VICTORIA POLICE

Bipolar Affective Disorder

Bipolar 1 Disorder, Bipolar II disorder/ Cyclothymia/ Mania/ Hypomania/

Psychiatrist & Psychologist & GP

Investigations and Reports for Consideration

- Relevant medical records or reports including the psychiatric and/or psychological assessment including all tests and treatments as well as reports from GP.
- It can be useful to see a FBE, thyroid study, ECG and blood pressure in a history to help rule out organic cause.
- Rarely organic conditions may present with symptoms of mania or hypomania, e.g. cerebral tumour, hyperthyroidism, pheochromocytoma, steroid induced hypomania or mania etc.

Considerations include (but are not limited to):

- Diagnosis and symptoms
- Duration of condition and recurrence and/or chronicity
- Insight and engagement with treatment
- Any comorbidities
- Social supports
- Collateral history should be obtained from a family member where possible as an individual in case an individual does not remember or be able to describe their manic episode well, this is routine to obtain for BPAD
- Any risk issues including suicidality or risks associated with a manic or hypomanic episode (e.g. excessive spending, promiscuity, gambling, excessive shopping, anger, irritability, psychotic symptoms e.g. grandiosity, poor judgement
- Treatments tried, response to treatment and side effects including psychological therapies and medications such as mood stabilisers e.g. lithium, sodium valproate, carbamazepine, lamotrigine and any side effects with same e.g. Steven Johnson syndrome, Hair Loss, Tremor, Sedation and frequency of levels and blood monitoring as applicable
- Lifestyle measures in place or recommended e.g. exercise, yoga, meditation
- Duration of treater involvement
- Compliance with treatment and ongoing treatment plan and monitoring in place
- Applicants insight and willingness to engage if future difficulties
- Demonstrated resilience to stress.
- Whether police work is likely to aggravate the condition if so how and mitigating factors
- Ability to meet the inherent requirements of an operational general police officer and protective services officer

- Prognosis

Medical Standard

Bipolar Affective Disorder as a general rule is not compatible with sworn police work. The specific occupational risks associated with a hypomanic or manic episode in the setting of police duties are too significant.

That is not suggest there may not be rare exceptional cases, where symptoms are very mild and when symptoms are at their worst, there are no risks associated with police work including the carriage of firearms.

Even when stable on medication, these risks persist – non-compliance with medication is a known risk in bipolar affective disorder and blood levels of medications can fluctuate e.g. lithium with hydration levels and interactions with other medications. Mood stabilisers are associated with a range of side effects e.g. lithium when levels are too high can cause tremor, nausea, poor renal function, confusion & sodium valproate can cause sedation. Medication usually needs to be taken at regular intervals and may require time bound blood levels

It should be noted that inter episode and when treated, an individual with BPAD may present well, however relapses can be unexpected and when they occur high risk.

Stress can be a precipitant to a relapse as can medication cessation or non-compliance or sometimes other medication interactions or intercurrent illness e.g. vomiting or diarrhoea leaving to missed doses or dehydration.

Suicide risk in generally higher in individuals with a history of BPAD.

Risks around suicide including past or present suicidality can be predictive of future risk, particularly ideation pertaining to lethal means (MVA/handing/ high lethality overdose/shooting) and extreme caution should be exercised in considering firearm access in an applicant with this history.

There may also be particular risks around driving in the case of a manic or hypomanic episode, these may include risk of psychosis in the case of Bipolar 1, risk of gross elevation in mood for Bipolar 1 or 2 resulting in for example - severely impaired judgement, situational awareness, impulsivity, anger & irritability. Members having a hypomanic or manic episode may also not be sleeping, may be distractible and may engage in high risk and/or reckless behaviours without concern for consequences.

Applicant should be individually and comprehensively assessed from a clinical and risk perspective with extensive treater involvement.

Generally, underlying organic causes need to be addressed and/or ruled out elevated thyroid function and blood pressure should be checked. There should be an exploration of the member's current circumstances particularly with respect to any ongoing work or personal stressors and coping mechanisms for same.

A medication history should be taken noting that steroids may cause transient hypomanic or manic symptoms, and those with an undiagnosed bipolar disorder may switch to a manic episode when started on an antidepressant e.g. SSRI.

Members who may appear to be in remission may still decompensate rapidly in the face of specific isolated triggers or higher workloads / greater demand and/or if there are additional stressors outside of work. They also may decompensate if there is medication non-compliance (a risk when people with this condition become feel well), fluctuating medication levels, drug interactions or when starting an SSRI.

In the event of uncertainty, opinion should be sought from a psychiatrist or an external IME.

This guideline is a brief summary only, does not replace individual clinical assessment, and must be considered in conjunction with the latest clinical practice guidelines from the RANZCP or peer reviewed bipolar guidelines as otherwise appropriate.

Impact on Job Performance

Bipolar Affective Disorder can significantly impact on the safe discharge of police duty, particularly where an individual experiences manic or hypomanic episodes.

This can include inflated self-esteem and or grandiosity, decreased need for sleep, pressured speech, irritability and/or anger, impulsivity, impaired judgement, flight of ideas, distractibility, psychomotor agitation, excessive involvement in high risk activities, in the cases of a manic episode, psychosis.

A manic or hypomanic episode may not be well predicted and individuals with BPAD may lack insight into recognising when they are becoming manic / hypomanic – this being an additional risk

There are specific risks associated with firearm access and potentially driving.

Medications may cause sedation, tremor and other side effects.

Individuals with BPAD may also experience depressive episodes only or depression and manic or hypomanic episodes.

A long period of symptoms stability and stabilisation on medication does not rule out another episode, particular with major life transitions e.g. childbirth, death of a family member, marriage or other circumstances.

This is broadly a very high risk condition in a police setting and extreme caution should be exercised, particularly with respect to any operational duties or OSTT qualification.