

Exploring Mental Health Stigma Among U.S. Law Enforcement Officers: Occupational Norms, Disclosure, and Personal Experiences

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Research Article

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Abstract

Law enforcement officers routinely encounter operational stress, yet their decisions about mental health care may depend on what they believe disclosure will cost them professionally. This exploratory cross-sectional study examined perceived occupational norms and personal stigma experiences among 31 current and former U.S. law enforcement officers recruited through social media and direct email outreach. Participants completed the 11-item Police Officer Stigma Scale (POSS) and the 28-item Stigma Scale developed by King and colleagues. The POSS demonstrated good internal consistency (Cronbach's $\alpha = .87$). Fear-of-disclosure items ($M = 3.82$, $SD = 0.79$) were endorsed more strongly than perceived-maltreatment items ($M = 3.23$, $SD = 1.05$). Eighty-one percent of participants believed most officers would not disclose a mental illness to a supervisor, 71% anticipated impaired promotion prospects, and 58% believed officers would avoid professional help. The Stigma Scale total averaged 46.71 ($SD = 11.43$; $\alpha = .72$), with disclosure concerns ($M = 2.06$, $SD = 0.75$) exceeding reported discrimination ($M = 1.15$, $SD = 0.64$). The correlation between total scores was small but imprecisely estimated ($r = .09$, $p = .615$), precluding firm conclusions about their relationship. Findings suggest that services may remain underused when officers question confidentiality or anticipate professional consequences for seeking care. Subgroup patterns are exploratory and require replication.

Introduction

Police officers are expected to enter volatile situations, make sound decisions under pressure, and return for the next shift prepared to do it again. The work may involve injury, death, threats, public scrutiny, irregular hours, administrative demands, and the quieter accumulation of stress that follows an officer home. These conditions make psychological strain foreseeable, yet the use of mental health services remains limited. In one survey of 434 officers from a large U.S. police department, 26% screened positive for current symptoms of mental illness, but only 17% of that group reported using mental health services during the preceding year (Jetelina et al., 2020). Haugen et al. (2017) reached a similar conclusion in their systematic review of first responders: the need for care can be substantial even when stigma and other barriers keep people from receiving it.

For police agencies, the problem is not resolved simply by making a counselor or employee assistance program available. Officers must also believe that using the service is confidential, professionally acceptable, and unlikely to affect assignments, evaluations, or promotion. That distinction matters because an officer may believe treatment is useful while remaining unwilling to disclose a personal need for it. Mental health stigma can include stereotypes, anticipated rejection, discrimination, shame, and the decision to conceal distress (Corrigan & Watson, 2002; King et al., 2007). In policing, those concerns develop within a culture that places considerable value on emotional control, reliability, trust, and fitness for duty.

Research with law enforcement personnel repeatedly returns to confidentiality and professional consequences. Bell and Eski (2016) found that attitudes toward officers with mental health problems

were tied to concerns about competence and occupational expectations. Karaffa and Koch (2016) showed that officers may underestimate how willing their peers actually are to seek help. That form of pluralistic ignorance can preserve a culture of silence even when individual attitudes are less negative than officers assume. Drew and Martin (2021) also connected stigma with help-seeking in a national U.S. sample, while Richards et al. (2021) identified negative perceptions, limited knowledge, confidentiality concerns, feared job consequences, and inadequate social support across the North American literature.

Peers and supervisors have particular influence because they are not distant observers of an officer's career. Coworkers affect belonging and operational trust; supervisors influence leave, assignments, evaluations, referrals, and advancement. Hofer and Savell (2021) found that officers' use of services depended in part on whether a credible plan and visible organizational support existed when help was needed. Training and experience have also been associated with attitudes toward professional treatment (Lane et al., 2022). More recent research found that coworker stigma reduced likely use of stress-relief programs, whereas confidence in confidentiality increased it (Whittington & Basham, 2024). Officers themselves continue to describe wellness services as potentially beneficial but, under different circumstances, "career ending" (Hancock & Clifton, 2025).

The Police Officer Stigma Scale (POSS) was designed to measure this occupational environment. Rather than asking only what respondents personally believe, it asks what "most police officers" would think or do when an officer experiences mental illness (Stuart, 2017). The wording captures perceived professional norms, which may guide behavior whether or not those norms accurately reflect every officer's private attitude. Burzee et al. (2022) found that the 11 POSS items can be understood through two related dimensions: fear of disclosing a mental disorder and perceived maltreatment of colleagues with a mental disorder. One concerns what an officer expects disclosure to set in motion; the other concerns how an affected colleague may be judged or treated.

The Stigma Scale developed by King et al. (2007) addresses stigma from another necessary vantage point. It measures personal experiences involving discrimination, disclosure, and potential positive aspects of mental illness. The two instruments therefore ask different but related questions. The POSS addresses what officers believe their occupational culture communicates, whereas the Stigma Scale addresses how respondents experience and manage stigma themselves. Neither perspective substitutes for the other, and both were retained as substantive measures in the present study.

Current Study

This exploratory study examined mental health stigma among current and former U.S. law enforcement officers from two complementary perspectives: perceived occupational norms and personal experiences of stigma. The primary objectives were to (a) describe the occupational beliefs most strongly associated with disclosure and help seeking, (b) compare disclosure-related concerns with perceived maltreatment of colleagues, and (c) estimate the association between the POSS and the Stigma Scale. Secondary analyses explored whether scores varied with age, gender, and years of service. Because the sample

provided adequate power chiefly for large effects, item frequencies, descriptive patterns, effect sizes, and uncertainty guided interpretation; significance tests were treated as exploratory rather than confirmatory.

Method

Participants

The final sample included 31 current or former law enforcement officers from the United States. Participants were required to be at least 18 years old and to have completed two or more years of law enforcement service. Their ages ranged from 18 to 64 years. Twenty-one participants identified as men (67.7%) and 10 as women (32.3%). Twenty-eight identified as White (90.3%), one as Black or African American (3.2%), and two were recorded in the de-identified dataset as Hispanic or another racial or ethnic identity (6.5%). Participants had between 3 and 35 years of service ($M = 16.08$, $SD = 9.49$; median = 14).

The sample included officers from local police departments (38.7%), county sheriff's offices (19.4%), federal agencies (12.9%), state police or highway patrol agencies (9.7%), and other law enforcement settings (19.4%). They worked in agencies ranging from 1–50 officers to more than 2,000. Reported positions included patrol, investigations, training, supervision, command, and retirement. Participant characteristics are presented in Table 1.

Table 1
Participant Characteristics (N = 31)

Characteristic	Category	n	%
Age	18–24	1	3.2
	25–34	8	25.8
	35–44	8	25.8
	45–54	7	22.6
	55–64	7	22.6
Gender	Men	21	67.7
	Women	10	32.3
Race/ethnicity	White	28	90.3
	Black or African American	1	3.2
	Hispanic or other identity	2	6.5
Marital status	Single	6	19.4
	Married	18	58.1
	Divorced	4	12.9
	Domestic partnership	3	9.7
Agency type	Local police department	12	38.7
	County sheriff's office	6	19.4
	State police/highway patrol	3	9.7
	Federal agency	4	12.9
	Other	6	19.4
Agency size	Small (1–50)	8	25.8
	Medium (51–500)	10	32.3
	Large (501–2,000)	4	12.9
	Very large (2,001+)	9	29.0
Education	High school/GED	8	25.8
	Associate's degree	4	12.9
	Bachelor's degree	8	25.8
<i>Note.</i> Percentages may not total 100 because of rounding.			

Characteristic	Category	n	%
	Master's degree	9	29.0
	Doctoral degree	2	6.5
Note. Percentages may not total 100 because of rounding.			

Procedure

Before data collection, the study received approval from the institutional review board at the author's university. Recruitment materials were then distributed on Facebook and LinkedIn and by direct email to current and former law enforcement personnel and agency contacts. Twenty-three responses came through social media and nine through email outreach. One record contained consent but no survey responses and was removed, leaving 31 complete cases. The SurveyMonkey questionnaire was open from May 1 through June 30, 2024. Participants reviewed an electronic informed-consent statement and affirmatively indicated consent before accessing the survey. Participation was voluntary, and the dataset used for analysis was de-identified.

During manuscript preparation, a large language model was used to assist with organization and language editing of text derived from the author's dissertation and de-identified study materials. The author reviewed and revised all output and remains solely responsible for the study design, analyses, interpretation, citation accuracy, and final manuscript.

Measures

Demographic and Occupational Characteristics

The questionnaire collected age category, gender, race or ethnicity, marital status, current or former rank or position, years of law enforcement service, agency type, agency size, and highest level of education. Rank and position were entered as free-text responses. Years of service were examined as a continuous variable and, for the planned group comparison, as fewer than 20 years versus 20 years or more.

Police Officer Stigma Scale

The POSS contains 11 statements about stigma expressed by police toward police (Stuart, 2017). Respondents rate what they believe most officers would think or do, including whether officers would disclose a mental illness to a supervisor, obtain professional help, accept an affected colleague as a partner, or trust that colleague. Responses in this study ranged from 1 (*strongly disagree*) to 5 (*strongly agree*), with higher scores representing greater perceived stigma. The total was calculated as the mean of all 11 items. Consistent with Burzee et al. (2022), items 1–5 and 7 were averaged for fear of

disclosure, and items 6 and 8–11 were averaged for perceived maltreatment of colleagues. Internal consistency was good for the POSS total ($\alpha = .87$), acceptable for fear of disclosure ($\alpha = .77$), and excellent for perceived maltreatment ($\alpha = .91$).

Stigma Scale

King et al.'s (2007) Stigma Scale measures personal experiences and perceptions of mental health stigma. Participants received the 42 statements used during instrument development; scoring for the present analysis was limited to the published 28-item final scale, comprising discrimination (13 items), disclosure (10 items), and potential positive aspects of mental illness (5 items). Items were scored from 0 to 4 in the direction of greater stigma, with reverse scoring applied according to the published instructions. Possible total scores ranged from 0 to 112. Higher scores represented greater stigma; for the positive-aspects dimension, higher scores represented fewer perceived positive outcomes associated with mental illness. Internal consistency was .72 for the total scale, .86 for discrimination, .78 for disclosure, and .45 for positive aspects. Because the instrument was developed with mental health service users and the present survey did not establish diagnosis or treatment history, these scores are interpreted as exploratory indicators of personal stigma experiences rather than population estimates. The positive-aspects dimension is interpreted especially cautiously because of its low reliability in this sample.

Analytic Strategy

All 31 participants provided complete responses, and no values were imputed. Frequencies and percentages were used for categorical variables. Continuous variables and scale scores were summarized with means, standard deviations, medians, and ranges. For each POSS item, responses of *agree* and *strongly agree* were combined to show how often the perceived occupational belief was endorsed. Cronbach's alpha was calculated for each scale and dimension.

Pearson and Spearman correlations were used to examine stigma scores in relation to age category and years of service. Welch's independent-samples *t* tests compared participants by gender and by the prespecified experience grouping of fewer than 20 years versus 20 years or more; Cohen's *d* summarized standardized mean differences. The POSS and Stigma Scale totals were also correlated to estimate the degree to which perceived occupational norms covaried with personal stigma experiences. All tests were two-tailed. Because multiple exploratory tests were conducted without adjustment and the sample was small, exact *p* values are reported as descriptive evidence and no isolated result is treated as confirmatory. Analyses were conducted in Python 3.12 using pandas 2.2 and SciPy 1.17.

Results

Scale Scores and Internal Consistency

The mean POSS score was 3.55 ($SD = 0.79$). Expressed as a summed score, the average was 39.03 ($SD = 8.73$) on the possible 11–55 range. Fear of disclosure averaged 3.82 ($SD = 0.79$), compared with 3.23 ($SD = 1.05$) for perceived maltreatment. Respondents therefore endorsed disclosure-related concerns more strongly than the set of items addressing direct rejection or devaluation of an affected colleague.

The average Stigma Scale total was 46.71 ($SD = 11.43$) on the 0-112 scale, and the overall item mean was 1.67 ($SD = 0.41$). Disclosure averaged 2.06 ($SD = 0.75$), while discrimination averaged 1.15 ($SD = 0.64$). The positive-aspects dimension averaged 2.23 ($SD = 0.72$); because scoring was oriented so that higher values indicated greater stigma, the higher value represented fewer perceived positive outcomes. The dimensions contain different numbers of items, so mean item scores provide the more useful comparison. Descriptive statistics and reliability estimates for both instruments appear in Table 2.

Table 2
Descriptive Statistics and Internal Consistency of Stigma Measures

Measure or dimension	Items	Range	M	SD	alpha
POSS total	11	1–5	3.55	0.79	.87
Fear of disclosure	6	1–5	3.82	0.79	.77
Perceived maltreatment	5	1–5	3.23	1.05	.91
Stigma Scale total	28	0-112	46.71	11.43	.72
Discrimination	13	0–4	1.15	0.64	.86
Disclosure	10	0–4	2.06	0.75	.78
Positive aspects	5	0–4	2.23	0.72	.45
<i>Note.</i> POSS = Police Officer Stigma Scale. POSS values are mean item scores. Stigma Scale total is a summed score; its dimension values are mean item scores. For positive aspects, higher values indicate fewer perceived positive outcomes.					

Perceived Occupational Stigma

The POSS items showed where participants believed the greatest professional risk existed. Twenty-five officers (80.6%) agreed or strongly agreed that most officers would not disclose a mental illness to a supervisor. Twenty-two (71.0%) believed a supervisor would not consider an affected officer for promotion, and 21 (67.7%) expected workplace discrimination after disclosure. The same number believed most officers viewed treatment as a sign of personal failure. Eighteen participants (58.1%) believed most officers would not seek professional help.

Responses concerning the treatment of colleagues were more mixed. Twenty-two participants (71.0%) believed most officers would not want a supervisor with a mental illness, and 17 (54.8%) believed an affected officer's opinions would be taken less seriously. Fourteen (45.2%) expected officers to think less

of an affected colleague, while 11 (35.5%) believed the colleague would be considered untrustworthy. Table 3 reports the item means and the complete agreement frequencies.

Table 3
Police Officer Stigma Scale Item Responses

Perceived belief or behavior of most officers	M	SD	Agree/strongly agree, n (%)
Would not disclose to a supervisor/manager	4.00	1.13	25 (80.6)
Would not disclose to a colleague	3.61	1.12	19 (61.3)
Would expect workplace discrimination after disclosure	3.77	1.33	21 (67.7)
Would not want a supervisor/manager with mental illness	4.06	1.18	22 (71.0)
Would view treatment as a sign of personal failure	3.84	1.19	21 (67.7)
Supervisor would not consider promotion application	3.74	1.24	22 (71.0)
Would not seek professional help	3.61	1.02	18 (58.1)
Would not willingly accept affected colleague as partner	3.29	1.13	15 (48.4)
Would think less of an affected colleague	3.03	1.28	14 (45.2)
Would take affected colleague's opinions less seriously	3.19	1.25	17 (54.8)
Would consider affected colleague untrustworthy	2.87	1.23	11 (35.5)
<i>Note.</i> Items were scored from 1 (strongly disagree) to 5 (strongly agree). All item-level percentages use N = 31.			

Occupational and Demographic Comparisons

Years of service showed a small-to-moderate positive association with the POSS total (Pearson $r = .25$, $p = .174$; Spearman rho = .26, $p = .156$). Age category was moderately associated with POSS scores (Spearman rho = .39, $p = .028$). Because age was recorded categorically and the p value was unadjusted within a set of exploratory comparisons, this pattern should be treated as a replication target rather than evidence of a settled age or generational effect.

Men averaged 3.69 ($SD = 0.84$) on the POSS, compared with 3.25 ($SD = 0.62$) among women, Welch's $t(23.34) = 1.66$, $p = .110$, $d = 0.57$. Participants with at least 20 years of service averaged 3.83 ($SD = 0.58$), whereas those with fewer than 20 years averaged 3.37 ($SD = 0.87$), Welch's $t(28.82) = 1.78$, $p = .085$, $d = 0.60$. These moderate standardized differences are imprecise and should be used to inform larger studies rather than interpreted as established subgroup effects. On the single item concerning avoidance of professional help, the experience groups differed little, $t(29) = -0.59$, $p = .562$, $d = -0.22$.

Stigma Scale totals showed little association with years of service (Pearson $r = -.12, p = .530$; Spearman $\rho = -.15, p = .430$) or age category (Spearman $\rho = -.16, p = .399$). Men reported a higher average total ($M = 50.19, SD = 8.95$) than women ($M = 39.40, SD = 13.03$), Welch's $t(13.20) = 2.37, p = .034, d = 1.04$. The two experience groups were similar, Welch's $t(28.49) = -0.26, p = .799, d = -0.09$. Finally, the POSS and Stigma Scale totals were weakly related (Pearson $r = .09, p = .615$). A Fisher-transformed 95% confidence interval for this correlation extended from approximately $-.27$ to $.43$, so the sample is compatible with both a modest negative and a moderate positive relationship. The estimate therefore does not establish that the instruments are unrelated or interchangeable. Table 4 summarizes the principal exploratory comparisons.

Table 4
Principal Associations and Group Comparisons

Analysis	Estimate	p	Interpretation
POSS with age category	$\rho = .39$	.028	Moderate positive estimate; exploratory
POSS with years of service	$r = .25$	.174	Small-to-moderate positive estimate
POSS: men vs. women	$d = 0.57$	.110	Moderate standardized difference
POSS: 20 + vs. <20 years	$d = 0.60$	.085	Moderate standardized difference
Help avoidance: 20 + vs. <20 years	$d = -0.22$	.562	Small standardized difference
Stigma Scale with age category	$\rho = -.16$	.399	Small negative estimate
Stigma Scale with years of service	$r = -.12$	.530	Small negative estimate
Stigma Scale: men vs. women	$d = 1.04$	.034	Large standardized difference; exploratory
Stigma Scale: 20 + vs. <20 years	$d = -0.09$	.799	Minimal standardized difference
POSS with Stigma Scale	$r = .09$	.615	Small estimate with wide uncertainty
Note. All tests were two-tailed. ρ = Spearman rank correlation; r = Pearson correlation; d = Cohen's standardized mean difference. P values are unadjusted and all comparisons are exploratory.			

Discussion

The study began with a practical concern: officers may need mental health support and still believe that asking for it is professionally unsafe. The results place that concern squarely around disclosure. Participants were more likely to expect concealment, discrimination, and career consequences than to endorse the strongest statements about rejecting or distrusting an affected colleague. This does not mean that interpersonal stigma was absent. A majority believed that an affected officer's opinions would

be taken less seriously, and 71% believed most officers would not want a supervisor with a mental illness. Even so, the strongest and most consistent responses concerned what might happen once mental health information became known.

Disclosure

to a supervisor stood out. More than four in five participants believed most officers would avoid it. About seven in ten anticipated workplace discrimination or impaired promotion prospects, and nearly three in five believed officers would not seek professional help. These are not direct admissions that the respondents themselves would make the same choices. The POSS asks about "most police officers," and the findings must be interpreted as perceived norms. That distinction does not make the results unimportant. An officer deciding whether to speak with a supervisor or contact a clinician cannot know in advance how the organization will respond. The decision is made using the culture the officer believes exists. Karaffa and Koch (2016) described how officers can underestimate the willingness of their peers to seek services, allowing silence to continue even when private attitudes are more accepting.

The results are consistent with research that places confidentiality and career consequences among the most persistent barriers to care. Richards et al. (2021) identified both concerns in their review of the North American literature. Jetelina et al. (2020) found unmet mental health needs among officers who also worried about confidentiality and being seen as unfit for duty. Whittington and Basham (2024) reported that confidence in confidentiality was associated with greater willingness to use stress-relief programs. The current item responses make the professional meaning of those concerns more visible. Participants did not describe stigma only as embarrassment or social discomfort. They connected disclosure with judgment, leadership suitability, promotion, and whether an officer could continue to be trusted in the same way.

The two measures contributed different information. The POSS concentrated perceived occupational stigma in fear-of-disclosure items, while the Stigma Scale showed that disclosure concerns exceeded reported discrimination among respondents' personal experiences. Their total scores were only weakly correlated in this sample, but the wide uncertainty around that estimate prevents a conclusion that the constructs are empirically independent. Conceptually, an officer may perceive the workplace as unsafe for disclosure without having personally disclosed a condition and experienced discrimination. Conversely, a respondent may have encountered stigma outside policing without treating that experience as evidence about police culture. Larger samples with relevant mental health history measures are needed to determine how these perspectives overlap.

The exploratory subgroup results do not support firm conclusions about who perceives or experiences more stigma. POSS differences by gender and length of service were moderate in standardized terms, and men reported higher Stigma Scale totals than women, but each estimate came from small groups within a sample of 31. Multiple tests were conducted without adjustment, increasing the possibility that apparently notable results reflect sampling variation. These patterns identify questions for adequately powered research; they should not guide differential policy or intervention on their own.

The positive association between age category and POSS scores also warrants replication. Age and tenure are related but may reflect different processes: cohort norms, experiences outside policing, exposure to agency policy, leadership, or changes in mental health training across a career. The present design cannot distinguish among these explanations. A larger sample would permit age, tenure, rank, supervisory status, agency context, and prior use of mental health services to be modeled together.

Implications for Law Enforcement Practice

Availability is not the same as access. An agency may have an employee assistance program, peer-support team, or contracted clinician and still have officers who will not use any of them. If participation is believed to reach a supervisor, affect an assignment, or become part of an informal reputation, the service may exist largely on paper. Agencies should explain confidentiality in concrete terms: what is protected, what exceptions apply, who can see records, and whether service use is separated from performance and promotion decisions. Written policy is a starting point, but officers will judge the policy by what they see happen to coworkers who ask for help.

Supervisors occupy a difficult but important position. They may notice changes in behavior and direct an officer toward assistance, but they also participate in decisions involving reliability, leave, assignments, evaluation, and promotion. Training should address that tension directly. Recognizing symptoms is not enough. Supervisors also need guidance on responding to disclosures, limiting unnecessary information sharing, making referrals, documenting legitimate performance concerns without treating help-seeking itself as misconduct, and avoiding actions that could reasonably be understood as retaliation. Hofer and Savell (2021) emphasized the need for a concrete organizational path to care, and Lane et al. (2022) connected training with attitudes toward treatment. A useful measure of these efforts is whether officers believe they can use the path without damaging their careers.

Peer support can provide another route because officers may be more willing to speak with someone who understands police work. That familiarity, however, does not automatically create trust. Peer supporters need careful selection, training, clear boundaries, clinical backup, and confidentiality rules that officers can understand before they disclose sensitive information. External clinicians familiar with policing may be especially important for officers who do not trust an internal program. Agencies should monitor not only utilization but also perceived confidentiality, satisfaction, and what officers believe happened professionally after they used a service.

Mental health policy should also be understood as part of organizational readiness. Officers are expected to exercise judgment, regulate emotion, and respond safely under difficult conditions. Supporting mental health is therefore not separate from the agency's public-safety mission. At the same time, agencies undermine that goal when officers learn that acknowledging a problem is more dangerous to a career than concealing it. A credible system must make early help-seeking ordinary while reserving fitness-for-duty action for circumstances in which it is actually warranted.

Limitations and Future Research

The findings should be read within the limits of the sample. Thirty-one participants can identify strong patterns, but they cannot represent the full range of U.S. law enforcement. The sample was predominantly White and was recruited through social media and direct email rather than probability sampling. Officers who were comfortable completing a mental health survey may differ from those who ignored or declined the invitation. The low response to direct email outreach makes that concern especially important. Current and former officers were both included, broadening the experience represented but also mixing people exposed to different agencies and different periods of mental health policy.

All data were cross-sectional and self-reported. The analyses therefore cannot establish that stigma caused a particular disclosure or treatment decision. The POSS captures beliefs about what most officers think, not a participant's private attitude or a verified supervisor response. Rank and position were collected in free-text form, which made detailed and reproducible occupational groupings difficult. Geographic and agency identifiers were not retained in the de-identified dataset. That protection was appropriate for a small occupational sample, but it prevented comparisons among agencies or regions.

The Stigma Scale presents a different measurement issue. Several items assume personal experience with mental health problems, yet the survey did not require participants to identify a diagnosis or treatment history. Some statements may therefore have been more personally relevant to certain respondents than to others. Participants received the 42-item development pool, while the analysis used only the 28 items retained in the published scoring structure (King et al., 2007). Reliability was acceptable for the total, discrimination, and disclosure scores but low for positive aspects. That dimension remains a substantive component of the measure, but it should not carry the same interpretive weight in this sample without further measurement work.

The study was capable chiefly of detecting large relationships. Nonsignificant findings therefore do not establish equivalence or absence of association, and the numerous unadjusted exploratory tests increase the chance of false-positive findings. The sample also yielded wide uncertainty around several practically meaningful estimates. Future studies should preregister a smaller set of primary hypotheses, recruit larger and more diverse samples, report interval estimates, and model age, tenure, rank, agency size, supervisory status, and prior treatment simultaneously. Longitudinal research could then test whether policy changes, leadership behavior, peer-support programs, and confidentiality protections alter both stigma and actual service use over time.

Conclusion

The clearest pattern in this exploratory sample was the perceived professional risk of disclosure. Participants commonly expected officers to conceal mental illness from supervisors and coworkers, anticipated discrimination and impaired promotion prospects, and believed professional help would often be avoided. Personal stigma responses likewise emphasized disclosure more than reported discrimination. These findings cannot establish national prevalence or causal effects, but they identify

organizational trust as a consequential target for larger studies and agency evaluation. Mental health programs are unlikely to function as intended unless officers understand and trust their confidentiality protections, supervisors respond consistently, and credible internal and external pathways to care are available.

Declarations

Author Contribution

N.C. conceived and designed the study, developed the methodology, recruited participants, collected and curated the data, conducted the formal analysis, interpreted the findings, and wrote and revised the manuscript. N.C. approved the final manuscript and accepts responsibility for the integrity and accuracy of the work.

Data Availability

The de-identified data generated and analyzed during the current study are not publicly available because open release could compromise participant confidentiality within this small occupational sample. Requests for access may be directed to the corresponding author and will be considered on a case-by-case basis, subject to confirmation that the proposed use is consistent with participant consent and applicable institutional review board requirements.

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