



The University of
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Institute of Work, Health & Organisations

Women Police Officers: Ageing, Work & Health

A research report on the experience of ageing at work, with particular reference to the menopause, and its impact on the well-being of women police officers aged 40+.

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TERMS OF REFERENCE

The authors of this report were commissioned by the British Association for Women in Policing (BAWP) to explore women police officers' experience of working through the menopause. In particular, the research aims were to:

- Review the scientific literature on work, health and ageing, with specific reference to the menopause
- Explore the experience of ageing at work for women police officers aged 40 +
- Focus specifically on health-related and workplace performance issues associated with the menopause in women police officers
- Provide recommendations for future practice

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EXECUTIVE SUMMARY

This study represents the results of a survey of 941 women police officers aged 40+. They ranged in rank from Police Constable to members of ACPO, with an average length of service of 21 years. The majority of results presented in this report refer to those 249 women who were going through the menopausal transition (as defined by their self-report of menopausal symptoms) at the time of completing the survey. The postmenopausal group also provided useful, albeit retrospective, information on their experiences of ageing, health and the menopause. The questions in the survey were designed after preliminary interviews with 24 women police officers of menopausal age, and by reference to the published literature on the menopause.

Officers were asked their views on which aspects of the menopause most affected their capacity to function normally at work. The main factors (as agreed by over half those who were in the early and late stages of menopausal transition, or who had gone through the menopause) were tiredness and insomnia. Factors reported by just under half the sample included perceived lower levels of physical fitness, loss of concentration and forgetfulness. Those characteristics of work and the working environment which were thought to affect menopausal symptoms adversely were temperature of the working environment, inadequate ventilation and workload. When asked how they coped at work when their menopausal symptoms were particularly challenging, most women said they tried to ignore it, used humour to cope, or distracted themselves with other activities.

Two thirds of women would not (or did not) disclose their menopausal status to their line managers. Half would not (or did not) disclose to their colleagues. The main reasons women gave for *not* disclosing to their manager were having a male manager, embarrassment, and having a younger manager. The main reasons women gave for disclosure were where symptoms became very obvious, when they felt their performance was affected, or when they were not coping with symptoms well. Some women reported that they would disclose as a means of justifying a change in their behaviour. The reasons given for disclosure/non disclosure to colleagues were the same, except that women also said that they would/did disclose to colleagues as a means of sharing experiences with other women who were going through, or who had gone through the menopause.

When asked what changes at work would be most helpful to them while going through the menopause, the most popular suggestions chosen (from a list compiled from the results of the interviews) were a comfortable rest room, better ventilation and the provision of fans. Women were also offered the opportunity to make additional suggestions as to what might ease their menopausal transition. Their suggestions included more flexibility in terms of working hours and roles, improved support and information from formal sources (eg. Occupational Health) and informal sources (eg. women's network groups and/or women's support contact number), and raising awareness and understanding among colleagues and managers.

Officers were also asked about their views, particularly as women, of getting older in the Police Service. The clear majority of women (87%) felt that the Police Service had the same expectations of the physical capabilities of younger and older officers. Less than half the sample (41%) agreed that the Police Service valued the contribution of older officers. When asked what changes at work would be most helpful to them as they got older, the most popular suggestions concerned (i) increased flexibility of working hours and roles (eg. flexitime, compressed hours, no night shifts after a certain age, work patterns, choice in move to office-based work or continuation of front-line/PSU role), (ii) workplace health promotion (eg. regular health checks, fitness programmes, greater knowledge by managers of health-related changes that affect older workers, easier access to Occupational Health), and (iii) changes to the physical work environment (eg. better women-only facilities including toilets, showers and restrooms, the provision of sanitary bins, more comfortable and suitable uniforms, reductions in the weight of equipment carried while on foot, and better quality of general facilities including chairs, desks, computer screens, access to cold drinking water, and more supportive car seats).

In summary therefore, recommendations concern (i) raising awareness of ageing and health issues in general, and the menopause in particular, among managers and colleagues, (ii) increasing access to informal and formal sources of support, (iii) improving aspects of the physical working environment and (iv) allowing more flexibility in job roles and working arrangements.

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The Institute of Work, Health & Organisations is an international postgraduate research school at the University of Nottingham. It is a centre of excellence in research in applied psychology and a major provider of quality postgraduate education. Occupational psychology, health psychology, occupational health psychology and clinical psychology are among its defining competencies, and over 120 MSc level students graduate in these subjects each year. The Institute is a designated Collaborating Centre for Occupational Health of the World Health Organization, and a member of the Topic Centre on good practice in health and safety management established by the European Agency for Safety and Health at Work. The Institute hosts the *European Academy of Occupational Health Psychology* and its journal *Work & Stress* - one of the top international journals in applied psychology.

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1 : LITERATURE REVIEW

1.1 The changing age profile of the UK's workforce

Contemporary demographic trends throughout Western Europe have seen an increasing number of women entering the workforce (Kandola, 1995). Women now form a substantial part of the active working force, with recent estimates suggesting that they represent nearly half of all UK employees (Geurts & Demerouti, 2003; Paul, 2003). This is also true of policing: there has been a notable increase in the number of women in the UK Police Force throughout the last decade (Metcalf & Dick, 2002). In parallel, the age structure of Europe's working population is changing (Griffiths, 1997). Life expectancy has increased dramatically since the beginning of the last century, which together with lower birth rates effectively means that declining numbers of younger people are entering paid employment (Kandola, 1995). Consequently, most Western countries have ageing workforces (Arnold, 1997). A growing proportion of women at work are in the older age groups; currently more than 1.5 million female workers in the UK are aged between 45 and 64 (Doyal, 2002).

There is increasing pressure, often financial, on both men and women to remain at work for longer than has been traditional in recent decades. The statutory retirement age is rising. This pressure is probably less intense for police officers than workers in other professions, due to the nature of their pension provision. Nonetheless, this pressure to work until older has not been accompanied by a consideration of the consequences for health, both in work and in later retirement (Griffiths, 1997). This is a particularly striking omission in view of the fact that over one third of the workforce above the age of 50 is likely to have been diagnosed with at least one disease of long duration (Ilmarinen, 1994). In particular, there has been a notable absence of research into the impact of work on the health of older women (Doyal, 2002). In a recent survey of health and safety representatives, for example, 85% reported they had never been asked for specific information regarding the health of women at work (Kirby, 1998).

With an estimated two-thirds of UK women aged between 50 and 59 in paid employment, more women are working through and beyond their menopausal years than before (Paul, 2003). The specific problems and risks that women may encounter at work have often been ignored or understated in occupational health and safety practices (Trades Union Congress, 2002). A general assumption remains that the health and safety needs of women workers are identical to those of men, and that women largely work in 'risk-free' occupations (Daley, 2002). This approach may be inadequate for many women in the modern workplace, particularly those in police work. It has been suggested that police women officers may suffer discrimination and prejudice because they are a minority group in a male-dominated organisation (Deschamps, Paganon-Badinier, Marchand, & Merle, 2003). For example, they are reported to face many work and cultural barriers deriving from police organisation and managerial structures, together with wider societal beliefs about women's ability to undertake policing work effectively (Metcalf & Dick, 2002).

It is important to optimise the working environment of all groups in a diverse workforce, by avoiding those work characteristics that may be detrimental to their physical or psychological well-being (Griffiths, 1997). This can only be achieved with a clear picture of risks. The brief review below considers the scientific literature with particular reference to the menopause and work, and attempts to address limitations of current understanding. The authors are not aware of such research that has specifically focussed on police officers. The review therefore draws on the wider literature relating to ageing, work, the menopause and health. In the scientific literature on older workers, 'older' usually refers to those employees aged 45 and above.

1.2 The menopause – its nature and effects on health and well-being

'Menopause', although widely thought to mean that stage of a woman's life marked by 'menopausal symptoms', actually refers to the single point in time in a woman's life when there has been no menstruation for 12 consecutive months. This usually occurs naturally between the ages of 45 and 55, but in the western world the average age is 51. Menopause is a result of the ageing ovaries and fluctuating levels of hormones that cause the reproductive system gradually to shut down. The period of hormonal change before the

menopause, the peri-menopause or menopausal transition, typically lasts about six years. It leads to menstrual irregularities (irregularity of the length of the period, the time between periods and the level of flow), and can be accompanied by vasomotor symptoms such as hot flushes, night sweats, sleep disturbances, fatigue (probably a result of sleep disturbance), poor concentration, irritability, lack of confidence, weight gain, somatic symptoms (such as dizziness), mood disturbances, skin dryness, vaginal dryness, decline in sexual desire (libido), and so on (Fisher, 1994; Ussher, 1998). The risk of osteoporosis (where bones lose elasticity and become brittle) increases after menopause, as a result of lower levels of oestrogen. Similarly, levels of high density lipoproteins (HDLs) decrease, low density lipoproteins (LDLs) increase, arteries lose elasticity and more weight is distributed in the waist area – all increasing the risk of heart disease. Cardiovascular disease is rarely seen in women before the menopause, yet is the leading cause of mortality in postmenopausal women (Sarrel, 1991; Maxwell, 1998). Other possible oestrogen-related changes include stress incontinence (resulting from decreased pelvic muscle tone), loss of elasticity in the skin, and hair thinning. As the period of hormonal deficiency lengthens, the physical consequences of the menopause become more marked (Sarrel, 1991). However, contrary to widespread opinion, it has been estimated that only about 10% to 15% of women experience severe symptoms during the menopause (Fisher, 1994).

Premature or induced menopause occurs when the ovaries are surgically removed (in this case, the onset of associated symptoms may be more rapid) or have been damaged by radiation, drugs or infection. Other causes of premature menopause include disorders like thyroid disease or diabetes mellitus. A straightforward hysterectomy, where only the uterus is removed, should not affect the production of hormones and thus does not induce menopause.

Hormone replacement therapy (HRT) was introduced in the 1970s to deal with the symptoms of the peri-menopause and menopause. Although HRT eases hot flushes and other symptoms and reduces the risk of osteoporosis, there have been some concerns over whether the benefits might outweigh the risks. Recent research has suggested that HRT may increase women's risk for Alzheimer's disease, breast cancer, heart disease and stroke. There is an ongoing debate in this area. In a recent survey of women 45-55 who sought advice for symptoms of the menopause, the clear majority said that their GP spent 10 minutes or less making a diagnosis and felt their doctors were either 'indifferent' or 'unsympathetic' (Elixir News, 17.10.2005). One in three who visited their GP to discuss HRT were prescribed anti-depressants, and felt that their doctors who were too busy to listen. It would seem that in addition to their lack of understanding of the menopause, not all women are happy about the available advice on treatment options. However, some women resist the implication that that menopause is a disorder that needs treatment, and regard it as a natural 'stage' in life.

Other approaches to dealing with menopausal symptoms include exercise (to help circulation, increase bone density and HDL levels and lower stress), avoidance of excess alcohol and smoking, and the provision of lubricants for vaginal dryness. More recently, dietary changes (eg. limiting protein and fat, and increasing calcium), have also been recommended, as have increases in the consumption of foods that mimic oestrogen (plant-based oestrogens) such as soy, and various supplements such as evening primrose oil, sage, and various other herbal supplements. Research into the efficacy of these approaches is limited to date but there is increasing interest in complementary approaches to easing symptoms.

For some women, menopause is a period characterised by a decrease in psychological health (Greer, 1991). It seems plausible however, that individual characteristics may increase the risk of poor psychological health in older women. For example, the literature suggests that women with low self esteem have more difficulty coping with menopausal changes (Reynolds, 2002) and consequently suffer most psychological distress at this stage (Bates Gaston, 1991). A study using prospective annual assessments of women's mood state during the menopausal transition concluded that the magnitude of negative mood was significantly predicted by baseline reporting of premenstrual complaints, and by negative attitudes to both menopause and ageing (Dennerstein, Lehert, Burger, & Dudley, 1999). Anxieties about ageing and concerns of health are concomitants of menopausal complaints (Greer, 1991).

It should be noted that the menopause, which can itself be an ordeal, typically occurs at challenging times in women's lives: they may be dealing with teenagers at home, or those

teenagers may have recently left home; they may be caring for elderly or unwell relatives. Women, whether in paid employment or not, still tend to bear the greater share of housework, child care and care of the elderly (Kapadia, 1996). These traditional patterns of domestic responsibility are most apparent in older age groups (Lloyd, 1999). The domestic pressures on older working women have received limited research attention (Lloyd, 1999) and are usually ignored in studies measuring the impact of work on health. This may have implications for research into the menopause; it has been suggested that lower life satisfaction is associated with a more difficult transition through the menopause (Greer, 1991). In addition to domestic pressures, working women of menopausal age may also be taking on the increased responsibilities that often accompany more senior roles. Perhaps encouragingly, a study examining the lifestyles of 200 women over the age of 50 reported that 76% of post-menopausal women reported experiencing improvements in their physical health after the menopause (Social Issues Research Centre, 2002).

1.3 The menopause and work

It should be noted that it is well documented that work can provide an important contribution to the psychological health of older women, functioning as a source of self esteem that grants emotional and material independence (Doyal, 2002). Women generally state that much of their social support derives from work colleagues; a large body of literature links such support to positive health and well-being (Doyal, 2002). Research is relatively consistent in suggesting that 'midlife' women who are employed report better health, lower anxiety, less depression and greater subjective well-being than those who are not (Bromberger & Matthews, 1994; National Association of Social Workers, 2003).

It has been suggested that employment only has a protective effect on the health of older women if they are of a higher social class and pursuing a professional career, with the higher the prestige of the job held being associated with higher ratings of well-being (Greer, 1991). Moreover, women who participate in rewarding work, which they find enjoyable, tend to cope better with their symptoms during the menopausal transition (Greer, 1991). Work provides opportunities for promoting skills, for interacting with others, keeping mind and body active, and for giving a sense of identity (Doyal, 2002). Working women report lower rates of menopausal symptomatology (Sarrel, 1991; Bates Gaston, 1991). Apter (1996) proposes the existence of a 'postmenopausal zest' whereby women over 50 become more self-confident, and experience greater energy to pursue new goals. It is suggested that midlife growth is common for women, but social and financial resources are necessary to such growth (Apter, 1996).

The cause and effect relationship between employment and women's health is difficult to disentangle; for example, it is clouded by the wealth of cross-sectional (rather than longitudinal research) and possibly by the 'healthy worker effect' (Jennings, Mazaik, & McKinlay, 1984). It seems plausible that less healthy women may withdraw from employment or choose to stay at home (Bates Gaston, 1991). Despite this, an increasing number of women are working through the menopause and will undoubtedly experience a degree of physical or psychological symptomatology that could affect their working day in a variety of ways. Hot flushes can cause embarrassment, and night sweats can bring about insomnia and daytime tiredness. Urinary symptoms of frequency and urgency might concern women working long shifts or without easy access to a toilet. There may be emotional or sexual difficulties that may not relate directly to work, but which nonetheless may affect women's psychological well-being (Kapadia, 1996). As well as symptoms affecting work, it is also plausible that work might exacerbate symptoms. Hot flushes, headaches and dizziness might be made worse by high working temperatures, or unsuitable uniforms might affect comfort and health (Paul, 2003).

It is clear from the published literature that the menopause is rarely seen as a workplace health and safety issue despite it being as a significant health concern for women and it remains under-researched (Paul, 2003; Lee, 2000). The strength of those studies to date that have concerned work and the menopause is thought to be limited, both by inappropriate study design and by the failure to account for potentially important factors that might confound the relationship between women's health and work, such as socio-economic status, educational level and social support networks (Jennings, Mazaik, & McKinlay, 1984). It has been suggested, for example, that women of a higher educational level demonstrate more positive attitudes toward the menopause than those of lower educational levels and that this may have implications for differences in their psychological

well-being during the transition (Greer, 1991). In general, insufficient knowledge exists about the psychological, physiological, social and cultural aspects associated with women's experience of the menopause at work (Bowles, 1986). It is necessary to understand the ways in which work can affect menopausal symptoms and the ways in which menopausal symptoms can affect the capacity to work (Sarrel, 1991), whilst bearing in mind that women's experience of the menopause varies greatly.

1.4 Disclosure

Discussing or publicly acknowledging health concerns and illness, and confiding in others at work are usually referred to as 'disclosure' or 'self-disclosure' in the scientific literature. Acknowledging the menopause at work can be threatening and embarrassing; women may feel that they cannot discuss their symptoms with supervisors or colleagues, particularly if these co-workers are men or younger women (Fisher, 1994). A recent survey of health and safety representatives about the workplace health and safety implications of the menopause concluded that women experience serious difficulties in discussing menopause with their employers, with one in five women reporting criticism, ridicule and harassment on this matter from managers (Paul, 2003). Whilst relatively few women may have experienced direct discrimination that could be attributed to the menopause, many acknowledge a work environment that they feel diminishes them via demeaning behaviours and jokes at their expense (Graves, 1996). Other research indicates that women encounter hostility in the work environment with regard to their menopausal symptoms (High & Marcellino, 1994); a situation that may be more apparent in traditionally male-dominated occupations. The issue of disclosure is an important one, in that employers and line managers can only be sympathetic to employees' needs if they are aware of them. There is evidence from the literature on chronic illness that where employees disclose problems to their line managers, those line managers are perceived to be more sympathetic. The direction of causality here is not always clear.

1.5 The menopause and work performance

Any consideration of the impact of the menopause on work needs to take account of the research on ageing in general because menopausal women are also older women. It is well documented that ageing is accompanied by deterioration in various physiological systems, and in tolerance of various aspects of work such as extreme hot or cold working environments, and shift work (Griffiths, 1997). The information from the general literature regarding age and work performance is limited, inconsistent, and obscured with methodological issues (Griffiths, 1997). The majority of studies are cross-sectional, involving small sample sizes and restricted age ranges, with the relationship dependent on the type of performance measure, the nature of the job and other factors, such as experience (Czaja, 2001).

Overall the empirical literature provides limited support for the belief that job performance declines significantly with age, but the relationship between age and job performance is complex and far from understood (Czaja, 2001). Most reviews of the scientific literature report little consistent relationship between ageing and job performance (Griffiths, 1997). Research suggests that older workers are more consistent in their performance and more effective in terms of reliability, conscientiousness and work effectiveness (Warr, 1994). On the other hand, population and laboratory-based studies reveal age-related declines in certain cognitive abilities, such as memory, although work rarely requires the level of sustained performance typical of such experiments (Griffiths, 1997). It is possible that there is little observable decrease in the performance of older workers, despite a decline in certain cognitive abilities, because they compensate for their diminished cognitive capacity with an increase in job knowledge, experience and skills (Salthouse & Maurer, 1996). Older workers (both men and women) may be perceived negatively by their employers and colleagues; commonly perceptions are that they are physically unable to do their job, less productive, less motivated, and demonstrate a higher rate of accidents and absenteeism than younger workers (Czaja, 2001). Studies on the effects of ageing on job performance testify to the older worker's increased stability, work motivation, involvement and commitment (Graves, 1996). The literature suggests that older workers demonstrate less absenteeism, lower turnover rates, fewer accidents and increased job satisfaction compared with their younger counterparts (Warr, 1994). However, research needs to take into account variations in organisational context. For example, research in the police domain has reported that ageing is negatively correlated with job satisfaction,

organisational commitment and sense of participation in work (Mason, 2000). The particular strengths of older workers (wisdom, experience, problem-solving expertise, etc) may not be well understood or appreciated (Griffiths, 1997).

It has been suggested that the widespread level of ignorance surrounding the menopause (High & Marcellino, 1994) can lead to a restricted, stereotypical view of women's general health and behaviour at work: behaviour that may be 'explained' in terms of 'getting old' or 'the menopause', or 'hysteria' (Gallagher, 1999). But the real relationship between the menopause and work performance has received scant attention in the scientific literature (High & Marcellino, 1994). It has been reported that the presence of vasomotor symptoms, such as hot flushes, do not impair cognitive performance in postmenopausal women; working memory and auditory attention are preserved irrespective of symptoms (Polo-Kantola *et al.* 1997). There is evidence to suggest that oestrogen deficiency is associated with cognitive impairment but it is quite possible however that these minor deficits found in cognitive processing efficiency are related to age rather than to the menopause (Polo-Kantola *et al.* 1997). In another study, the majority of menopausal women stated that their symptoms did not impede overall performance, although some aspects of their work could be affected; for example, productivity can fall off if tired at work (Lee, 2000). In this way perhaps menopause *per se* does not adversely affect women's working lives (Social Issues Research Centre, 2002), but may function indirectly. Sleep disturbances, hot flushes, anxiety attacks and depression seem likely to affect the capacity to function at work.

Research in the US - the Yale Midlife Study - investigated a wide variety of biological and psychological measures associated with the menopause, before and after hormone replacement (Sarrel, 1991). Two thirds of the women who worked outside the home believed that the menopause had a moderate to severe effect on their capacity to function at work, citing sleep disturbance as the symptom that affecting daily functioning (Sarrel, 1991). In another study, a third of working postmenopausal women reported that menopausal symptoms had adversely affected their job performance; irritability and mood changes in particular were cited as being associated with poorer job performance (High & Marcellino, 1994). In comparing different job roles, the study further concluded that 'non-managerial' women report a higher percentage of symptoms and greater detriments in job performance than women of managerial status (High & Marcellino, 1994). This is consistent with the more general literature that suggests age related performance declines are less likely for professional groups and those of lower status in organisations (Czaja, 2001).

A recent national survey reported that over half of women over the age of 50 believed their ability to work and pursue a career had improved since the onset of menopause (Social Issues Research Centre, 2002). This perception is consistent with the view that the performance of postmenopausal women may be superior to younger women (Bates Gaston, 1991).

1.6 Shift work

It is possible that the nature of work in the Police Service may have a greater impact on mid-life women's health than that of other more 'predictable' occupations. Police work varies considerably from locality to locality and although few published studies exist (Wedderburn, 1995), it is clear that shift work is a common feature.

The social and family circumstances of a shift worker change greatly with age (Harma, 1996). A growing intolerance of shift working with age has been extensively reported in the literature (Harma, 1996; Mason, 2000). Older people generally retire, rise, and take meals earlier, as well as demonstrate lack of flexibility in sleep patterns (Harma, 1996). They may experience more problems resulting from working shifts, for example rotating systems, that require constant readjustment of routine (Folkard & Hill, 2002). An increase has been reported in disturbances of sleep, gastrointestinal and cardiovascular disorders, and absenteeism in older shift workers (Folkard & Hill, 2002). Shift workers tend to report shorter sleep length and poorer subjective sleep quality (Harma, 1996). The older worker adjusts more slowly to consecutive night shifts, resulting in an accumulation of sleep disturbances. A study of police officers reported that both age and length of service were significant indicators of the perceived negative effects of the night shift (Mason, 2000). Older officers (here, above mid-30s) reported greater fatigue, greater sleepiness on late

shifts, and indicated generally higher stimulant intake, specifically the use of caffeine (Mason, 2000).

Shift work, especially night work, may demonstrate more specific adverse effects on women's health both in relation to their particular hormonal and reproductive function, and their reproductive roles (Costa, 1996). It has been reported that women night workers with children have a shorter and more frequently interrupted day time sleep, leading to cumulative tiredness (Costa, 1996). Evidence from empirical studies in the general shift work domain suggests that female shift workers have higher absenteeism rates and report more symptoms of chronic fatigue as well as psychoneurotic, digestive and circulatory complaints (Folkard & Hill, 2002). This may be a concern for the symptomatic menopausal woman at work, with possible accumulation of sleep debt from sleep disturbances associated with the menopause. Cumulative sleep loss can result in immediate performance decrements and potential negative health effects in the longer term (Mason, 2000). Potentially the greatest danger would be falling asleep 'on the job', or reaching a trough in alertness which is quite close to sleep (Wedderburn, 1995). In summary, it is possible that in comparison with other occupations that do not require shift work, police work has the potential to be particularly challenging for menopausal women.

1.7 Summary

Many of the problems traditionally identified with menopausal transition may not be the result of hormonal imbalances; rather some are the consequences of ageing, while others have a basis in psychological factors and life patterns (Bowles, 1986). There has been extensive research into the nature of the menopause and its effects on mid-life women's health, but despite increasing numbers of older women workers, limited investigations into its effects on work and work performance. Even less research has explored how women cope with this major health event at work and what their employing organisations could do to improve matters for them. The authors of this report could find no research on this subject with regard to women police officers. However, until recently there has been a lack of research in general into the role and experience of women within the Police Force (Metcalf & Dick, 2002). Employers should ensure that the diversity of their workforce is represented in risk assessments, allowing suitable arrangements to be employed for all (Doyal, 2002; Paul, 2003). Raising awareness, providing appropriate guidance and training have been suggested as possible ways forward in tackling the secrecy, embarrassment and confusion that frequently surrounds the menopause (Paul, 2003).

The study presented in this report was designed to be contextualised, and to explore how women police officers experience the menopause at work, and to harvest their views on what changes could be made to their work and working environment that would improve their experience and that of future women police officers.

2: RESEARCH DESIGN & METHODS

The research reported here was designed to explore the experience of ageing at work, with particular reference to the menopause, and its impact on the health and well-being of women police officers aged 40 years and above. It used a combined qualitative and quantitative approach. Semi-structured interviews were used to collect qualitative information exploring the experience of ageing at work and the experience of working during the menopause. Key issues were elicited from participants and used to inform the development of a tailor-made questionnaire-based survey that explored the relationship between work, health and ageing. The design of the study, the participants, interviews, questionnaire and procedures used are described below.¹

2.1 Design

The study was based on the risk assessment-risk management paradigm, which has been developed and used in a series of case studies (notably on work-related stress and on the management of chronic illness at work) at the Institute of Work, Health & Organisations, funded by the British Government's Health & Safety Executive and many other bodies (eg. European Social Fund, Home Office, British Medical Association, National Association of Colitis and Crohns Disease, UNISON and organisations from the private sector). The aim of a risk assessment in this context is to identify, for a defined employee group, any significant potential hazards to health and well-being relating to work and working conditions (Cox, Griffiths & Randall, 2003). Risk management represents an attempt to remove or otherwise reduce the impact of those hazards. The study reported here represents the first of these stages – a risk assessment. A risk assessment is carried out in four stages:

- Stage 1: Establishing a Project Steering Group of key stakeholders to oversee the project, and provide approval to progress at key stages.
- Stage 2: Conducting semi-structured (work analysis) interviews to identify potential sources of problems relating to work and working conditions for older women police officers.
- Stage 3: Designing and distributing a tailor-made questionnaire, based on information gathered during the interview stage, to explore problems specific to older women police officers, and their own recommendations for improvements.
- Stage 4: Analysis of data, reporting results at two BAWP conferences, receiving feedback and further questions, and producing Final Report and recommendations.

2.2 The Steering Group

The Steering Group (comprised of employee representatives as well as members of BAWP) advised the researchers on marketing the project appropriately, the selection of samples for interview and survey and on further research questions. Their representatives either met with the researchers at key stages of the project or were consulted via e-mail, and provided comment on and approved the final version of the questionnaire and Draft Final Report.

¹ The study's methodology and procedures were approved by the Institute's Ethical Committee, within the framework of the professional and scientific Codes of Practice of the British Psychological Society.

2.3 Interviews

With the approval of the Project Steering Group, five forces were approached to take part in the interview stage of the study. They represented rural and urban constabularies of different sizes from the Midlands, London, the South and the East of England. Officers from these forces had already expressed an interest in participating to the Research Team when the project was first announced at a publicity event at a BAWP conference. The HR functions of these five forces were approached by letter or email to request permission to interview their officers. Initial contact detailed the nature and importance of the study and the procedures involved. It guaranteed the anonymity of those participating (both forces and individual officers) and emphasised that participation was entirely voluntary. Four of the five forces responded, identifying a point of contact that would be responsible for promoting the research and arranging interviews with interested officers. For three forces, interviews were conducted face-to-face at individual stations or at Police Federation Headquarters as convenient. The remaining force requested that their officers participate by telephone. A total of 22 officers were interviewed from these four forces. Another two officers from two further forces contacted the Research Team to volunteer their participation, following publicity of the study in an internal police publication. Both these officers were interviewed by telephone. Thus, a total of 24 interviews were conducted.

Each participant was provided with a summary sheet detailing the nature of the study. It outlined that the purpose of the interviews was to identify sources of difficulties and problems (potential work-related hazards) for women police officers aged 40+, particularly with regard to ageing and the experience of working during the menopause. At the beginning of each interview session this information was reiterated and the major questions outlined. Participants were assured of the anonymity and confidentiality of their responses. They were notified of their right to withdraw from the interview at any time (although none did). Participants were also asked to provide various biographical and occupational details. Each semi-structured interview, lasting between 30-45 minutes, consisted of a series of standard questions that covered, where appropriate:

- Participant's knowledge of, and attitude towards, the menopause specifically and ageing more generally
- The nature and severity of the participant's menopausal symptoms (if any)
- The impact of work and working conditions on the participant's experience of the menopause
- The impact of menopausal symptoms, and symptoms more generally related to ageing, on the participant's performance at work
- Employers' and colleagues' knowledge of the participant's menopausal symptoms, and symptoms more generally related to ageing (and willingness of the participant to disclose such information to them), and the impact of that knowledge on their relationship with the participant
- The perceived impact of working shifts on the experience of ageing and the menopause
- Participant's own strategies for coping with the experience of ageing and the menopause at work
- Adjustments to policy or practice that could make working life easier for women police officers aged 40+, particularly for those working during the menopause

Due to the sensitivity of the topic, the unpredictable nature of police work, and the locations at which many interviews were conducted, it was decided not to tape record the interviews. The interviewer made comprehensive notes of key points raised by each participant; these were later transcribed and analysed. Interviews were analysed using an explicit, structured method of qualitative data analysis (Ritchie & Spencer, 1994). This method, entitled 'FRAMEWORK', employs a number of distinct but interconnected stages in a systematic process. The five key stages are: familiarisation; identifying a thematic framework; indexing; charting; mapping and interpretation. The analysis focused on the identification of main issues and themes that characterised each individual participant's input and which were common across participants.

Once initial analysis of the transcripts was completed by the interviewer, the initial framework resulting from this qualitative analysis was considered and audited by the principal investigators. Areas of disagreement were discussed and the scheme amended where necessary.

Preliminary findings from the interviews suggested that:

- Women police officers feel that menopause is not taken seriously as an occupational health issue
- Experience of the menopause at work can present challenges to women's confidence and psychological well-being
- Women can encounter or are wary of ridicule and ignorance in the workplace with regard to menopausal symptoms and felt that it did not help them in their struggle for equality
- Many of the issues facing these women were psychosocial (e.g. support and understanding) rather than characteristics of the physical work environment or the job itself.

Using these findings, comments from the Project Steering Group, feedback from delegates at BAWP conference, and information from the review of the scientific literature, a bespoke questionnaire was designed to tap specifically into issues about work, ageing, health and the menopause among British women police officers.

2.4 Questionnaire Survey

With the guidance of the Project Steering Group, seven forces were invited to participate in the questionnaire survey, representing officers from each region of England in both rural and urban constabularies of different sizes. The four that took part in the interview stage were approached to request their continued participation in the study. A further three forces were selected from the North West, North East, and South West of England, to ensure that every region of the country was adequately represented. Each force identified a point of contact to liaise with the Research Team, publicise the research, and arrange the distribution of questionnaires to all women officers aged 40+ in their respective forces.

A total of 2,242 questionnaires were distributed across the seven forces either via an internal mailing system or an existing email distribution list as requested. All completed questionnaires were returned directly to the research team. A cover sheet from the research team detailed the nature and importance of the study and emphasised anonymity, confidentiality and the voluntary nature of the exercise. Each force was encouraged to include their own cover letter with each questionnaire to highlight their support for the study. In addition, each force was encouraged to use their internal publications or communications to publicise the research. Reminders to complete the questionnaire were issued to participants two weeks after initial distribution.

A total of 943 completed questionnaires were returned. Two were excluded from further analysis because the participants indicated that they were under the age of 40. This gave a final response rate of 42%. This is higher than that reported in most survey-based research, and considerably higher than the 25-30% found in most police force surveys (Brodeur, 1998).

The average age of respondents was 45 years. Length of service ranged from 6 months to 35 years (average 21 years). The majority of the sample (622, 66%) was at the rank of constable. The highest reported rank was a member of ACPO. Nearly half of the sample (437, 47%) was educated to GCSE level or equivalent. Almost a quarter (202, 21%) had a degree or higher degree. The majority of the sample (894, 96%) was white.

Work, Ageing and the Working Environment

The items in the first part of the questionnaire included coverage of:

- Physical and psychosocial issues associated with the experience of getting older in the Police Service, including possible adjustments to work and working conditions

- Disclosure of menopausal symptoms (perceived or actual) to line managers and colleagues, and reasons for this decision
- Strategies for coping with general problems at work and problems specific to the menopause, including preferred sources of support
- Specific menopausal symptoms and their individual effect on work performance
- Physical and psychosocial aspects of work and their effects on the experience of menopausal symptoms
- Physical and psychosocial adjustments that could make working life easier during the menopause

As well as being asked to complete a 'menopausal' symptom checklist (see below) participants were asked to self-select their menopausal status from the following three options: (i) pre-menopausal (ii) currently experiencing the menopause or (iii) post-menopausal. Only those in the latter two groups were invited to complete the sections of the questionnaire relating to the menopause and to indicate whether they were taking (or had taken) hormone replacement therapy (HRT) or whether they had undergone a hysterectomy (partial or complete) prior to the onset of menopause. This information was collected so that these women could, if necessary, be treated separately for analysis rather than excluded from the research (Birkhäuser, Dennerstein, Sherman, & Santoro, 2004). Subsequent exploratory analyses revealed no distinguishing features of women from any of the groups who had taken HRT. However, participants who had undergone a complete hysterectomy (so-called 'induced menopause') were categorised separately; subsequent analyses revealed that their experience of 'menopausal' symptoms was significantly different to that reported in the other groups.

The questionnaire also sought a variety of biographical and occupational details and included established measures of (i) general well-being and (ii) symptoms relating to the menopause. These are described below.

General Well-Being

The general well-being of participants was assessed using the short version of the General Well-Being Questionnaire (GWBQ) (Cox et al, 1983; Cox & Griffiths, 1995). The GWBQ was developed at the University of Nottingham during the 1980s and been used extensively in a wide variety of occupational groups, in both health- and work-related research. It is a symptom-based instrument that assesses two aspects of general malaise or poor well-being: feelings of exhaustion (or being worn-out) and feelings of anxiety and tension. This information is used to determine which of the various possible problems at work is associated with the health of those exposed to them or the healthiness of their organisation (Cox, Griffiths, & Randall, 2003).

The short version of the questionnaire, used in this study, presents the exhaustion ('worn out') scale only. The exhaustion scale measures three aspects of poor well-being: fatigue, mental confusion and emotional fragility (irritability). This scale consists of 12 questions about the frequency with which particular symptoms of malaise are experienced during the six-month window leading up to questionnaire completion.

Menopausal Symptoms

The wide range of physical and emotional symptoms or sensations associated with the menopause was assessed in the current study with use of the Women's Health Questionnaire (WHQ) (Hunter *et al.*, 1986; Hunter, 1990; Hunter, 1992). The WHQ is a widely used reliable and valid measure of women's perceptions of emotional and physical health (Hunter, 2000). It consists of 36 items exploring both physical and psychological symptoms (eg. mood, concentration, anxiety, depression, sexual behaviour, menstrual problems, etc). It asks respondents to assess their current level of symptomatology.

The WHQ was designed specifically to study possible changes in health and well-being during the menopausal transition. Any measure of health and well-being for this age range needs to provide measures of various symptoms, so that their effects can be separately assessed. The benefits of such a breakdown of symptoms are that the WHQ may enable detailed descriptions and more accurate explanations of emotional and physical complaints experienced by mid-aged women (Hunter, 1992).

3: RESULTS

This section provides coverage of the results of the questionnaire survey. It describes the nature of the sample and their menopausal status, how working through the menopause might present a problem for women police officers, how they cope with it, whether or not they feel comfortable discussing these issues with their managers and colleagues, and what they feel could be improved by way of work adjustments.

Analyses presented in this section are conducted with different numbers of participants, according to their menopausal status as appropriate. The majority of results presented in this report refer to those 249 women who appeared to be going through the menopausal transition (ie. as defined by their reporting of menopausal symptoms) at the time of completing the survey. The postmenopausal group also provided useful, albeit retrospective, information on their experiences of ageing, health and the menopause. The majority of respondents (622, 66%) reported themselves to be premenopausal.

Those women who were experiencing the menopausal transition (described in tables below as 'early' and 'late' menopausal transition – see section below for an explanation of 'early' and 'late')) and post-menopausal women, provided information on how their symptoms affected them at work, on how they were treated by their colleagues and line managers, and on how the experience of working through the menopause might be improved for them and for future generations of women police officers. Those women who reported having taken HRT were included in the late menopausal group. The remaining 4% were categorised as 'induced menopause' as they had undergone a total hysterectomy. Their experience of the menopause was therefore atypical. About half of the sample worked shifts.

3.1 Description of Sample

Table 1 overleaf describes the nature of the responding sample of 941 women police officers in terms of their age, rank, length of service, caring responsibilities outside work and education. The majority of the sample was at the rank of Constable (67%), with an average age of 45 and an average length of service of 21 years. The majority had caring responsibilities at home (63%) and on average worked about 44 hours per week. Table 1 breaks down these data by menopausal status, revealing no major differences between the groups other than, as might be expected, chronological age (with the pre-menopausal group being the younger officers, and post-menopausal being older).

A comparison for women's own report of menopausal status proved interesting. Some of those women who categorised themselves as 'pre-menopausal' (and were not therefore invited to complete the menopausal symptoms questionnaire) did go on to complete the menopausal symptoms questionnaire, and were clearly reporting significant symptoms of early menopausal transition. For the purposes of this report these women were therefore deemed to be in early menopausal transition and were referred to as the 'early menopausal' group in the report. Women who reported themselves as 'menopausal' (i.e. 'currently experiencing the menopause') did seem to be experiencing menopausal symptoms, but at significantly higher levels. These women were deemed to be in late menopausal transition and were referred to as the 'late menopausal' group in the report.

	Total Group	Pre-menopausal	Early Menopausal	Late Menopausal	Post-menopausal	Induced menopause
Number of participants	941	622	114	135	33	37
Average age	45 yrs	43 yrs	45 yrs	48 yrs	51 yrs	47 yrs
Majority rank	Constable (66.7%)	Constable (66%)	Constable (67%)	Constable (70%)	Constable (58%)	Constable (81%)
Highest rank	ACPO	Ch. Supt.	Supt.	ACPO	Ch. Supt.	Ch. Supt.
Average length of service	21 yrs	20yrs	22 yrs	21 yrs	21 yrs	22 yrs
Percentage with caring responsibilities outside of work	63%	64%	69%	62%	52%	56%
Highest level of qualification	GCSE or equiv. (47%)	GCSE or equiv. (45%)	GCSE or equiv. (51%)	GCSE or equiv. (53%)	GCSE or equiv. (34%)	GCSE or equiv. (51%)

Table 1: Description of sample by menopausal status

3.2 The Menopause and Work

Three measures were used to provide information on the experience of menopause and work: (i) the menopausal symptoms scales (ii) a scale assessing the effect of symptoms of the menopause on the capacity to work and (iii) a scale assessing the effect of aspects of work and the working environment on menopausal symptoms. Finally, (iv) women were asked to make suggestions regarding possible changes to work and the working environment that might facilitate their menopausal transition. The results from these four sections of the questionnaire are presented below.

(i) Menopausal symptoms

The results in Table 1 demonstrated, as might be expected, that those women in early menopausal transition demonstrated significantly fewer or less severe symptoms than women in the later menopausal stages of menopausal transition.

Menopausal Group	Depressed Mood	Somatic Symptoms	Memory and Concentration	Vasomotor Symptoms	Sleep Problems
Early Menopausal	0.31 (N=88)	0.46 (N=91)	0.54 (N=93)	0.42 (N=92)	0.49 (N=93)
Late Menopausal	0.38 (N=133)	0.58 (N=130)	0.69 (N=134)	0.83 (N=135)	0.62 (N=135)

Table 2: Average Scores of the Various Menopausal Symptom Scales of the WHO

(ii) Reported effect of symptoms of the menopause on capacity to work

There was a significant difference between the three groups in terms of reporting of the perceived effect of menopausal symptoms on capacity to function at work ($p=0.002$). As might be expected, the late menopausal group reported that symptoms of the menopause had a greater effect on capacity to work than the early menopausal or the post-menopausal group. However, it is important to note that the post-menopausal group was answering these questions retrospectively. The less marked effect of menopausal symptoms on capacity to work reported could be due to respondents' diminishing memory. In other words, their answers may not accurately reflect the actual impact of the symptoms on their work while they were undergoing the menopause.

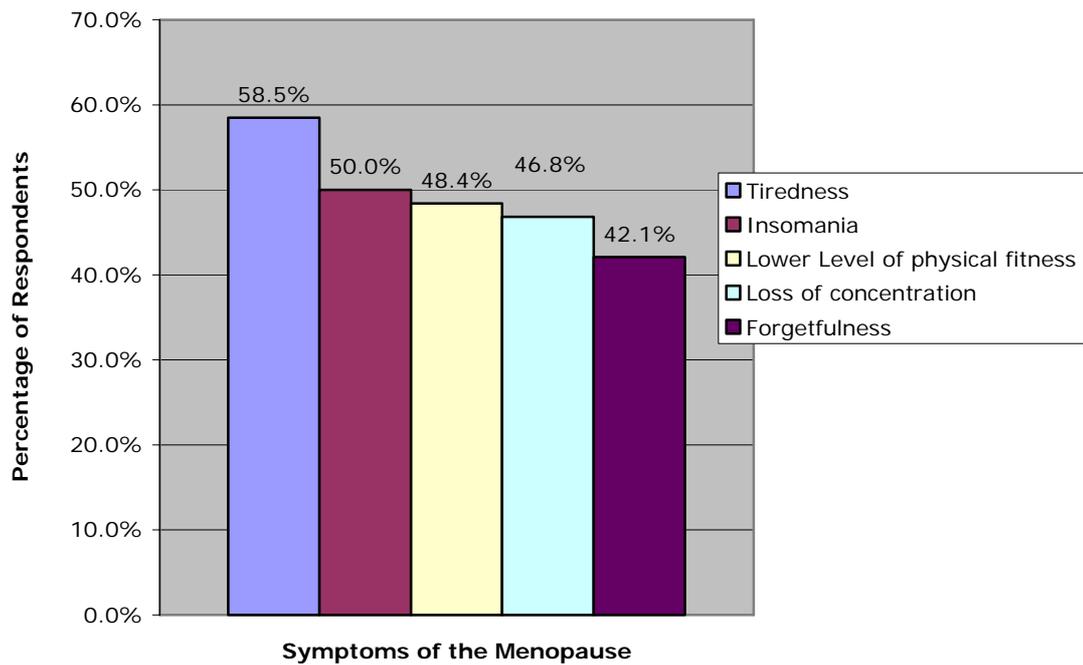
Sample	Number of respondents	Average score
Early Menopausal	78	27.3
Late Menopausal	129	31.2
Post-menopausal	32	27.1

Table 3: Average effect of symptoms of the menopause on capacity to function at work

The following are the aggregated results of the three menopausal groups (early menopausal, late menopausal and post-menopausal) unless otherwise stated. Detailed results of each subgroup can be found in Appendix II.

Figure 1 below presents the percentage of those who agreed or strongly agreed that particular symptoms of the menopause (as listed by women at the interview stage) affected their capacity to function at work. The main factors that emerged (as rated by over half those women who had experienced or were experiencing the menopausal transition) were tiredness (59%) and insomnia (50%). Factors that were reported by just under half of the sample included: having a lower level of physical fitness (48%), loss of concentration (47) and forgetfulness (42%). Results of each subgroup can be found in Appendix II, Table 1.

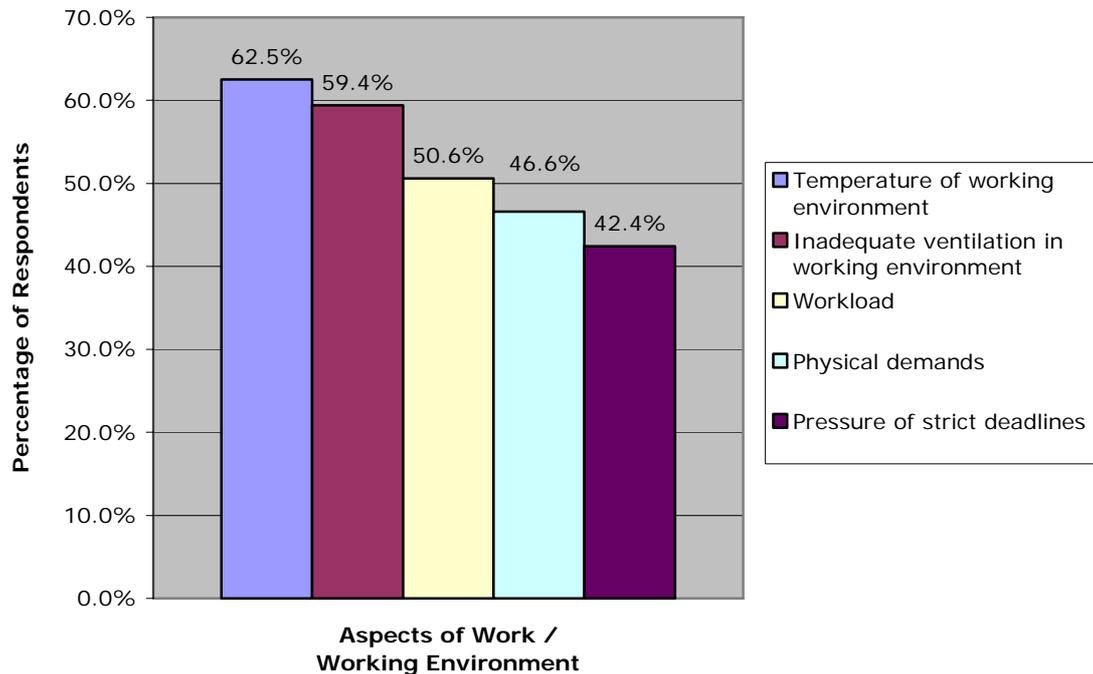
Figure 1 : Effect of Symptoms of the Menopause on Capacity to Work



(iii) Reported effects of work on the symptoms of the menopause

Respondents were asked to indicate how much they felt that various aspects of work adversely affected their capacity to function at work. Figure 2, below, presents the percentage of those who agreed that particular aspects of work or the working environment (as mentioned by women at the interview stage) were having or had an effect on their menopausal symptoms. The main factors that emerged as being problematic (as rated by over half of the sample) were temperature of the working environment (63%), inadequate ventilation (59%) and workload (51%). Factors that were reported by just under half of the sample included the physical demands of the job (47%) and the pressure of strict deadlines (42%). Results of each subgroup can be found in Appendix II, Table 2.

Figure 2 : Effects of Work on the Symptoms of the Menopause

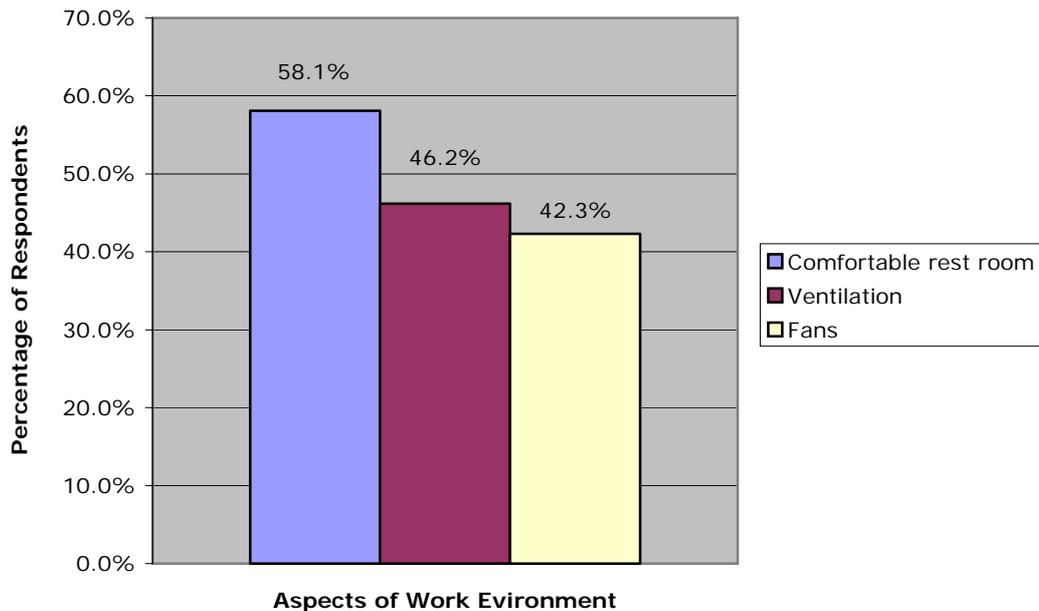


Post-menopausal women were asked whether they perceived any changes in their line managers' attitude towards their post-menopause. None did so. Very few (3 %) reported that they had experienced changes in their colleagues' attitudes.

(iv) Suggested work adjustments during the menopause

Respondents were asked to indicate whether they thought the aspects of work environment listed in the questionnaire were problematic and were making or had made their working life difficult during the menopause. The options given were 'access to cold drinking water', 'toilet facilities', 'comfortable rest room', 'fans', 'adequate ventilation', 'comfortable chair', 'shower facilities' and 'others, please specify'. The three major problematic aspects of work environment were: not having a comfortable rest room (58%), poor ventilation (46%) and lack of fans (42%). Other problematic aspects of work environment, as listed by about a third or less of the women, and results of each subgroup can be found in Appendix II, Table 3.

Figure 3 : Problematic Aspects of Work Environment in the Police Force



Respondents were also asked to write down the things that they would most like to see happening (in terms of policy or practice) to support women working through the menopause in the Police Service. The most common suggestions fell into three categories:

Flexibility of Working Hours and Role

- Flexibility of working hours (e.g. ability to make necessary adjustment to work hours and demands - a flexible approach to night shifts and the working week where appropriate, a shorter working week, the option of working from home)
- Flexibility of role (e.g. option of transfer to less physically demanding roles, particularly on a 'bad' day)

Raising Awareness and Understanding among Colleagues and Managers

- Education and awareness training of police officers and line managers, particularly male officers and managers, about ageing in general and the symptoms and effects of menopause, perhaps via through seminars on equality/diversity training and management training so as to change negative attitudes (perceived to arise from a lack of understanding)

Improved Formal and Informal Support

- Delegation of an officer in each division to offer informal help and advice (e.g. about where to seek formal help, medical consultations or counselling)
- Existence of a women's support group (or women's support contact number) for experience sharing and emotional support (perhaps also a women's network group that feeds issues through to senior management)
- Direct, confidential and easier access to Occupational Health (i.e. without having to go through the line manager so as to ensure confidentiality)²
- Medical check-ups and professional advice on how to ease the menopausal Symptoms, offered by Occupational Health or other medical bodies

² It may be that different forces have different provisions in this respect

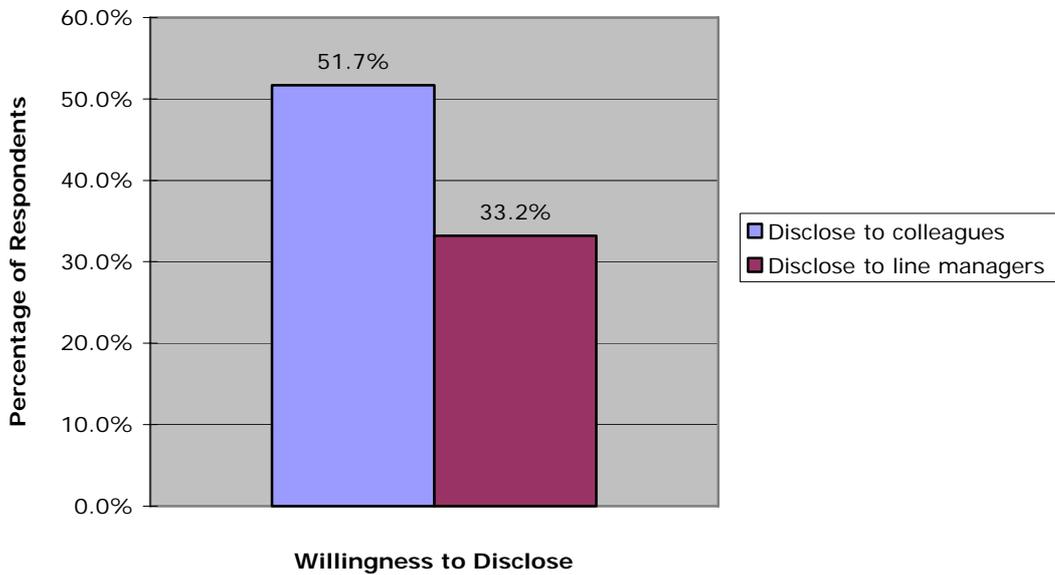
3.3 Disclosure

It was clear at the interview stage that women police officers varied in their willingness to disclose or discuss their menopause-related health problems with their line managers and colleagues. The questionnaire therefore asked whether women would (or did) disclose their difficulties to their managers and colleagues, and the reasons for disclosing/not disclosing.

(i) Disclosure to line manager and colleagues

The figure below presents the percentage of those who would/did disclose to their line manager. Whereas over half the sample (52%) would disclose their menopausal status to their colleagues, less than half of the sample (33%) would disclose their menopausal status to their line manager. Results of each subgroup can be found in Appendix II, Table 4.

Figure 4 : Percentage of Respondents who would / did Disclose their Menopausal Status

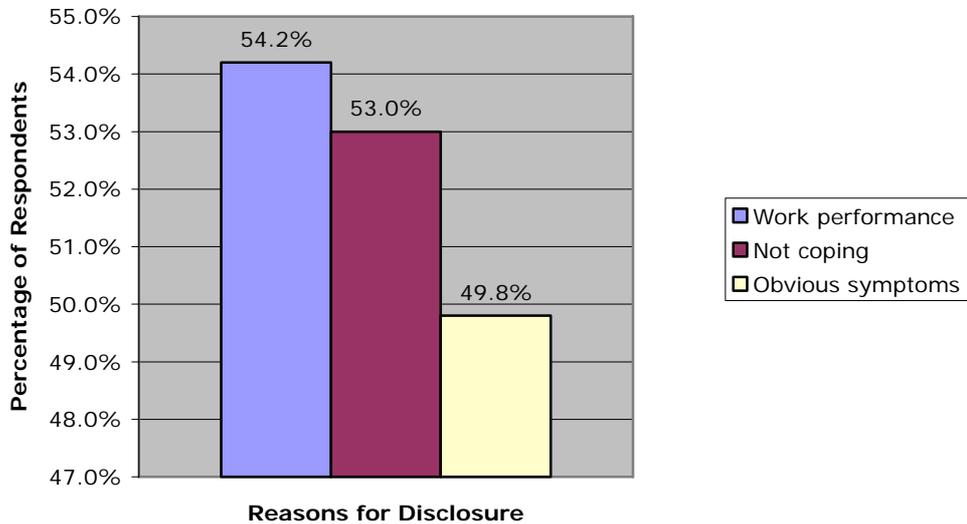


(ii) Reasons for disclosure to line manager

During the interview stage, various reasons emerged as to why women police officers would disclose their menopausal status to their line manager. These were listed in the questionnaire and the entire sample was asked to note whether they agreed or disagreed with various statements that reflected those reasons.

The main reasons that emerged (i.e. those which were rated by at least half the sample) were due to the effect of menopause on performance at work (54%), to not being able to cope with the symptoms of menopause (53%) and obvious symptoms (50%). Results of each subgroup can be found in Appendix II, Table 5.

Figure 5 : Reasons for Disclosure of Menopausal Status to Line Managers

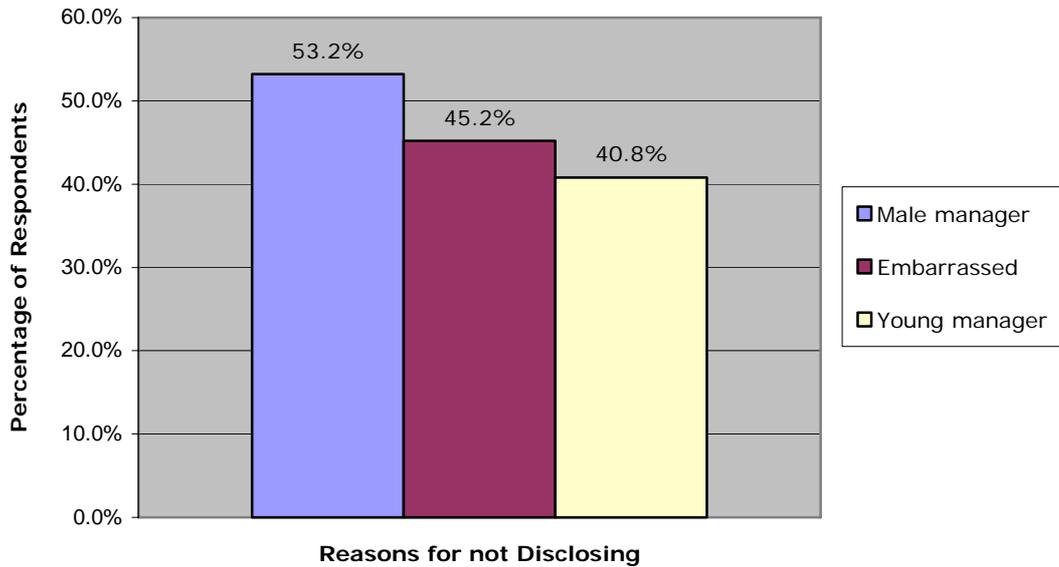


(iii) Reasons for not disclosing to line manager

During the interview stage, various reasons emerged as to why women police officers would *not* disclose their menopausal status to their line manager. Again, these were listed in the questionnaire and the entire sample was asked to note whether they agreed or disagreed with statements which reflected those reasons. The statements were: As a woman, I constantly have to prove myself to him/her, He/she would ignore the menopause as it only affects women, He/she would see the menopause as a sign of weakness, The menopause would be a taboo subject with him/her, He/she would not be interested or supportive, I would be too embarrassed, I worry that he/she would make jokes at my expense, He/she is younger than me (omit if your current line manager is older than you), He is a man (omit if your current line manager is a woman), I would rather discuss my symptoms with a support group (e.g. Female Support Network, Association of Senior Women Officers), I worry that it would negatively affect my opportunities for promotion.

The results of this section of the questionnaire are presented below. The main reason women gave for *not* disclosing their menopausal status to their line manager (agreed by 53% of the sample) was having a male manager. Embarrassment was also reported as a reason by almost half (45%) of the sample, and having a younger manager by 41% of the sample. Other reasons agreed by about a third or less of the sample and results of each subgroup can be found in Appendix II, Table 6.

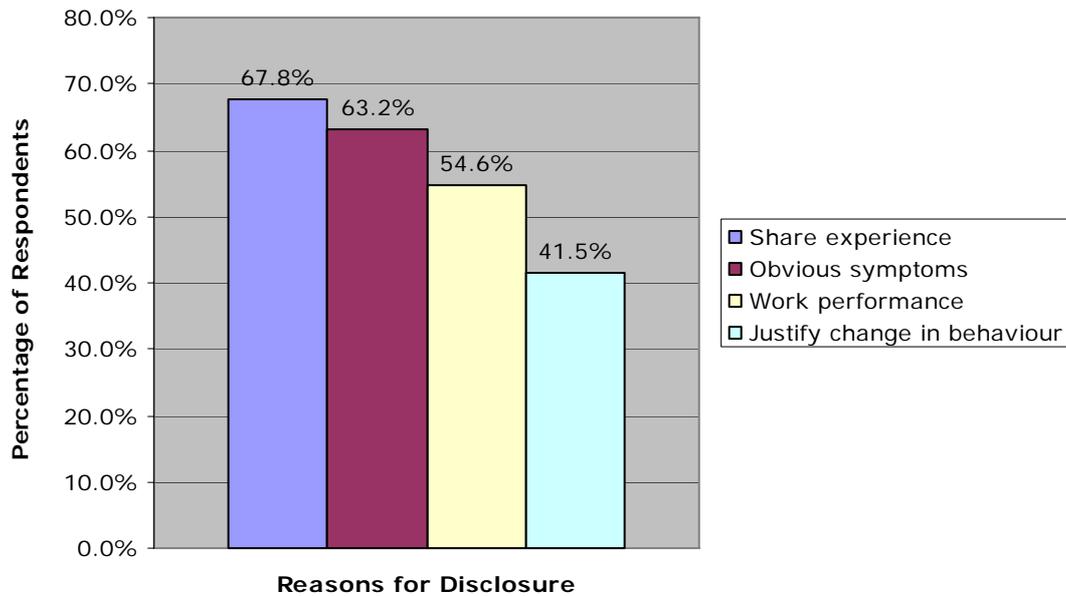
Figure 6 : Reasons for not Disclosing Menopausal Status to Line Manager



(iv) Reasons for disclosure to colleagues

When examining the reasons why women would disclose their menopausal status to their colleagues, the main reasons that women agreed they would do so (i.e. those which were rated by at least half the sample) were due to sharing experiences about the menopause with other women who were going through menopause or who had gone through the menopause (68%), obvious symptoms (63%), feeling that the menopause was affecting their performance at work (55%) and justifying the change in behaviour (42%). Results of each subgroup can be found in Appendix II, Table 7.

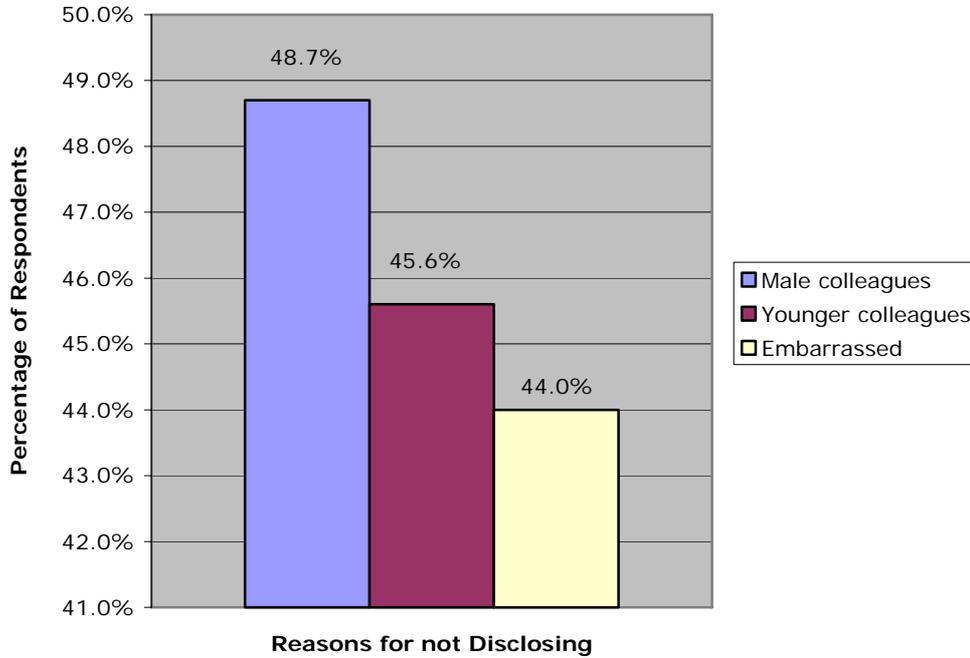
Figure 7 : Reasons for Disclosure of Menopausal Status to Colleagues



(v) Reasons for not disclosing to colleagues

When examining the reasons why women would not disclose their menopausal status to their colleagues, the main reasons that emerged were having male colleagues (49%), younger colleagues (46%) or embarrassment (44%). Other reasons, as listed by about a third of women, and results of each subgroup can be found in Appendix II, Table 8.

Figure 8 : Reasons for not Disclosing to Colleagues

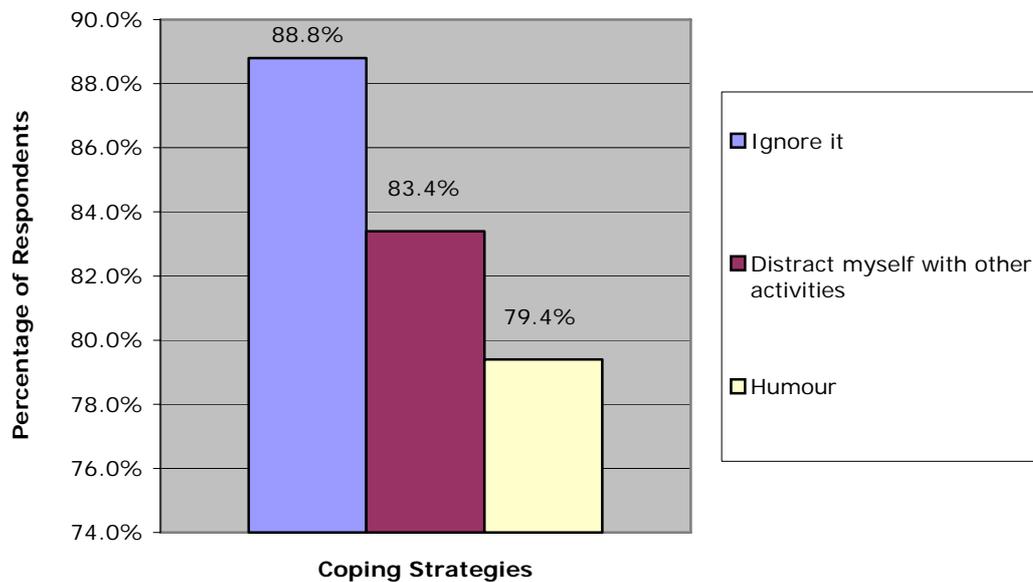


3.4 Coping with menopause at work

(i) Responses to coping with menopausal symptoms at work

Women were asked if they were having a particularly difficult day at work because of their menopausal symptoms, how did they feel about it and how did they cope. At the interview stage, the strategies mentioned were: Ignore it, Talk to someone at work, Telephone a family member and/or friend, Get upset, Get irritable/angry, Humour, Exercise, Distract myself with other activities. The majority of the sample reported that they would ignore their symptoms (89%), distract themselves with other activities (83%) and use humour to cope (79%). Results of each subgroup can be found in Appendix II, Table 9.

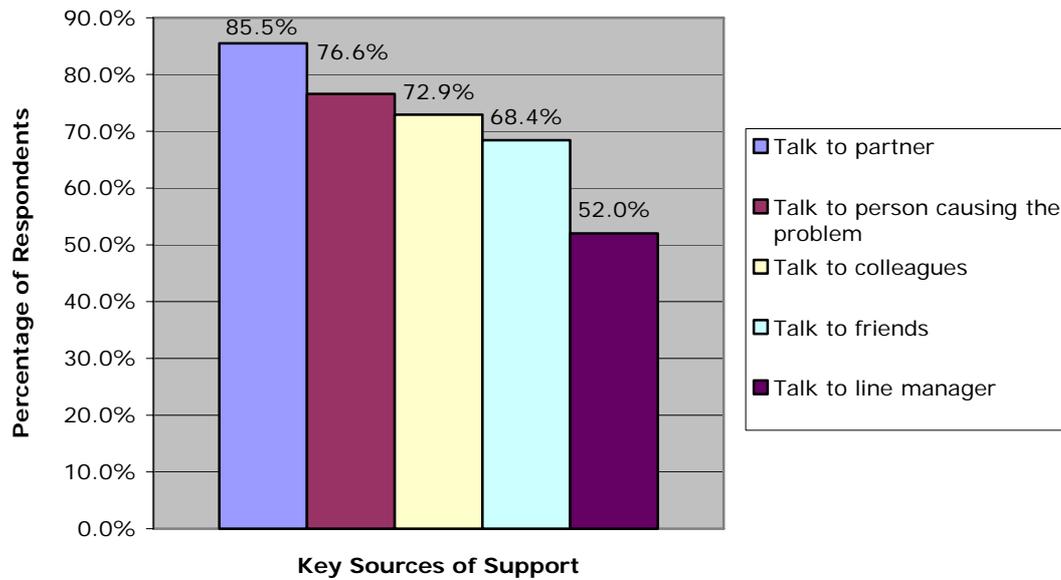
Figure 9 : Coping with Menopausal Symptoms at Work



(ii) Sources of support for coping with problems at work

Respondents were also asked whom they would talk about problems (in general) that they encountered at work. The majority of the sample reported that they would talk to their partner (86%), the person causing the problem (77%), their colleagues (73%) or their friends (68%). Just over half of the sample reported that they would talk to their line manager (52%). Results of each subgroup can be found in Appendix II, Table 10.

Figure 10 : Key Sources of Support for Problems Encountered at Work

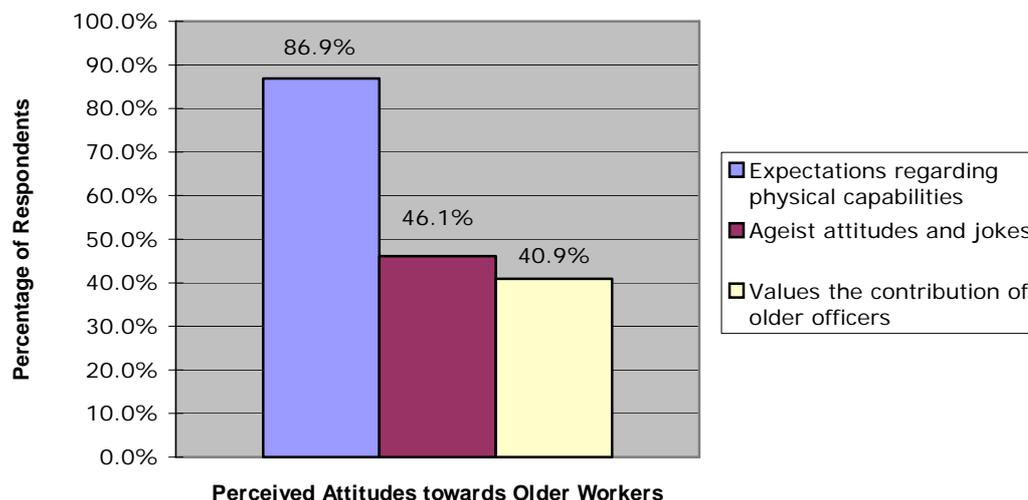


3.5 Ageing at work

(i) Perceived attitudes to older workers in the Police Service

The women police officers were asked about whether they felt the Police Service 'valued' older workers in general. Some comments had been made at interview stage that older workers were not appreciated, or that their particular needs and abilities were not taken into account. These were presented as statements in the questionnaire and respondents asked whether they agreed or disagreed with them. Three of these are noteworthy: "The Police Service values the contribution of older officers", "Ageist attitudes and jokes are part of police culture" and "The Police Service has the same expectations of the physical capabilities of younger and older officers". The figure below shows the responses for the total group. Less than half of the sample (41%) agreed that the Police Service valued the contribution of older officers. Just under half of the sample (46%) agreed that ageist attitudes and jokes were part of the police culture. The majority of the sample (87%) agreed that there were not different expectations regarding the physical capabilities of older workers in the Police Service. Results of each subgroup can be found in Appendix II, Table 11.

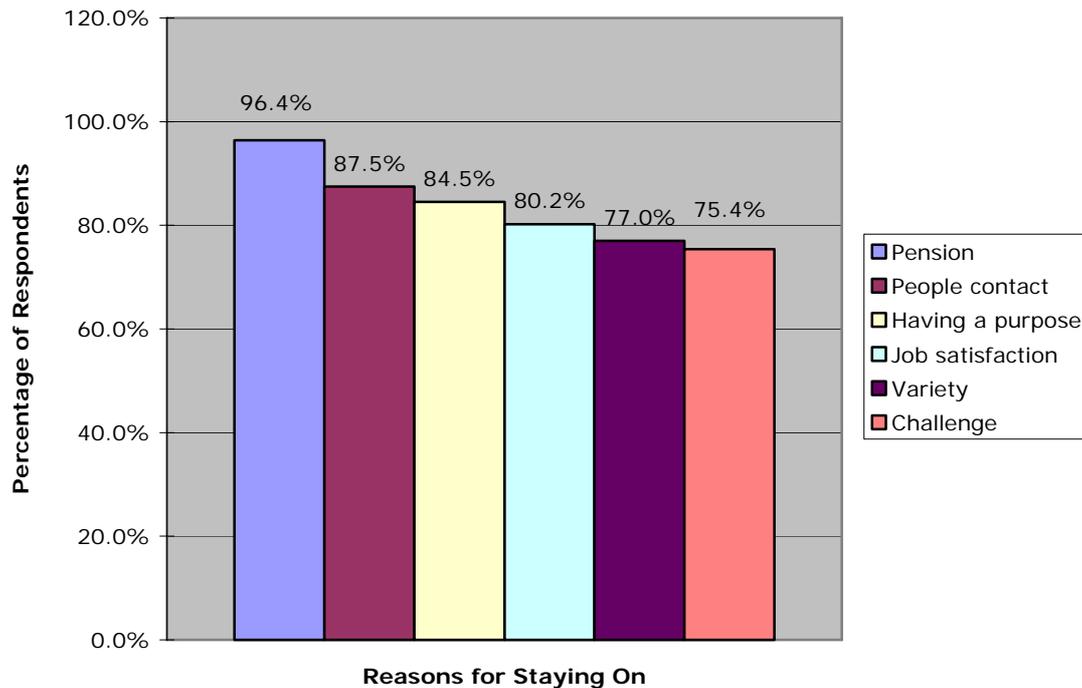
Figure 11 : Perceived Attitudes towards Older Workers in the Police Service



(ii) Staying on

Women were asked whether they agreed that certain aspects of work led to them remaining in the Police Service as they got older. This emerged as a topic during the interview stage: despite the various problems encountered at work, many women listed that there were good reasons for staying on. The majority listed as key factors, with the most important first: pension (96%), the people contact involved in the job (88%), the feeling of having a purpose (85%), job satisfaction (80%), the variety of the job (77%) and the challenge (75%). Results of each subgroup can be found in Appendix II, Table 12.

Figure 12: Reasons for Remaining in the Police Service



(iii) Suggested work adjustments for older workers

Respondents (including pre-menopausal group) were asked for their suggestions regarding adjustments that they felt would make their working life easier as they got older. The most common answers fell into three categories:

Flexibility of Working Hours and Role

- Flexitime, for example, late start times and early finish times, compressed hours and shorter night shifts
- Part-time working (already available, but there were concerns over the effects on pensions)
- No night shifts over a certain age (e.g. 45 years old)
- Be able to decide one's own work pattern (e.g. whether to work on night shifts or not) and role (e.g. whether to move into office-based work or continue to stay in front-line/PSU work) which, according to many respondents, should be determined by individuals' competence and fitness at the time, rather than by age

Workplace Health Promotion

- Regular health checks should be provided to all officers irrespective of age
- Sports facilities (e.g. gyms) should be made available to officers (irrespective of age) other than those based at HQ
- Fitness and exercise programme for all officers irrespective of age
- Officers should have increased access to fitness facilities or exercise programmes

- Greater acknowledgement by managers of health-related changes that affect older workers, and more support and acceptance in the workplace
- Easier access to Occupation Health

Changes to the Physical Work Environment

- Improve the condition of women only facilities (e.g. women's toilets, availability of sanitary towels in toilets, provision of sanitary bin in each toilet cubicle, more female toilets, female only showers and restrooms)
- More comfortable and suitable uniform for the type of work (e.g. light sweaters for winter wear for office workers, smart casual rather than police uniform for office based workers)
- Reduce stress to the body caused by the weight of equipment which officers carry around while on foot (e.g. by taking regular breaks over 10-hour shifts, or reducing the amount of equipment carried)
- Better general facilities (e.g. well designed chair and computer screen of higher quality, access to cold drinking water, supportive car seats, better desks)

Generally speaking, respondents expressed a view that what would be most helpful would be more flexible policies and a more flexible approach. They did not particularly wish for a blanket list of exclusive adjustments for older workers, but rather that the organisation and its managers recognised their individual needs, competencies, skills and other characteristics. They preferred to maintain some autonomy over their working hours and roles. Many of their suggestions relate to problems (e.g. with computer equipment) which might affect officers of any age, and in some cases, gender.

3.6 General well-being of sample

The general well-being of the sample was measured using the 'exhaustion' (or feeling worn-out) scales of the General Well-being Questionnaire (GWBQ). The 'exhaustion' scale measures three aspects of poor well-being: fatigue, mental confusion and emotional fragility (irritability). In terms of general well-being, the late menopausal group reported significantly higher levels of exhaustion than the pre-menopausal, the early menopausal or the post-menopausal group ($p < 0.001$). Levels of exhaustion in the pre-menopausal, the early menopausal and the post-menopausal group were all roughly the same.

Comparison with Female Employees in Other Organisations

The GWBQ exhaustion data from the pre-menopausal, early menopausal, late menopausal and post-menopausal groups are presented in Table 4, together with normative data from a representative sample of the female British working population. The overall level of exhaustion reported by the pre-menopausal, early menopausal and post-menopausal groups could be judged to be roughly similar to that of the female general working population. The average level of exhaustion reported by the late menopausal group could be judged to be on the high side of the normal range. This, however, could be confounded by the overlap in symptoms of the menopause and the ratings of exhaustion.

Sample	Number of respondents	Average score
Pre-menopausal	596	20.1
Early Menopausal	108	22.1
Late Menopausal	131	25.7
Post-menopausal	31	20.5
General Working Population (female)	1087	19.7

Table 4: General well-being

Separate Analyses were done to look at respondents' tolerance to shift work. There were no significant differences between the four groups. All respondents indicated that shift working had a significant impact on their general well-being.

4: SUMMARY & RECOMMENDATIONS

The menopause is a major life event that affects virtually every working women of the appropriate age. Little research has been conducted on how they cope in general with this transition at work, and even less on the experience of particular occupational groups. Women police officers represent a particularly interesting group in terms of the nature of their job requirements, and the fact that police work has traditionally been a male-dominated occupation. Recommendations about how to improve the experience of women police officers as they get older, and as they go through the menopause, follow from the results of this study, many suggested by the survey's respondents. Suggested changes fall into three major categories, concerning: (i) characteristics of the physical working environment, (ii) perceived knowledge and attitudes of managers and colleagues, and (iii) demands of the job and flexibility in working arrangements. The first two may be somewhat more straightforward to implement than the latter. Clearly, it is outside the researcher's remit or expertise to comment authoritatively on recommendations, but they are offered as a starting point for internal discussion.

This study represents the results of a survey of 941 women police officers aged 40+. The questions in the survey were designed after preliminary interviews with 24 women police officers, and with reference to the published literature on the menopause. Respondents ranged in rank from Police Constable to ACPO, with an average length of service of 21 years. The majority of results presented in this report refer to those 249 women who appeared to be going through the menopausal transition (ie. as defined by their reporting of menopausal symptoms) at the time of completing the survey. The postmenopausal group (33 women) also provided useful, albeit retrospective, information on ageing, health and the menopause. It should be noted that retrospective reports are not always as accurate as contemporaneous accounts, as accuracy and salience often fade with time. Nonetheless, the experiences of postmenopausal officers was thought to be well worth including. It should also be noted that women vary greatly in their experience of menopausal symptoms – some 'sail through' with relative ease, whilst others find it very unpleasant and challenging. When asked how they coped at work when their menopausal symptoms were particularly challenging, most women said they tried to ignore it, used humour to cope, or distracted themselves with other activities.

In the survey, officers were asked their views on which aspects of the menopause most affected their capacity to function normally at work. The main factors (as agreed by over half those who were in the early and late stages of menopausal transition, or who had gone through the menopause) were tiredness and insomnia. Factors reported by just under half the sample included perceived lower levels of physical fitness, loss of concentration and forgetfulness.³ The clear majority of women (87%) felt that the Police Service had the same expectations of the physical capabilities of younger and older officers. This may be something that needs to be addressed, given the increasing diversity of the workforce.

Those characteristics of work and the working environment which were thought to affect menopausal symptoms adversely were: temperature of the working environment, inadequate ventilation and workload. The first two may be matters to be addressed in future audits of the work environment and in risk assessments. The latter (workload) may present a particular challenge for women experiencing high levels of tiredness.

Clearly, it would appear that being able to disclose and discuss menopausal symptoms and related problems with managers would afford women the theoretical possibility of sympathetic management. However, two thirds of women who were going through or who had gone through the menopause would not (or did not) disclose their menopausal status to their line managers, and half would not (or did not) disclose to their colleagues. The main reasons women gave for *not* disclosing to their manager were having a male manager, embarrassment, and having a younger manager. The main reasons women gave *for* disclosure were because symptoms became very obvious, they felt the menopause was affecting their performance, or they felt they were not coping with their symptoms well. Some women also reported that they would disclose as a means of justifying some change in their behaviour. The reasons given for disclosure/non disclosure to colleagues were the same, except that women also said that they would/did disclose to colleagues as a means

³ It is possible that some of these latter problems were caused or made worse by the former (tiredness and insomnia).

of sharing experiences with other women who were going through, or who had gone through the menopause. It seems that there is scope for addressing these issues of embarrassment. Women did comment that they felt negative attitudes were largely the result of ignorance and lack of understanding among managers and colleagues. Such matters could be addressed in routine diversity training, under the auspices of age-related health issues (for example, for men, prostate problems; for women, menopause) and the management of chronic health conditions. It is important to inform the entire workforce about age-related issues. Research from the Finnish Institute of Occupational Health has demonstrated that the two major predictors of long, healthy and productive working life are (i) line managers who are knowledgeable about ageing, and (ii) physical exercise in leisure time.

When asked what changes at work would be most helpful to them while going through the menopause, the most popular suggestions chosen from those listed (as drawn up from the results of the initial interviews) were: a comfortable rest room, better ventilation and the provision of fans. These might be explored as part of future audits of the working environment. Women were also offered the opportunity to make additional suggestions as to what might ease their menopausal transition. Their suggestions included: more flexibility in terms of working hours and roles, improved support and information from formal sources (eg. Occupational Health) and informal sources (eg. women's network groups and/or women's support contact number), and (again) raising awareness and understanding among colleagues and managers. Just under half the sample felt that ageist attitudes and jokes were part of the police culture. Less than half the sample (41%) agreed that the Police Service valued the contribution of older officers. Given the advantages of experience and wisdom, especially in occupations such as the Police Service, it would be worth addressing these negative perceptions.

When asked for their reasons for staying in the Police Service as they got older, the majority of women listed as key factors (in order of importance): pension, the people contact involved in the job, having a purpose, job satisfaction, variety and challenge. When asked what changes at work would be most helpful to them as they got older, the most popular suggestions concerned (i) increased flexibility of working hours and roles (eg. flexitime, compressed hours, no night shifts after a certain age, work patterns, choice in move to office-based work or continuation of front-line/PSU role), (ii) workplace health promotion (eg. regular health checks, fitness programmes, greater knowledge by managers of health-related changes that affect older workers, easier access to Occupational Health), and (iii) changes to the physical work environment (eg. better women-only facilities including toilets, sanitary bins, showers and restrooms, more comfortable and suitable uniforms, reductions in the weight of equipment carried while on foot, and better quality of general facilities including chairs, desks, computer screens, access to cold drinking water, more supportive car seats). Many women commented that some of these improvements should be offered to officers across the board, regardless of age. Some of the suggested changes that involve increased flexibility and work role transitions, could be addressed at senior management levels. Some, however, may be addressed at local levels, by sympathetic line management, provided that more women feel comfortable in disclosing these problems to their managers. It seems that much many of the issues raised here might be addressed either directly or indirectly, by raising awareness and by extended management training.

In summary therefore, recommendations concern:

- Raising awareness of ageing and health issues in general and the menopause in particular, among managers and colleagues
- Increasing access to informal and formal sources of support
- Improving aspects of the physical working environment
- Allowing more flexibility in job roles and working arrangements

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APPENDIX I : Instructions to Respondents

The following text was presented on the front of each questionnaire:

The British Association of Women in Policing (BAWP) has commissioned researchers from the Institute of Work, Health & Organisations, as independent experts in occupational health psychology, to explore the experience of ageing and health at work for older women police officers (defined as aged 40 or above), with reference to the experience or anticipation of the menopause. Your views are vital for the success of this project. This questionnaire is based on key issues raised in a series of interviews with older women police officers from a selection of forces across the country. A Final Report and Executive Summary will draw together the findings from the study. It will be delivered to BAWP, the Police Federation, ACPO and to occupational health groups in the Home Office, and will be available on the BAWP website for you to see (<http://www.bawp.org>).

In completing this questionnaire, please be honest and frank. This is an important opportunity to provide information relevant to your job, health and welfare, and for other current and future women police officers. We would like to assure you that we are **entirely independent** and **your completed questionnaire will *only* be read by our research team. No questionnaires will be read by anyone from BAWP or the Police Service. The questionnaires are anonymous. Identifiable personal details have deliberately been omitted.** Any personal comments from the returned questionnaires that are used in academic papers, feedback to BAWP or to the Police Service will be quoted anonymously and anything that might possibly identify you will be removed.

Completion and return are entirely voluntary. By completing this questionnaire, you are giving your consent for this anonymous data to be stored electronically and used solely for research purposes. If completing this questionnaire raises any concerns for you, please do not hesitate to approach your occupational health service.

We know that you are very busy but hope you can find time to complete the questionnaire, which should take approximately 15 minutes. We hope that you will find it interesting and will assist us by returning it as soon as possible. Please return your completed questionnaire FREEPOST to Rhian Griffiths in the envelope provided within 2 weeks.

If you require any further information regarding the nature of this study or have any comments to make, please contact Rhian Griffiths from the research team.

Thank you very much for your time and help.

Yours faithfully,

The Research Group
Institute of Work, Health & Organisations
University of Nottingham

APPENDIX II: Tables

Symptoms	Total Group	Early Menopausal	Late Menopausal	Post-menopausal*
Tiredness (%)	58.5	53.5	61.9	57.6
Insomnia (%)	50.0	40.2	57.5	45.5
Lower level of physical fitness (%)	48.4	43.5	52.2	45.5
Loss of concentration (%)	46.8	41.2	52.2	39.4
Forgetfulness (%)	42.1	35.6	45.5	45.5
Irritability (%)	40.7	39.1	45.1	27.3
Aches and pains (%)	40.1	36.0	43.6	36.4
Hot flushes (%)	35.2	10.5	52.7	30.3
Lack of confidence (%)	33.7	29.4	42.5	39.4
Anxiety (%)	33.1	29.1	36.4	30.3
Depression (%)	32.9	31.0	36.1	25.0
Urinary frequency and urgency (%)	30.8	27.9	35.1	21.2
Difficulty in decision making (%)	30.6	24.1	36.8	21.9

Table 1 : Effect of symptoms of the menopause on capacity to work
** The post-menopausal group were answering these questions retrospectively*

	Total Group	Early Menopausal	Late Menopausal	Post-menopausal*
Temperature of working environment (%)	62.5	53.6	70.1	54.5
Inadequate ventilation in working environment (%)	59.4	47.6	65.7	63.6
Workload (%)	50.6	56.0	49.2	42.4
Physical demands (%)	46.6	48.8	45.5	45.5
Pressure of strict deadlines (%)	42.4	48.8	42.1	27.3
Design of uniforms (%)	40.1	34.2	45.1	35.5
Making difficult decisions (%)	39.8	40.5	42.4	27.3
Working twice as hard as male colleagues to be thought 'half as much of' (%)	38.0	34.9	40.3	36.4
Male dominated environment when experiencing visible symptoms (%)	34.3	27.7	37.9	36.4
Ridicule from colleagues / management (%)	18.0	14.5	19.4	21.2

Table 2 : Effects of work on the symptoms of the menopause
** The post-menopausal group were answering these questions retrospectively*

	Total Group	Early Menopausal	Late Menopausal	Post-menopausal*
Comfortable rest room(%)	58.1	54.5	63.4	48.5
Ventilation (%)	46.2	39.0	48.9	57.6
Fans (%)	42.3	36.0	44.4	53.1
Comfortable chair (%)	37.1	37.3	38.9	29.0
Shower facilities (%)	32.8	29.7	37.1	25.0
Cold drinking water (%)	29.1	22.5	32.3	36.4
Toilet facilities (%)	21.3	18.8	23.3	21.2

Table 3 : Problematic aspects of work environment in the Police Force
**The post-menopausal group were answering these questions retrospectively*

	Total Group	Early Menopausal	Late Menopausal	Post-menopausal*
Disclose to colleagues (%)	51.7	45.5	61.7	53.3
Disclose to line manager (%)	33.2	27.0	40.0	29.0

Table 4 : Percentage of participants who would / did disclose their menopausal status
** The post-menopausal group were answering these questions retrospectively*

	Total Group	Early Menopausal	Late Menopausal	Post-menopausal*
Work performance (%)	54.2	51.0	57.9	50.0
Not coping (%)	53.0	52.0	54.5	50.0
Obvious symptoms (%)	49.8	40.2	59.2	44.4
Justify change in behaviour (%)	32.4	29.0	35.0	33.3

Table 5 : Reasons for disclosure of menopausal status to line manager
**The post-menopausal group were answering these questions retrospectively*

	Total Group	Early Menopausal	Late Menopausal	Post-menopausal*
Male manager (%)	53.2	51.0	57.9	42.9
Embarrassed (%)	45.2	51.9	40.7	40.6
Younger manager (%)	40.8	35.2	44.6	41.4
Support group (%)	37.5	35.2	41.5	30.3
Prove self (%)	34.9	31.7	37.6	34.4
Menopause as a weakness (%)	32.8	26.0	37.6	36.4
Affect promotion (%)	32.6	33.7	33.9	24.2
Menopause as taboo (%)	31.7	24.0	36.8	36.4
Not interested/supportive (%)	28.5	25.0	27.4	43.8
Ignore menopause (%)	27.9	22.1	32.0	30.0
Jokes at my expense (%)	27.8	26.7	27.2	33.3

Table 6 : Reasons for not disclosing menopausal status to line manager
** The post-menopausal group were answering these questions retrospectively*

	Total Group	Early Menopausal	Late Menopausal	Post-menopausal*
Share experiences (%)	67.8	69.5	67.5	63.3
Obvious symptoms (%)	63.2	55.8	69.3	63.3
Work performance (%)	54.6	48.5	60.6	50.0
Justify change in behaviour (%)	41.5	37.9	45.6	36.7

Table 7 : Reasons for disclosure of menopausal status to colleagues
** The post-menopausal group were answering these questions retrospectively*

	Total Group	Early Menopausal	Late Menopausal	Post-menopausal*
Male colleagues (%)	48.7	52.7	46.7	42.9
Younger colleagues (%)	45.6	44.4	46.2	46.7
Embarrassed (%)	44.0	49.5	42.5	32.3
Ignore menopause (%)	37.7	37.5	38.1	36.7
Support group (%)	37.3	40.0	38.1	25.8
Menopause as taboo (%)	37.0	34.3	38.1	41.9
Not interested/supportive (%)	36.8	35.7	39.8	29.0
Jokes at my expense (%)	36.0	41.8	32.7	29.0
Menopause as a weakness (%)	35.8	34.3	38.1	32.3
Prove self (%)	34.0	30.6	38.1	30.0

Table 8 : Reasons for not disclosing menopausal status to colleagues
** The post-menopausal group were answering these questions retrospectively*

	Total Group	Early Menopausal	Late Menopausal	Post-menopausal*
Ignore it (%)	88.8	86.3	93.0	78.10
Distract myself with other activities (%)	83.4	91.3	78.3	84.4
Humour (%)	79.4	79.0	81.5	71.9
Exercise (%)	56.6	60.0	59.2	37.5
Get irritable / angry (%)	54.5	57.5	55.4	43.8
Talk to someone (%)	36.8	36.3	36.2	40.6
Get upset (%)	35.7	40.0	34.9	28.1
Phone family or friends	29.3	31.3	30.0	21.9

Table 9 : Coping with menopausal symptoms at work
**The post-menopausal group were answering these questions retrospectively*

	Total Group	Early Menopausal	Late Menopausal	Post-menopausal
Talk to partner (%)	85.5	86.4	85.6	82.1
Talk to person causing the problem (%)	76.6	75.2	78.6	73.3
Talk to colleagues (%)	72.9	78.4	70.2	64.5
Talk to friends (%)	68.4	64.0	69.0	81.3
Talk to line manager (%)	52.0	52.7	51.5	51.6

Table 10 : Key sources of support for problems encountered at work

	Total Group	Early Menopausal	Late Menopausal	Post-menopausal
Expectations regarding physical capabilities (%)	86.9	87.7	86.7	84.8
Ageist attitudes and jokes (%)	46.1	41.6	51.1	40.6
Values the contribution of older officers (%)	40.9	37.7	40.7	53.1

Table 11 : Perceived attitudes towards older workers in the Police Service

	Total Group	Early Menopausal	Late Menopausal	Post-menopausal
Pension (%)	96.4	97.3	96.2	93.8
People contact (%)	87.5	85.9	89.5	84.4
Having a purpose (%)	84.5	82.1	88.4	77.4
Job satisfaction (%)	80.2	75.5	84.9	75.9
Variety (%)	77.0	70.8	82.0	78.6
Challenge (%)	75.4	68.4	79.6	82.8

Table 12 : Reasons for remaining in the Police Service