VICTORIA POLICE

Psychosis

Schizophrenia, Schizophreniform Disorder, Brief Psychosis, Delusional Disorder, Schizoaffective Disorder

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, UEC, LFT, thyroid study, in cases of sudden onset psychosis with no prior history, brain imaging (CT scan and/or MRI) can be useful to see to run out organic cause such as space occupying cerebral lesion where there is a sudden onset of psychotic symptoms e.g. in middle age with no prior history, brain imaging is not done in all cases but selectively based on the history.

Considerations include (but are not limited to):

- Diagnosis and symptoms
- E.g. delusions if so what type, auditory hallucinations, ideas of reference, thought interference or projection, thought disorder
- Duration of condition and recurrence and/or chronicity
- Insight and engagement with treatment.
- Any comorbidities e.g. depression, mania or trauma or substance use
- Social supports
- Any risk issues including suicidality, acting on psychotic beliefs e.g. in the case of paranoia, approaching people and getting into arguments based on delusional beliefs, in the case of delusions of infidelity – any obsessional monitoring or stalking behaviours and/or confrontations which may heighten associated risks
- Note that are particularly high risks associated with command hallucinations, delusions of infidelity e.g. of spouse and post-natal psychosis including potentially homicide/infanticide
- Treatments tried, response to treatment and side effects
- Medication treatment e.g. antipsychotics - dose, duration, response, side effects
- Note there can be particular side effects associated with antipsychotic dopamine blockage including, Parkinsonian symptoms, torticollis, dystonia, hypertonic muscles, bradykinesia, oculogyric crisis, lengthened QR interval on ECG predisposing to Torsade De Point, Clozapine has a range of very specific side effects
- Some antipsychotics e.g. olanzapine and quetiapine can also be associated with sedation and/or weight gain, and/or metabolic syndrome and diabetes.
- Duration of treater involvement
- Compliance with treatment and ongoing treatment plan and monitoring in place

- Applicant's 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 for operational and non-operational work, specific concerns around firearms, now and or if condition should worsen

Medical Standard

Psychosis is broadly not compatible with the exercise of operational police work. This can be for a range of reasons including impaired reality testing and situation awareness and distraction for example by hallucinations that render operational police work dangerous.

Non-operational duties can is some circumstances be considered but should be approached conservatively due to the potentially unpredictable nature of psychotic symptoms in both time and manifestation, and the potential for these symptoms to be exacerbated in a police environment and/or when a member is under stress.

Consideration of non-operational duties would generally be with expert specialist advice from a psychiatrist who had known the patient over a sustained period and could comment on the patients stability, compliance with medication and the broader features of the illness and risk in the context of police work and the members ability to safely meet the requirements of this without risk to self or others including colleagues and/or the community. The examining treater should make their own independent assessment of this based on inherent knowledge of the operating environment and its inherent risks. There would need to be ongoing treater monitoring in such cases.

There are certain situations that may warrant a different approach, broadly this is where it emerges that the psychotic symptoms are not in fact part of a psychotic illness but are a treatable and correctable manifestation of an underlying organic condition, e.g. tumour pressing on part of the brain and/or paraneoplastic syndrome, side effect of steroid treatment etc. In such cases there may be a careful investigation of whether the condition is likely to fully remit with treatment of the underlying medical condition and expert advice should be sought about this to ensure the symptoms are transient, reversible and not likely to recur.

Psychotic symptoms can also be induced by illicit substances or alcohol, this is a complex area that will require specialist input and consideration and very comprehensive assessment to determine the nature of the symptoms, frequency of use and risks, noting that both substance use and psychotic symptoms are both independent risks in a safety critical environment and that substance use disorders can run an unpredictable course. A conservative approach should be taken noting the grave risks that may be associated with psychosis in a police setting. Expert advice should be sought.

The applicant's level of insight, ability to recognise and manage early relapse signs and seek assistance is also relevant., however a patient may not realise when psychotic symptoms are emerging, and in the early stages this may not be apparent to others.

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).

There can also be particular risks around driving in the case of psychosis e.g. hallucinations and command hallucinations and/or other psychotic symptoms

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

Each case must be individually considered on its merits.

Applicants 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.

Each applicant must be individually clinically assessed, a history of their condition taken including associated psychosocial, family history, history of other substance use, social history, psychiatric history including past hospitalisation and self-harm attempts.

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

This guideline is a brief summary only of some general guidance points, does not replace individual clinical assessment by a clinician with expertise in these matters to determine the individua nature of the condition, its clinical history and inherent risks, and must be considered in conjunction with latest clinical practice guidelines from the RANZCP, RANZGP, or peer reviewed guidelines as otherwise appropriate.

Impact on Job Performance

Psychosis has the potential to impact gravely on the discharge of police duties due to the potential for impaired reality testing and judgement as well as potential distraction by psychotic symptoms e.g. hallucinations.

Each case must be individually assessed however to determine the functional and occupational impacts of the disorder. As a general principle, psychosis will not be compatible with operational police work and may not be compatible with non-operational police work, depending on the circumstances and clinical history and risk.

Impaired judgement or reality testing, delusions or hallucinations have the potential to result in grave risks to self, others or the community with respect to police work.

Antipsychotic medications may also cause a range of side effects that in themselves may not be compatible with police work.