VICTORIA POLICE

Obsessive Compulsive Disorder

May be characterised by obsessions, compulsions or both. Generally, symptoms need to be present for at least 1 hour a day to meet the diagnosis (refer DSM V).

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

Considerations include (but are not limited to):

- Diagnosis and symptoms
- Duration of condition and recurrence and/or chronicity
- Onset of condition
- Severity of symptoms at worst including how many hours of the day symptoms are present, whether obsessions, compulsions or both and a detailed assessment of functional impact and impact on ADLs
- Insight and engagement with treatment
- Fluctuation in symptoms with stress and resilience / testing under pressure
- Any comorbidities e.g. depression, anxiety trauma or substance use, tics, developmental disorders.
- Social supports
- Any risk issues including suicidality and or intrusive thoughts and/or compulsions re same
- Treatments tried, response to treatment and side effects including psychological therapies such as CBT, Exposure Response Prevention, OCD inpatient or outpatient programs, medications tried and effectiveness
- Specialist involvement
- Medication treatment e.g. SSRI, SNRI, benzodiazepine or other, dose, duration, response, side effects
- Lifestyle measures in place
- 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
- 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 in the setting of intrusive thoughts or compulsions, 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 also 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.

OCD symptoms can vary from mild symptoms which may have little if any functional impact to severe and debilitating. To meet the DSM V diagnosis of OCD however symptoms must be present for at least one hour a day and cause 'clinically significant distress or impairment in social, occupational or other areas of functioning.'

Intrusive thoughts are generally unwanted thoughts that are recurrent e.g. fears of contamination, compulsions are behaviours e.g. handwashing, checking, counting, straightening, cleaning (utilise YBOCS questionnaire for a more comprehensive guide about OCD intrusions and compulsions).

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

Generally, underlying organic causes and substance use need to be addressed and/or ruled out as causes.

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 and or any assistance required with ADLs.

Broadly, best results are achieved when the individual recognises, they have a difficulty, self-initiates treatment, receives treatment as appropriate. Very mild symptoms that don't meet threshold diagnosis may not require treatment. Mild to moderate OCD may be treated with psychological therapy. The gold standard is exposure response prevention therapy which can be offered as an outpatient, or some facilities such as Melbourne clinic offer inpatient programs. Moderate to severe symptoms may require concurrent treatment with psychotropic medication such as an SSRI and will generally require expert involvement.

Each case must be individually considered on its merits.

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

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, medical history, history of other substance use, social history, history of the condition, past hospitalisation and self-harm attempts.

It is useful to explore the onset for the OCD 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 the latest clinical practice guidelines from the RANZCP, RANZGP, or peer reviewed OCD guidelines as otherwise appropriate.

Impact on Job Performance

Mild OCD traits that are 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.

Obsessional thoughts may impact on policy duty – intrusive recurrent thoughts may be distracting from the task at hand which may post a risk in a safety critical environment. Intrusive thoughts instructing the member to engage in harm to self or others should be referred for expert opinion for assessment and risk advice and to differentiate from other psychiatric conditions such as psychosis.

Compulsions to act may be mild and innocuous, or a person with OCD may be compelled to perform ritualistic actions and/or actions that may either distract them from the task at hand or compel them to take actions which are harmful to self or others. Examples of compulsions are straightening, cleaning, handwashing, touching, counting.

A specialist assessment is required where there are prominent symptoms to assess the condition and risk.

A YBOCS assessment can be helpful in eliciting a full range of symptoms and grading severity but does not replace a clinical assessment.

Anxiety and OCD 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 OCD.

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

Standardised tools such as a YBOCS may be useful as screening tools to assist in the clinical assessment of OCD and measure its severity and ongoing improvement or deterioration.