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Sworn to protect, left unprotected: a mixed-methods exploration of the gendered toll of policing on women's health and wellbeing

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Briefing summary

Purpose of this briefing: This briefing provides evidence on how organisational structures, workplace culture, and workplace social support (WSS) shape the health and wellbeing of women in UK policing across different career and life stages. It seeks to inform workforce wellbeing policies, gender equality strategies, and organisational reforms aimed at improving retention, health, and career progression for women in policing.

Key issue: Despite the increasing number of women in the UK Police forces, persistent gendered norms, and cultures within policing expose females to workplace discrimination and exclusion which limits their ability to maintain and advance their career. This, in turn, affects their health and wellbeing which is evident through the prevalence of higher rates of stress, burnout, and mental health challenges compared to their male colleagues.

Key findings:

- Organisational injustice, in the form of procedural, relational, distributive, and gendered injustice, negatively affects women's mental, physical, social, and workplace wellbeing.
- WSS acts as a critical protective factor for mental health and overall wellbeing. When the gendered aspect of parenthood and WSS was taken into account, mothers showed higher odds of anxiety, depression, and sleep disturbances than fathers despite having higher odds of overall wellbeing. Similar results yielded when mothers in policing were compared with non-mothers in policing. Poor WSS from supervisors and colleagues was associated with higher risks of depression, anxiety, and prolonged sickness absence, particularly among mothers.
- Exploration of retrospective accounts to identify poignant or significant moments within their working life course further highlighted how social support, conditional acceptance, and career plotting were key mechanisms that shape mental health and revealed how cumulative harm builds up over their life and career courses within gendered policing organisations.

Key recommendations:

- Mandatory leadership training programs for line managers focused on organisational justice, equity, and inclusion.
- Standardised implementation of gender-sensitive wellbeing policies including policies for menstruation, pregnancy, and menopause across all UK police forces through national oversight, monitoring, and accountability mechanisms.
- Establish a centralised knowledge-sharing platform or expand the operations of existing platforms to disseminate best practice, monitor implementation, and ensure consistent delivery of gender-sensitive wellbeing initiatives.
- Routinely collect and monitor workforce health and wellbeing data, disaggregated by gender and other demographic characteristics, to support evidence-based policy and targeted interventions.

Context & Background

The issue –scale and impact

Female police officers experience disproportionately higher proportion of mental health conditions, such as stress, depression, burnout, PTSD, and work-family conflict, compared to their male counterparts (1,2). This disparity can be attributed to unique psychosocial hazards stemming from gendered organisational cultures that can expose them to workplace sexism, discrimination and lack of workplace social support (WSS) based on their gender and minority status within policing (3, 4, 5). At the same time, women usually carry the greater burden of domestic and childcare responsibilities than their male partners (6, 7). To balance caregiving responsibilities, female police officers adopt more flexible or part-time patterns of work compared to their male counterparts (7, 8). These competing demands can exacerbate their negative health outcomes (6, 7), and eventually hinder their entry, progression, and retention in police organisations (9, 10).

Why it matters now

Sickness absence (SA) among UK police officers is increasing, with mental health-related absences reaching record highs (11, 12). This coincides with the exposure of high-profile cases of sexism and misogynist behaviour within policing prompting several inquiries commissioned by the government and policing bodies (13, 14). These inquiries rendered visibility to violence against women and girls (VAWG), and sexual misconduct both within UK policing and broader society (15). These separate but interconnected veins position female police officers and staff in a unique spot, highlighting the pressing need to understand the realities of systemic, cultural, and structural factors shaping the health and wellbeing of female police officers and staff to improve their retention and career progression for a sustainable police force and safer society.

Policy and practice context

Despite significant progress in flexible working arrangements, historically policing institutions have not been fast enough to embrace such arrangements (8,16, 17). As a result, some female officers with caregiving responsibilities may still face challenges in career progression (16, 18).

Moreover, rising mental health-related SA has also prompted agencies to prioritise police workforce health and wellbeing (19, 20). For instance, Personnel wellbeing is a strategic objective within the Scottish Police Authority's People Strategy 2024–27 (21). However, gender-sensitive health policies continue to lack the requisite prioritisation and institutional integration within UK Police Forces.

Evidence & Key findings

Methods used to review evidence/conduct research

This study employed a mixed-methods approach to explore the health and wellbeing of female police officers and staff in the UK. First, a seven-step inductive and interpretative meta-ethnographic review was undertaken to analyse qualitative evidence on the health and wellbeing of female police officers and staff globally. Informed by this review, particularly the critical role of WSS in shaping female officers' wellbeing, quantitative analysis of the Airwave Health Monitoring Study (AHMS) (22,23) explored whether and how WSS affects probable depression and anxiety, as well as SA, and how motherhood impacts this relationship. However, any gender-sensitive comparisons were not possible due to the lack of a variable on fatherhood status or variables from which fatherhood status could be inferred. Therefore, another large UK Police survey- The Job The Life Survey (TJTL) (24), was used to investigate gender differences in the relationship between WSS and mental health outcomes among police professionals and examined how parenthood status moderates these associations. However, in the secondary databases used for this thesis, variables related to key aspects of women's health such as menstruation, menopause, existing health conditions, and career stages such as promotion, retention, and voluntary resignation were either unavailable or, when available, unsuitable for use. These topics were explored through in depth semi-structured interviews exploring the lived experiences of current and former female police officers across the UK. This qualitative phase examined how life and career trajectories interact and influence female officers' overall health and wellbeing within the police workforce.

What works / what does not

This study is one of the few studies conducted in the UK focusing on the health and wellbeing of women in policing. The primary data of this study has an inclusive sample population which covered voices from both current and former police officers who have left the force for any reason including retirement or voluntary resignation. Although most of the data in this study relied on self-reported experiences, an added strength of this study is using administrative data in the second phase, which is a known challenge in occupational health research. While the study considered key life and career transition points exploring the experiences of working in policing and motherhood, as well as women's health and wellbeing journey across their career and life courses, it does not involve a long-term longitudinal design that tracks individuals over extended periods. Nonetheless, the support received from key stakeholders such as the Scottish Institute for Policing Research (SIPR) and the Scottish Women's Development Forum (SWDF), facilitated access to target participants within a short period of time during the recruitment process for the primary data collection and also with the dissemination of the study findings.

Comparative insights

As the context of the current study is mostly specific to UK police forces it may not be generalisable to other policing environments, especially those with different cultural or institutional structures (25,26). However, despite these structural and foundational differences, UK policing has a variety of gendered challenges similar to other policing organisations, both within (10, 27) and beyond the Global North (28). These include gender-based discrimination, limited opportunities for advancement, and a lack of institutional support. These accounts suggest that the findings in this study may hold some valuable insights relevant to other countries, where police organisations often face similar challenges during periods of organisational transformation, marked by male-dominated structures and the persistent presence of the glass ceiling in leadership positions (29).

Thematic findings

Theme 1- Health and wellbeing as a mosaic of interdependent factors

Women's health and wellbeing in policing cannot be understood as an isolated phenomenon but rather as an interconnected reality shaped by interdependent factors influencing their overall wellbeing.

Theme 2- Health as an organisational justice issue

The systemic precipitation of organisational injustice over time impacts health and wellbeing, framing health as an organisational justice issue and a shared responsibility for both the organisation and the individual, rather than an individual burden for women in policing.

Theme 3- The Dual Role of Workplace Social Support

Workplace social support emerges as a critical yet inconsistent factor in shaping women's health and wellbeing in policing. When present, it acts as a protective buffer to negative health and wellbeing outcomes. However, when absent, it becomes a barrier to positive health and wellbeing outcomes.

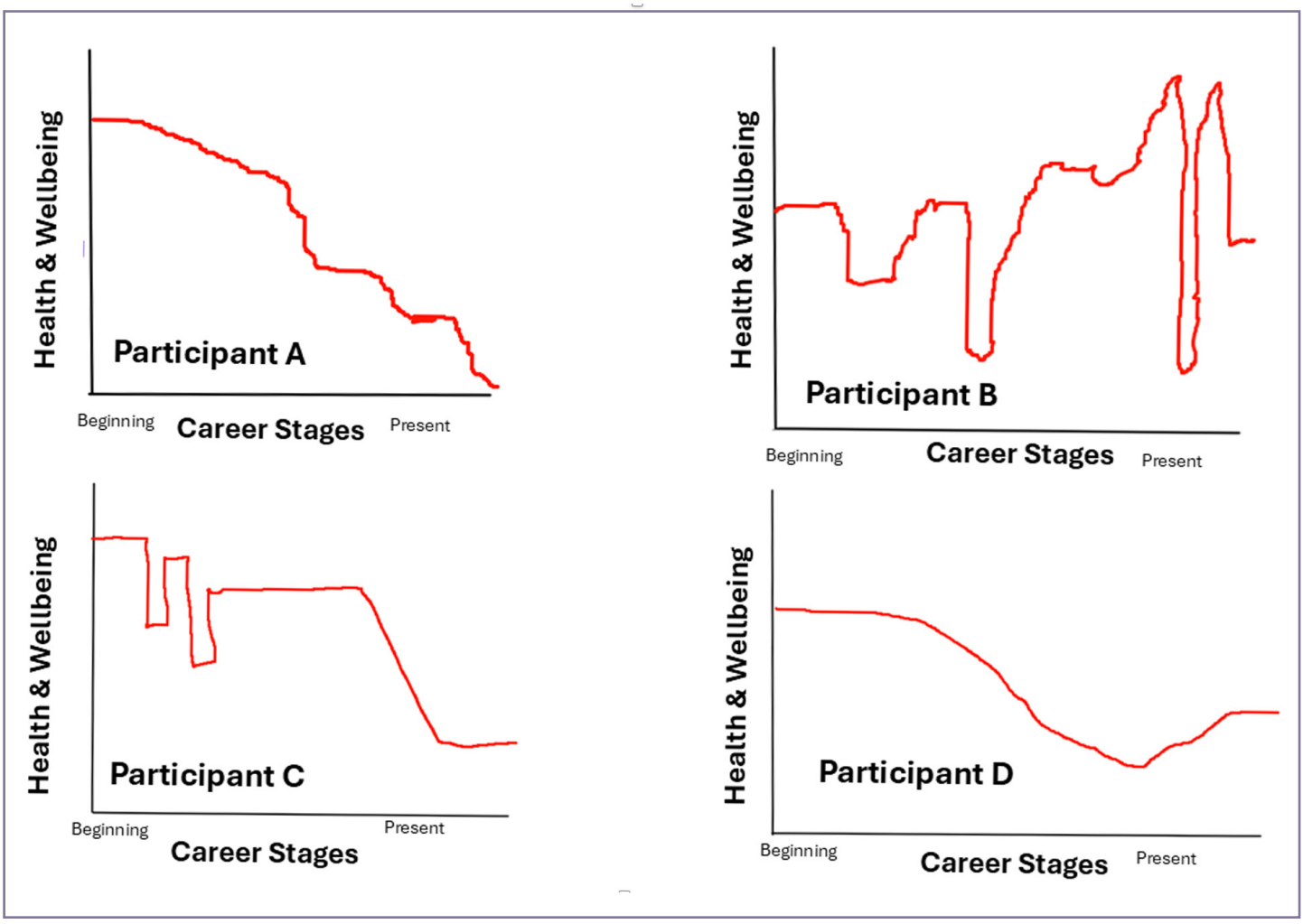

Figure 1: *Graphs drawn by study participant(s) showing their perceived health and wellbeing trajectories across career stages within policing*

Implications/Recommendations for Policy & Practice

For Line Managers (LMs):

- Mandatory leadership training programs for line managers focused on organisational justice, equity, and inclusion especially on supporting women's health through the day-to-day management of workplace interactions, addressing exclusionary behaviours within teams, or providing tailored support for women in policing that experience gender-specific challenges, including issues related to menstruation, menopause, and caregiving responsibilities.
- Take an active role in encouraging participation in structured support initiatives, ensuring that all women in policing irrespective of their rank, location, or personal networks have equal access to mentoring, peer support programs, and wellbeing resources.

For Senior Management and Leaders in Policing:

- Establish a centralised knowledge-sharing platform or expand the operations of the existing platforms such as Oscar Kilo or Scottish Institute for Policing Research (SIPR), potentially through the College of Policing or the National Police Chiefs' Council (NPCC) to disseminate best practice, monitor implementation, and ensure consistent delivery of gender-sensitive wellbeing initiatives.

For Policy:

- This study reinforces the need for nationwide organisational reforms rather than localised interventions limited to a single force or region.
- Implement workplace policies and interventions that explicitly account for menstruation-related needs including but not limited to menopause.
- UK police forces should collect and analyse health data routinely, disaggregated by gender and other demographics to support evidence-based policy and targeted interventions.

Conclusion

Moving forward there is a need for research using longitudinal designs and cross-cultural comparability to monitor and identify best practices. It is also crucial to extend this work through consideration of how intersectionality in terms of different intersecting social identities such as race, ethnicity, sexuality, and disability shape health inequalities. Finally, robust quantitative studies using validated measures of women's health, including reproductive health, caregiving responsibilities, and career transitions, are needed to address important evidence gaps identified in this study.

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