBO or MBO).

Compared to their colleagues from other *task areas*, police officers from Leadership & Management and In Training are relatively healthy. This is illustrated by their very high levels of work engagement, their low scores on anxiety and depression, and their low levels of sickness absence. This favorable outcome may be explained by a positive selection effect. It is likely that the most engaged and healthy police officers are promoted and land in leading management positions. Those who are in training are young, enthused, and motivated and are starting their careers so that it is likely that they are healthy as well. The task area Intake & Service is the least psychologically healthy. This is not only exemplified by the relative low experienced health of police officers in this task area, but also by relatively high anxiety and depression scores, suicidality, and high levels of sickness absence.

It can be concluded that the favorable picture of the previous study is confirmed, also after the more detailed follow-up study has been carried out; the average Dutch police officer has a good psychosocial health. However, based on this follow-up study, four nuances should be made regarding this overall picture: (1) female police officers seem to be more healthy than male police officers; (2) older police officers feel less healthy and suffer more from overweight that younger police officers; but the latter show higher sickness absence rates than the former; (3) police officers with lower education suffer more from overweight than their colleagues who have a higher education; (4) police officers in the task areas Leadership & Management and In Training are relatively healthy, whereas those in the task area Intake & Service are less healthy.

Sub-study 2: Psychosocial health, work- and demographical characteristics

The second sub-study focuses seeks to answer the question to what extent differences in psychosocial health of police officers from different task areas are explained by negative work characteristics (job demands), positive work characteristics (job resources) and/or demographical characteristics.

Generally speaking, correction for work- and demographical characteristics yields different findings compared to those that result from the analysis where no corrections are made. In principle, the number of significant differences between task areas decreases. This means that "real" differences in psychosocial health between task areas do not exist and are due to the fact that these task areas differ in terms of the characteristics of the task that are typically conducted in these task areas, and/or are due to differences in the demographical characteristics of the average police officer working in these areas.

After correction for job resources the number of initial differences between task areas *decreases* for all indicators of psychosocial health. This is the most salient for work engagement, for which the number of differences decreases from 7 to only 1 (please note that the total number of possible differences between the 6 task areas is 15). This means that differences in levels of work engagement – like differences in levels of burnout, depression and experienced health – are almost completely accounted for by differences in the prevalence of job resources in various task areas. The more job resources are available, the higher the levels of work engagement (and the lower the levels of burnout, depression, and experienced health), *irrespective* of the task area.

Correction for job demands has the opposite effect; the number of significant differences between task areas *increases*. However, this is a statistical artefact and is therefore ignored.

After correction for demographical characteristics (age and education) the number of initial differences between task area also *decreases* for all indicators of psychosocial health. Differences is anxiety, suicidality and overweight are even *completely* explained for by differences in age and level of education.

When the analyses control for all work- and demographical characteristics simultaneously, either no difference at all emerges between the task areas (as is the case for anxiety, suicidality and overweight), or only one difference remains (as is the case for work engagement, burnout, depression and experienced health). Only for posttraumatic stress symptoms differences between more task areas remain after correction. For instance, police officers in the task area Leadership & Management report fewer posttraumatic stress symptoms than those in the task areas Intake &

Service and Support, and officers in the task area Intake & Service report more posttraumatic stress symptoms than those from the areas Investigation and In Training.

It can be concluded from sub-study 2 that differences in psychosocial health between the various task areas of the police force can be explained to a large extent by differences in work- and demographical characteristics (notably, job resources, age and level of education). After controlling for these characteristics differences in psychosocial health between task areas mostly disappear.

What does that mean for practice? First of all the awareness is important that differences in posttraumatic stress symptoms, anxiety, suicidality, and overweight between the various task areas is completely of largely caused by demographical characteristics and *not* by work characteristics. That means that the options for interventions are limited since, as such, demographic characteristics cannot be changed. In contrast – and secondly – differences in work engagement, burnout and experienced health are completely or largely caused by work characteristics, which, indeed, can be influenced.

Sub-study 3: Psychosocial health and relevant work characteristics

The third sub-study focuses on the identification of relevant work characteristics that play a role in the psychosocial health of police officers. In order for a particular job demand or job resource to be "relevant" in a specific task area, two criteria have to be met: (1) the job demand or job resource should be related in a meaningful way ($r >$ .30) with psychosocial health; (2) the job demand or job resource in that task area should significantly deviate from the average of the total sample of police officers. Relevant job demands and job resources offer clues for measures that can be taken to increase psychosocial health of police officers.

Preliminary to the identification of relevant work characteristics, the number of indicators of psychosocial health was reduced from 11 to 3 (by using factor analysis). These three new components are: (1) *energy* (including burnout and work engagement); (2) *mental symptoms* (including anxiety, depression, posttraumatic stress symptoms, and suicidality), and (3) *fitness* (including overweight and experienced health). In all analyses, demographic characteristics are controlled for.

The summary table below displays all relevant work characteristics for each task area. For reasons of clarity the three components of psychosocial health mentioned above are not distinguished in the table. However, by far the largest number of relevant work characteristics has been found for the energy component, followed at some length by the mental symptoms component, whereas only few relevant work characteristics were found for fitness.

The summary table includes two types of measures: maintaining and tackling. Maintaining focuses on those relevant work characteristics that play a health protective role. This may either pertain to the presence of particular job resources which are positively related to psychosocial health, or to the absence of particular job demands, which are negatively related to psychosocial health. Hence, it boils down to the fact that the current *high* level of job resources or the current *low* level of job demands should be maintained. That means that first and foremost active monitoring is necessary to observe whether or not this is the case. As soon as relevant job resources decrease or relevant job demands increase, action should be taken.

Tackling focuses on those aspects of work characteristics that threaten psychosocial health of police officers. This is the case when either relevant job resources are absent which are positively associated with psychosocial health, or when relevant job demands are present which are negatively related to psychosocial health. In order to increase psychosocial health of police officers, job resources should be increased and job demands should be decreased.

The table below summarizes possible measures in terms of maintaining of tackling job demands and job resources.

Summary table of possible measures per task area to improve psychosocial health

	Leadership & Management	Enforcement & Emergency	Investigation	Intake & service	Support	In Training
Job resources						
Task variety		*maintain*	*tackle*			
Arousal	*maintain*	*maintain*	*tackle*	*tackle*	*tackle*	*maintain*
Autonomy	*maintain*		*maintain*		*maintain*	*maintain*
Awareness of strong/weak points of colleagues	*maintain*					
Pay						
Meaningfullness of work	*maintain*			*maintain*		
Feedback			*maintain*			*maintain*
Opportunities of learning and development	*maintain*		*tackle*	*tackle*	*tackle*	*maintain*
Professionalism			*maintain*			
Social support from colleagues		*maintain*				*maintain*
Social support from supervisor	*maintain*		*maintain*			*maintain*
Job demands						
Red tape/bureaucracy			*tackle*	*maintain*		
Obstruction by others in the police	*tackle*					
Obstruction by agencies other than the police						
Emotional demands				*maintain*		
Intimidation, viollence and bullying			*maintain*	*maintain*	*maintain*	*maintain*
Physical demands						
Mental demands						
Task unclarity						
Dissatisfaction with prosecution and criminal law						
(Social) media						
Technostress						
Job insecurity						
Changing tasks	*tackle*					
Work-home conflict	*tackle*	*tackle*	*maintain*	*maintain*	*maintain*	*maintain*
Work overload						
Work shifts		*tackle*		*maintain*		*maintain*

Note: maintaining refers to the current *high* level of job resources or the current *low* levelk of job demands, tacking refers to the current *high* levels of job demands and the current *low* levels of job resources.

The table above shows that the total number of identified relevant work characteristics is relatively low. It mainly concerns job resources and – to a much

lesser extent – job demands. Obviously when it comes to psychosocial health of police officers job resources are more salient than job demands.

With the exception of the task area In Training, at least two work characteristics should be tackled in each of the five remaining task areas in order to increase psychosocial health. Each of the task areas has his own unique profile of work characteristics which should be tackled. Nevertheless, it is noteworthy that in the task areas Investigation, Intake & Service and Support a similar combination of increasing arousal and offering more possibilities for learning and development emerges.

It can be concluded from sub-study 3 that for each task area a specific set of relevant work characteristics exists that either should be maintained or tackled in order to foster psychosocial health of police officers.

Final conclusion

The psychosocial health of Dutch police officers is good. This applies particularly for female and young officers, for those with higher educational levels and for those who are employed in the task areas Leadership & Management and In Training.

More detailed analyses revealed that differences in demographical and work characteristics are for the most part responsible for the observed differences in psychosocial health between task areas. This means that the psychosocial health of police officers does *not* depend on the task area in which they are employed, but on their age and level of education, and on whether they can draw upon more or less job resources.

For each of the six task areas specific relevant job resources are identified that could be tackled in order to boost the psychosocial health of police officers. However, it should be noted that the room for a further increase in psychosocial health among police officers is limited since the overall level of health is already relatively high.