VICTORIA POLICE

Anxiety

Anxiety disorder +/- panic attacks +/- agoraphobia

Psychiatrist & Psychologist & GP

Investigations and Reports for Consideration

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

Considerations include (but are not limited to):

- Diagnosis and symptoms
- Duration of condition and recurrence and/or chronicity
- Insight and engagement with treatment.
- Any comorbidities e.g. depression or trauma or substance use
- Social supports
- Any risk issues including suicidality
- Treatments tried, response to treatment and side effects including psychological therapies such as CBT, MBCT, DBT duration and nature of treatment
- Medication treatment e.g. SSRI, SNRI, benzodiazepine, quetiapine or other, dose, duration, response, side effects
- Lifestyle measures in place or recommended e.g. exercise, yoga, meditation
- Alternative coping mechanisms
- Duration of treater involvement
- Compliance with treatment and ongoing treatment plan and monitoring in place
- Members insight and willingness to engage if future difficulties
- Demonstrated resilience to stress.
- Whether police work is likely to aggravate the condition if so how and mitigating factors
- Ability to meet the inherent requirements of an operational general police officer and protective services officer
- Prognosis for operational and non-operational work, specific concerns around firearms, now and or if condition should worsen

Medical Standard

Determination will include an assessment of the severity of the condition, treatment engagement, effectiveness of treatment, side effects, risk issues and safety around firearms and any potential for aspects of the police role, including stress & re-exposure, to aggravate the condition.

The applicant's level of insight, ability to recognise and manage early relapse signs and seek assistance is relevant.

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

There can be particular risks around driving in the case of severe anxiety or panic attacks which can lead to experiences of psychological immobilisation distraction or dissociation under extreme stress.

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

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

Broadly, best results are achieved when the individual recognises they have a difficulty, self-initiates treatment, receives treatment as appropriate. Psychological therapy is generally suitable for mild anxiety, more severe anxiety may require a combination of medication, psychological therapy and lifestyle measures such as meditation, yoga, exercise, diet measures and social measures.

Each case must be individually considered on its merits.

Applicants who may appear to be in remission may still decompensate rapidly in the face of specific isolated triggers or higher workloads / greater demand and/or if there are additional stressors outside of work.

This determination of fitness will be made based on examining treaters experience with similar conditions, information from treating practitioners and review of the detailed medical guidelines.

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

It is useful to explore the onset for the anxiety to determine any pattern or likely triggers.

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

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

Impact on Job Performance

Mild anxiety that is well controlled may not appreciably impact on the delivery of police duties.

Each case must be individually assessed however to determine the functional and occupational impacts of the disorder.

Anxiety can result in fight / flight responses, rapid heart rate, gastrointestinal symptoms, light headedness and severe anxiety or panic attacks may also result in distraction, psychological immobilisation, or dissociation which can in turn impact on the safe discharge of duty, in particular by the member being distracted or experiencing clouded judgement.

Anxiety and Depression are common comorbidities though each may be experienced independently.

Particular driving risks should also be considered which may be more significant in the face of certain forms of anxiety such as PTSD and/or panic attacks.

The impact of police work on the underlying anxiety disorder, i.e. whether police work may aggravate an underlying condition also needs to be considered.

Standardised Tools such as a DASS 21 may be useful as screening tools to assist in the clinical assessment of anxiety and measure its ongoing improvement or deterioration.