NPCC National Police Chiefs' Council

The National Police Wellbeing Service

College of Policing

Occupational Health assessment of new police officer applicants

Annex B: Schema for mental health assessment

Contents

Introduction

Mental health and wellbeing is a priority for UK policing. Policing roles are challenging and there is accumulating evidence of mental ill health in police officers. However, it can be difficult to predict which police officer applicants will develop mental ill health during their careers based on an occupational health assessment. (See appendix 1) The biopsychosocial model, which should now be the cornerstone of occupational health practice, helps us understand how aetiological factors may interact and develop over time. Many of these factors relate to work organisation rather than to factors intrinsic to policing. 3P and 4P models have been proposed to help clinicians with case formulation.[1] [2] When considering the mental health of police officer applicants assessment of the presence of preconditions or predisposing factors, precipitating factors, and perpetuating factors of illness (3P model) should help to estimate suitability to join the police. In addition, the identification of protective factors (4P model) will add to the risk assessment. This schema sets out the approach to be taken by police occupational health (OH) services when assessing police officer applicants wishing to join recruiting police forces. It addresses the assessment of mental health and the relevance of indicators of mental ill health to recruitment decisions.

The schema is divided into two parts. Part A sets out a rational approach to a stepped assessment of mental health. It is evidence-based, where this is possible. However, the lack of a robust evidence base to support occupational health decision making and the prediction of future functioning in the police necessitates guidance in the form of a framework and principles exemplified in case scenarios, rather than explicit decision flow charts. Part B consists of six hypothetical case scenarios depicting OH assessments that describe predisposing, precipitating, perpetuating and protective factors linked to a fictional case. The intention is that occupational health professionals use the hypothetical cases as a guide and a template for their own clinical assessments of applicants.

1 Casey D Wright et al, ‘A framework for Understanding the Role of Psychological Processes in Disease Development, Maintenance, and Treatment: The 3P-Disease Model’, Front Psychol 10 (2019): 2498, doi: 10.3389/fpsyg.2019.02498.

2 Jonathan W Bolton, ‘Case formulation after Engel – The 4P model: A philosophical case conference’, Philosophy, Psychiatry & Psychology 21 No. 3 (2014): 179-189, doi: 10.1353/ppp.2014.0027

Part A: Setting the scene

Background – why is the schema needed?

Concerns have been raised in many sectors of British policing about inconsistencies in OH decision-making regarding acceptance or rejection of applicants to the police. The advent of the Police Uplift programme has amplified concerns. This is particularly true for the assessment of applicants with a history of mental ill health. Concerns include:

- Inconsistent decisions for similar types of health conditions across the 43 police Forces in England and Wales
- Unlawful discrimination against applicants with a history of mental ill health

The role of a front-line officer is safety critical. The recruitment and subsequent training of police officers prepares them, initially, for a response role. Where there is direct entry into detective roles, the expectation is that officers are competent to perform front-line roles and are fit to do so. The challenge facing police occupational health clinicians is how to assess the relevance of current mental health symptoms, or a history of previous mental ill health, in police officer applicants balancing the requirements of the Equality Act with the needs of both the recruiting police force and the individual applicant.

Framework for assessment

The health assessment is for the role of a response police officer. The role, key accountabilities and expected behaviours are described by the College of Policing.[3] This is supplemented by the police code of ethics and the competency and values framework.

The schema is an integral part of the College of Policing guidance – Assessment of police officer applicants: a functional approach. Assessment of fitness of police applicants should be made against the requirements set out in the key accountabilities and skills. Assessment should consider the following risk considerations:

- Assessment against the functional requirements of the scenario-based personal safety training curriculum
- Assessment of the risk of sudden incapacitation / fitness for ‘blue light driving’
- Assessment of the likelihood of providing regular and efficient service

In addition, reference should be made to the ‘ordinary duties of a constable’.

3 ‘Police constable’ (Professional profile, College of Policing, 2023) <Police Constable - College of Policing>

The objective of an OH assessment of mental health is to ascertain that police officer applicants can function appropriately in the role of a response police officer, are able to train effectively and that recruitment will not undermine their health and safety, nor that of colleagues or the public. It will also identify where the application of workplace adjustments should be recommended.

A stepped approach to assessment is used, as for the assessment of physical illness. Step 1 is a health questionnaire that contains questions to assess functional abilities, to detect the occurrence of symptoms suggestive of current (mental) ill health and to obtain a past medical history. Step 2 is an occupational health technician and/or nurse-based clinical assessment of applicants whose questionnaire answers merit further enquiry. Step 3 is a doctor-based assessment which will usually involve the Force Medical Advisor (FMA) and may require additional input from a clinical psychologist or consultant psychiatrist.

OH advice to the recruiting force is not always binary, I.E., pass or fail. Advice categories are:

- Fit for the role of front line police officer
- Fit for the role of front line police officer subject to defined adjustments
- Decision pending receipt of further information
- Likely to be unfit for the role of front line police officer

The responsibility for appointing police officer candidates rests with the force appointment panel. (See section 2.7 in the main guidance) The role of OH is to perform a suitable and sufficient clinical assessment and to advise the panel on fitness for the proposed role, the need for workplace adjustments, where relevant, or that the applicant is likely to be clinically unfit for the role (with reasons). In some cases, additional information will be required before advice may be given. The panel should be advised about likely timescales.

Principles underpinning mental health assessment of police officer applicants

1. The health assessment of applicants should focus on the existence of current symptoms and their impact on functional ability
2. Assessment of mental health disorders for employment purposes has limited predictive capability[4]

a. The existence of other health problems may be relevant and should be explored. Applicants with a history of current or previous symptoms of mental ill health may have other psychological problems. Anxiety may co-exist with depression or an eating disorder. Chronic physical health conditions may commonly be associated with mental ill health. Neurodiverse applicants may have mental health problems

b. The UK Psychological Trauma Society does not support pre-enlistment assessment based on psychometric testing or profiling of candidates for trauma-prone roles[5]

c. Asking about alcohol and substance misuse should be done with reference to the local substance abuse policy.[6] Use of alcohol should be assessed

3. Many mental health conditions have a relapsing and remitting nature

a. The periodicity of relapses and the triggers should be considered, as well as the duration of the relapse and response to treatment. Insight into preventing, detecting and managing relapses should be assessed

b. Consider the potential for workplace adjustments to manage the health condition. Also consider the opportunity to offer support to applicants during their initial training to assess the impact of workplace adjustments and/or assist rehabilitation following illness

c. Consider the side-effects of drugs used to manage mental ill health. For example, medication might cause drowsiness and poor concentration, especially at the beginning of treatment, but subsequently be taken without side effects impacting on everyday function

4. Use of prescribed medication could affect the ability to drive police vehicles, especially blue light, and advanced driving. (DVLA) [7]

(All drugs with an action on the central nervous system can impair alertness, concentration and driving performance.)

- This is of relevance at the initiation of treatment, or soon after, and when dosage is being increased. Anyone who is adversely affected must not drive.
- Antipsychotic drugs, including depot preparations, can cause motor or

4 Nick Glozier 'Mental ill health and fitness for work' Occup Environ Med 59 (2002): pp 714-720 doi: 10.1136/oem.59.10.714.

5 Noreen Tehrani & Ian Hesketh, 'The role of psychological screening for emergency service responders' International Journal of Emergency Services 8, no. 1(2019): pp 4-19, doi: 10.1108/IJES-04-2018-0021.

6 Officers may be subject to testing for substance abuse – pre-appointment, random screening, "with cause" testing – in accordance with substance abuse policies

7 Drug misuse or dependence. Assessing fitness to drive – a guide for medical professionals. DVLA. Assessing fitness to drive – a guide for medical professionals (publishing.service.gov.uk)

extrapyramidal effects as well as sedation or poor concentration. These effects, either alone or in combination, may be sufficient to impair driving, and careful clinical assessment is required.

- The epileptogenic potential of psychotropic medication should be given consideration in patients who are professional drivers.
- Benzodiazepines are the psychotropic medications most likely to impair driving performance – the long-acting compounds in particular – and alcohol will potentiate effects.
- Doctors have a duty of care to advise their patients of the potential dangers of adverse effects from medications and their interactions with other substances, especially alcohol.
    - Reliance on continuing or recent prescription of antidepressant medication as a sole reason for rejecting an application to join the police is inappropriate. Other supporting health reasons relevant to the performance of the duties of a response police officer must be explored: functional impairment, risk of sudden incapacitation or inability to render regular and efficient service.

5. Decisions not to recruit must be justifiable and should not discriminate unlawfully against applicants with medical histories of mental ill health.

a. A ‘precautionary principle’ approach is legitimate given the many safety critical roles performed by front-line officers
b. The ‘precautionary principle’ should not be used as a cover for prejudices against mental health and disability
c. The potential for implementing workplace adjustments must be considered in every case
d. Recruitment and selection must be aligned with a policy of reducing workplace risks and providing early treatment for those that become unwell
e. The schema aims to be proportionate to the need for challenge (efficient and not overly intrusive), to be fair (utilising best available evidence to advise on risk) and to be safe (appropriate assessment of risk and the use of the precautionary principle)

Part B: Practical guidance in assessment

Clinical assessment

When assessing suitability to become a police officer, it is important to distinguish the role-related health risks from the health risks related to poor management and low job quality, such as extreme time pressures and harassment. In both cases, workplace adjustments may be indicated and appropriate. However, the former health risks are unlikely to reduce whereas there should be an expectation of improvement for the latter because of the employer's duty of care and legal requirement to improve the working environment to reduce the risks to health.

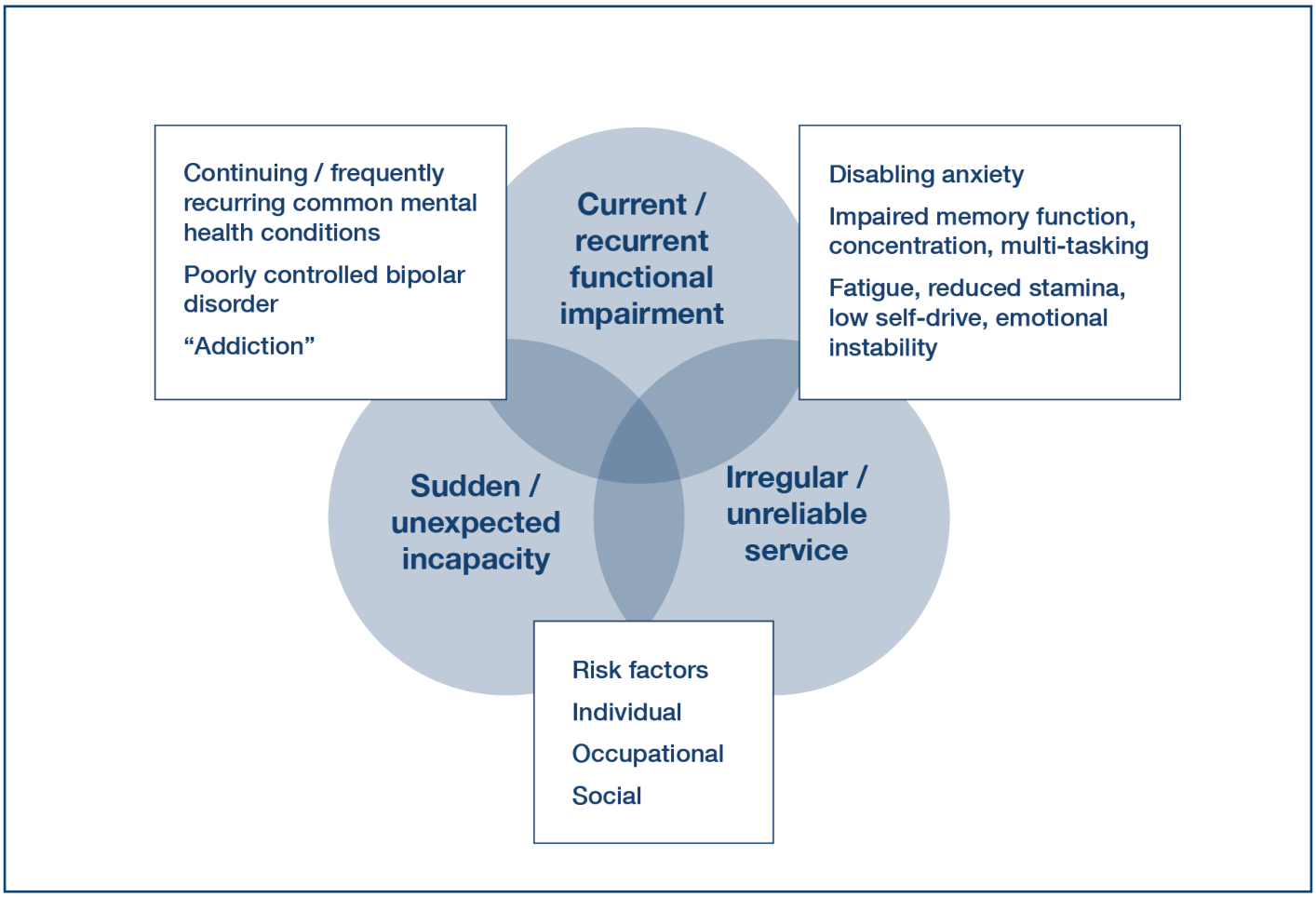

Figure 1. Possible indicators of unsuitability for the role of a police officer. processstrategic model.

Figure 1 depicts areas of concern in relation to the three areas of risk assessment: functional ability, risk of sudden incapacity / impairment and ability to render regular and efficient service. The key accountabilities of a police officer include providing initial and ongoing frontline support to a wide range of incidents that may involve confrontation and may be complex. Such situations may involve a risk to an officers' health and wellbeing, or to others. This must be assessed. Police officers are expected to be able to engage effectively with victims, witnesses, suspects, and vulnerable people. The ability to gather and handle information, intelligence and evidence is a fundamental part of the criminal justice system. Any symptoms that impact on these functional requirements may render applicants unsuitable. Symptoms of anxiety, cognitive impairment, lack of stamina and drive, and emotional instability, particularly in stressful situations should be assessed.

Risk of sudden incapacity due to a mental health condition is less likely than for a physical condition. However, changes in level of functioning or ability to attend work may occur. Depression is often a recurrent condition. Bipolar disorder (formerly called manic-depressive illness or manic depression) is characterised by clear changes in mood, energy, and activity levels. Finding the right medication to stabilise mood is often a case of trial and error and might take time. Side-effects of medication should be considered. Although symptoms may vary over time, bipolar disorder usually requires lifelong treatment. Adherence to a prescribed treatment plan can help people manage their symptoms and function effectively and safely.

Step 2: mental health triage

This stage of assessment is a triage of applicants that have given positive responses to the mental health questions on the initial health questionnaire. It may be performed by suitably trained occupational health technicians or clinic nurses. Any “No” answers indicate the need for a full clinical assessment by a suitably trained occupational health nurse, a mental health nurse and/or a Force Medical Advisor.

	Yes	No
No symptoms, or only trivial symptoms of mental ill health, for at least 6 months.		
If antidepressant medication has stopped, has there been a six-month period off medication without a recurrence of symptoms?		
If taking prescribed psychiatric medication has the applicant been well for at least one year without significant side effects (see below)*		
No ongoing talking therapy or completed at least 6 months ago		
No more than 1 past episodes of depression and anxiety		
The episode did not lead to more than one month off work or education		
No evidence of pat or current substance or alcohol misuse		
No history or evidence of an eating disorder, OCD, bipolar illness, schizophrenia, psychosis, personality disorder		
No episodes of self-harm or suicide attempts		
No previous contact with a psychiatrist, social services, or police		

If ALL boxes ticked YES FIT. If one or more ticked NO, refer to MO.

Table 1. Mental health triage checklist

(* Sertraline no more than 50mg daily; citalopram no more than 20mg daily; fluoxetine no more than 20mg daily; escitalopram no more than 10mg daily; venlafaxine no more than 150 mg daily; mirtazapine no more than 30mg daily; duloxetine no more than 60 mg daily. All other or atypical antidepressants should be referred to MO.) This empirical triage should be audited and revised, as required.)

Step 3 assessment

This level of assessment should be performed by either a suitably trained occupational health nurse, a mental health nurse in consultation with a senior occupational health nurse / Force Medical Advisor or a Force Medical Advisor. Recommendations to police forces about candidates deemed unlikely to be fit to be front line police officers should be made by Force Medical Advisors.

Further guidance to support a step 3 clinical assessment may be found in table 2. This shows the potential impact of mental health conditions on the ability to demonstrate the required skills of a police constable. This should be explored in the consultation.

Mental health condition	Skills							
	Empahty and social connectivity	Communication	Team working	Proactive / self-starter	Critical questioning and problem solving	Analysis and use of IT	Self- and Time management	Insight and self-awareness
Adjustment disorder			●	●			●	
Recurrent mood disorder and medication	●	●	●	●			●	●
Generalised anxiety disorder	●		●	●		●	●	●
Bipolar disorder	●	●	●	●	●	●	●	●
Eating disorder							●	●
PTSD	●		●				●	
Schizophrenia	●	●	●	●	●	●	●	●
Emotionally unstable personality disorder	●		●				●	●

Table 2. Potential impact of mental health conditions on the skills requirements of a police constable

(This empirical function / diagnosis table offers a pragmatic approach that will be subject to audit and review)

Substance abuse

The issue of substance abuse and addiction is a challenging one. The Association of Chief Police Officers (ACPO), now the National Police Chiefs' Council (NPCC) issued guidance on substance misuse and testing in 2012.[8] It states that the misuse of alcohol and drugs can lead to reduced efficiency, increased risk of accidents, increased sick leave, potential misconduct, and criminality. Because of interaction with drug dealers, there is a risk of manipulation of police personnel who take drugs. Possessing and supplying illegal drugs are criminal offences. Thus, a history of substance abuse is also a vetting risk that requires assessment. Please refer to the vetting APP for further information. The need for a full professional assessment by the FMA is highlighted, as is that neither police officers, nor Force vetting managers, are qualified to assess medical conditions. It is the role of the FMA to advise on suitability to be a police officer; the Appointments Panel procedure (Annex C) is the route to channel this advice. The Home Office circular 011/2012 provides guidance on changes made to Police Regulations with regards to drug and alcohol testing for police officers and candidates for appointment as police officers.[9]

All forces should have a substance misuse policy and procedure for testing at recruitment, at random and where there is cause to require it. Occupational health has a role to support any officer who declares that they have a problem. Medical confidentiality rules will apply, albeit the circular notes that there are circumstances where the proper administration of justice overrides an absolute duty of confidentiality. For example, there is a responsibility to declare any matter that might affect the credibility of an officer as a witness at court. (Joint operating instructions agreed between ACPO and the Crown Prosecution Service) The occupational health assessment should take place in the context of national and local substance misuse policies and current vetting requirements, which should be made clear to applicants in advance.

Psychosocial considerations

When assessing the impact of a health condition on suitability to join the police, assessment of individual risk factors will be important including the response to diagnosis and treatment and choice of lifestyles. Occupational risk factors – occupational stressors – may have to be modified and reasonable workplace adjustments considered. Ability to maintain work-life balance may be important. If both partners are shift workers, any caring responsibilities may be difficult to fulfil. Social isolation or loneliness may be relevant, as may be recent bereavement or a breakup of a relationship, social disadvantage, poverty, or debt. How an individual copes with life events and the behaviours displayed as a marker of insight and resilience should be explored.

8 'Guidelines on substance misuse and testing' (ACPO, 2012)

9 'Circular: Testing police officers for substance misuse' (Circular 011/2012, Home Office, 2012) <Circular: testing police officers for substance misuse - GOV.UK (www.gov.uk)>

Case Scenarios

1. Adjustment disorder following break up of a longstanding relationship

Presenting scenario

The applicant described the occurrence of the following symptoms – being unduly emotional, feeling sad and not enjoying things, worrying a lot and not sleeping. They developed following the breakup of a long-term relationship. This happened about 6 months ago. S/he was otherwise well. The applicant became withdrawn and noticed that s/he was using alcohol to try to get to sleep. Help was sought from a GP and a referral to NHS Talking Therapies. There was a good response to a step 2 intervention.[10] At the time of application there were no symptoms of concern.
Further enquiry revealed evidence of being bullied as a child and time off school due to recurrent headaches or abdominal symptoms. The applicant had struggled to establish relationships with peer groups and had felt 'socially awkward' as a teenager. However, s/he reported taking steps to join clubs and had become a volunteer at a local foodbank.

Clinical information

Adjustment disorder usually lasts from a few days to several weeks and is the result of an acute reaction to a recent stressful or traumatic event, or extreme distress resulting from a recent event, or preoccupation with the event. Adjustment disorder requires that a person develop emotional or behavioural symptoms in response to identifiable stressors within 3 months of the onset of those stressors. Once the stressor has been removed, or the person is beginning to cope, the symptoms should subside within 6 months.

The symptoms of adjustment disorder including acute stress reaction tend to be short term.[11]

- Individuals may feel overwhelmed or unable to cope
- There may be stress-related physical symptoms such as insomnia, headache, abdominal pain, chest pain and palpitations
- Individuals may report symptoms of acute anxiety or depression but the symptoms and/or the impact of the symptoms are insufficient to establish a diagnosis of depression or an anxiety disorder
- Alcohol use may increase

10 'Talking therapies' (CNWL NHS, 2023) <How we can help :: CNWL Talking Therapies>

11 'Adjustment disorder' (Military Mental Health Service, Midlands Partnership University NHS Foundation Trust, 2023) <Adjustment Disorder :: Midlands Partnership University NHS Foundation Trust (mpft.nhs.uk)>

Risk assessment [12]

Clinical

- Major stress as a child, such as bullying or difficulties with school
- Divorce or marriage problems
- Relationship problems or trouble getting along with others
- Major changes in life, such as retirement, having a baby or moving away
- Bad experiences, such as losing a job, loss of a loved one or having money problems
- Problems in school or at work
- Life-threatening experiences, such as physical assault, combat, or natural disaster
- Ongoing stressors, such as having a medical illness or living in a neighbourhood that has a lot of crime
- More than one major change or bad experience happening at the same time
- Only diagnosed if the patient is not ill enough to meet criteria for depression or anxiety

If adjustment disorders do not resolve, they may lead to more serious mental health conditions such as anxiety, major depression, or misuse of drugs or alcohol.

Organisational

Assess the likelihood of relapse in symptoms because of exposure to police-related stressors and the resilience of the applicant following recovery. Consider the relevance of any associated health conditions. Consider possible workplace adjustments contingent on the risk assessment.

Positive indicators

- Small number of clinical risk factors
- Symptoms diminishing after removal of stressor
- Developed good coping strategies and demonstrating resilience in daily life

12 Adjustment disorders. Mayo Clinic.

2. Recurrent mood disorder treated with medication

Presenting scenario

The applicant described several episodes of low mood prior to submitting the application. The first episode occurred whilst at school studying for exams. No treatment was given but there was a period of absence from school of 3 months, and it was necessary to re-sit the examinations, which were passed successfully. The second episode occurred in the early twenties whilst training to be a teacher. On this occasion a medical assessment took place in primary care and there was a referral to talking therapies. 12 sessions of cognitive behavioural therapy (CBT) were given. No medication was prescribed. During this time, the applicant had to pause training. There was a good outcome symptomatically. It was necessary to re-sit the academic year. Following qualification as a teacher, there was a third episode of low mood associated with a 4-month period of absence from work. An SSRI antidepressant was prescribed by a GP and there was another referral for talking therapy – CBT. There was a good outcome and the applicant had been symptom free for 6 months prior to submitting an application to become a police officer. There were no other health concerns.

Clinical information

- A validated depression questionnaire to assist clinical assessment is the Patient Health Questionnaire (PHQ-9)
- When considering prevention of relapse, a history of recurrent episodes of depression, particularly if they occur within the last 2 years, increases the risk of relapse
- Other risk factors include incomplete response to treatments / residual symptoms, unhelpful coping styles (avoidance, rumination), history of severe depression, other physical health or mental health problems and personal, social, and environmental factors that have contributed to the depression[13]
- Assess any health and safety risks from the side-effects of medication
- Continuing with a talking therapy is a recommended option for prevention of relapse of symptoms

13 Depression in adults: treatment and management.(NICE guideline NG222. June 2022) Recommendations | Depression in adults: treatment and management | Guidance | NICE

Risk assessment

Clinical

- Female
- Older age
- History of depression
- Personal, social, or environmental factors – e.g., relationship issues, bereavement, stress, financial difficulties, unemployment, social isolation, adverse childhood experiences
- Postnatal depression
- Family history of depressive illness (first-degree relative of person with major depressive episode) or suicide
- History of other mental health conditions and/or substance abuse
- History of chronic physical health conditions.
- Insight
- 50% of those with a first depressive episode will go on to have a recurrent illness; episodes tend to get worse with time
- Treating residual symptoms is very important

Organisational

- Personal, social, or environmental factors in policing (See above)
- Risk of trauma exposure
- Side-effects of medication – risks to safety in front-line policing and/or high speed/ advanced driving
- Risk of reduced attendance at work
- Consider the need for workplace adjustments during training and in frontline policing.
- Stigma?

Positive indicators

- Good response to treatment
- Development of good coping strategies and lifestyle behaviours
- Positive approach to engagement with talking therapies
- Positive social and environmental factors
- No family history of depressive illness

3. Generalised anxiety disorder with intermittent sickness absence

Presenting scenario

The applicant describes symptoms including being restless, feeling anxious, unable to concentrate and poor sleep associated with feeling fatigued lasting for about 9 months following a first pregnancy three years ago. She consulted her GP and was offered cognitive behavioural therapy (CBT) combined with sleep hygiene education and mindfulness / meditation training.

Since then, the severity of the symptoms had improved to the extent that she was sleeping better, and she did not feel as fatigued. She still had a tendency to worry about day-to-day things, such as finances and the health of her child. She found it difficult to relax completely and sometimes felt 'on edge'. If she felt particularly on edge, she found it hard to concentrate.

Clinical information

- NICE characterises generalised anxiety disorder as excessive worry about everyday issues that is disproportionate to any inherent risk
- There should be at least three of the following symptoms:
  - Restlessness or nervousness
  - Easily fatigued
  - Poor concentration
  - Irritability
  - Muscle tension
  - Sleep disturbance
- Symptoms to be present for at least six months, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Generalised anxiety should be considered if:
  - There is a history of generalized worry not related to particular circumstances
  - Regular attendance in primary care with chronic physical conditions, or are seeking reassurance about somatic symptoms
- The generalised anxiety disorder questionnaire (GAD-7) may be used to assess the likelihood of GAD and to begin to assess severity
- NICE recommends a stepped approach to management
- GAD is chronic condition that may fluctuate in severity with low rates of remission in the short and medium term. Substantial improvement is possible but not everyone recovers completely. Long term prognosis is less good if diagnosis delayed (it often is for many years) or if other psychiatric comorbidity which is common (other anxiety disorder / depression)
- NICE states that most people with GAD still have symptoms 10-years from diagnosis and half of people who remit will relapse

Risk assessment

Clinical

- GAD is twice as common in women than in men
- Co-morbid anxiety disorder, e.g., panic disorder or social phobia or depression
- A family history of anxiety disorders, depression, or other psychiatric disorders
- Adverse childhood events / experiences
- History of physical, psychological, or sexual trauma
- Sociodemographic factors, such as separation, bereavement, or unemployment
- History of substance misuse
- History of a chronic physical condition

Organisational

- Difficulty adjusting to training, combining classroom and probationary training with university degree
- Coping with confrontation – physical and psychological
- Coping with shift work, including night working, causing sleep disturbance
- Reduced attendance linked to reduced stamina
- Risk to colleagues / the public linked to increased irritability

Positive indicators

- Good response to a therapeutic dose of medication
- Good engagement with psychotherapy and good outcome
- Achieving a remission – no longer meets the criteria for anxiety disorder
- Absence of co-morbid conditions, such as depression, substance abuse
- Development of coping strategies to underpin maintenance of symptom reduction
- Functioning well in daily life

4. History of Bipolar disorder

Presenting scenario

The applicant stated on their Medical History Questionnaire a history of bipolar disorder.

The applicant described the first episode occurring at school whilst studying for exams. Symptoms included experiencing low mood, poor sleep, poor concentration, socially withdrawing, and sadness. This resulted in being absent from school for a month. No treatment was given.

A second episode occurred a year later; the applicant described a traumatic event (unexpected death of a parent) followed by an inability to focus on everyday tasks, feeling sad, not enjoying things, not sleeping, and having a negative thought pattern. The applicant reported use of alcohol to try to sleep.

A referral to the Community Mental Health team was made leading to a period of one month's hospitalisation. The applicant was treated with mood stabilising medication, anti-depressants and talking therapies for 12 sessions to which they responded well.

The applicant is currently under the care of their Community Mental Health Team with prescribed medication reviews every three months. At the time of submitting the form the applicant had been stable for the past six months and had been effectively managing their Bipolar disorder with medication

Clinical information

Hobson 2019 suggests that bipolar disorder, which was formerly known as manic depression, is a condition that effects an individual's moods which can go from one extreme to another.[14]

It is characterized by episodes of:

- Depression: feeling very low and lethargic
- Mania: feeling very high and overactive and experiencing grandiose ideas regarding themselves. Mania has a significant impact on day-to-day activities and typically lasts for more than one week. Hypomania is less disruptive although it will be noticeable to others and has a shorter duration, typically a few days
- Bipolar 1 disorder has at least one episode of mania and bipolar 11 disorder is characterised by at least one episode of hypomania and at least one depressive episode
- Both individuals with bipolar 1 disorder and bipolar 11 disorder commonly experience major depressive episodes

NICE states that episodes of bipolar disorder can occur for periods of a few weeks up to two months in any 12 month period. It could take anywhere from a year to 18 months to recover. If treated effectively an episode will usually improve within 3 months.[15] Most people return to normal function between episodes. Adherence to a treatment plan can reduce the risk of relapse.

14 John Hobson, Fitness for Work The Medical Aspects (6th Edition, Oxford University Press, 2019) 890

15 'Bipolar disorder' (National Institute for Health and Care Excellence – NICE CKS, August 2023) <Bipolar disorder | Health topics A to Z | CKS | NICE> accessed 13 December 2023

Symptoms of bipolar disorder depend on which mood the individual is experiencing. For example:

Depression

- Overwhelming feelings of Worthlessness
- Suicidal Ideation
- Sadness
- Lessened pleasure or interest in activities
- Insomnia
- Increase in appetite
- Preoccupying worries
- Difficulty in concentration

Mania

- Talking fast
- Feeling of being elated
- Sleeping very little
- Being easily irritated or agitated
- Risk taking behaviour e.g., spending large amounts of money, social disinhibition
- Feeling indestructible
- Psychosis with delusional, and illogical thinking, and hallucinations:
  - Belief of self-efficacy greater than others
  - Ability to see or hear things that others can't

Risk assessment

Clinical

- Periods of high stress such as death of a loved one or another traumatic event like breakdown of a relationship
- Drug/alcohol abuse
- Parent with a history of depression, bipolar disorder, suicide
- Genetic factors
- Chemical Imbalance in the brain
- Abuse
- Chronic physical illness

Organisational

- Personal, social or environment factors in policing
- Risk of trauma exposure
- Need to make reasonable adjustments.
  - time to attend medical reviews
  - rota changes to support the individual
  - Reduced attendance at work due to changes in working hours / sleep deprivation
  - Medication side effects – risk to safety in front line policing e.g., high speed/ blue light driving, using a taser
- Operational performance
  - Psychomotor skills slowing down
  - Effect on judgement / risk taking during episodes of mania / hypomania
- Suicide risk during severe depressive episode

Positive indicators

- Good response to medication
- Adherence to the treatment plan
- Short duration of episodes
- Long intervals between episodes
- Good insight into the management of the disorder
- Absence of comorbid anxiety or substance abuse
- Lack of family history of bipolar disorder or suicide
- Good support network – family and friends
- Psychosocial stability

5. History of an eating disorder and adverse childhood experiences

Presenting scenario

The applicant stated a history of an eating disorder on her health questionnaire.

She described a traumatic event (unexpected death of a parent) whilst at school which made her feel out of control and unable to cope with intense mood swings. She referred to exercising intensively as she was fearful of gaining weight.

At the face-to-face occupational health assessment, she was noticeably slim (BMI 18 kg/m2) and had poor dental hygiene. She described sometimes missing meals and being choosy about her diet. (Avoiding foods thought to be fattening) However, she did not hide the fact that she was controlling her weight and was open about her weight recordings.

The applicant was under the care of her GP and had previously been referred to the Community Mental Health Team for talking therapy. She had received 12 sessions of cognitive behavioural therapy (CBT) and was currently on the waiting list for assessment and treatment at a specific eating disorders clinic.

The applicant was not on any prescribed medication but described feelings of anxiety, depression, and thoughts of self-harm.

Clinical information

Anorexia Nervosa is considered to be a mental health disorder defined by abnormal eating behaviours that negatively affect a person's physical or mental health.

When assessing for an eating disorder NICE suggest the following should be considered.[16] They are relevant to an assessment for joining the police service and undertaking the ordinary duties of a police officer:

- An unusually low Body Mass Index (BMI)
- Affect any age group or gender but most common in females aged 13-17
- Any rapid weight loss
- Disproportionate concern regarding weight or body shape
- History of trauma, childhood abuse, leading to mental health disorders such as anxiety and depression
- Excessive exercise
- Dieting
- Obvious poor dentistry and tooth erosion
- Dizziness

16 'When should I suspect an eating disorder?' (CKS eating disorders, NICE, July 2019) < Clinical features | Diagnosis | Eating disorders | CKS | NICE>

Risk assessment

Clinical

- Female
- Adolescence
- Obsessive / perfectionist traits
- Genetic influence (Twins studies)
- Household stressors, social isolation, poor social support
- Height and weight
- Fragile frame and dizzy spells due to reduced nutritional intake[17]
  - Bone health should be considered if weight has been low for 2 years or more in adults
  - Cardiovascular instability (Bradycardia, tachycardia on standing, prolonged QT interval on ECG, postural hypotension)
  - Reduced muscle power (Sit up, squat, stand test[18] (SUSS) and hand-grip test)
  - Abnormal blood haematology and biochemistry
- Treatment of Anorexia Nervosa usually involves a combination of talking therapy and supervised weight gain. Antidepressant medication, such as fluoxetine, are sometimes prescribed in combination with other therapies
- The co-existence of a common mental health disorder may require treatment
- Acute mental health risks

Organisational

- Health and safety
  - Strength and stamina to be able to cope with physical demands of policing, including conflict
  - Fitting of body armour.
  - Ability to pass Job Related Fitness Test or cope with the pressures of Police Safety Training
- Operational
  - Blue light driving in view of history of dizziness
  - Attendance management
- The impact of Anorexia Nervosa may constitute a disability under the Equality Act 2010 and therefore it is important for the organisation to assess the need for reasonable adjustments
- Substantial delays in accessing NHS Eating Disorder services. Treatment once initiated is prolonged and there is a high chance of relapse
- Suicide

Positive indicators

- Young person
- Early specialist treatment
- Short illness duration
- Achieve full weight restoration
- Absence of sexual problems, impulsivity, protracted duration of illness and long inpatient treatment[19]

17 Medical emergencies in eating disorders: guidance on recognition and management (College Report CR233, Royal College of Psychiatrists, October 2023) 187 <college-report-cr233-medical-emergencies-in-eating-disorders-(meed)-guidance.pdf (rcpsych.ac.uk)>

18 Sara Etemadi et al, 'The Sit Up Squat Stand test and Hand Grip Strength: What is the role of tests of muscle power in risk assessment in Anorexia Nervosa?' Eur Eat Disorders Rev (2021): pp 1-10, doi: 10.1002/erv.2839.

19 'Anorexia nervosa, prognosis' (BMJ Best Practice, 12 December 2023) <Anorexia nervosa - Prognosis | BMJ Best Practice> (Log in required)

6. Post-traumatic stress disorder

Presenting scenario

The applicant was joining the police from the army. He had no symptoms at the time of application. Whilst in the army, he had a tour of duty in Afghanistan where he witnessed a fellow soldier and friend being badly injured when an improvised explosive device exploded whilst on patrol. He later began to experience recurring thoughts about the incident. At times, he felt as though he was re-experiencing the incident; it felt as though he was at the scene, and he could vividly recall the sights, sounds and smells. He began to have nightmares about it. He became withdrawn and very anxious about going on patrol. He was easily startled by bangs around the camp. He did not have any thoughts about suicide or self-harm.

He was monitored after the incident by the army via TRiM. He was identified as being in need of further assessment and treatment. He received trauma-focussed psychotherapy in the form of trauma-focused CBT. He had 12 sessions. His symptoms abated and did not recur, despite continuing to be fully deployed in the army for another 12 months.

Clinical information

There are different diagnostic criteria for PTSD according to WHO International Classification of Diseases (ICD-11) or the American Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). People with PTSD may present with a range of symptoms associated with functional impairment, including (NICE[20]):

- Re-experiencing
- Avoidance
- Hyperarousal (including hypervigilance, anger, and irritability)
- Negative alterations in mood and thinking
- Emotional numbing
- Dissociation
- Emotional dysregulation
- Interpersonal difficulties
- Negative self-perception

Nice advises that, when assessing someone for PTSD, ask specific questions about re-experiencing, avoidance, hyperarousal, dissociation, negative alterations in mood and thinking and associated functional impairment.

20 'Post-traumatic stress disorder' (NICE [NG116], 5 December 2018) < Recommendations | Post-traumatic stress disorder | Guidance | NICE>

Risk assessment

Clinical

People who are at risk of PTSD include those who have been exposed to, or who have witnessed, extreme traumatic stressors.
The criteria for extreme trauma are actual or threatened death, serious injury or other threat to physical integrity. (BMJ Best Practice[21])
PTSD can occur in people who were previously well.

- People with PTSD can recover with no, or limited, interventions.
- Other people who do not receive effective treatment may develop chronic symptoms and impairment
- DSM-5-TR distinguishes between acute stress disorder (also known as combat and operational stress in the military) where symptoms are present for less than 1 month, and PTSD, where symptoms are present for greater than 1 month
- PTSD may be classified by symptom severity:
  - Mild: Distress due to symptoms is manageable by the patient, and the patient's social and occupational functioning are not significantly impaired
  - Moderate: Distress lies between mild and severe – there is no considered risk of suicide, harm to self or harm to others
  - Severe: Distress is considered to be unmanageable by the patient, and the symptoms cause significant impairment in social and/or occupational functioning; there may be a significant risk of suicide, harm to self or harm to others
- Treatment of severe PTSD after the first month of symptoms usually lasts between 8 and 12 sessions and provision of treatment beyond 12 sessions may be required if there is traumatic bereavement, multiple traumatic events, chronic disability resulting from the trauma or the presence of co-morbidities
- Trauma-focused CBT is offered to patients with any level of severity that are present for more than 3 months; the duration of treatment is usually between 8 and 12 sessions, as for the above. (Eye movement desensitisation and reprograming (EMDR) is an alternative treatment. Treatment is normally between 8 and 12 sessions after a single traumatic event)
- Pharmacotherapy may be considered after trauma-focused psychological treatment has been initiated, or if patients express a wish not to engage in / cannot start a trauma-focused psychological therapy
- Systematic reviews show only a small effect size for pharmacotherapy. The strongest evidence is for the use of an SSRI such as paroxetine, fluoxetine, or sertraline
- Patients with PTSD have an increased risk of other health conditions, such as cardiovascular disease
- Increased use of alcohol may be associated with PTSD
- Patients with PTSD and who are prescribed an antidepressant are considered to be at an increased risk of suicide and frequent monitoring is recommended, especially of those patients who were assessed as being at risk prior to treatment commencing

21 'Post-traumatic stress disorder' (BMJ Best Practice, 16 January 2024) https://bestpractice.bmj.com/topics/en-gb/430

Risk assessment

Organisational

- Screening applicants for PTSD is not recommended
- The occupational health assessment should identify any applicants who are experiencing mental health symptoms likely to impair their functional abilities to be front line police officers
- Organisationally, police forces are becoming trauma aware
- Awareness of trauma-related mental ill health is part of the training curriculum for police officer recruits
- Some police forces are investing Trauma Impact Prevention Techniques (TIPT) developed by Police Care UK and the University of Cambridge
- The Police Trauma Events Checklist (PTEC) has been included as part of a new police trauma tracker and this will assist supervisors and managers to have conversations with police officers who experienced psychological trauma.
- A national police health and wellbeing strategy is predicated on the promotion and protection of mental health and addresses the prevention, early detection, and treatment of trauma-related ill health
- Many police forces have invested in both general peer support networks and/or TRiM
- Attention should be paid to the HSE stress management standards and training managers to promote and support mental health and wellbeing at work.

Positive indicators

- Single exposure to trauma
- Good peer / social support
- Receipt of TRiM
- Good access to appropriate treatment at the right time
- Lack of co-morbidity, such as mood disorder, generalized anxiety disorder or substance misuse
- No suicidal ideation or self-harm following the exposure
- Effective coping strategies

Appendix 1: Mental health and the police

Symptoms associated with mental ill health are common in the UK population. A report by the Royal College of Psychiatrists indicated that one in six of the working age population experience symptoms, such as sleep problems, fatigue, irritability and worry, that do not meet the criteria for a diagnosis of a mental health disorder but can affect ability to function.[22] A further one in six of the working age population have symptoms whose nature, severity and duration would meet the diagnostic criteria of a mental disorder, but sufferers may not have come to the attention of a healthcare professional. The National Institute for Health and Care Excellence (NICE) reports an average 12-month prevalence of depression in adults in high-income countries as 5.5%.[23] However, it is noted that there is a lack of large-scale longitudinal studies to assist estimates. The NICE estimate for the prevalence of generalised anxiety in primary care is 4 – 7.9%, albeit this disorder is considered to be underdiagnosed.[24] An estimate from the Nuffield Trust repeats the statistic of one in six adults experiencing a common mental health disorder.[25] The incidence of depression in women is double that of men and the presence of depression in a first-degree relative increases risk two to three times. Two-thirds of people diagnosed with generalised anxiety disorder are female and the prevalence is higher in people with chronic physical health conditions.[26] The Royal College of Psychiatrists report that 0.5% of the population has a probable psychotic illness and that between 1% and 2% of the population will have a severe mental illness, such as schizophrenia, bipolar disorder, or severe depression.

It is likely, therefore, that some police officer applicants will either have current or recent symptoms associated with a common mental health disorder, or a medical history of a diagnosable mental health disorder. Some applicants may be in receipt of treatment at the time of application. Anecdotally, it appears that the frequency of this has increased since the advent of the Police Uplift Programme; the increased numbers of applicants means that number of people with health questionnaire declarations has also increased in proportion to this, and / or people who would not have previously applied to work in the police are now doing so. It is less likely that people with severe

22 Mental Health and Work (Royal College of Psychiatrists. 17 March 2008) 64

23 'Depression: How common is it?' (CKS, NICE, November 2023) <Prevalence | Background information | Depression | CKS | NICE>

24 'Generalized Anxiety Disorder: How common is it?' (CKS, NICE February 2023) <Prevalence | Background information | Generalized anxiety disorder | CKS | NICE>

25 'Mental Health quality watch' (Nuffield Trust, 20 January 2022) <Mental health | Nuffield Trust>

26 'Bipolar disorder in adults' (BMJ Best Practice, 28 November 2023) < Bipolar disorder in adults - Symptoms, diagnosis and treatment | BMJ Best Practice> (log in required)

mental illness will apply to work in the police and progress through the early assessment stages to reach the stage of an occupational health assessment. However, it is possible that applicants with a controlled bipolar disorder or a history of a previous episode of severe mental illness might be assessed. Risk factors for bipolar disorder include a family history of bipolar disorder, onset of a mood disorder before the age of 20 years, childhood trauma, presence of an anxiety disorder and a lifetime history of substance misuse disorder. Infrequently, applicants who would meet diagnostic criteria for emotionally unstable personality disorder reach the occupational health assessment stage. Some applicants may have a history of an eating disorder. There may be a history of substance abuse.

What are the occupational health considerations when assessing the relevance of mental health conditions? There is a scarcity of good research evidence on which to base a schema. Working as a police officer is demanding. Houdmont found evidence of psychological distress, emotional exhaustion and depersonalisation in English police officers linked to working long hours.[27] More than 25% of the sampled officers reported working long hours and were significantly more likely to report common mental disorders. Response and patrol officers are required to work 24/7 shifts, including night work. Shifts often run over to complete cases. Financial austerity has exacerbated this problem although the Police Uplift Programme has increased the number of police officers. The annual national wellbeing survey carried out by the University of Durham on behalf of the NPWS has identified fatigue as a key and continuing wellbeing issue. Trauma-related mental ill health is a particular health issue in policing. Probably the best-known survey of trauma-related ill health in UK policing – The Job, the life (TJTL) - reported a prevalence of PTSD of 8% and complex PTSD of 12.6%.[28] These rates are high compared to those reported for the UK military – 6% PTSD (combat troops) and 4% PTSD in deployed personnel.[29] Whilst the method used in the TJTL survey was probably biased towards reporting higher levels of PTSD and complex PTSD, the findings do point towards the existence of a working environment associated with trauma-related psychological morbidity.

Will 'pre-employment' / pre-placement health assessment predict mental health outcomes at work and vulnerability to PTSD and other mental health disorders? A systematic review of published cohort studies linking pre-employment or pre-duty measures in first responders with later mental health outcomes was unable to find sufficient evidence to advocate a specific approach to assessment.[30] There was moderate evidence that personality factors, such as trait anger, might have a predictive power. It was concluded that a combination of personality factors and dynamic measures of physiological and psychological coping strategies may be able to identify

27 Jonathan Houdmont & Raymond Randal, 'Working hours and common mental disorders in English police officers' Occup Med 66, no. 9 (2016): pp 713-718, doi:10.1093/occmed/kqw166.

28 Chris R Brewin et al. 'Posttraumatic stress disorder and complex posttraumatic stress disorder in UK police officers', Psychological Medicine 52, no. 7 (2022): pp 1287-1295, doi.org/10.1017/S0033291720003025.

29 Elizabeth JF Hunt et al, 'The mental health of the UK armed forces: where facts meet fiction' Eur J Psychotrauma Aug 14;5 (2014) doi: 10.3402/ejpt.v5.23617.

30 Ruth E Marshall et al, 'A systematic review of the usefulness of pre-employment and pre-duty screening in predicting mental health outcomes amongst emergency workers' Psychiatry Research 253 (2017): pp 129-137, doi: 10.1016/j.psychres.2017.03.047.

some personnel at risk of mental health disorders. However, a more recent study of pre-employment psychological testing of police officer recruits found no association between validated measures of pre-employment personality and psychopathy and mental health outcomes in police officer recruits over a 7-year follow up.[31] Screening to prevent the development of PTSD in the military is not supported.[32]

Why might working for the police be associated with mental health morbidity? There are role-related causes of mental ill health – possible exposure to a variety of psychological traumas – and organisational causes of mental ill health linked to job design, management practices and culture. The UK Health and Safety Executive have published management standards to assess the likelihood of the adverse impact of stress at work.[33] They cover six areas of work design:

- Demand
- Control
- Support
- Relationships
- Role
- Change

Police forces have been under immense pressure due to changing demands related to new stressors linked to contemporary law enforcement and the demands of being the service of last resort in an era of collapsing public services and financial austerity. Whilst there has been significant investment in wellbeing at work, led by the NPWS, the demands on police officers are unremitting. A recent systematic review of the evidence for work-related factors related to the development of common mental disorders has reinforced the association between high job demands, low job control, high effort–reward imbalance, low relational justice, low procedural justice, role stress, bullying and low social support in the workplace and the risk of developing common mental health problems.[34] All these factors may be relevant to policing. These factors may also be important in assessing risks of developing PTSD in the police. A follow-on paper from the TJTL study has looked at the association between job quality and the incidence of PTSD amongst police personnel.[35] In this study there was unequivocal evidence of an association between job quality and the occurrence of reported symptoms indicative of PTSD. Police forces with better working conditions – the feeling of doing meaningful work, support from colleagues and managers, work-life balance, job security, and promotion prospects - tended to have markedly lower rated of PTSD even after adjusting for the level of trauma exposure.

31 Ruth E Marshall et al, 'A prospective study of psychological pre-employment testing amongst police officer recruits' Occup Med 70, no. 3 (2020): pp 162-168, doi:10.1093/occmed/kqaa008.

32 Roberto J Rona et al, 'Mental health screening in armed forces before the Iraq war and prevention of subsequent psychological morbidity: follow-up study' BMJ 333, no. 7576 (2006): pp 991-995, doi: 10.1136/bmj.38985.610949.55.

33 'What are the management standards' (HSE, 2023) <What are the Management Standards? - Stress - HSE>

34 Sam B Harvey et al, 'Can work make you mentally ill? A systematic meta-review of work-related risk factors for common mental health problems' Occup Environ Med 74, no. 4 (2017): pp301-310, doi.org/10.1136/oemed-2016-104015.

35 Brendan Burchell et al, 'The association between job quality and the incidence of PTSD amongst police personnel' Policing 17, (2022): paac054, doi:10.1093/police/paac054.