Workers' Comp

Clinical and Pharmaceutical Best Practices for PTSD

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Tom Kerr: Over the next few days, work comp professionals will be making the annual trek to Orlando, FL, for the WCI conference. A topic that will be top of mind for attendees is how to best treat employee mental health issues resulting from experiencing or witnessing a catastrophic incident in the workplace.

On Monday, Aug. 21, Enlyte's Tammy Bradly and Nikki Wilson will share their expertise in the panel session "PTSD and its Doppelgangers." The session is designed to help claims professionals better understand the

diagnostic criteria that leads to a successful post-traumatic stress disorder diagnosis. Tammy and Nikki join us today to talk more about this topic.

Tammy, let's start with you. Why do you feel it's important that WCI attendees learn more about PTSD in comp?

Tammy Bradly: Well, we are seeing more and more states recognize mental injuries, and we really need to be prepared to manage these claims. Here are some really good stats, and we're going to cover these and some additional stats in our session.

Thirty-four states have recognized mental injury as a work comp injury, most on a limited basis and often limited to the diagnosis of PTSD. We're seeing this for first responders, mainly. However, I think the industry is anticipating that compensation for PTSD will continue to expand over the next few years.

There are typically confounding psychological or neurocognitive conditions and or medication interactions that make it difficult to tease apart what is PTSD and what is something else, yet the distinction is really critical to identifying the most appropriate psychological and pharmacological treatment. Our session really focuses on these topics.

In about 35 percent of the diagnosed PTSD cases, they often become chronic. That's why early identification and proper treatment are so important. Those with premorbid or comorbid psychological problems tend to have poorer outcomes.

And it's also important to note that PTSD patients who do not improve also tend to have a protracted physical recovery when there's physical injury as well. And lastly, in many cases, opportunities for early intervention are not taken simply for a lack of knowledge as to what can be done to help these individuals.

Kerr: OK, great. And are there measures an employee can take to prepare for managing PTSD conditions should a catastrophic work event occur?

Bradly: Absolutely. Employers should always have a crisis response plan in place that includes crisis intervention services. And crisis intervention is simply a short?term acute intervention designed to stabilize and mitigate the person's response or persons' response to an incident. We refer to it as psychological first aid, really there to prevent disability from occurring.

The goals of crisis intervention include stabilization, reducing the symptoms and helping to return that individual to function and, if needed, facilitate them getting access to continued care if indicated.

Kerr: And Tammy, what are the challenges in determining if an employee is coping with PTSD or trying to cope with it?

Bradly: I would say first and foremost, many individuals never discuss their symptoms with their medical provider or even get diagnosed.

If you don't understand the common symptoms and behavior patterns, it can often go overlooked, undiagnosed, and even complicate a physical injury. Often these individuals may be misdiagnosed, so it's important to get them to a provider trained in diagnosing and treating PTSD.

Kerr: Are there certain triggers or indications to look out for in determining if an employee is exhibiting symptoms of PTSD?

Bradly: Well, it starts with exposure to a traumatic event or a critical incident. Some examples include natural disasters, workplace violence, even witnessing a catastrophic or fatal injury of a coworker just to name a few.

For PTSD to be diagnosed symptoms must last 30 days or more. It's important to understand that PTSD disrupts a person's normal life pursuits, meaning their activities of daily living interactions with others, work, all of those things that are part of our daily life.

There are some main symptom patterns.

- Intrusion- is how a person sees the aspects of the event over and over again. They may hear things, or smell things, or tastes things over and over again that remind them of the event. They're just really unable to stop thinking about it. They may even have dreams and nightmares.
- Avoidance- oftentimes individuals with PTSD may avoid going to certain places, may avoid certain people, even family and close friends. They may avoid having conversations, experience excessive sleep and limit their activities. They may not even go outdoors.
- Arousal- this kind of incorporates all of those factors. That sleepless, restless, loss of attention span, inability to concentrate, inability to relax, and just being hyper?alert.
- Negative cognition or mood- oftentimes, they may have persistent and exaggerated beliefs about the impact of the trauma. Persistent or distorted cognitions about what caused the trauma. They may blame other people. They may have persistent negative emotional states, again, that fear, anger, things like that. Diminished interest in participating in significant activities, feeling detached or estranged from others. And persistent inability to experience positive emotions.

I think some of the common symptoms that we see, and everyone should look for are when individuals that we are interacting with have problems with concentration or reporting sensitivity to sounds, or having that sleep disturbance, are highly irritable and have greater than normal difficulty managing stress.

Kerr: OK. And I'm going to ask you both this next question. Nikki, let's start with you. What are some pharmaceutical best practices in addressing PTSD in comp?

Nikki Wilson: Yeah, several national organizations have produced evidence?based recommendations and guidelines around the treatment for PTSD, including pharmacologic management, outlining drugs, place in therapy, frequency dose, duration of treatment, indications for discontinuation.

So, looking at things like, is it working? What kind of adverse effects do we have? Did the resolution of PTSD occur and we don't need the medication any longer? It's been sufficient.

So, the pharmaceutical management of PTSD specifically, we do have good evidence there for which drugs can be a part of therapy first?line that's supported by those guidelines and clinical studies and in the literature.

Really what it comes down to as far as clinical best practices for pharmaceutical management, it starts with assessment, diagnosis, and then the initial therapy. As far as medications are concerned, it centers around selective serotonin reuptake inhibitors, which are a particular class of antidepressants that have been studied for the condition.

And there's only two that are FDA?approved today for PTSD, but a number of them are used off?label. So, we have basically the brand named Zoloft or Paxil, which are paroxetine and sertraline. They are indicated for initial therapy. And, generally, things to remember as far as clinical best practices go is to start one of those SSRIs three to four weeks after exposure to the trauma or the event that triggered the symptoms of PTSD and to start low and titrate gradually up to the dose of response, which it could take 8 to 12 weeks to determine response.

It's a pretty slow march in the world of mental health treatment with pharmaceuticals. And actually, most guidelines recommend anytime we're switching medications or looking at trial and error of these drugs, we do that for 12 weeks at least. So, it can be quite lengthy.

Other pieces that are important in overall treatment from a pharmaceutical perspective are to perform follow?up after that initial drug has started. So, during that acute phase of therapy, it's recommended that patients be seen more frequently. And then as we continue on through recovery, that follow?up can be extended.

If we have a patient on a year of pharmacotherapy that's extended even further, the provider should constantly be assessing how are the symptoms improving. That's really what management is focused on when it comes to the medications themselves. And then monitoring for any drug adverse effects as with this class, we know there can be many, and we'll get into that a little bit.

Then if there's remission, which is defined typically as a good response to these medications. Maybe the symptoms are improving on their own through other therapies, but the benchmark that's typically used is greater than a 75 percent reduction in symptoms and a response maintained for at least three months.

So, those are some things that should be considered as clinical guidance when treating PTSD.

Kerr: Tammy, same question. What are some clinical best practices in addressing PTSD in comp?

Bradly: Yes. I would say from a clinical perspective, and I'm going to speak from the case manager's perspective, it's so important for us to be asking the right questions using techniques like motivational interviewing to identify if the employee is experiencing any of the common symptoms documenting our observations, how long the symptoms have persisted. If the employee is also being treated for a physical injury, talking with that treating provider about referral for evaluation. And I think that oftentimes case managers get to know not only the injured employee but their spouses and other close family members.

It's important that we listen to what they're saying as well and what they are seeing looking for those common symptoms. For instance, are their loved ones withdrawing from family and friends?

Certainly, something we can help facilitate is making sure that we do get that person appropriately evaluated by a provider that is qualified to both diagnose and treat PTSD. We want to also engage with one that will outline a treatment plan, expected timeframes, and really manage according to those nationally recognized treatment guidelines that Nikki mentioned earlier.

Kerr: OK, great. And Nikki, when should pharmaceuticals be considered in addressing PTSD in comp?

Wilson: So, I think the easiest way to answer this, for mental health in general, but specifically for PTSD, it needs to be very individualized based on that particular patient's specific needs, their preferences. What's their tolerance to medication? What's their reaction?

And while we have evidence to support psychotherapeutic options or medications that can help symptom reduction for these patients, those must be used in conjunction with, or as part of a trauma?focused psychotherapy to be most effective.

So, we know that PTSD and its symptoms can be treated with various types of non?drug therapy, including trauma?focused psychotherapies like cognitive therapy, anxiety management, exposure therapy good evidence for eye movement desensitization and reprocessing (EMDR). So, it's not really treatment in a vacuum.

So when should we be looking to meds or when are they appropriate? One of the ways that we guide decisions for psychotherapeutic treatment is when the patient has met criteria outlined in the *DSM?5* or the *Diagnostic and Statistical Manual for Mental Health Disorders.* There's a various set of criteria that pays more attention to the behavioral symptoms that accompany PTSD, and those criteria use for distinct diagnostic clusters to determine whether or not that patient has a true diagnosis.

And once that diagnosis is achieved, or if we have symptoms that fit the bill enough where medications may be beneficial, we know that the handful of medications that can be prescribed for PTSD symptoms because of the way they act, we know how they might play a role.

So, their mechanism of action, they act on various neurotransmitters within the body that play a role in fear, anxiety, and mood. Some common terms for those particular neurotransmitters are substances like serotonin, norepinephrine, dopamine, GABA, glutamate. All of those are affected by the handful of medications that can be applied.

And I mentioned earlier, there's only two meds that are approved by the US Food and Drug Administration specifically for PTSD, and those are Paxil and Zoloft, which are both SSRI antidepressants. But when those medications are ineffective or not tolerated, we have this whole cascade of alternative options that might be tried or used in addition to first?line agents. Many of those are used off?label, but we do have good evidence to support their use.

And the goals of therapy overall when we're considering a pharmaceutical is to look in the short term for symptom reduction. We're looking for things like improving intrusive re?experiencing, improving avoidance or numbing — which Tammy talked about a little bit, some of those changes in behaviors that those individuals might be exhibiting — improving hyperarousal, and in the long term, we're really looking for overall remission.

So, that is always the goal and there's much to manage throughout, but that's one of the ways we can look to initiate therapy or when it might be appropriate.

Kerr: Nikki, what are some challenges in ensuring the right pharmaceutical interventions are incorporated into the injured employee's care plan to address PTSD?

Wilson: So, psychotherapeutic management can be a really challenging science. There are a number of different considerations that we have to consider when we're dealing with a medication in this class. I've mentioned a couple of them in passing already. The medication selection itself for mental health can present its own challenges.

Did we have an adequate trial? I mentioned earlier it takes time for response … up to 12 weeks. The dose and duration, did we get to that optimal dose? How are we monitoring response? Did we look at the baseline mental health status and do an examination? Did we develop a specific target symptom list that we're going to be testing against throughout the treatment?

It's basically, as I mentioned, very individualized based on the patient's age, medical history, current physical health, current medication use. We need to know what else are they on? There's a number of drug?to?drug interactions that are of concern with some of these medications.

But we do have sort of the standardized approach for initial assessment and follow?up of patients with PTSD outlined in the *DSM?5*, and that can address some of those interview questions for assessment as well as suggested management, which typically involves, as I mentioned, a multidisciplinary mental health care environment.

So, generally, the approach employs not only psychotropic meds that will be applied along with comprehensive psychosocial services for many of those mental health conditions. So, here are some of the challenges:

- Titration or dose?response is one.
- Adequate response timelines. How long did we treat with the medication?
- We have stigmas that we're often dealing with when it comes to a medication for a mental health disorder, whether it's the patient's or external influences where the patient may be hesitant to take that medication.
- Problems adhering to the medication protocol.
- Side effects-are they limiting the patient's ability to tolerate the medication? Is the patient taking them on schedule and as they should be?
- And then, how are we measuring our outcomes, and what are we looking to achieve with the medication itself?
- Additionally, and Tammy touched on this a little bit, the presence of confounding factors and conditions. So, other mental health conditions that might be limiting response or other things going on in that patient's home life could be impacting the response to treatment.
- Treatment in a vacuum, so, we're not applying that recommended multidisciplinary focus with multiple modalities, multiple providers, trying to just tackle one arm of it. Not individualizing treatment can be a mistake. Do we have the correct diagnosis?
- There's a lot of overlap with other conditions and even some medications the patient might be on, like Tammy mentioned could look like symptoms of PTSD or could lead to some of those anxiety and fear and avoidance behaviors.
- Mixed psych?related disorders. Is the patient also dealing with depression or anxiety as another condition on top of their PTSD?
- And then, return?to?work concerns and how we manage through those on some of these medications is always part of the overall approach and the overall look.

So, just looking to make sure that we've got the right fit for that patient given their circumstances. Walking through, if the patient isn't responding to treatment, what we can change. Asking those questions about what challenges might be in the way, and then looking for what we're going to do if there is not a response to that medication.

And typically that results in stopping the trial of one agent and initiating a new one and then, or perhaps, augmenting the current antidepressant the patient might be on with addition of adjunctive drugs.

So, one concern I want to hit on that we see in our industry is over-coverage for psych. If one of those meds all of a sudden becomes on board. And I know Tammy mentioned a really interesting stat earlier that we've got more and more states now recognizing mental health injuries in comp. So, I think this is going away more and more, that stigma with the adjuster and payers, because that medication might not work the first time and there isn't really a quick fix and it's difficult to measure outcomes.

Similar to pain, we don't really have a physical measure of psychological affects, like a lab test. It's very subjective, it's by patient report, it's by symptom resolution. That can all be a major challenge in treatment, which I think we're getting better as an industry at pointing to the evidence?based guidelines to address some of those challenges and to follow through.

But I think it's important to level set. It could be a long haul before we've got good success just because of the nature of psychotherapeutic management in general.

Kerr: Final question, and Tammy, we'll start with you on this one. What do you hope attendees will take away from your session?

Bradly: I think first and foremost that PTSD is a real condition and it can affect anyone. It's not just limited to people who may have some type of other psychosocial issue going on. It's associated with broader health concerns.

While it can resolve on its own, if symptoms persist, treatment is strongly advisable. And don't ignore the signs and symptoms thinking it'll go away because it just won't. Other conditions can look like PTSD but are not. So, this certainly has implications for treatment and compensability.

Kerr: Thanks, Tammy. Nikki?

Wilson: So, I think the takeaway is the importance of understanding that there isn't a quick fix, there's not a one ?size?fits?all, but that we do have some really great resources and game plan outlines to help us provide the best support. I think it's really important to find a good and trusted partner to help navigate some of those challenges, especially in the comp space.

It's so important the mental health treatment is looking beyond the medications alone and focusing on other modalities to determine how to be most effective. So, things like following the guidelines to support an overall recovery plan, making adjusters more aware of how pharmaceuticals can help influence return to work and what are the other options out there. Overcoming concerns about approving anything around psych because it might be accepted as part of the claim, and just the importance of how those may improve overall outcomes for that injured employee.

And then, even applying simple things like drug formularies with treatment varying depending on the states, but just putting some guardrails around that and really partnering with a resource that understands these conditions and some of the challenges that might be faced within the industry. I think that's really important to having success here.

And we have a number of new medications on the horizon. A lot of investigational treatments are coming, so there will be more in this space to question and wonder about. And so, partnering with someone who can really help guide those decisions and provide the best outcomes for the claim is pretty critical.

Kerr: Thanks Nikki and Tammy. And if you're going to WCI, be sure to check out their session: "PTSD and its Doppelgangers" on Aug. 21. We'll be back with a new podcast soon. Until then, thanks for listening.