Medical Conditions

Guidance for the
Medical Evaluation of Law Enforcement Officers

provided by ACOEM

Mental Health Disorders
Guidance for the Medical Evaluation of Law Enforcement Officers (LEO)

MENTAL HEALTH DISORDERS

Introduction
In many cases, the well-educated, well-motivated law enforcement officer (LEO) whose mental health condition is properly treated can be capable of safe and effective job performance. However, untreated psychiatric conditions or unresponsiveness to treatment, may place the LEO at risk for significant impairment or sudden incapacitation. Symptoms may interfere with good judgment and the ability to interact with others. For some LEOs, internal stimuli may be distracting. These factors may jeopardize the LEO’s ability to perform essential job tasks (see Chapter 3). In all cases, an individualized clinical evaluation of the LEO’s mental health condition should be performed to determine whether the LEO’s condition permits safe and effective job performance (see section on Police Physician’s Initial Assessment).

In writing this document, the LEO Task Group reviewed existing mental health qualification standards for workers in other safety-sensitive fields. These are summarized in Appendix C. The following concepts support guidance of the Task Force:

- Mental health disorders (and some treatments) in the LEO may pose a risk to the individual officer, co-workers, and the general public
- Law enforcement work creates unique stresses, hazards, and safety concerns for LEOs with mental health disorders
- The course of a mental health disorder is not always predictable
- Treatment efficacy can take several weeks to months to assess
- Development of adverse effects requiring medication changes is not uncommon
- Even when treatment is efficacious, LEO adherence is often sub-optimal
- Nonadherence is often underestimated by mental health providers
- For many mental health disorders, the risk of recurrence is high

Psychological evaluation of LEOs most often occurs during the pre-employment phase after the conditional offer of employment. However, it is also acceptable to order such evaluations to assess the fitness for duty of current officers. In Watson v. City of Miami Beach, 177 F.3d 932 (11th Cir. 1999), the Eleventh Circuit considered the legality of a fitness-for-duty evaluation (FFDE) for an officer who displayed “unusually defensive and antagonistic behavior towards his co-workers and supervisors,” but whose job performance was otherwise satisfactory. Id. at 934. Recognizing that “[p]olice departments place armed officers in positions where they can do tremendous harm if they act irrationally,” the court held that the Americans with Disabilities Act (ADA) does not “require a police department to forego a fitness for duty examination to wait until a perceived threat becomes real or questionable behavior results in injuries.”

This document does not address administrative issues, such as inappropriate performance or conduct, which occur in the absence of a mental health diagnosis, nor is this document meant to address every type of mental health disorder. For example, personality disorders can lead to performance or conduct issues and are rarely accommodated with work restrictions. It is anticipated that behavioral manifestations of personality disorders will be handled administratively rather than medically. This document is limited to mental health disorders that are most common and relevant to LEOs.

The police physician should always assess for adverse effects from any medication or other treatment the LEO may be using to treat these disorders (see LEO Medications chapter). For issues relating to substance use and abuse, see the LEO chapter on Substance Use Disorders.

This chapter addresses the following mental health conditions as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), 5th edition (see Appendix A).
- Depressive Disorders
- Bipolar Disorders
- Anxiety Disorders
- Psychoses
- Post-traumatic Stress Disorder (PTSD) and Acute Stress Disorder
- Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)
Police Physician’s Initial Assessment

The role of the police physician is to explore the following:

- LEO’s behavior and state of physical and mental health
- coordinate with appropriate health care providers to clarify the diagnosis, prognosis, and implications for fitness for duty
- capacity to perform physical, emotional, and cognitive functions of law enforcement work
- evaluate for medication/treatment adverse effects, physical illness(es), cognitive disorders, and substance use disorders

If after initial review, the suspicion for an impairing mental health condition is substantiated, the police physician should recommend modified duty until the evaluation has been completed. The police physician’s assessment may require consultation with the LEO’s personal health care provider. If indicated, referral to a doctoral-level licensed mental health provider, acceptable to the police physician, who understands the functions and demands of police work and is familiar with fitness guidelines from the International Association of Chiefs of Police (IACP) should be undertaken (see Appendix B).*

The medical evaluation consists of the following elements:

- suspicion of a significant mental health disorder, the reason for referral
- recognition of impairment due to a mental health disorder
- assessment
- recommendations regarding duty status, work restrictions and follow-up

Suspicion of a Significant Mental Health Disorder

The LEO may disclose to the employer that he/she has a mental health diagnosis and/or has been treated for such a condition. Absent direct disclosure by the LEO, an evaluation by the police physician should occur based on a credible third-party report or observation of one or more of the following work behaviors:

- physical and mental slowing (psychomotor retardation)
- flashbacks
- responding to internal stimuli (e.g., hallucinations)
- active or passive suicidal or homicidal ideation, gestures, threats or attempts
- inappropriate affect
- recurrent Monday lateness, unscheduled absences
- change in appearance and hygiene
- involvement in accidents
- inappropriately aggressive behavior
- worsening performance
- unreliability in someone previously reliable
- inability to concentrate
- changes in nature of interpersonal relationships (such as conflict or withdrawal)
- complaints against the LEO by members of the public, arrestees, or other officers
- use of force incidents
- time and attendance analysis (number of days, days of week – Monday/Friday, type of injuries/illnesses)
- unusual or excessive workers’ compensation claims
- falling asleep on the job (while driving, during meetings, in a parked car)
- safety errors/risk-taking behavior (speeding, not calling for back up)
- hostility/anger/paranoia towards suspects or members of the public

Many of the above behaviors are also possible signs of drug or alcohol abuse. There is substantial substance abuse co-morbidity in persons with mental health disorders. The need for mental health evaluation may also become apparent to the police physician in the course of other evaluations of the LEO, such as return to work, periodic exams, injury care, and other referral settings.

*It is possible to hold a doctorate in another field, such as Divinity, and only master’s level training in psychology or psychiatry. Two states permit licensure as psychologist.]
**Preliminary Assessment**

Excluding cases of psychiatric emergency, the police physician should conduct or review a medical evaluation of the LEO. If available, the following information should be requested:

1. written job description containing a list of essential job functions
2. performance evaluations of the last year (before and after injury or incident if relevant and available)
3. any disciplinary write-ups or performance improvement plans
4. discussion with or review of reports by collateral sources of information who have observed LEO behaviors of concern.

The history and physical should include the following:

1. medical history
2. psychiatric or psychological history including history of psychiatric hospitalizations, outpatient care, previous trials of psychotropic medications, and suicide attempts
3. medications, including all supplements, non-prescription and prescription
4. sleep history
5. educational history, including academic performance and any academic disciplinary issues
6. occupational history, including performance in prior work roles
7. social history, review of psychosocial stressors associated with family life and personal finances, marital history, legal history, military history, including disability applications
8. substance use/abuse history (including anabolic steroids), including any prior diagnosis, treatment, and social or legal consequences if there is reason to believe substance use/abuse contributes to the circumstances leading to evaluation (see LEO chapter on Substance Use Disorders)
9. mental status evaluation: brief assessment of affect, mood, thought processes, abnormalities of thought (e.g., delusions) judgment, hallucination, speech, suicidal/homicidal ideation, if there are questions concerning cognition, brief screening instruments such as the Montreal Clinical Assessment, or the Mini Mental Status Examination can be administered (for evaluation of depression there are a variety of office screening tools available see Appendix E)
10. physical exam focusing on neurological, endocrine, substance abuse and cognitive findings
11. if appropriate, medication levels should be obtained (to evaluate adherence or diversion)

**Evaluation of Specific Mental Health Disorders in LEOs**

**Overview**

Specific diagnoses most relevant to the police physician are discussed below. In its *Cautionary Statement for Forensic Use of DSM-5* (in Section 1 of DSM-5), the American Psychiatric Association notes: “It is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigators rather than all of the technical needs of the courts and legal professionals.”³

The focus of the assessment should be on those behaviors and deficits of capacity that impair performance of essential job tasks. The diagnosis is a common frame of reference for conducting the inquiry. When considering the LEO’s fitness for duty, all relevant data should be carefully reviewed. Summary information concerning specific diagnoses is provided in Appendix A to facilitate thorough case-by-case analyses.

The recommendations which follow pertain to the LEO’s return to usual work. Return to limited duty may occur sooner. The appropriateness of limited duty is in part determined by:

- the residual work capacities of the LEO while in treatment
- the degree to which work activities may interfere with treatment and recovery
- specific workplace stressors which may impact the LEO
- the availability of work that does not pose a risk to the LEO or others while the LEO is symptomatic.

The police physician may consult with the LEO, representatives of the agency, and evaluating and treating providers in considering work restrictions. It is also appropriate for the police physician to be available to the employer to discuss the appropriateness of a proposed modified-duty assignment. Each case requires an individual review of all relevant factors. These include the impaired LEO’s risk to collaterals and the department’s duty to protect others from a LEO’s known impairment.
Ongoing modified work will need regular progress reports to the police physician by the treating providers and re-evaluation of the LEO at frequent intervals. If the LEO’s fitness for duty depends on treatment, the return-to-work plan must include a mechanism for monitoring adherence to treatment going forward, with an emphasis on behavioral indicators not limited to mere attendance at appointments, medication compliance or development of insights.

**Depressive Disorders: Duty Status and Work Restrictions**

Following the initial episode of any depressive disorder (e.g., major depressive disorder, depression not otherwise specified) with no history of suicide attempt or psychosis – the criteria below apply for return to work without restrictions.

The following conditions must be met:

- full remission as defined by DSM-5 (“During the past two months, no significant signs or symptoms of the disturbance were present”)³
- absence of impairing symptoms in the past 2 months
- if requested by the police physician, an evaluation by a doctoral-level mental health provider acceptable to the police physician, who understands the functions and demands of police work
- adherence to treatment and ongoing evaluations
- no disqualifying adverse effects from treatments such as medication, electroconvulsive therapy, etc. (see LEO Medications chapter)
- unimpaired judgment and attention
- appropriate inter-personal interaction
- treatment of comorbidities (including substance abuse and sleep disorders)
- no imminent risk of harm to self or others

LEOs with current or past psychotic symptoms, suicidal ideation or attempt, or personality disorders will require additional evaluation. It is the consensus of the LEO Task Group that follow-up evaluations* should be undertaken as follows:

- regular evaluations over a period of at least 6 months
- regular evaluations on a monthly basis or more frequently when the anti-depressant is tapered
- regular evaluations on a monthly basis or more frequently after discontinuing anti-depressant, for at least 3 months, and at 6 and 12 months after discontinuing anti-depressant

*Evaluations by a health care provider knowledgeable about mental health disorders and management acceptable to the police physician.

**Recurrent Depressive Disorder:**

With recurrence of any depressive disorder (e.g., major depressive disorder, depression not otherwise specified, uncomplicated by suicide attempt or psychosis) – criteria for return to work without restrictions are the same as above. Treatment recommendations are also the same as for an initial episode, **but careful consideration must be given to whether the LEO requires work restrictions if anti-depressant medication is discontinued or changed.** The police physician may also require ongoing follow-up to monitor for recurrence.

**Bipolar Disorder: Duty Status and Work Restrictions**

**Bipolar I:**
An individual with a confirmed diagnosis of bipolar I disorder is unable to perform LEO essential job functions.

**Other Bipolar Disorders** (including bipolar II disorder, cyclothymic disorder and unspecified bipolar disorder): LEOs with these diagnoses may be able to perform as a LEO, but following the first episode of any other bipolar disorder must meet all of the following criteria for return to work without restrictions:

- No lifetime history of any manic episode
- absence of impairing symptoms in the past 2 months
if requested by the police physician, an evaluation by a doctoral-level mental health provider acceptable to the police physician, who understands the functions and demands of police work

- full remission as defined by DSM-5 (“During the past 2 months, no significant signs or symptoms of the disturbance were present”)\(^3\)
- adherence to treatment and ongoing evaluations
- no disqualifying adverse effects from treatments such as medication, electroconvulsive therapy, etc. (see LEO Medications chapter)
- unimpaired judgment and attention
- appropriate inter-personal interaction
- treatment of comorbidities (including substance abuse and sleep disorders)

LEOs with psychotic symptoms, suicidal ideation or attempt, rapid cycling, substance abuse, or personality disorders will require additional evaluation.

It is the consensus of the LEO Task Group that follow-up evaluations\(^*\) should be undertaken as follows:

- regular evaluations over a period of at least 6 months
- regular evaluations on a monthly basis or more frequently when the anti-depressant is tapered
- regular evaluations on a monthly basis or more frequently after discontinuing anti-depressant, for at least 3 months, and at 6 and 12 months after discontinuing anti-depressant

\(^*\)Evaluations by a health care provider knowledgeable about mental health disorders and management acceptable to the police physician.

**Recurrence of Bipolar Symptoms:**
With recurrence of any bipolar symptoms, criteria for return to work without restrictions are the same as above. Careful consideration must be given to whether the LEO requires work restrictions if medication is discontinued or changed. The police physician may also require ongoing follow-up to monitor for recurrence.

**Anxiety Disorders: Duty Status and Work Restrictions**
LEOs with these diagnoses may be able to perform as an officer, but must meet all of the following criteria for return to work without restrictions:

- absence of impairing symptoms in the past 2 months
- if requested by the police physician, an evaluation by a doctoral-level mental health provider acceptable to the police physician, who understands the functions and demands of police work
- no symptomatic phobia specifically related to workplace activities or stimuli
- adherence to treatment and ongoing evaluations
- no disqualifying adverse effects from treatments such as medication, electroconvulsive therapy, etc. (see LEO Medications chapter)
- unimpaired judgment and attention
- appropriate inter-personal interaction
- treatment of comorbidities (including substance abuse and sleep disorders)

**Follow-up evaluations:** regular evaluations for at least 6 months.

**Schizophrenia Spectrum and Other Psychotic Disorders**

**Schizophrenia**
An individual with a confirmed diagnosis of schizophrenia is unable to perform the essential job functions of an LEO.

**Schizoaffective Disorder**
An individual with a confirmed diagnosis of schizoaffective disorder is unable to perform LEO essential job functions.

**Other Psychotic Disorders: Recommendations Regarding Duty Status and Work Restrictions**
- An individual with delusional disorder is unable to perform LEO essential job functions.
For LEOs with a single brief psychotic disorder or schizophreniform disorder** the following required conditions must be met prior to return to full duty:

- no psychotic symptoms for 6 months after completion of treatment (off medication)
- absence of impairing symptoms in the past 2 months
- if requested by the police physician, an evaluation by a doctoral-level mental health provider acceptable to the police physician, who understands the functions and demands of police work
- adherence to treatment and ongoing evaluations
- no disqualifying adverse effects from treatments such as medication, electroconvulsive therapy, etc. (see medications chapter)
- unimpaired judgment and attention
- appropriate inter-personal interaction
- treatment of comorbidities (including substance abuse and sleep disorders)

LEOs suicidal ideation or attempt, or personality disorders will require additional evaluation.

**Follow-up evaluations:** regular evaluations for at least 12 months

For LEOs with secondary psychosis the following required conditions must be met prior to return to full duty:

- the cause of the psychotic disorder has been successfully treated and managed
- the psychotic symptoms have resolved for at least 6 months
- off antipsychotic medication for 6 months
- evaluation by a psychiatrist or by a licensed doctoral-level psychologist

**Post-Traumatic Stress Disorder: Recommendations Regarding Duty Status and Work Restrictions**

The following conditions must be met prior to return to full duty:

- Absence of impairing symptoms in the past 2 months, including, but not limited to:
  - significant dissociative episodes (flashbacks)
  - recklessness, self-destructive or avoidant behavior which could interfere with work performance
- If requested by the police physician, an evaluation by a doctoral-level mental health provider acceptable to the police physician, who understands the functions and demands of police work
- Adherence to treatment and ongoing evaluations
- No disqualifying adverse effects from treatments such as medication, electroconvulsive therapy, etc. (see LEO Medications Chapter)
- Unimpaired judgment and attention
- Appropriate interpersonal interaction
- Treatment of comorbidities (including other mental health issues, substance abuse, and sleep disorders)

LEOs with current or past psychotic symptoms, suicidal ideation or attempt, or personality disorders will require additional evaluation.

**Follow-up evaluations:**

- Regular evaluations for at least 6 months (or longer depending on comorbidities)
- Four instruments for evaluating PTSD are included in Appendix E:
  - primary care PTSD screen, PC-PTSD, is a 4-item screening tool
  - Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) is a 20-item instrument which has high sensitivity and specificity for diagnosis, it is also useful for following LEOs over time
  - Structured Interview for PTSD (SI-PTSD) is a longer test which requires 20-30 minutes to administer
  - a still longer interview, the Clinician-Administered PTSD Scale (CAPS-5) has not been included, but is on the U.S. Veterans Administration website

**These two diagnoses can only be made after secondary psychoses have been excluded.**
Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder (ADHD/ADD): Recommendations Regarding Duty Status and Work Restrictions

The following conditions must be met prior to return to full duty:

- Absence of impairing symptoms in the past 2 months
- If requested by the police physician, an evaluation by a doctoral-level mental health provider acceptable to the police physician, who understands the functions and demands of police work
- Adherence to treatment and ongoing evaluations
- No disqualifying adverse effects from treatments such as medication, electroconvulsive therapy, etc. (see LEO Medications Chapter)
- Unimpaired judgment and attention
- Appropriate inter-personal interaction
- Treatment of comorbidities (including other mental health issues, substance abuse and sleep disorders)

Suicidal Behavior: Recommendations Regarding Duty Status and Work Restrictions

Suicidal Attempt: Recommendations Regarding Duty Status and Work Restrictions

The following conditions must be met prior to return to full duty:

- Absence of impairing symptoms in the past 2 months
- Evaluation by a doctoral-level licensed mental health provider acceptable to the police physician, who understands the functions and demands of police work
- If a mental health disorder is diagnosed, the LEO must also meet return-to-work criteria for the underlying mental disorder
- Adherence to treatment
- No disqualifying adverse effects from treatments such as medication, electroconvulsive therapy, etc. (see LEO Medications Chapter)
- Treatment of comorbidities (including substance abuse and sleep disorders)
- No cognitive impairment
- No suicide attempt within a minimum of 6 months
- No suicidal ideation within 2 months
- Recurrent attempts will likely require permanent restrictions

Follow-up evaluations:

- Regular evaluations by a doctoral-level mental health professional, at least monthly, for at least 6 months:
  - evaluator should seek corroboration of the LEO’s status from collateral sources, e.g., family, peers, supervisors
- If medications have been prescribed for an associated mental illness, regular evaluations on a monthly basis or more frequently when the medication is tapered:
  - regular evaluations on a monthly basis or more frequently for at least 3 months after discontinuing medication
  - evaluation 6 and 12 months after discontinuing medication
- Annual evaluation by the police physician or departmental mental health consultant

Suicidal Ideation (within 6 months)***: Recommendations Regarding Duty Status and Work Restrictions

- If there is a history of suicide attempt (see above)
- Restrictions, if needed, will depend on the risk posed by the ideation

The following conditions must be met prior to return to full duty:

- Absence of impairing symptoms in the past 2 months
- Evaluation by a doctoral-level licensed mental health provider who understands the functions and demands of police work
- If a mental health disorder is diagnosed, the LEO must meet return-to-work criteria for the underlying mental disorder

***Thoughts of suicide, or suicidal ideation, exists on a continuum from passive thoughts that ‘one is better off dead’ which may be fleeting, to fantasies of, or plans for, suicide with high levels of detail.
- Adherence to treatment
- No suicidal ideation within 2 months
- No disqualifying adverse effects from treatments such as medication, electroconvulsive therapy, etc. (see LEO Medications chapter)
- Treatment of comorbidities (including substance abuse and sleep disorders)
- No cognitive impairment

Follow-up Evaluations:
- Regular evaluations as recommended by the doctoral-level mental health professional
- If medications have been prescribed for an associated mental illness, regular evaluations on a monthly basis or more frequently when the medication is tapered
  - regular evaluations on a monthly basis or more frequently for at least 3 months after discontinuing medication
  - evaluation 6 and 12 months after discontinuing medication
- Annual evaluation by the police physician or departmental mental health consultant
Appendix A

Depressive Disorders
Depressive disorder is among the most common mental health disorders affecting people in the U.S. and Canada: 12-month prevalence of any depression in the U.S. is 9.1%, and 7% for major depressive disorder.\(^5,6\) The condition is more common in persons with other chronic medical illness such as diabetes, heart disease and obesity. The female-to-male ratio for the diagnosis is approximately 1.5-3:1. The spectrum of symptom severity is wide, and most people with depressive disorder work. Nevertheless, depressive disorder is a major cause of disability in the general population. A 2010 study suggests it is the second largest cause of disability worldwide.\(^7\)

For purposes of this document, we will consider both the DSM-5 diagnoses of major depressive disorder and persistent depressive disorder (PDD.) The latter diagnosis is an amalgamation of dysthymia and chronic major depressive disorder, two DSM-IV TR diagnoses.\(^3\) PPD has a wider spectrum of clinical severity than its two components. A comparison of diagnostic criteria from DSM-IV TR and DSM-5 is provided in Appendix A as not all mental health providers have adopted DSM-5 at the time this guidance was developed.

Symptoms of depressive disorder lead to marked distress, and impairments of cognition, judgment, and, inter-personal relationships. Sleep and appetite disturbances are common, as is psychomotor retardation, and impaired concentration which may decrease cognition and reaction time. Over 50% of persons experiencing a major depressive episode (MDE) acknowledge feeling it would be better if they were dead and 30-40% consider suicide.\(^8,9\) Suicidality is of special concern in LEOs given their ready access to firearms. Approximately 15% of individuals with major depressive disorder kill themselves, with availability of a firearm as a major risk factor; owners of firearms have a 3-12 times higher risk of a lethal suicide attempt.

Of those experiencing moderate to severe major depressive disorder, 50% will improve with treatment.\(^10\) Successful treatment often occurs within 1-3 months.\(^11\) However, 12-35% of depressed patients do develop a chronic form of the disorder. Risk of recurrence is also high, 50% after a single episode, 75% after two episodes, and 90% after a third. This underscores the importance of ongoing evaluation after return to work following treatment for this diagnosis.

Treatment modalities include antidepressant medications, adjunctive treatment with other classes of psychoactive medication (e.g., aripiprazole, lithium), electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS) and psychotherapy (particularly cognitive behavioral psychotherapy and interpersonal psychotherapy). ECT bears specific mention as this therapy involves electric stimulation of the brain which produces seizure-like activity. Post-treatment impairments of cognition and memory are usually transient but may persist for months.

Bipolar Disorder
“Bipolar disorders are separated from the depressive disorders in DSM 5 and placed between the chapters on schizophrenia and other psychotic disorders and depressive disorders in recognition of their place as a bridge between the two diagnostic classes in terms of symptomatology, family history and genetics.”\(^3\) DSM 5 recognizes several bipolar and related disorders:
- Bipolar I
- Bipolar II
- Cyclothymic Disorder
- Substance/Medication-Induced Bipolar and Related Disorder
- Bipolar and Related Disorder Due to Another Medical Condition
- Other Specified Bipolar and Related Disorder
- Unspecified Bipolar and Related Disorder.

Diagnoses in this class are associated with severe disturbances of mood, including mood instability, markedly elevated risk of suicide, and impaired judgment. Up to two-thirds of bipolar patients will experience psychotic episodes.\(^12\) Occupational and social consequences are often severe. The risk of recurrent impairing episodes is as high as 90%. Possible exceptions are substance/medication-induced bipolar and related disorder, and bipolar and related disorder due to another medical condition – in cases where exposure to a specific precipitant can be completely controlled.
Taken together, the three most common bipolar diagnoses, bipolar i, bipolar ii, and cyclothymic disorder affect 1.5-2.0% of the population. Diagnostic criteria for all of these conditions require that “the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.” All are recurrent by definition, and associated with impairment of cognitive processes, judgment and impulse control which create important concerns for the police physician.

**Bipolar I**

To meet the diagnostic criteria for Bipolar I, the LEO must have experienced at least one manic episode. Some LEO’s may experience only manic episodes, some a combination of manic as well as major depressive episodes (MDE), and some only MDE as long as they met diagnostic criteria for a manic episode at some point in their history. Of note, a manic episode may have preceded or be followed by a major depressive episode or a hypomanic episode. Episodes may last from days to months – and there may be no intervening period of normal mood. Changes in mood are unpredictable and can be abrupt. When more than four distinct episodes occur in 1 year, the designation of “with rapid cycling” is used. Rapid cycling is associated with greater risk of suicide and poorer prognosis in general.

Mania is characterized by expansive, usually elevated mood (euphoria) or may present with only an irritable mood. In addition to this mood disturbance, individuals may exhibit grandiosity, inflated self-esteem, less or no need for sleep, distractibility, increase in speech and motor activity, and impulsivity. Unfortunately, thinking may become illogical and disordered. The manic individual typically lacks insight into the impairment of their thought process. This may lead to gross over-estimation of their own abilities, impulsive and outlandish behavior, and failure to observe social conventions. Family problems, legal complications, financial, and sexual indiscretion are common. Psychosis occurs in a high percentage of bipolar I cases. Patients may experience delusions of grandeur (e.g., thinking they are Jesus Christ or the President). Impaired judgment leads to elevated risk of accidental death during manic episodes.

In contrast, depressive episodes leave the patient with severely depressed mood, anhedonia, hopelessness, feelings of guilt and worthlessness. Changes in sleep (insomnia or hypersomnia), changes in appetite (anorexia or hyperphagia) and reduced energy are typical. Psychotic features, such as auditory hallucinations or delusions may occur. The major depressive episode as defined for major depressive disorder has the exact same diagnostic criteria as that of Bipolar I or II; the only distinction is that to meet criteria for bipolar I, the individual must have had a manic episode, for bipolar II, a hypomanic episode. As is true of all major depressive episodes, impairment cognition and reaction time may occur.

**Bipolar II**

In bipolar II disorder, the LEO must experience one or more episodes of major depressive disorder lasting at least 2 weeks and one or more episodes of hypomania, lasting at least 4 days. The presence of a manic disorder at any time during the illness changes the diagnosis from bipolar II to bipolar I. This occurs in 5-15% of bipolar II patients.

A hypomanic episode is a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least four consecutive days and present most of the day, nearly every day. By definition, the episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. During periods of hypomania, patients may feel unusually productive and creative.

As is true of bipolar I disorder, diagnosis of bipolar II in childhood or adolescence is associated with a more severe lifetime course. Rapid cycling is associated with worse prognosis: 15% of patients have inter-episode dysfunction and 20% go from one episode to another with no inter-episode recovery. When periods of recovery occur, restoration of cognitive function lags resolution of symptoms significantly. This affects vocational performance negatively.

Typical age of onset is mid-20s, starting with a depressive episode. At the time of publication of DSM-V, 12% of persons initially diagnosed with a depressive disorder were subsequently diagnosed with bipolar II after a hypomanic episode. Angst, in a 2013 study, suggested that changes in classification of hypomania in DSM-IV TR and DSM-V will lead to a marked increase in diagnosis of bipolar II in those previously diagnosed with major depressive disorder. In DSM-V,
hypomania arising in treatment of major depressive disorder is an explicit criterion for bipolar II. In DSM-IV TR it had been an exclusion criterion for bipolar II.\textsuperscript{13} For the police physician, knowledge of this change in diagnostic categories is important in communicating with the treating providers of LEOs with depressive disorder, bipolar II, and substance/medication-induced bipolar and related disorder.

**Cyclothymic Disorder**
Cyclothymic disorder is a chronic mood disturbance involving numerous distinct periods of hypomanic symptoms and depressive symptoms which do not by definition meet criteria for hypomanic or major depressive episodes in terms of number, severity, pervasiveness, or duration. There is a 15-50% lifetime risk that a cyclothymic patient will experience mania, a hypomanic episode, or a MDE at which point the diagnosis of bipolar I or II is made.

**Substance/Medication-Induced Bipolar and Related Disorder**
LEOs in this diagnostic category experience mood changes similar to those with other bipolar disorders, but symptoms can be shown to develop during or soon after substance intoxication or withdrawal, or after exposure to a medication. Additionally, the implicated substance or medication is known to be capable of inducing these symptoms. Causal agents include amphetamines, cocaine, steroids, sedatives, hypnotics, anxiolytics, and others.

**Bipolar and Related Disorder Due to Another Medical Condition**
LEOs in this diagnostic category experience mood changes similar to those with other bipolar disorders, but there is evidence from history, physical examination, or laboratory testing that the disturbance is the direct pathophysiological consequence from another medical condition.

**Complications and Comorbidities of Bipolar Disorders:**
Suicide risk is markedly elevated in persons with bipolar disorders – some 15x population baseline. Despite the relatively low prevalence of bipolar disorders, bipolar patients account for up to 25% of all suicide attempts and 20% of suicide deaths.

Bipolar patients are also highly likely to experience other mental health disorders – 75% will experience some form of anxiety disorder, and 50% will experience some disorder of impulse control or conduct, e.g., ADHD, intermittent explosive disorder, or conduct disorder.

LEOs with bipolar disorders have a very high risk of concurrent substance abuse, greater than 50% in cases with bipolar I. Concurrent substance abuse can interfere with treatment of bipolar disorders.\textsuperscript{14} Those dually diagnosed with bipolar disorder and substance use disorders are at higher risk of suicide.

**Non-adherence:** A recent British study found that >50% of bipolar and schizophrenic patients interviewed took their medication in ways their physicians had not intended; 29% were satisfied doing so.\textsuperscript{15} Manic and hypomanic patients often experience a sense of well-being and do not acknowledge the need for treatment.

**Treatment of Bipolar Disorders**
Medication is the primary treatment for bipolar disorders. Psychotherapy, such as cognitive behavioral therapy (CBT) can be a useful adjunct. In some cases, electro-convulsive therapy is used to assist in mood stabilization.

Lithium or anticonvulsants such as valproate, lamotrigine or carbamazepine are usually first line for mood stabilization. Antipsychotics may be used to control mania; usually in addition to a mood stabilizer. There remains considerable debate regarding the use of antidepressant medications for the treatment of depression in bipolar disorders.

Lithium, the most commonly used agent, has a narrow therapeutic range and therapeutic drug monitoring is required. Toxicity can result in cognitive impairment and altered gait.

Medical treatment results in reduction of mood episodes by 30-40%. Episodes continue to occur in most treated patients.\textsuperscript{16} Of the medications used, only lithium has been shown to reduce suicide rates among bipolar patients. This effect is substantial, an 80% reduction of lifetime risk.\textsuperscript{17} As noted above, non-adherence is a particular problem in bipolar disorders.
Anxiety Disorders

Overview
Anxiety disorders are the most common mental health disorder, exceeding mood disorders and substance abuse in the general population. One-year prevalence for criterion-based anxiety disorders is 16% (ranging from 14-30% in primary care settings) and lifetime prevalence is 28.8%; lifetime prevalence is 22.7% for isolated panic attacks.18 For most of these diagnoses there is a female predominance of 2:1.3 Often acquired in childhood, these disorders tend to persist throughout life.

This spectrum of disorders is characterized by excessive fear and anxiety, which are disproportionate to any perceived threat. The disorders differ in regard to the objects or situations, which precipitate symptoms, and the cognitive and behavioral responses of the patient. Specific anxiety disorders tend to be highly co-morbid with other disorders in this class, as well as major depressive disorder and substance abuse disorders. In large surveys, anxiety and related disorders were independently associated with a significant 1.7-2.5 times increased risk of suicide attempts.19

Anxiety can be nearly constant, as in generalized anxiety disorder, or episodic. Episodes of anxiety can come on without warning or provocation, as in panic disorder, or may occur predictably in certain situations, as in simple or social phobia. The patient’s lifestyle is impacted by efforts to avoid precipitating situations or objects, as well as the symptoms of anxiety themselves.

Generalized Anxiety Disorder
Generalized anxiety disorder (GAD) is the most common anxiety disorder encountered in primary care. It presents as excessive anxiety and worry over several situations or activities which occurs more often than not for at least 6 months. The anxiety and worry must be accompanied by 3 (or more) of the following 6 symptoms:
1. Restlessness, feeling keyed up or on edge
2. Being easily fatigued
3. Difficulty concentrating or “mind going blank”
4. Irritability
5. Muscle tension
6. Sleep disturbance (typically difficulty falling asleep, staying asleep, or restless unsatisfying sleep

Adults with GAD often worry about routine concerns which are shared by persons without this disorder: job responsibilities, health, finances, family matters. In GAD, however, anxieties are excessive and interfere with psycho-social functioning – concerns are disproportionate and pre-occupying. By comparison with non-pathological anxieties, worries in GAD are more intense, last longer, and create higher subjective levels of distress. They are also less likely to have clear precipitants. Non-pathological anxiety is also much less likely to be accompanied by physical symptoms.

A 12-month prevalence of GAD is approximately 3% with a 2:1 female predominance. Median age of onset is approximately age 30. The course is typically chronic, with symptoms waxing and waning over time and in response to situational stressors. GAD is more common in those with chronic medical conditions.

Comorbidities include somatic symptoms (e.g., fatigue, muscle tension memory loss, insomnia, indigestion, cramping). Major depressive disorder is the most common co-existing psychiatric illness, occurring in almost two-thirds of individuals with this disorder. Alcohol abuse occurs in more than one third, and more than one quarter have panic disorder.20 Other conditions that may be associated with stress (e.g., irritable bowel syndrome, headaches) may accompany generalized anxiety disorder.

Treatment may include psychotherapy, such as cognitive behavioral therapy or behavioral therapy. SSRI are usually the first line agents in terms of psychopharmacology, but SNRI antidepressant medications are also utilized. Benzodiazepines are commonly prescribed, but are associated with significant adverse effects of sedation, memory impairment, and risk of psychological and/or physical dependence. Clinicians should look at other strategies if long term treatment is indicated. Buspirone, a non-benzodiazepine anxiolytic, has also been shown to have some benefit in GAD. It causes less sedation, and does not cause physical dependence. However, it lacks the efficacy of other agents and is more commonly added to antidepressants as an augmenting agent.
Specific Phobia
In this disorder, the patient experiences marked fear, anxiety, or avoidant behavior in response to a specific object or situation, e.g., flying, animals, heights, or seeing blood. The patient’s experience causes clinically significant distress or impairment in the social, occupational or other important areas of function. The 12-month community prevalence in the U.S. is 7-9%.3

The principal concern for the police physician in evaluating LEOs with a specific phobia is whether the precipitating object or situation is neutral or interferes with the performance of the essential functions of the job. For example, a well-circumscribed fear of flying may have little impact on the day-to-day performance of a police officer who has no required flight responsibilities. It would be incompatible with the duties of an air marshal.

Treatment is typically with psychotherapy, either exposure therapy or cognitive behavioral therapy. Systematic desensitization is a very helpful behavioral strategy. In a recent meta-analysis, Hofmann and Smits showed efficacy of psychotherapy to be moderate at approximately 25% with an attrition rate of 14%. In cases where exposures can be predicted, prior use of benzodiazepines, beta blockers or SSRIs may be helpful in controlling symptoms.21

Agoraphobia
Marked fear or anxiety about two of the following 5 situations:
1) using public transportation
2) being in open spaces
3) being in enclosed spaces
4) standing in line or being in a crowd
5) being outside of the home alone

When experiencing symptoms, individuals typically believe escape from the precipitant is difficult or impossible, or that assistance is unavailable. Panic-like symptoms are experienced (see Panic Disorder below). Agoraphobic situations are avoided or endured with intense fear or anxiety. In extreme cases, people become housebound. In two thirds of cases, onset occurs before the age of 35; the mean age of onset is 17; 30-50% of cases experience a preceding panic attack. The condition is usually persistent with only 10% remission rate. This diagnosis is associated with significant occupational impairment and 30% are completely house bound and unable to work.3

There is little research in the treatment of agoraphobia in the absence of panic disorder. Treatment can include CBT, systematic desensitization, and exposure therapy. Those with panic disorder and agoraphobia should be pharmacologically treated as panic disorder below. Agoraphobic persons who are not well controlled are unlikely to seek work as a police officer. The police physician is more likely to encounter agoraphobia as an acquired condition in incumbent LEOs.

Social Anxiety Disorder (SAD)
Persons with SAD, also known as social phobia, experience intense fear or anxiety in one or more social situations in which they are potentially scrutinized by others. Social interactions such as meeting an unfamiliar person, being observed eating or drinking, performing in front of others are common contexts for this disorder.

With exposure to the precipitant, the individual reliably fears acting in a manner, or showing anxiety symptoms which will result in humiliation or a negative evaluation from others. Exposure to the feared social situation may bring on intense anxiety feelings with rapid heartbeat and breathing, sweating, and feelings of impending doom. Such situations are avoided or endured with intense fear and anxiety.3

For some individuals, the condition is very circumscribed – with a specific fear of speaking in public only, or a fear of asking someone on a date. As with other anxiety disorders, understanding how and when, if at all the precipitant condition will arise while on-duty is critical to assessing the impact of this diagnosis on the ability to work as a police officer. Persons with generalized SAD in poor control may be unlikely to seek work as a police officer.

The 12-month prevalence of SAD in the U.S. is approximately 7%. For diagnosis, the condition must last at least 6 months. In 30% of cases, remission of symptoms will occur within 1 year. In 60% of cases without specific treatment, the condition lasts for several years or longer.3
Treatment may include CBT as well as pharmacotherapy SSRI or SNRI antidepressants. Benzodiazepines should be avoided if possible. In management of circumscribed disease where exposures are predictable – such as public speaking – anti-adrenergics and beta-blockers may be used to control symptoms.

This condition is often comorbid with other anxiety conditions (which it normally precedes) and with depressive disorder, bipolar disorders, and substance use disorders. Self-medication with legal and illegal substances is common.

**Panic Disorder**

Panic disorder is characterized by recurrent episodes of intense fear and somatic symptoms called panic attacks. These events are incapacitating and occur with no clear precipitant. DSM-5 lists the following criteria for a panic attack:

An abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and includes ≥4 of the following symptoms:

1) Palpitations, pounding heart, or accelerated heart rate
2) Sweating
3) Trembling or shaking
4) Sensations of shortness of breath or smothering
5) Feelings of choking
6) Chest pain or discomfort
7) Nausea or abdominal distress
8) Feeling dizzy, unsteady, light-headed, or faint
9) Chills or heat sensations
10) Paresthesias (numbness or tingling sensations)
11) Derealization (feelings of unreality) or depersonalization (being detached from oneself)
12) Fear of losing control or going crazy
13) Fear of dying

For the diagnosis of panic disorder, recurrent panic attacks must occur. At least 1 attack must be followed by at least one of the following:

1) Persistent concern or worry about additional panic attacks or their consequences
2) Significant maladaptive change in behavior related to the attacks.

Maladaptive changes may include reluctance to leave the home, or reorganizing daily life to insure help is available in the event of an attack. Activities of daily living such as shopping and use of public transportation may be curtailed. The behavior resembles that of agoraphobics, but the motivation in this case is preventing and/or minimizing the impact of panic attacks.

When panic attacks occur in the setting of another mental health disorder, but criteria for panic disorder is not met, the specifier “with panic disorder” is appended to the diagnostic label. In this case, the police physician should consider guidance applicable to panic disorder as well as that pertaining to the primary diagnosis.

The 12-month prevalence of panic disorder is 2-3%, with a mean age of onset between 20-24. As with other anxiety disorders, there is a 2:1 female predominance. The typical course of panic disorder is chronic, but with waxing and waning frequency of attacks. Some individuals can experience years of remission between periods of active disease. 50% of those with panic disorder have both expected and unexpected panic attacks.

In most cases panic disorder occurs with other psychopathology. Other anxiety disorders, bipolar disorder, major depressive disorder, and alcohol use disorder are all associated with higher prevalence of panic disorder. Panic disorder is also significantly comorbid with several general medical conditions: asthma, COPD, hyperthyroidism, irritable bowel syndrome, cardiac arrhythmia and dizziness.

First-line agents for pharmacologic treatment of panic disorder are SSRIs, with venlafaxine, a SNRI antidepressant, as a second-tier alternative. Other treatments for those who do not respond to multiple SSRIs or venlafaxine could include...
tricyclic antidepressants and benzodiazepines. Short-term benzodiazepine use may also have an adjunct role in accelerating the course of treatment. CBT is recommended in conjunction with pharmacotherapy. For patients experiencing agoraphobic symptoms, CBT and behavioral forms of psychotherapy may be useful adjuncts in treatment.21

Substance/Medication-Induced Anxiety Disorder
LEOs in this diagnostic category experience panic attacks or anxiety, but the symptoms can be shown to develop during or soon after substance intoxication or withdrawal, or after exposure to a medication. Additionally, the implicated substance or medication is known to be capable of inducing these symptoms. Causal agents include amphetamines, cocaine, steroids, sedatives, hypnotics, anxiolytics, and others. This diagnosis must be carefully distinguished from substance use disorder; it is used when the panic or anxiety symptoms predominate.

Anxiety Disorder Due to Another Medical Condition
LEOs in this diagnostic category experience mood changes similar to those with other anxiety disorders, but there is evidence from history, physical examination, or laboratory testing that the disturbance is the direct pathophysiological consequence from another medical condition. The diagnosis is not meant to include anxiety disorders which arise in the setting of chronic illness. This diagnosis should only be made when:
1) A clear temporal association is present between the anxiety symptoms and onset, exacerbation, or remission of the medical condition and anxiety symptoms.
2) Features atypical of a primary anxiety disorder are present, e.g. unusual age of onset or course.
3) Evidence in the literature exists to support that a known physiologic mechanism causes anxiety.
4) The condition is not better explained by a primary anxiety disorder, or another mental health disorder such as adjustment disorder.

Diagnostic clarity is essential for the police physician in considering workability of the officer or candidate.

Schizophrenia Spectrum and Other Psychotic Disorders
Overview
In DSM 5, this family of diagnoses includes schizophrenia, brief psychotic disorder, schizophreniform disorder, schizoaffective disorder, substance/medication-induced psychotic disorder, and psychotic disorders due to another medical condition, and schizotypal personality disorder.

This spectrum of disorders is characterized by abnormalities in the following domains:
1. Delusions: These are fixed beliefs which do not change despite conflicting evidence. Delusional ideas may have persecutory, referential, somatic, religious, and grandiose themes. They may or may not have bizarre content.
2. Hallucinations: These phenomena appear to the patient to be genuine perceptions, but have no external stimulus. Like genuine perceptions, they appear vivid. Auditory hallucinations are most common, but hallucinations may occur in any sensory modality. An example is hearing “voices” which are experienced as distinct from the patient’s thoughts.
3. Disorganized thought: This is normally inferred from patient speech. There may be looseness of association, tangentiality, and/or incoherence.
4. Grossly disorganized or abnormal motor behavior.
5. Negative symptoms including diminished emotional expression (speech, eye contact, “body language”); avolition (reduced self-motivated purposeful action), alogia (reduced speech output), anhedonia (loss of ability to experience pleasure) and asociality (apparent lack of interest in social interactions.)

Current abnormalities in these domains are disqualifying for law enforcement work.

Delusional Disorder
The essential diagnostic feature of this disorder is one or more delusions lasting more than 1 month. A delusion is a fixed false belief which does not change despite conflicting evidence. Delusional ideas may have persecutory, referential, somatic, religious, and grandiose themes. They may have bizarre content (criterion A); not meet criterion A for schizophrenia (i.e., does not have an abnormality in any of the other 5 domains of function listed above) Finally, apart from the impact of the delusion, functioning is not impaired and the person tends to appear normal to others.
There is a 0.2% lifetime prevalence without gender differences in frequency. Several types of delusional disorder are recognized, based on the focus of the delusions:

<table>
<thead>
<tr>
<th>Type of Delusional Disorder</th>
<th>Theme of Delusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erotomanic</td>
<td>The central theme of the delusion is that another person is in love with the patient.</td>
</tr>
<tr>
<td>Grandiose</td>
<td>Patient believes they possess some unique or exceptional quality or talent or have made some extraordinary discovery not recognized by others.</td>
</tr>
<tr>
<td>Jealous</td>
<td>Patient is convinced, in the absence of evidence, that their significant other is unfaithful.</td>
</tr>
<tr>
<td>Persecutory</td>
<td>The central belief is that the patient is being held back, monitored, conspired against, poisoned, drugged, or harassed by another party.</td>
</tr>
<tr>
<td>Somatic</td>
<td>An unshakable belief in abnormal bodily functions, or conditions, such as an imagined infestation with parasites, bodily odors or emanations not perceived by others.</td>
</tr>
<tr>
<td>Mixed</td>
<td>This subtype is utilized when no single delusional theme is predominant.</td>
</tr>
<tr>
<td>Unspecified</td>
<td>This subtype refers to cases in which the delusional theme does not fall into one or more of the above categories.</td>
</tr>
</tbody>
</table>

When not focused on the delusion(s) persons with delusional disorder appear normal to others in their personal appearance and behavior. However, when focused on their delusions difficulties with others may arise. Violence may occur, in particular with jealous, erotomanic, and persecutory types. The condition is typically stable, with a small proportion going on to develop schizophrenia.

**Brief Psychotic Disorder and Schizophreniform Disorder**
Both conditions will present with a psychotic episode. These disorders differ from Schizophrenia in terms of the duration of the episode. In the case of brief psychotic episode psychotic symptoms may last 1-30 days, but not longer. In Schizophreniform Disorder the duration, may be 1-6 months, but not longer. Once these conditions have resolved, the long-term prognosis may be good. However, one cannot prospectively distinguish between a brief psychotic episode or schizophreniform disorder and schizophrenia in a period of remission. A period of observation, and medication management over time is required to clarify the diagnosis.

**Substance/Medication-Induced Psychotic Disorder**
Patients in this diagnostic category exhibit psychosis, but the symptoms can be shown to develop during or soon after substance intoxication or withdrawal, or after exposure to a medication. Additionally, the implicated substance or medication is known to be capable of inducing these symptoms. Causal agents include amphetamines, cocaine, steroids, sedatives, hypnotics, anxiolytics, and others. Once the precipitant is identified and eliminated or controlled, return to duty may be considered per the recommendation in the guidance.

**Psychotic Disorders Due to Another Medical Condition**
Patients in this diagnostic category experience mood changes similar to those of patients with other anxiety disorders, but there is evidence from history, physical examination, or laboratory testing that the disturbance is the direct pathophysiological consequence of another medical condition.

This diagnosis should only be made when:

1) A clear temporal association is present between the anxiety symptoms and onset, exacerbation, or remission of the medical condition and psychotic symptoms.

2) Features atypical of a primary psychotic disorder are present, e.g., unusual age of onset or course.

3) Evidence in the literature exists to support that a known physiologic mechanism causes psychosis.

4) Condition is not better explained by a primary schizophrenia spectrum disorder or another mental health disorder.

Diagnostic clarity is essential for the police physician in considering workability of the officer or candidate. If the precipitating condition is recurrent or chronic, the associated medical condition must be controlled to an extent that eliminates all psychotic symptoms before return to unrestricted work is considered. Prognosis is also important. The risk of recurrence of psychotic symptoms must be negligible (not higher than that in the general population.)
Post-traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a complex response to psychological trauma. The somatic, cognitive, affective and behavioral symptoms of PTSD develop following at least 1 traumatic event. In this regard it is an exposure related disease. The duration of diagnostic symptoms must be greater than 1 month. If symptoms resolve within 1 month following the inciting event, a diagnosis of acute stress disorder (ASD) may be made. This discussion is restricted to PTSD as diagnostic criteria and disability associated with the 2 conditions are similar except for duration.

PTSD patients vary greatly with regard to the nature and duration of symptoms, the social and occupational dysfunction the condition poses, and their response to treatment. Avoidance of reminders of the inciting trauma is a diagnostic criterion. This feature poses particular challenges in diagnosis and treatment of this condition, as patients are often reluctant to reveal or discuss traumatic events.

PTSD may result in extreme alteration of levels of arousal, negative changes in mood and cognition, intrusive thoughts or memories, dissociative events such as flashbacks, nightmares and other sleep disturbances, and distress with recollection of traumatic events. Symptoms may be triggered by workplace experiences that remind the LEO of prior trauma. Dissociative episodes (e.g., flashbacks) may be so severe as to reduce or eliminate situational awareness. Avoidant behavior, and heightened arousal and aggressive behavior in particular, may negatively affect work performance.

Epidemiology

U.S. lifetime prevalence is 8.7%, 12 months prevalence of 3.5%. Rates are lower in Europe and most African, Asian, and Latin American countries. Assuming similar exposure to traumatic events, the likelihood of developing PTSD may also vary across cultural groups. Prevalence and duration of symptoms of PTSD is greater among females than males, but this may be due to greater exposure to traumatic events.

By comparison with non-Latino whites, and after adjustment for demographics and traumatic exposure, rates in the U.S. are higher among Latinos, African Americans, and Native Americans. Rates are lower among Asian Americans. Rates are higher among those with greater exposure to trauma, including veterans, police officers, firefighters. With the highest rates (33-50%) among: victims of sexual violence; history of military combat and/or captivity; victims of “ethnically or politically motivated internment, or genocide.”

The diagnosis of PTSD is common among veterans. After hearing loss and tinnitus, PTSD is the third most common reason for Veterans Administration disability awards; 58% of VA awards for mental health disorders are for PTSD. Among veterans of Operation Enduring Freedom/Operation Iraqi Freedom with awards for mental health disorders, 75% are for PTSD. This is relevant given the large proportion of veterans among candidates for LEO positions.

PTSD symptoms and their severity may vary over time; 50% of persons diagnosed with PTSD will experience complete recovery within 3 months. However, more than 30% of those diagnosed with PTSD are symptomatic for at least 1 year. For some, symptoms last for decades. Symptoms may recur or increase in intensity with reminders of the inciting trauma, new traumatic events, or life-stressors.

Comorbidities

Persons with PTSD are 80% more likely to have symptoms meeting diagnostic criteria for another mental health disorder than those without PTSD. Depressive disorders, anxiety disorders, and substance abuse are 2-4 times more prevalent in patients with PTSD; substance abuse is often an attempt to self-medicate. There is also a high prevalence of PTSD in persons with history of traumatic brain injury (TBI). In one study returning soldiers with mild TBI, 62% screened positive for PTSD. Risk of developing PTSD following trauma is modified by pre-traumatic, peri-traumatic, and post-traumatic factors.

Pre-traumatic:
- Childhood emotional problems by age 6
- Prior mental disorders: panic disorder, depressive disorder, PTSD, or obsessive-compulsive disorder.
- Lower socio-economic status, lower education, childhood adversity and trauma, lower intelligence, minority racial/ethnic status, family psychiatric history, female gender, lower age at time of exposure.
• Social support prior to exposure is protective. Self-resilience may be another protective characteristic. In a 2015 cross-sectional study, 112 Korean police officers were tested using the Connor-Davidson Resilience Scale-Korean (CD-RI-K) and found that PTSD symptoms were more likely to be reported by officers with low self-resilience that those with high self-resilience (odds ratio of 3.5 CI: 1.06-19.23).26

Peri-traumatic:
• Severity of the experienced trauma, perceived life threat, personal injury, interpersonal violence (particularly trauma perpetrated by a caregiver, or involving a witnessed threat to caregivers in children), and, for military personnel, being a perpetrator, witnessing atrocities, or killing the enemy, finally, dissociation that occurs during the trauma and persists afterward.

Post-traumatic:
• Upsetting reminders, subsequent adverse life events;
• Negative appraisals, inappropriate coping strategies, development of acute stress disorder;
• Social support is a moderating factor which improves outcomes after trauma.

Treatment
Both psychotherapy and medication have been proven useful in treatment of PTSD, but no randomized trials have compared the two approaches. A systematic review of combined pharmacotherapy and psychological therapies did not find any significant increase in efficacy over either treatment alone.27

Trauma focused psychotherapeutic approaches to PTSD treatment have been shown to be effective by randomized controlled trials. These include cognitive therapy, trauma-focused cognitive-behavioral therapy (TF-CBT), behavioral therapy (typically exposure therapies), and eye-movement desensitization and reprocessing (EMDR). Evidence suggests that the key component of success with cognitive behavioral therapy and EMDR is exposure to traumatic memories.28

A systematic review of 35 randomized controlled studies found SSRIs effective as first-line agents in PTSD, and are recommended by the American Psychiatric Association practice guidelines for this disorder.29 These agents reduce intrusive thoughts, pathologic avoidance, hyperarousal, depression, vigilance, and impulsivity. Prazosin, an alpha-1-antagonist has been used to treat nightmares and improve overall PTSD symptoms, but studies are conflicting.30,31

Critical incident stress debriefing (CISD) is an intervention often used by police departments and fire departments following traumatic events involving first responders. The technique typically involves group recollection and discussion of a traumatic event. Despite the continued popularity of CISD, meta-analyses of clinical trials have found no evidence of effectiveness in preventing PTSD.32,33

Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD)
In adults, ADHD presents as a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning. The condition occurs in 2.5% of adults with a 1.6:1 male to female ratio. Persons with ADHD experience difficulty maintaining focus and persistence. They may appear disorganized. Motor activity may be excessive (hyperactivity). They may appear restless, and their hyperactivity may distress others. Impulsivity refers to the tendency to take action without suitable forethought – may have high potential to harm the individual. This can manifest socially through intrusiveness and interruption of others. Hasty decision-making without consideration of long-term consequences may also reflect impulsivity, and can affect multiple domains of function.

The risk of suicide may be increased in ADHD patients. A 2016 study using data from the adult psychiatric morbidity study showed odds ratios of 1.6 for lifetime suicidal ideation.34 A 2012 review of 25 studies found a positive relationship between ADHD and risk to self.35

Some diagnostic criteria may require consultation with collateral sources of information such as friends, co-workers, and/or family members. Two specific examples are: first, the requirement that several symptoms arise before age 12; and second, the requirement that symptoms must also manifest themselves in more than one setting.
Appendix B: Formal Assessment of Psychological Fitness for Duty

In addition to performing the initial evaluation of the LEO, the police physician should establish a referral relationship with a psychologist, psychiatrist, neuropsychologist or other licensed mental health professional qualified to offer a formal opinion of the LEO’s psychological fitness for duty. These evaluations should be performed by doctoral level mental health professionals and could include standardized testing. Some agencies may have their own mental health professionals who can perform such evaluations. Police physicians with specific training in this area may choose to do the formal assessment themselves. When available, preference should be given to professionals with formal public safety psychology training. When available, preference should be given to psychiatrists for medication management.

Irrespective of credentials, the mental health professional should not serve dually as the evaluator and therapist or after-action support personnel because of the potential for a conflict or the appearance of a conflict stemming from multiple roles.

In 2018, the International Association of Chiefs of Police (IACP) Police Psychological Services Section (PPSS) updated a set of guidelines to educate and inform the public safety agencies that request fitness-for-duty evaluations (FFDEs) and the practice of examiners who perform them (see https://www.theiacp.org/sites/default/files/2019-05/Fitness%20for%20Duty%20Evaluation%20Guidelines%202018.pdf). These guidelines represent an excellent framework for conducting the evaluation.

In advance of referral to a specialist, the police physician should acquaint the evaluator with LEO duties, circumstances and responsibilities, and could provide questions from Appendix D (provider’s questionnaire). Any collateral information provided by the agency for review in the preliminary assessment should also be provided to the specialist. It is the responsibility of the police physician to review the formal assessment from the licensed mental health professional and make final clearance recommendations to the agency. Given the sensitivity of mental health records, the minimum information needed for agency decision-making should be provided to the agency. In Pettus v. Cole, 49 Cal. App. 4th 402 (1996), medical providers were admonished against providing more information derived from evaluation than was actually needed to accomplish legitimate business objectives.
Appendix C: Return-to-Work Guidance for Safety-Sensitive Workers by Disorder

Several authorities have issued guidance concerning return to work for safety-sensitive employees suffering from mental health disorders. For ease of use, these are listed below, by disorder:

**Depressive Disorder**
- The U.S. Federal Motor Carrier Safety Administration (FMCSA) recommends that commercial drivers with major depressive disorder should not be certified until they have been asymptomatic for 6 months, 12 months if they were suicidal or psychotic features were present. Certification is not recommended for patients who display active psychosis, compromised judgment, attentional difficulties, suicidal behavior or ideation, a personality disorder which is repeatedly manifested by overt, inappropriate acts, or experiencing treatment adverse effects which interfere with driving.36
- The U.S. Air Force (USAF) specifies that a waiver is considered after depressive disorder is completely resolved and medications and psychotherapy have been discontinued for 6 months. Recurrent episodes are disqualifying.37
- The Australian Federal Police do not consider candidates until they have been stable, off of all treatment for a period of time up to 2 years following use of psychotropic medication, which includes SSRI and SNRI antidepressants by their definition. The waiting period depends on prior treatment duration. The minimum is 6 months.38
- The U.S. Federal Aviation Administration (FAA) has a specific selection process for individuals treated for depressive disorder with SSRIs who wish to fly. To qualify for consideration, pilots must have been on stable dose of a listed anti-depressant for 6 months. There can be no symptoms or history of: psychosis, suicidal ideation, electroconvulsive therapy, treatment with multiple SSRIs concurrently, multi-agent drug protocol use (prior use of other psychiatric drugs in conjunction with SSRIs.39
- The Canadian Railway Association’s railway medical guidelines requires that railway personnel with depressive disorder who serve in safety critical positions must undergo evaluation by a physician, and, at the discretion of the railway’s chief medical officer, by a psychiatrist, who will produce a written report. This report should include an assessment of the individual’s judgment, attention, insight, alertness, and also on the adverse effects of any medication. The length of the monitoring period follow-up, the frequency of assessments and the stringency of observation required may vary depending on the individual’s diagnosis and degree of disability. Fitness for duty requirements of all individuals with mental disorders will be established on a case-by-case basis at the discretion of the chief medical officer.40
- The National Transport Commission of Australia notes that for persons with any mental disorder, a conditional license may be considered by the driver-licensing authority, subject to periodic review and accounting for the nature of the driving task and information provided by a psychiatrist as to whether the following criteria are met41:
  - condition is well controlled and;
  - person is compliant with treatment over a substantial period; and
  - person has insight into the potential effects of their condition on safe driving; and
  - no adverse medication effects that may impair their capacity for safe driving; and
  - impact of co-morbidities has been considered (e.g. substance abuse).
- The U.S. Army, which is the lead agency for DoD Civilian security officers, states security officers should have no presence or history of, or signs associated with, the following diagnoses42:
  a) Delirium, dementia, and amnestic and other cognitive disorders
  b) Major depressive disorder
  c) Manic-depressive disorder (bipolar)
  d) Dissociative disorders
  e) Kleptomania
  f) Panic disorder and other anxiety disorders (depending upon etiology, duration and severity of clinical expression)
  g) Pathological gambling
  h) Pyromania
  i) Schizophrenia and other psychotic disorders
j) Personality disorders
k) Mental retardation
l) Alcohol or drug dependence
m) Other diagnoses not listed which may impair the performance of duties or which might endanger the lives of themselves or others.

The Army further states that: “Psychiatric disorders, which could affect safe and efficient job performance, require additional evaluation to determine whether the individual is able to safely and successfully perform the essential job functions. The presence of any psychiatric disorders, or a history of such, warrants referral for further evaluation by a psychologist or psychiatrist.”

Bipolar Disorder
The U.S. Federal Motor Carrier Safety Administration (FMCSA) recommends that commercial drivers with bipolar disorder not be certified until they have been asymptomatic for 6 months; 12 months if they were suicidal or psychotic features were present. Certification is not recommended for patients who display active psychosis, compromised judgment, attentional difficulties, suicidal behavior or ideation, a personality disorder which is repeatedly manifested by overt, inappropriate acts, or experiencing treatment adverse effects which interfere with driving. Recommendations specific to use of lithium, commonly utilized in treatment of this spectrum of disorders, are:

• Recommend to certify if the driver:
  - Is asymptomatic.
  - Has lithium levels that are maintained in the therapeutic range.
  - Has no impairment that interferes with safe driving.

• Recommend not to certify if: The driver has:
  - Disqualifying underlying condition.
  - Disqualifying symptoms.
  - Lithium levels that are not in the therapeutic range.

• The U.S. Air Force (USAF) waiver guide specifies that any aviator with any of the bipolar disorders is permanently disqualified due to the risk of recurrence, the presenting symptoms of loss of insight, tenuous reality-testing, and the unlikely-hood of self-referral, poor judgment and poor treatment compliance.

• The Australian Federal Police do not consider candidates with mental health disorders until they have been stable, off of all treatment for a period of time up to 2 years following use of psychotropic medication, which includes SSRI and SNRI antidepressants by their definition. The waiting period depends on prior treatment duration. The minimum is 6 months.

• The U.S. Federal Aviation Administration (FAA) advises that all applicants with a diagnosis of bipolar disorder must be denied or deferred. Those with a diagnosis of cyclothymia are included. The rationale is that “even if the bipolar disorder does not have accompanying symptoms that reach the level of psychosis, the disorder can be so disruptive of judgment and functioning (especially mania) as to pose a significant risk to aviation safety. Impaired judgment does occur even in the milder form of the disease.”

• The Railway Medical Guidelines of The Canadian Railway Association requires that railway personnel with bipolar disorder who serve in safety critical positions should undergo evaluation by a psychiatrist who will produce a written report. This report should include an assessment of the individual’s judgment, attention, insight, alertness, and also on the adverse effects of any medication. The length of the monitoring period follow-up, the frequency of assessments and the stringency of observation required may vary depending on the individual’s diagnosis and degree of disability. Fitness-for-duty requirements of all individuals with mental disorders will be established on a case-by-case basis at the discretion of the chief medical officer.

A person with bipolar disorder must be in remission for 1 year or longer – if indicated by medical evidence. Prior to return to work, individuals with this diagnosis must be evaluated by a psychiatrist. The chief medical officer may request regular follow-up reports once the individual has returned to work.
• The National Transport Commission of Australia notes that for persons with any mental disorder, a conditional license may be considered by the driver licensing authority, subject to periodic review and accounting for the nature of the driving task and information provided by a psychiatrist as to whether the following criteria are met:
  ▪ The condition is well controlled and;
  ▪ The person is compliant with treatment over a substantial period; and
  ▪ the person has insight into the potential effects of their condition on safe driving; and
  ▪ there are no adverse medication effects that may impair their capacity for safe driving; and
  ▪ the impact of co-morbidities has been considered (e.g., substance abuse).

• The U.S. Army, which is the lead agency for DoD Civilian security officers, states officers should have no presence or history of, or signs associated with, the following diagnoses:
  a) Delirium, dementia, and amnestic and other cognitive disorders.
  b) Major depressive disorder
  c) Manic-depressive disorder (bipolar)
  d) Dissociative disorders
  e) Kleptomania
  f) Panic disorder and other anxiety disorders (depending upon etiology, duration and severity of clinical expression)
  g) Pathological gambling
  h) Pyromania
  i) Schizophrenia and other psychotic disorders
  j) Personality disorders
  k) Mental retardation
  l) Alcohol or drug dependence
  m) Other diagnoses not listed which may impair the performance of duties or which might endanger the lives of themselves or others.

The Army further states that: “Psychiatric disorders, which could affect safe and efficient job performance, require additional evaluation to determine whether the individual is able to safely and successfully perform the essential job functions. The presence of any psychiatric disorders, or a history of such, warrants referral for further evaluation by a psychologist or psychiatrist.”

Anxiety Disorders
• The U.S. Federal Motor Carrier Safety Administration (FMCSA) does not directly address anxiety disorders and does not offer specific advice to examiners regarding any waiting period for certification. Specific recommendations concerning use of anxiolytic medications are as follows: “You should not certify the driver until the medication has been shown to be adequate/effective, safe, and stable.”

  Recommend to certify if the driver uses:
  • A hypnotic, if the medication is:
    ▪ Short-acting (half-life of less than 5 hours).
    ▪ The lowest effective dose.
    ▪ Used for a short period of time (less than 2 weeks).
  • Non-sedating anxiolytic...

  Recommend not to certify if the driver:
  • Uses a sedating anxiolytic.
  • Has symptoms or adverse effects that interfere with safe driving.

• The U.S. Air Force (USAF) specifies that a waiver is considered after an anxiety disorder is completely resolved and medications and psychotherapy have been discontinued for 6 months. In some cases continued treatment with SSRIs may be permissible.
• The **Australian Federal Police** do not consider candidates until they have been stable, off of all treatment for a period of time up to 2 years following use of psychotropic medication, which includes SSRI and SNRI anti-depressants by their definition. The waiting period depends on prior treatment duration. The minimum is 6 months.  

• The **U.S. Federal Aviation Administration (FAA)** requires additional history taking for persons with history of anxiety symptoms or disorders. The examiner is required to defer issuance to the FAA. With regard to medication use: “The use of a psychotropic drug is disqualifying for aeromedical certification purposes – this includes all antidepressant drugs, including selective serotonin reuptake inhibitors (SSRIs), antianxiety drugs and sedative hypnotics.” However, FAA has determined that airmen requesting first-, second-, or third-class medical certificates while being treated with one of four specific SSRIs may be considered (see Item 47, Psychiatric Conditions – Use of Antidepressant Medications). The authorization decision is made on a case by case basis by the FAA, the Examiner may not issue. To qualify for consideration, individuals treated for with SSRIs who wish to fly must have been on stable dose of a listed medication for 6 months. There can be no symptoms or history of: Psychosis, Suicidal ideation, Electro convulsive therapy, Treatment with multiple SSRIs concurrently, Multi-agent drug protocol use (prior use of other psychiatric drugs in conjunction with SSRIs).  

• The **Railway Medical Guidelines of The Canadian Railway Association** requires that railway personnel with Anxiety Disorders who serve in safety critical positions must undergo evaluation by a physician, and, at the discretion of the railway’s chief medical officer, by a psychiatrist, who will produce a written report. This report should include an assessment of the individual's judgment, attention, insight, alertness, and also on the adverse effects of any medication.

The length of the monitoring period follow-up, the frequency of assessments and the stringency of observation required may vary depending on the individual’s diagnosis and degree of disability. Fitness-for-duty requirements of all individuals with mental disorders will be established on a case-by-case basis at the discretion of the chief medical officer.

Specific diagnoses differ in regard to the asymptomatic post treatment period required, and special considerations:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Asymptomatic Post-treatment Period Required</th>
<th>Specific issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>3 months</td>
<td>Treating provider’s report must address recurrence, hyper-arousal, and affective problems</td>
</tr>
<tr>
<td>Acute Stress Disorder</td>
<td>1 month</td>
<td>Treating provider’s report must address recurrence, hyper-arousal, and affective problems</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder (PTSD)</td>
<td>3 months</td>
<td>Treating provider’s report should show clear evidence the disorder has completely resolved.</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>6 months</td>
<td>Diagnosis must be in response to neutral objects. If the phobic object is work-related, the diagnosis must be treated as above for panic disorder.</td>
</tr>
<tr>
<td>Phobic Disorder</td>
<td>None required</td>
<td></td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder (OCD)</td>
<td>3 months</td>
<td></td>
</tr>
</tbody>
</table>

• The **National Transport Commission of Australia** notes that for persons with any mental disorder, a conditional license may be considered by the driver-licensing authority subject to periodic review and taking into account the nature of the driving task and information provided by a psychiatrist as to whether the following criteria are met:
  - condition is well controlled and;
  - person is compliant with treatment over a substantial period; and
  - person has insight into the potential effects of their condition on safe driving; and
  - no adverse medication effects that may impair their capacity for safe driving; and
  - impact of co-morbidities has been considered (e.g., substance abuse).

• The **U.S. Army**, which is the lead agency for DoD Civilian security officers, states officers should have no presence or history of, or signs associated with, the following diagnoses:

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\[ Page 23 | 37 \]
a) Delirium, dementia, and amnestic and other cognitive disorders.
b) Major depressive disorder
c) Manic-depressive disorder (bipolar)
d) Dissociative disorders
e) Kleptomania
f) Panic disorder and other anxiety disorders (depending upon etiology, duration and severity of clinical expression)
g) Pathological gambling
h) Pyromania
i) Schizophrenia and other psychotic disorders
j) Personality disorders
k) Mental retardation
l) Alcohol or drug dependence
m) Other diagnoses not listed which may impair the performance of duties or which might endanger the lives of themselves or others.

The Army further states that: “Psychiatric disorders, which could affect safe and efficient job performance, require additional evaluation to determine whether the individual is able to safely and successfully perform the essential job functions. The presence of any psychiatric disorders, or a history of such, warrants referral for further evaluation by a psychologist or psychiatrist.”

Psychoses
• The U.S. Federal Motor Carrier Safety Administration (FMCSA) recommends that commercial drivers with psychoses should not be certified until they have been asymptomatic for 6 months, 12 months if they were suicidal or psychotic features were present. Certification is not recommended for patients who display active psychosis, compromised judgment, attentional difficulties, suicidal behavior or ideation, a personality disorder which is repeatedly manifested by overt, inappropriate acts, or experiencing treatment adverse effects which interfere with driving.

“Except for a confirmed diagnosis of schizophrenia, determination may not be based on diagnosis alone. The actual ability to drive safely and effectively should not be determined solely by diagnosis but instead by an evaluation focused on function and relevant history.”

A minimum 6-month symptom-free period is required if the diagnosis is brief reactive psychosis or schizophreniform disorder. A minimum of 1-year symptom free is required for any other psychotic disorder, except schizophrenia, which is disqualifying. The maximum period of certification is 1 year.

Recommend to certify if the driver:
• Completes an appropriate symptom-free waiting period.
• Complies with treatment program.
• Tolerates treatment without disqualifying adverse effects (e.g., sedation or impaired coordination).
• Has a comprehensive evaluation from an appropriate mental health professional who understands the functions and demands of commercial driving.

Recommend not to certify if the driver has:
• Diagnosis of schizophrenia.
• Active psychosis.
• Prominent negative symptoms, including:
  ▪ Substantially compromised judgment.
  ▪ Attentional difficulties.
  ▪ Suicidal behavior or ideation.
• Personality disorder that is repeatedly manifested by overt, inappropriate acts.
• Treatment adverse effects that interfere with safe driving.
• The U.S. Air Force (USAF) considers schizophrenia, schizoaffective disorder, delusional disorder, brief psychotic disorder without marked stressor(s), and shared psychotic disorder permanently disqualifying for flying duties. For other psychoses, a waiver is considered after the patient has been free of psychotic symptoms and off all mental health treatment including psychotropic medications for 1 year. A psychotic episode caused by alcohol, and occurring during the course of alcohol abuse or alcohol dependence, is considered for waiver in accordance with the waiver requirements for alcohol abuse or dependence. A psychotic episode caused by alcohol, but not in the setting of alcohol abuse or dependence, is considered for waiver according to the guidance in [the] waiver guide. In cases of psychotic disorder due to a general medical condition waiver may be considered once the psychosis and the medical condition have completely resolved and are unlikely to recur, and if the medical condition itself is waiverable.37

• The Australian Federal Police do not consider candidates until they have been stable, off of all treatment for a period of time up to 2 years following use of psychotropic medication, which includes SSRI and SNRI anti-depressants by their definition. The waiting period depends on prior treatment duration (minimum is 6 months).38

• The U.S. Federal Aviation Administration (FAA) advises that any applicant with a history or clinical diagnosis of Psychosis must be declined or deferred.39

• The Railway Medical Guidelines of The Canadian Railway Association requires that railway personnel with psychosis who serve in safety critical positions must undergo evaluation by a psychiatrist who will produce a written report. This report should include an assessment of the individual’s judgment, attention, insight, alertness, and also on the adverse effects of any medication. Schizophrenia spectrum and other psychotic disorders other than brief psychotic disorder and delusional disorder are contraindications to employment in safety-sensitive positions. Regular follow-up reports indicating fitness for duty may be requested at the discretion of the chief medical officer.40

• The National Transport Commission of Australia notes that for persons with any mental disorder, a conditional license may be considered by the driver-licensing authority, subject to periodic review, and accounting for the nature of the driving task and information provided by a psychiatrist as to whether the following criteria are met41:
  - The condition is well controlled and;
  - The person is compliant with treatment over a substantial period; and
  - the person has insight into the potential effects of their condition on safe driving; and
  - there are no adverse medication effects that may impair their capacity for safe driving; and
  - the impact of co-morbidities has been considered (e.g., substance abuse).

• The U.S. Army, which is the lead agency for DoD Civilian security officers, states officers should have no presence or history of, or signs associated with, the following diagnoses42:
  a) Delirium, dementia, and amnestic and other cognitive disorders
  b) Major depressive disorder
  c) Manic-depressive disorder (bipolar)
  d) Dissociative disorders
  e) Kleptomania
  f) Panic disorder and other anxiety disorders (depending upon etiology, duration and severity of clinical expression)
  g) Pathological gambling
  h) Pyromania
  i) Schizophrenia and other psychotic disorders
  j) Personality disorders
  k) Mental retardation
  l) Alcohol or drug dependence
  m) Other diagnoses not listed which may impair the performance of duties or which might endanger the lives of themselves or others.

The Army further states: “Psychiatric disorders, which could affect safe and efficient job performance, require additional evaluation to determine whether the individual is able to safely and successfully perform the essential
job functions. The presence of any psychiatric disorders, or a history of such, warrants referral for further evaluation by a psychologist or psychiatrist.”

Post-traumatic Stress Syndrome (PTSD)

- The U.S. Federal Motor Carrier Safety Administration (FMCSA) does not directly address PTSD or its treatment (see Anxiety above). 
- The U.S. Air Force (USAF) specifies that no waiver is required for the diagnosis of PTSD if patient is able to return to full duty within 60 days with minimal symptoms at most. A waiver is required for the following patients:
  - Those who are assigned DNIF (duties not including flying) for more than 60 days;
  - Those who experience a recurrence of debilitating symptoms on return to the operational environment;
  - Those for whom the original symptom severity was such that in the opinion of the flight surgeon, return to the operational environment would entail high risk to the member, the mission or flight safety should the symptoms recur; and
  - Most waivers granted have been for those with 6 months free of symptoms off of all pharmacotherapy.
- The Australian Federal Police do not consider candidates until they have been stable, off of all treatment for a period of time up to 2 years following use of psychotropic medication, which includes SSRI and SNRI anti-depressants by their definition. The waiting period depends on prior treatment duration (minimum is 6 months).
- The U.S. Federal Aviation Administration (FAA) has no specific guidance for assessment of pilots with PTSD. There is a specific selection process for individuals treated for depressive disorder with SSRIs who wish to fly, which may be applicable to PTSD patients who use SSRIs. To qualify for consideration, they must have been on stable dose of a listed anti-depressant for 6 months. There can be no symptoms or history of: psychosis, suicidal ideation, electro-convulsive therapy, treatment with multiple SSRIs concurrently, and/or multi-agent drug protocol use (prior use of other psychiatric drugs in conjunction with SSRIs).
- The Railway Medical Guidelines of The Canadian Railway Association lists PTSD with anxiety conditions. See the entry under this heading above.

- The National Transport Commission of Australia notes that for persons with any mental disorder, a conditional license may be considered by the driver licensing authority subject to periodic review, taking into account the nature of the driving task and information provided by a psychiatrist as to whether the following criteria are met:
  - The condition is well controlled and:
    - person is compliant with treatment over a substantial period; and
    - person has insight into the potential effects of their condition on safe driving; and
    - there are no adverse medication effects that may impair their capacity for safe driving; and
    - the impact of co-morbidities has been considered (e.g., substance abuse).

- The U.S. Army, which is the lead agency for DoD Civilian security officers, states officers should have no presence or history of, or signs associated with, the following diagnoses:
  a) Delirium, dementia, and amnestic and other cognitive disorders
  b) Major depressive disorder
  c) Manic-depressive disorder (bipolar)
  d) Dissociative disorders
  e) Kleptomania
  f) Panic disorder and other anxiety disorders (depending upon etiology, duration and severity of clinical expression)
  g) Pathological gambling
  h) Pyromania
  i) Schizophrenia and other psychotic disorders
  j) Personality disorders
  k) Mental retardation

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1. Alcohol or drug dependence
m) Other diagnoses not listed which may impair the performance of duties or which might endanger the lives of themselves or others.

The Army further states: “Psychiatric disorders, which could affect safe and efficient job performance, require additional evaluation to determine whether the individual is able to safely and successfully perform the essential job functions. The presence of any psychiatric disorders, or a history of such, warrants referral for further evaluation by a psychologist or psychiatrist.”

**Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

- The **U.S. Federal Motor Carrier Safety Administration (FMCSA)** recommends that commercial drivers with ADD/ADHD should not be certified until the etiology is confirmed and treatment has been shown to be adequate/effective, safe, and stable.

Prior to certification, the driver should have a comprehensive evaluation from an appropriate mental health professional who understands the functions and demands of commercial driving. The driver must be compliant with the treatment program, and tolerate treatment without disqualifying adverse effects (e.g., sedation or impaired coordination). No specific waiting period is recommended.

Certification is not recommended for patients who display active psychosis, compromised judgment, attentional difficulties, suicidal behavior or ideation, a personality disorder which is repeatedly manifested by overt, inappropriate acts, or experiencing treatment adverse effects which interfere with driving. Annual recertification is recommended.

- The **U.S. Air Force (USAF)**: A confirmed diagnosis of ADHD was disqualifying for all classes of flying until 2009. Since then, ADHD is no longer considered disqualifying if the individual can demonstrate passing academic performance and there has been no medication use in the past 12 months. With the policy change and the increased incidence of diagnosis in the community, aviators with a diagnosis of ADHD or a history of such are more common. ADHD is only disqualifying for flying duties in the USAF if the applicant requires the use of medication or if there is demonstrated academic performance failure.

- The **Australian Federal Police** do not consider candidates until they have been stable, off all treatment for a period of time up to 2 years following use of psychotropic medication, which includes SSRI and SNRI anti-depressants by their definition. Waiting period depends on prior treatment duration (minimum is 6 months).

- The **U.S. Federal Aviation Administration (FAA)**: Pilots with ADHD must be deferred by the examiner and FAA has a specific disease protocol for evaluation of ADHD patients which includes detailed specifications for neuropsychological evaluation. The following must be submitted to the FAA for consideration:
  - Review of all available records, including academic records, records of prior psychiatric hospitalizations, and records of periods of observation or treatment (e.g., psychiatrist, psychologist, or pediatric neuropsychiatrist treatment notes). Records must be in sufficient detail to permit a clear evaluation of the nature and extent of any previous mental disorders.
  - A thorough clinical interview to include a detailed history regarding psychosocial or developmental problems; academic and employment performance; legal issues; substance use/abuse (including treatment and quality of recovery); aviation background and experience; medical conditions, and all medication use; and behavioral observations during the interview and testing.
  - Mental status examination.
  - Interpretation of a full battery of neuropsychological and psychological tests including but not limited to the core test battery (specified below).
  - An integrated summary of findings with an explicit diagnostic statement, and the neuropsychologist’s opinion(s) and recommendation(s) regarding clinically or aeromedically significant findings and the potential impact on aviation safety consistent with the Federal Aviation Regulations.
• Results of a urine drug screening test for ADD/ADHD medications, including psychostimulant medications. The sample must be collected at the conclusion of the neurocognitive testing or within 24 hours afterward.

• Specific neuropsychological tests are listed

• The Railway Medical Guidelines of The Canadian Railway Association states that individuals suffering from ADD/ADHD cannot work in a safety critical position if their symptoms affect their ability to perform their duties in a safe, predictable manner. They must be assessed by their own physician or a psychiatrist who is required to submit a written report to the chief medical officer. This report must include an assessment of the individual’s judgement and attention and also on the adverse effects of any medication. Regular follow-up reports indicating fitness for duty may be requested at the discretion of the chief medical officer.40

• The National Transport Commission of Australia notes that for persons with any mental disorder, a conditional license may be considered by the driver licensing authority, subject to periodic review and accounting for the nature of the driving task and information provided by a psychiatrist as to whether the following criteria are met41:
  - The condition is well controlled and;
  - The person is compliant with treatment over a substantial period; and
  - The person has insight into the potential effects of their condition on safe driving; and
  - There are no adverse medication effects that may impair their capacity for safe driving; and
  - The impact of co-morbidities has been considered (e.g., substance abuse).

• The U.S. Army, which is the lead agency for DoD Civilian security officers, states officers should have no presence or history of, or signs associated with, the following diagnoses42
  a) Delirium, dementia, and amnestic and other cognitive disorders
  b) Major depressive disorder
  c) Manic-depressive disorder (bipolar)
  d) Dissociative disorders
  e) Kleptomania
  f) Panic disorder and other anxiety disorders (depending upon etiology, duration and severity of clinical expression)
  g) Pathological gambling
  h) Pyromania
  i) Schizophrenia and other psychotic disorders
  j) Personality disorders
  k) Mental retardation
  l) Alcohol or drug dependence
  m) Other diagnoses not listed which may impair the performance of duties or which might endanger the lives of themselves or others.

The Army further states that: “Psychiatric disorders, which could affect safe and efficient job performance, require additional evaluation to determine whether the individual is able to safely and successfully perform the essential job functions. The presence of any psychiatric disorders, or a history of such, warrants referral for further evaluation by a psychologist or psychiatrist.”42
Appendix D: Suggested Questions for Treating Providers and Mental Health Consultants

Articulation of clear questions to be answered by the evaluator is one of the primary ways the police physician can improve the quality of the result obtained. It is good practice to review questions for an external evaluator with the employer to be certain the evaluation will address their concerns. Communication between the police physician and both treating and consulting mental health specialists is important to ensure accuracy and relevance.

1) Do you believe the LEO now has suicidal intent? If yes, does the LEO have a plan?

2) Does the LEO's present diagnosis(es) and/or treatment interfere with cognition, judgment, or attention to a degree which could compromise the safe performance of their duties?

3) Is there any evidence of substance use/abuse which interferes with the LEO's cognition, judgment, or attention to a degree which could compromise the safe performance of their duties?

4) Is there any evidence of cognitive slowing, active psychosis, or response to internal stimuli which interferes with the LEO’s awareness of, interpretation of, or response to their physical and interpersonal environment?

5) If you have responded affirmatively to any of questions 1 to 4, please indicate if and when you feel it would be appropriate to re-evaluate the LEO.

6) Please make any recommendations you feel are appropriate concerning the LEO’s diagnosis and treatment plan.

7) Does the LEO present a risk to himself/herself or others in the workplace due to one or more of the following factors:
   a. Attentional difficulties
   b. Hostility or intent to do harm to self or others
   c. Inability to follow work rules, including safety procedures
   d. Inability to understand, remember, or execute complex job instructions
   e. Impairment of judgment and decision-making abilities

8) If so, please specify.

9) Do you anticipate the LEO will encounter any difficulty in relating to co-workers or supervisors which would prevent return to the work environment?

10) If you have responded in the affirmative to questions 7 or 9, please recommend any ways in which the employer can facilitate the LEO’s safe and successful return to duty.

11) If it is your view that the LEO is not yet ready to return to work, please indicate when re-evaluation would be appropriate in terms of duration and milestones to be met.
## Appendix E: Screening Tools

The table below lists screening tools which the police physician may find useful in evaluation and re-assessment of LEOs with mental health disorders. The instruments described are not copyrighted and may be used freely.

The following is a list of screening tests which are useful in evaluation of listed conditions. All of these are in the public domain. Screening tests are not diagnostic and should be used to determine the need for a diagnostic evaluation.

<table>
<thead>
<tr>
<th>Condition of Concern</th>
<th>Screening Test</th>
<th>Web-link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar Disorder</td>
<td>Mood Disorder Questionnaire (MDQ)</td>
<td><a href="http://www.integration.samhsa.gov/images/res/MDQ.pdf">http://www.integration.samhsa.gov/images/res/MDQ.pdf</a></td>
</tr>
<tr>
<td>Psychosis</td>
<td>Brief Psychiatric Rating Scale (BPRS)</td>
<td><a href="http://uwaims.org/files/measures/BPRS.pdf">http://uwaims.org/files/measures/BPRS.pdf</a></td>
</tr>
<tr>
<td>Cognitive</td>
<td>Montreal Cognitive Assessment (MOCA)</td>
<td><a href="https://www.mocatest.org/">https://www.mocatest.org/</a></td>
</tr>
</tbody>
</table>
Appendix F: Suicidal Behavior

Introduction
Suicide is a major public health problem in the United States and internationally. It affects LEOs in numerous ways. LEOs are often the first on the scene where a suicide is in process or has been completed. There is the phenomenon of "suicide by cop" where officers may be provoked to kill individuals who are seeking to die. There is suicidality among police officers, who face numerous occupational risks for suicidality and, typically, a culture which does not encourage protective activities such as seeking mental health care, and other assistance – which can mitigate risk.

Per WHO, the definition of suicide is “an act of self-harm taken with the expectation that it will be fatal.” “A suicide-attempt is a non-fatal act of self-harm, often with the aim of mobilizing help.”43 Schneidman, a prominent American suicidologist, offers a useful, expanded definition of suicide:

“Suicide is a conscious act of self-annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which suicide is perceived as the best solution.”44

Thoughts of suicide, or suicidal ideation, exists on a continuum from passive thoughts that ‘one is better off dead’ which may be fleeting, to fantasies of, or plans for, suicide with high levels of detail. Suicidal behaviors are behaviors, not diagnoses unto themselves. It is true they are commonly associated with mental health such as major depressive disorder, bipolar disorder, PTSD, substance use disorder, and borderline personality disorder. However, suicidality can also be precipitated by personal losses, humiliation, major medical illness, and other psychosocial stressors – even in the absence of a mental health disorder.

Treatment of suicide as a public health problem can be divided into three categories, prevention, intervention, and postvention.45 As police physicians we may play a role in all three processes, but the focus of this guidance is to facilitate assessment of LEO safety and workability after they have expressed suicidal ideation, planning, or made an unsuccessful attempt.

Epidemiology
CDC data from 1999 through 2017 indicates suicide is among the top 10 causes of death for Americans of all age groups from 10-14 to 55-64, and for all ages. For age groups 10-14, 15-24, 25-34 suicide is the second leading cause of death. Heyman et al. observe that among LEOs, suicide rates hover close to the national rates in the U.S., 11-17 per 100,000, vs. civilian average of 13. An organization called Badge of Life which tracks media reports of police suicides identified 140 cases in 2017. This exceeded the number of line-of-duty deaths (127) for that year.46

Some studies have found that police suicide rates trail those of their communities. Marzuk looked at suicide rates for New York City police officers from 1977-1996, and found that they trailed demographically adjusted rates for New Yorkers as a whole. (14.9 vs. 18.3 per 100,000) However, methodological problems, biases of officers and departments probably lead to an underestimate of police suicides.47

More recently, Violanti conducted a large proportional mortality study of suicide among US law enforcement workers between 1999 and 2007. He showed proportionate mortality ratios (PMRs) were higher for those in law enforcement professions – ranging from 133 to 388 depending on demographic and occupational factors.48

Police suicide rates are known to be elevated elsewhere in the world. A study of Italian police suicides from 1995-2017, found rates to be consistently in excess of rates for national resident population below age 65.49 Loo performed a meta-analysis of studies of police suicide rates internationally and found great variability from 0-75.28 per 100,000, with the lowest rates in Asia, Africa and the Caribbean, and the highest rates in American and European countries. As in American studies, firearms were the predominant method.50
Suicide Mythology and Stigma:

<table>
<thead>
<tr>
<th>Fable</th>
<th>Fact</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who talk about suicide don’t commit suicide.</td>
<td>Of any 10 persons who kill themselves, 8 gave warning of their intentions.</td>
</tr>
<tr>
<td>Suicide happens without warning.</td>
<td>Studies show the suicidal person gives many clues and warnings regarding suicidal intentions.</td>
</tr>
<tr>
<td>Suicidal people are fully intent on dying.</td>
<td>Most suicidal people are undecided about living or dying, and they “gamble with death,” leaving it to others to save them. Almost no one commits suicide without letting others know how they are feeling.</td>
</tr>
<tr>
<td>Once a person is suicidal, he or she is suicidal forever.</td>
<td>Individuals who wish to kill themselves are suicidal only for a limited period of time.</td>
</tr>
<tr>
<td>Improvement following a suicidal crisis means that the suicidal risk is over.</td>
<td>Most suicides occur within about three months following the beginning of “improvement,” when the individual has the energy to put their morbid thoughts and feelings into effect.</td>
</tr>
<tr>
<td>Suicide strikes much more often among the rich; or conversely, occurs almost exclusively among the poor.</td>
<td>Suicide is neither the rich person’s disease nor the poor person’s curse. Suicide is very democratic and represented proportionally among all levels of society.</td>
</tr>
<tr>
<td>All suicides are mentally ill, and suicide is always the act of a psychotic person.</td>
<td>Studies of hundreds of suicide notes indicate that though the suicidal person is extremely unhappy, he/she is not necessarily mentally ill.</td>
</tr>
</tbody>
</table>

Misinformation concerning suicide, its causes, and the behavior of suicidal people is pervasive and damaging to efforts to deal constructively with this problem. This is a longstanding problem. The table above, listing several common misconceptions, and the associated facts dates to 1967.51 Their persistence speaks to a general societal failure to address suicidality. For medical professionals to be effective with suicidal patients we must start with the truth.

It is generally accepted that culturally, LEOs place a high value on self-reliance, and the ability to shake off the daily stresses and traumas associated with their work. Seeking help for personal mental health conditions, or suicidal thoughts does not conform to these standards. Bell and Eski note that fear of the consequences of non-conformance contributes significantly to LEOs’ reticence to come forward when in distress. LEOs believe that discussion of mental illness, suicidal thoughts, or even serious stressors may be “career ending.”52

In contrast, Karaffa and Koch found that when individual officers were interviewed privately about their own attitudes, they had a relatively nuanced and more accepting attitude toward mental illness and suicidality. However, when asked what they thought their colleagues felt about these conditions, they described their views as harsher and more negative. In social psychology this is referred to as pluralistic ignorance – a situation in which a majority of group members privately reject a norm, but go along with it because they incorrectly assume that most others accept it.53

The stereotypical attitudes, and a potentially faulty belief in their true prevalence are important reinforcers of the stigma associated with mental health disorders and suicidality among LEOs. In the field of police suicidiology, these are part of what are referred to as the blue walls. Leenaars describes three phenomena in suicidal patients which are particularly relevant to the police physician.45 The first is masking, or dissembling, in which a suicidal patient seeks to conceal their intent, to prevent interference.

The second phenomenon is contagion. Among occupational groups, LEOs and other first responders are more likely to encounter suicidal people, while alive and after suicides have been completed. Contagion is said to occur when one suicidal event resonates with other suicidal people and causes them to think it may be a solution for them. In the year following comedian Robin Williams’ suicide by hanging – the frequency with which that method was used increased significantly. This was attributed to the publicity associated with his death. CDC has issued guidance on avoiding contagion with suicide reporting which is useful for departments in crafting their communications about these events.54 Suicide is traumatizing for first responders, whether it is their own suicidal thinking, or the thoughts or actions of others, to whom they must respond. Contagion should be considered after any critical incident involving LEOs and suicide.

The third phenomenon is constriction of thought – for the suicidal person, their problems and the perceived solution becomes so prominent in their thinking that the rest of the world falls away. This irrational tunnel vision can be evident on interview.
Risk Factors and Protective Factors
Suicide risk is determined, in part, by the interplay of risk factors and protective factors – which differ in each individual case. Risk factors may be divided into individual and environmental factors. Some are chronic and or recurrent conditions, others are fleeting.

General Risk factors for Suicide in the General Population

<table>
<thead>
<tr>
<th>Individual Risk Factors</th>
<th>Environmental Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous attempt</td>
<td>Chaotic family situation</td>
</tr>
<tr>
<td>Physical illness, chronic pain</td>
<td>Lack of support/isolation</td>
</tr>
<tr>
<td>Psychiatric conditions</td>
<td>Access to means</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Contagion</td>
</tr>
<tr>
<td>Anhedonia, hopelessness, helplessness, impulsivity</td>
<td>Legal difficulties</td>
</tr>
<tr>
<td>History of trauma or abuse</td>
<td>Barriers to healthcare access</td>
</tr>
<tr>
<td>Family history of suicide</td>
<td>Cultural/religious beliefs</td>
</tr>
<tr>
<td>Precipitating events that contribute to shame, humiliation, despair</td>
<td></td>
</tr>
<tr>
<td>Previous attempt</td>
<td></td>
</tr>
<tr>
<td>Physical illness, chronic pain</td>
<td></td>
</tr>
<tr>
<td>Gender dysphoria</td>
<td></td>
</tr>
</tbody>
</table>

Leenaars notes that alcohol and other substance abuse is associated with police suicide in most studies.45 Per Violanti, PTSD, depressive disorder, and substance use disorder are more prevalent that can be explained by chance alone in suicidal officers.55 Marzuk, in a study of New York police officers found marital/relationship problems, job suspensions, and alcoholism were commonly associated with police suicides.47

General Protective Factors in the General Population

<table>
<thead>
<tr>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
</tr>
<tr>
<td>Living situation</td>
</tr>
<tr>
<td>Friends</td>
</tr>
<tr>
<td>Coworker relationships</td>
</tr>
<tr>
<td>Therapist</td>
</tr>
<tr>
<td>Trusted physician</td>
</tr>
<tr>
<td>Pastor/church</td>
</tr>
<tr>
<td>Knowledge base</td>
</tr>
<tr>
<td>Financial standing</td>
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</tbody>
</table>

Protective factors reduce the likelihood of suicidality. As described below, evaluation of suicide risk involves consideration of relevant risk factors and protective factors. For a police physician engaged in longitudinal preventive care of LEOs, developing an understanding of these aspects of the officers’ histories could be useful in maintenance of mental wellness.

Access to firearms is a part of the job for most LEOs in the U.S. Firearms are likely used in the majority of police suicides. Firearms are an especially lethal means of suicide, especially in the hands of a trained person. For the general population firearms are used in only 5% of attempts, but are the means used in 53% of suicide deaths. At times it may be necessary to limit a LEO’s access to firearms. This should include unsanctioned access to weapons at while on light duty. Departments may also want to consider whether off duty officers should routinely carry their service weapons, as this significantly increases access.
Assessment of the Acutely Suicidal LEO

The police physician, will, from time to time, encounter a LEO with acute suicidal thoughts. Careful attention should be paid to safety and security. If the examination cannot be performed safely, the LEO should be referred to a facility, such as a psychiatric emergency room, where this can occur. The assistance of the department may be required.

If an evaluation can be conducted it is useful to have a structured clinical approach to initial assessment. The Suicide Assessment Five-step Evaluation and Triage (SAFE-T) card, is one such an approach. Steps 1 and 2 are the identification of risk factors and protective factors respectively. Step 3 involves conduct of a suicide inquiry. Step 4 is determination of risk level and selection of an appropriate intervention. Step 5 is documentation.

The suicide inquiry (Step 3) is a process of uncovering suicidal thinking and attempts by interview. Some useful questions:

- Sometimes people in your situation lose hope. I’m wondering if you’ve felt that, too?
- Have you ever thought things would be better if you were dead?
- Have you ever thought about hurting or killing yourself?
- Have you ever tried to kill yourself?

If suicidal thoughts are initially denied but you remain suspicious – it is OK to ask again. If the denial is convincing it is OK to stop.

If suicidal ideation is present, inquire about frequency, duration, and intensity:

- When did you begin having suicidal ideation?
- Did anything seem to set off your thinking?
- How often do you have these thoughts? How long do they last? How strong are the thoughts?
- What is the worst they’ve ever been?
- What do you do when you have suicidal thoughts?

Ask about suicide planning:

- Do you have a plan for how you would end your life? How would you do it? Where would you do it?
- Do you have the (drugs/gun/rope) that you would use? Where is it now?
- Do you have a timeline in mind? Is there something that would tell you it’s time?

Remember, asking about a patient’s suicidal thinking is not going to cause them to act on their thoughts. Lastly, evaluate the patient’s level intent:

- What would you accomplish by ending your life?
- How confident are you that the plan would end your life?
- What have you done to begin carrying out the plan?
- Have you rehearsed or practiced?
- Have you made arrangements to take care of finances, family, pets?
- How likely do you think you are to carry out your plan?

The table below shows the process for using recorded risk/protective factors and assessed degree of suicidality to place the LEO in high-, moderate-, or low-risk categories and decide on a range of possible interventions.

<table>
<thead>
<tr>
<th>RISK LEVEL</th>
<th>RISK / PROTECTIVE FACTOR</th>
<th>SUICIDALITY</th>
<th>POSSIBLE INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Psychiatric disorders with severe symptoms, or acute precipitating events; protective factors not relevant</td>
<td>Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal</td>
<td>Admission generally indicated unless a significant change reduces risk. Suicide precautions</td>
</tr>
<tr>
<td>Moderate</td>
<td>Multiple risk factors, few protective factors</td>
<td>Suicidal ideation with plan, but no intent or behavior</td>
<td>Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers</td>
</tr>
<tr>
<td>Low</td>
<td>Modifiable risk factors, strong protective factors</td>
<td>Thoughts of death, no plan, intent or behavior</td>
<td>Outpatient referral, symptom reduction. Give emergency/crisis numbers</td>
</tr>
</tbody>
</table>

This is useful when it is not possible to make a referral to a mental health professional for initial assessment. Clear documentation of the evaluative process is essential. For non-emergent cases, referral to EAP, peer counselling, may be appropriate acutely. Referral to the department’s mental health consultant for a more formal FFD evaluation is likely to be necessary in any high or moderate risk case.
Role of Police Physicians, Departmental Management, and Mental Health Consultants in Managing Suicidality in Law Enforcement Agencies

<table>
<thead>
<tr>
<th></th>
<th>Prevention</th>
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</thead>
</table>
| Police Physician       | • Routinely explore mental health disorders, substance use, psychosocial stressors, suicide risk factors  
                          | • Remind LEOs about available resources                                     
                          | • Referrals when appropriate                                                 
                          | • Act on recommendations of mental health consultant in advising the department |
| Department             | • Make mental health and resiliency a leadership priority                    
                          | • Institutionalized mental wellness and suicide prevention policies and practices |
                          | • Agency campaigns to raise awareness                                       
                          | • Invest in training re: mental health/resiliency/dealing with critical incidents (suicides, traumatic events) – focus on first-line supervisors |
                          | • Provide family training and events                                        |
| Mental Health Consultant | • Post-offer screening and recommendations.                                 
                            | • Periodic mental health wellness screenings                                 
                            | • Work with department and police physician in clinical management          |

<table>
<thead>
<tr>
<th></th>
<th>Intervention</th>
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</thead>
</table>
| Police Physician       | • Be prepared to manage LEO suicidality from ideation to attempts          
                          | • Referrals when appropriate                                                 
                          | • Act on recommendations of mental health consultant in advising the department |
                          | • Consult with mental health consultant and department concerning needs intervention programs in context of specific events |
| Department             | • Make mental health and resiliency a leadership priority                   
                          | • Establish intervention protocols for assisting officers at risk (for mental health crises, suicidal ideation of behavior |
                          | • Audit psychological service providers to insure effective intervention. This includes peer providers. |
                          | • Pay closer attention to at risk groups                                   |
| Mental Health Consultant | • Fitness for duty assessments                                             
                            | • Follow-up visits                                                         
                            | • Consult with police physician and department concerning needs intervention programs in context of specific events |

<table>
<thead>
<tr>
<th></th>
<th>Post-Intervention</th>
</tr>
</thead>
</table>
| Police Physician       | • Routinely explore: MHD, substance use, psychosocial stressors, suicide risk factors  
                          | • Remind LEOs about available resources                                     
                          | • Referrals when appropriate                                                 
                          | • Be prepared to assist department with family, agency, and community notification |
                          | • Support department in post-incident counselling and agency-wide mental health awareness actions |
| Department             | • Make mental health and resiliency a leadership priority                   
                          | • Institutionalized mental wellness and suicide prevention policies and practices |
                          | • Agency campaigns to raise awareness                                       
                          | • Invest in training re: mental health/resiliency/dealing with critical incidents – focus on first-line supervisors |
                          | • Provide family training and events                                        |
| Mental Health Consultant | • Post event screening and recommendations. Focus on higher-risk LEOs.     
                            | • Periodic mental health wellness screenings                                
                            | • Be prepared to assist department with family, agency, and community notification |
                            | • Assist department with revision of agency trainings in context of event   |
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