“attitudes of the Spanish Police Towards Patients With Schizophrenia or Depressive Disorders”

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Research Article

Keywords: Stigma, stereotypes, Police, schizophrenia, depression, forensic psychiatry

Posted Date: September 17th, 2021

DOI: https://doi.org/10.21203/rs.3.rs-882723/v1

Abstract

Background: Police officers have become an important part of psychiatric patients´ care; however, few studies have assessed the Police´s attitudes toward these patients. Our aim is to analyze the effect of the stigma associated with different mental illnesses on police officers.

Methods: the attitudes of 927 officers of the Spanish National Police Force towards a person with schizophrenia or depressive disorder in the role of person in need of assistance, victim, witness, or suspect, were assessed by means of the Attribution Questionnaire adapted to the police context. Different socio-demographic variables were also collected.

Results: Police officers expressed more willingness to help, felt more pity and considered psychiatric patients to be less responsible for their situation than people who were not described as being mentally ill. They also showed increased feelings of anger and avoidance, greater danger perception and need for segregation and coercion for medical treatment, especially in schizophrenia. Being a woman, the elderly and having more working experience, are associated with less stigmatizing attitudes among officers.

Conclusions: Police officers have certain attitudes about mental illness particularly schizophrenia, that require special attention, as they may disrupt police action. We found several factors associated with the persistence of these stigmatizing attitudes in the Police that can guide us to implement training programs to promote attitude changing especially at the beginning of the professional career.

Background

In the last twenty years in Spain and other European countries there has been a significant development and improvement of the mental health facilities, due to different health care policy changes. There has been a transition from institutional care of people with mental illness to family and community-based care. Most regions in Spain have their own mental health plans that support social inclusion, independent living, employment, and human rights [1]. Despite the progress made in this area, society in general, and even health professionals themselves, still maintain certain negative attitudes that can promote rejection and social isolation of psychiatric patients [2–8]. Recent studies suggests that professional encounters between the Police and mentally ill persons have increased considerably in recent years [9–11]. For instance, in the United Kingdom approximately 2% of incidents reported to the Police in a year were linked to mental health issues [11].

Police Officers (PO) have become an important part of the care of psychiatric patients due to the increase in encounters involving people with mental illness following deinstitutionalization [10, 12, 13]. In addition, society demands greater skills from the Police as a public service of protection and assistance to citizens, as they are generally the first professionals to assist in urgent situations [9, 13, 14]. This circumstance leads us to question what the attitudes of the Police are during mental health-related encounters, since if they are negative, they could be an obstacle to the exercise of the defense of rights and protection of psychiatric patients. It is for these reasons that over the last years, there has been a growing trend to incorporate assessment of stigma in PO as a linked party in the care of psychiatric patients [15]. Previous studies that have evaluated this phenomenon mostly reflect that PO maintain the same points of view as the general population, and in certain aspects with more negative connotations [13, 15, 16]. The limitations of these studies include small sample sizes, the little sociodemographic information collected, the heterogeneity of the assessment instruments and the undifferentiated role of the

psychiatric patient during law enforcement. On the other hand, most studies assess attitudes towards a single type of mental illness, which is usually schizophrenia, not exploring other common and prevalent disorders such as depressive ones. Furthermore, most of the research has been carried out in the USA, Canada [16–18] and to a lesser extent in European countries [19, 20], which makes it difficult to extrapolate the results to the Spanish police context. To the best of our knowledge, no previous study has evaluated to date the phenomenon of stigma associated with mental illness in our setting. Therefore, we sought to assess how the knowledge that a person has a mental illness may influence members of the Spanish Police.

Methods

Type of study

A cross-sectional study was conducted and approved by the Research Ethics Committee of the University of Murcia and was authorized by the Division of Training and Development within the Directorate General of Police.

Participants

The study was conducted in the National Police School located in Ávila, the city in center of Spain where all the training courses for the institution are carried out. Members of the Spanish Police who are promoted to a higher rank must undergo a period of training that last 10 months. Those who attend different training courses in the last year were invited to participate.

Measures

Information was collected for each participant by means of a questionnaire designed to ascertain the socio-demographic variables that may influence the attitudes of the PO according to previous research (gender, age, educational level, familiarity with mental illness, frequency of encounters with mentally ill people) [21].

To evaluate how the stereotype of mental illness can influence the behavior of the participants, vignettes designed by Watson et al. were used [15]. These neutral vignettes describe a hypothetical subject in the role of a person in different police situations: person in need of assistance, a victim, a witness, and a suspect. The hypothetical subject called “Pedro” may suffer from schizophrenia, depressive disorder, or no psychiatric illness. The vignettes did not describe any symptomatic behavior or physical description of the fictitious protagonist, as their aim was to analyze how mental illness label influences the behaviors of PO [15]. On the other hand, the vignettes did not intentionally portray serious infractions or disturbances, so the PO had the maximum possible discretion in responding, otherwise he or she would have to act in accordance with the Spanish criminal code, limiting his/her responses. PO were randomly assigned one of twelve survey versions—the four different roles of Pedro (person in need of assistance, victim, witness, or suspect) by whether or not he was labeled as having schizophrenia, depressive disorder or no mental illness.

Stigmatizing attitudes and beliefs towards mental illness were assessed using the Attribution Questionnaire-27 (AQ-27) designed by Corrigan et al. [22] and modified by Watson et al. [23]. This tool has been translated to many languages [24–26]. The study used the validated Spanish version of the modified scale developed by Muñoz et al. [26]. This self-administered questionnaire consists of 31 items grouped in nine factors/dimensions, each assessing the following stigma-related constructs: responsibility, pity, anger, dangerousness, help, coercion, segregation, credibility, and avoidance. Participants were asked to rate their level of agreement with each

statement on a Likert scale ranging from 1 (“not at all”) to 5 (“very much”). Each dimension score was the mean score of the respective items (the items of avoidance are reversed in Spanish version). Higher scores indicated greater stigmatization.

Procedures

A member of the research team met with the potential participants and explained them the study. They both carefully reviewed the study information together and an informed consent form was signed. The PO fulfilled the requirement to voluntarily participate in the study. Sociodemographic information was collected through the questionnaire designed *ad hoc* and after reading the vignettes, the participants completed the modified AQ questionnaire.

Statistical analysis

The statistical analysis was conducted using the software program SPPS v25. Normality and homogeneity of variance were tested prior to analysis. Differences between groups concerning ordinal or continuous data were analysed with the Student t/ANOVA test. Pearson's $\chi 2$ test was used to examine differences in categorical variables between groups and correlations between quantitative variables (the scores of each of the AQ factors and socio-demographic variables) were also examined using Pearson coefficient.

Results

Of the 1090 surveys submitted, 163 refused to participate (15%) and 927 officers completed the study. The baseline characteristics of the participants are shown in Table 1. The mean age of PO was 35.5 (SD = 6.68) years and 82.4% were male. The mean length of service was 11.26 (SD = 7.15) years. Of the group, 72.1% (n = 668) of the PO had some previous contact in their personal lives with people with mental illness.

Table 1
Baseline characteristics of participants (n = 927)

	Category	Number of cases	Percentage
Gender	Men	764	82.4
	Women	163	17.6
Civil status	Single	451	48.7
	Married/cohabiting	427	46
	Previously married	49	5.3
Educational level	Secondary	46.5	431
	University	53.5	496
Professional status	Official	395	42.6
	Sub-Inspector	240	25.9
	Inspector	235	25
	Chief Inspector	37	4
	Commissioner	20	2.2
	1st year executive student	41	4.4
	2nd year executive student	22	2.4
Range age	Less than 31	218	23.5
	31–40	526	56.7
	More than 41	183	19.7
Familiarity with mental illness	Yes	668	72.1
	No	259	27.9
Encounter frequency	Rarely	452	48.8
	Sometimes	309	33.3
	Often	169	17.9
			Mean (SD)
Age			35.5 (6.68)
Lenght of duty			11.26 (7.15)
Academy training			10.95 (26.02)
Previous year trainning			13.11 (18.7)
Weekly encounters with mentally ill people			3.15 (4.00)

SD: standard deviation

The 927 participants completed the modified AQ questionnaire in relation to a vignette they had previously read. 28.2% (*n* = 262) of the PO received a vignette of a hypothetical person in need of assistance, 25.8% (*n* = 239) a vignette of a victim, 23.2% (n = 215) a witness and 22.8% (*n* = 211) a suspect. Table 2 shows the modified AQ dimensions scores according to each hypothetical situation. Help was the construct with the highest scores and anger had the minimum score. Comparative analyses of each factors in different situations (assistance *vs.* victim *vs.* witness *vs.* suspect) revealed statistically significant differences in all dimensions except for the responsibility construct.

Table 2
Attribution Questionnaire factors scores according to the vignette role

Factors	Assistance Mean (SD) (*n* = 262)	Victim Mean (SD) (*n* = 239)	Witness Mean (SD) (*n* = 215)	Suspect Mean (SD) (*n* = 211)	*p**
Responsibility	2.08 (0.64)	2.10 (0.58)	2.12 (0.62)	2.19 (0.62)	.251
Pity	3.31 (0.7)	2.77 (0.74)	2.74 (0.76)	2.86 (0.79)	< .001
Anger	1.54 (0.63)	1.77 (0.76)	1.67(0.66)	1.83 (0.79)	< .001
Dangerousness	2.47(0.56)	2.35 (0.63)	2.26 (0.58)	2.56 (0.64)	< .001
Help	3.99 (0.84)	3.58 (0.86)	3.64 (0.93)	3.68 (0.86)	< .001
Coercion	3.09 (0.92)	2.76 (0.89)	2.44 (0.97)	2.91 (1.00)	< .001
Segregation	2.34 (0.70)	2.31 (0.81)	1.95 (0.75)	2.55 (0.85)	< .001
Avoidance	3.20 (0.74)	3.15 (0.79)	2.95 (0.75)	3.44 (0.74)	< .001
Credibility	3.16 (0.68)	2.84 (0.59)	3.26 (0.58)	2.72 (0.49)	< .001
SD: standard deviation					

*ANOVA

Association between psychiatric history and AQ scores

Table 3 summarizes the relationship between modified AQ scores and psychiatric history. All factors except for credibility were significantly different. 33.8% (*n* = 313) of the PO did not receive any information about mental health status. When no background information was available, the dimensions with the highest overall mean scores were help and credibility with 3.58 (SD = 0.95) and 3.06 (SD = 0.64) points, respectively. When the hypothetical subject had a mental illness, the dimensions with the highest scores were help and avoidance with a mean score of 3.82 (SD = 0.83) and 3.28 (SD = 0.72) points respectively, and anger and responsibility were the dimensions that presented the lowest scores with 1.74 (SD = 0.71) and 2.04 (SD = 0.58) points, respectively. PO showed toward psychiatric patients, compared to someone whose mental health status is unknown, more willingness to help, greater feelings of pity, and consider them less responsible for their situation ($p < .001$). They also showed more reactions of anger and avoidance, consider them more dangerous, and see a greater need to segregate and coerce them to receive medical treatment ($p < .001$).

Table 3
Attribution Questionnaire factors scores according to the psychiatric history

Factors	No mental illness Mean (SD) (n = 313)	Mental illness Mean (SD) (n = 614)	p*
Responsibility	2.29 (0.64)	2.04 (0.60)	< .001
Pity	2.70 (0.82)	3.06 (0.74)	< .001
Anger	1.62 (0.73)	1.74 (0.71)	.027
Dangerousness	2.24 (0.62)	1.81(0.87)	< .001
Help	3.58 (0.95)	3.82 (0.85)	< .001
Coercion	2.22 (0.87)	3.11 (0.89)	< .001
Segregation	1.96 (0.77)	2.46 (0.77)	< .001
Avoidance	3.01 (0.80)	3.27 (0.75)	< .001
Credibility	3.06 (0.64)	2.98(0.64)	.276
[1] SD: standard deviation			
*: Student t			

As can be observed in Table 4, the impact of different types of mental illness (schizophrenia or depression) in the modified AQ factors revealed significant differences for the dimensions dangerousness, coercion and segregation (p < .02; p < .008 and p < .002 respectively).

Table 4
Attribution Questionnaire factors scores according to the psychiatric diagnosis

Factors/Nº items	Schizophrenia Mean (SD) (*n* = 312)	Depression Mean (SD) (*n* = 302)	*p**
Responsibility	1.99 (0.57)	2.08 (0.60)	.090
Pity	3.08 (0.72)	3.03 (0.75)	.395
Anger	1.74 (0.70)	1.72 (0.72)	.707
Dangerousness	2.55 (0.58)	2.45 (0.58)	.029
Help	3.82 (0.81)	3.81 (0.88)	.898
Coercion	3.20 (0.85)	3.00 (0.91)	.007
Segregation	2.54 (0.74)	2.36 (0.78)	.004
Avoidance	3.30 (0.74)	3.23 (0.75)	.263
Credibility	2.94 (0.63)	3.01 (0.63)	.180
[1] SD: standard deviation			
*: Student t			

The differences between the questionnaire constructs according to the vignette role and psychiatric history are shown in Table 5. All factors except credibility showed statistically significant differences in the different vignettes' roles.

Table 5
Attribution Questionnaire factors scores according to the vignette role and the psychiatric history.

Factors		Assistance	*p**	Victim	*p**	Witness	*p**	Suspect	*p**
Responsibility Mean (SD)	No mental illness	2.24 (0.68)	.007	2.21 (0.56)	.069	2.29 (0.62)	.008	2.43 (0.67)	< .001
	Mental illnes	2.00 (0.61)		2.06 (0.51)		2.04 (0.61)		2.06 (0.55)	
Pity Mean (SD)	No mental illness	3.24 (0.60)	.16	2.48 (0.81)	< .001	2.34 (0.77)	< .001	2.62 (0.81)	.001
	Mental illness	3.36 (0.75)		2.90 (0.68)		2.96 (0.69)		2.99 (0.76)	
Anger Mean (SD)	No mental illness	1.49 (0.66)	.001	1.58 (0.65)	.014	1.60 (0.63)	.241	1.84 (0.93)	.952
	Mental illness	1.57 (0.62)		1.85 (0.79)		1.72 (0.68)		1.83 (0.82)	
Dangerousness Mean (SD)	No mental illness	2.33 (0.55)	.003	2.07 (0.63)	< .001	2.13 (0.62)	.016	2.38 (0.66)	.003
	Mental illness	2.55 (0.55)		2.48 (0.58)		2.34 (0.56)		2.66 (0.61)	
Help Mean (SD)	No mental illness	3.96 (0.85)	.661	3.50 (0.88)	.333	3.29 (1.04)	< .001	3.48 (0.89)	.014
	Mental illness	4.01 (0.84)		3.62 (0.87)		3.82 (0.82)		3.79 (0.83)	
Coercion Mean (SD)	No mental illness	2.56 (0.85)	< .001	2.16 (0.77)	< .001	1.88 (0.84)	< .001	2.24 (0.88)	< .001
	Mental illness	3.36 (0.84)		3.01 (0.82)		2.74 (0.92)		3.29 (0.87)	
Segregation Mean (SD)	No mental illness	2.06 (0.69)	< .001	1.91 (0.76)	< .001	1.69 (0.70)	< .001	2.13 (0.85)	< .001
	Mental illness	3.36 (0.84)		2.49 (0.78)		2.10 (0.74)		2.79 (0.76)	

[1] SD: standard deviation

*: Student t

Factors		Assistance	*p**	Victim	*p**	Witness	*p**	Suspect	*p**
Avoidance Mean (SD)	No mental illness	3.10 (0.73)	.11	2.90 (0.87)	.001	2.69 (0.75)	< .001	3.33 (0.74)	.128
	Mental illness	3.26 (0.75)		3.27 (0.73)		3.09 (0.73)		3.50 (0.75)	
Credibility Mean (SD)	No mental illness	3.20 (0.67)	.513	2.92 (0.63)	.244	3.35 (0.54)	.178	2.74 (0.51)	.760
	Mental illness	3.15 (0.69)		2.81 (0.57)		3.23 (0.61)		2.72 (0.49)	
[1] SD: standard deviation									
*: Student t									

When considering different hypothetical roles, we found no significant differences between people suffering from schizophrenia or depression except in responsibility and segregation dimensions in the person in need of assistance 1.86 (SD = 0.52) *vs.* 2.13 (SD = 0.65) points; (t = − 2.95, *p* =. 004) and 2.59 (SD = 0.64) *vs.* 2.38 (SD = 0.68) points (t = 1.98, *p* = .049) respectively and in coercion dimension in the roles of victim and witness 3.13 (SD = 0.74) *vs.* 2.88 (SD = 0.88) points (t = 1.98, *p* = .049) and 2.89 (SD = 0.87) *vs.* 2.57 (SD = 0.95) points (t = 2.60, *p* = .041) respectively.

Association between socio-demographics variables and AQ scores

Regarding the impact of different socio-demographic variables on the modified AQ factors when the hypothetical person had a psychiatric history, we found that female PO showed greater feelings of pity and desire to help than male PO: 3.24 (SD = 0.80) *vs.* 3.02 (SD = 0.72) points; (t = − 2. 81, p = .005) and 3.99 (SD = 0.86) *vs.* 3.77 (SD = 0.84) points; (t = − 2.43, *p* = .016) respectively. Younger PO had a greater perception of danger and desire for avoidance psychiatric patients than older ones: 2. 56 (SD = 0.62) *vs.* 2.38 points (SD = 0.59; t = 2.30, *p* = .022) and 3.30 (SD = 0.69) vs. 3.08 points (SD = 0.85; t = 2.26, *p* = .024) respectively. Staff members who were more familiar with mental health had greater feelings of pity and help 2.99 (SD = 0.78) *vs.* 2.83 points (SD = 0.79; t = 2.70, *p* = .007) and 3.78 (SD = 0.89) *vs.* 3.62 points (SD = 0.88; t = 2.52, *p* = .012) respectively. Length of service was negatively correlated with desire for avoidance (r = − .102; p = .02) and dangerousness (r = − .120; *p* < .001). In the rest of the studied variables, we found no statistically significant differences.

Discussion

We believe this study is important because is the first to specifically evaluate in our setting the phenomenon of stigma associated with mental illness in the State Security Forces and Corps. Our findings indicate that in Spanish Police, the label of mental illness was associated with greater desire to help, more feelings of pity and less consideration of responsibility for the situation. We also found increased feelings of anger and avoidance, a greater perception of danger, and desires for segregation and coercion to obtain medical treatment. In addition, we evaluated the possible influence of different illnesses (schizophrenia and depressive disorders) on police

encounters. According to our results, the diagnosis of schizophrenia increased the perception of danger and the desire to segregate and coerce for medical treatment compared to depression.

Since Watson´s work [15] who studied the phenomenon of stigma in the American police with the modified- AQ questionnaire [15, 23], no previous study has applied this tool in the Police force which gives our research an added value. In general, our results are consistent with those of Watson [15], except for the anger dimension, where they did not find association. When comparing the scores for each factor according to whether the person had a mental illness or not, the differences were low (< 0.5 points) except for pity and coercion dimensions, where Watson et al. obtained lower scores than we did. These results could be due to the fact that we included in our study two types of illnesses with different expected associated stigma (schizophrenia and depression) [27]. The differences in pity dimension may highlight the fact that the PO are increasingly aware of the phenomenon of stigmatization towards psychiatric patients. Other possible explanation is the cultural differences between continents as some studies suggest less stigma in the Spanish population [28]. However, the desire for coercion for medical treatment may also indicate a deficit in knowledge about the recovery and treatment of people with mental illness.

The differences in stigma-related constructs according to whether a person was diagnosed with schizophrenia or depressive disorder may be explained by the fact that the stereotype of dangerousness is more ingrained in schizophrenia than in depression [27, 29]. However, for the avoidance factor, which is an indicator of social distance, we found no significant differences between the two diagnoses. Even though the officers showed more positive attitudes towards depressive disorders, avoidance behaviors are one of the elements most related to stigmatization. Therefore, according to our findings, we cannot conclude that a diagnosis of depression generates less stigma in the Police than schizophrenia, as studies in the general population suggest [6, 27, 30, 31]. Perhaps, the most positive finding to highlight in the comparative analysis between both disorders, is that the responsibility dimension did not revealed significant differences. This finding is likely related to officer´s knowledge that depressive disorders, like schizophrenia, are mental illnesses. One of the great scourges suffered by people with depression is that they may be considered weak and responsible for their situation because of the stereotypes at the general population that perpetuate this consideration [29, 32–35].

We also analyzed the differences between the questionnaire constructs according to the vignette role and the psychiatric diagnosis. The most relevant finding was that dangerousness, coercion and segregation factors were significantly different in all roles, being higher in psychiatric patients regardless of the diagnosis. The result on dangerousness suggests that this stereotype is intrinsically linked with the diagnosis of mental illness. Although the information provided about the type of mental illness and the vignette role may be different, the perception of dangerousness in the police context does not vary. These findings are consistent with those found in various police institutions around the world, where researchers argue that the most common police misconception is that all people with mental illness are dangerous [12, 15, 16, 18, 20, 36]. Unfortunately, the desire for segregation and coercion for treatment together with the perception of dangerousness, may PO to inadvertently escalate situations through approaching patients with threatening body language and speech and may evoke of unnecessary violence in police encounters [15].

Finally, we found relationship between different sociodemographic variables and the AQ factors when the hypothetical person had a psychiatric history. Our findings indicated that women showed more feelings of pity and desire to help people with mental illness than male PO. These results seem to support the conclusions of surveys of the general population that suggest that women had less stigmatizing attitudes towards mental illness

than men [37]. In the police context, however, this desire to help could be understood as an indicator that female PO accept their role of help of this population. On the other hand, younger PO maintain a greater perception of danger and desire for avoidance psychiatric patients than older PO. These findings are consistent with previous research that suggests that veteran PO have less stigmatizing attitudes [20]. However, research in the general population concludes that older people have more stigmatizing attitudes [38]. These differences may be due to the fact that younger PO in their early years in the Police force have a biased contact with psychiatric patients during periods of acute symptoms. These encounters in crisis situations can be generalized and form a misperception of danger, which can be nuanced over the years by having contact with these individuals in a wider range of situations. We also found that the length of service was positively correlated with the responsibility dimension and negatively correlated with avoidance. As previous studies have shown that training programs may reduce stigma [14, 39–41], we believe that the fact that veteran PO consider psychiatric patients more responsible for their situation is a consequence of a lack of knowledge since the range of labor seniority in our sample is very wide and consequently the training programs received as well.

Some limitations should be considered when interpreting our results. The vignettes did not include environmental variables that are usually present in daily law enforcement. Further studies should evaluate these results in other situations more representative of daily police practice. A second limitation we should consider is that we explore the phenomenon of stigma with a self-administered questionnaire. Although these questionnaires have proven to be practical, cost-effective, and low participant- burden, they have some limitations in terms of recall bias and social desirability [42]. These unresolved issues should be better assessed in future studies.

The greatest strength of this research lies in the fact that it can provide valuable information to improve the protocols for law enforcement of the Spanish Police with psychiatric patients and to guide and update the training activities of the Police in this field. Recent studies carried out in police forces in other countries have shown that a specific training program on mental health helps to reduce stigmatizing attitudes, and increases understanding and support for people with a psychiatric diagnosis [14, 39–41].

Conclusions

Our findings highlight several issues that should be addressed in the police institution. Although PO are aware of the reality of mental illness, they hold certain attitudes and beliefs that require special attention. Our study provides evidence that labeling a subject with mental illness has negative effects on decision-making within law enforcement. Furthermore, when the type of mental illness is specified, the effect is more detrimental to schizophrenia than to depression. We found several factors associated with the persistence of these stigmatizing attitudes in the Police that can guide us to implement anti-stigma training to encourage attitude change, especially at the beginning of the professional career. Since people with mental illness may be more vulnerable and suffer from an unequal provision of health services, promoting more active involvement of the Police could generate a message of confidence towards victims and reduce the alienation and stigma towards mental illness.

Abbreviations

Police Officers (PO); Attribution Questionnaire-27 (AQ-27); SD: standard deviation

Declarations

Ethics approval The study was conducted according to the guidelines of the Declaration of Helsinki, and approved by the Ethics Committee of UNIVERSITY OF MURCIA (protocol code 3374 and June 1st, 2021).

Consent to participate All participants gave their informed consent prior to their inclusion in the study.

Consent for publication Not applicable

Availability of data and materials The datasets generated and analyzed during the current study are not publicy available on request from the corresponding author. The data are not publicly available due to privacy restrictions (include information that allows the identification of members of state security forces) but are available from the corresponding author on reasonable request.

Competing interest "The authors declare that they have no competing interests" in this section.

Funding: This research received no external funding.

Author Contributions I.M.S., M. M.-P., and M.D. P.-C have made substantial contributions to the conception and design of the work; M. M.-P., and M.D. P.-C. made the analysis and prepared the figures. A. L. R.-C participated in the funding acquisition. I.M.S wrote the main manuscript. All authors reviewed the manuscript and approved the submitted version

Acknowledgments: We would like to thank the participation of the Training Division of the National Police Force, the Spanish Police Foundation and the collaboration of the National Police School and the Center for Higher Studies in the sampling work.

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