DEPARTMENT OF LABOR AND INDUSTRY

Meeting minutes: MSRB PTSD Workgroup

Date: Aug. 29, 2018
Minutes prepared by: Anita Hess
Location: DLI Minnesota Room

Attendance

Workgroup members	Interested parties
Beth Baker	Kim Olson – MSRB RN alternate, Corvel Corporation
Buck McAlpin	
Dan Wolfe (phone)	**Guests**
	Gary Thaden – MMCA and NECA
DLI staff members	William Wilson – Occupational medical physician resident at HealthPartners
Anita Hess	Karen Ebert (phone) – MCIT
Ernest Lampe	Brian Gould (phone) – psychiatrist, Courage Kenny
Ethan Landy	Sue Abderholden – Executive director, NAMI
Chris Leifeld	John Sutherland (phone)
Alexis Russell	
Laura Zajac	

Call to order

Chairwoman Dr. Beth Baker welcomed attendees to the second PTSD Workgroup meeting. Introductions were made around the room.

Comments, presentations about treatment of PTSD

Baker announced that, today, the workgroup is hearing perspectives and information from speakers, which will help the workgroup to draft treatment parameters. She stated we have three people on the schedule who will give testimony. Questions are welcome.

Baker introduced Gary Thaden, who requested to address the workgroup. Thaden is a member of the Workers' Compensation Advisory Council (WCAC) and is the government affairs director for the Minnesota Mechanical and Electrical Contractors Associations (MMCA/NECA). Thaden attended the most recent workgroup meeting and noticed there were multiple options for treatment of post-traumatic stress disorder (PTSD). As a representative for the construction industry, he likes processes that are effective and work quickly. The workers' compensation system is an impediment to people's lives and we should get them in and out of the system as quickly as possible. Thaden recommended the workgroup not limit itself to choosing the single best option for treatment of PTSD. Instead, he suggested the workgroup select several effective options for treatment and let the patient and physician select the best option for the patient from those choices.

a) Sue Abderholden

Alexis Russell, Department of Labor and Industry (DLI), introduced Sue Abderholden, executive director, National Alliance on Mental Illness Minnesota (NAMI MN). Abderholden explained NAMI MN is a statewide, grassroots organization providing education and support for people with mental illness and their families. NAMI MN does not provide clinical treatment, but it does advise families about evidence-based treatment, so its knows what works and what doesn't.

Abderholden said NAMI MN is glad the legislation passed and that PTSD and the impact of trauma on people's lives is being recognized. The suicide rate among first responders is extremely high; 27.8 percent of Minnesota first responders experience suicidal ideation. Firefighters are even more likely to die from self-inflicted harm.

Abderholden said NAMI MN is concerned about how MSRB will decide which treatments will be covered. They were puzzled about why the American Psychological Association (APA) treatment guidelines were the only ones mentioned in the legislation. Abderholden didn't think the APA recommendations were very helpful and suggested there are other places to look for guidance. One is the National Institute on Mental Health (NIMH), which funds the most research about PTSD. Another is the Substance Abuse Mental Health Services Administration (SAMSA), which has a national registry of evidence-based programs and practices. SAMSA is currently closed for updates.

Abderholden thinks it's important to look at emerging – and not just evidence-based – treatment, because the mental health field does not have as much research funding to determine which treatments are effective. There is emerging best-practices information for culturally specific populations. Another source is the Veterans Administration (VA) National Center for PTSD. Also the American Psychiatric Society has treatment recommendations that focus more on medications, although they are not as up to date. NIMH and the VA center have very up-to-date research. The research in this area is really moving forward quickly.

Abderholden stated individually based treatment is very important, because what you have been through affects how you will react to different types of therapies. She noticed the APA wasn't that supportive of eye movement desensitization and reprocessing (EMDR), but we know EMDR actually works really well for some people who witness certain types of events. Abderholden recommends that instead of just looking at cognitive behavior therapy or exposure therapy, the workgroup consider a variety of things that might work for patients. Also, people metabolize medication differently, so what works for one person might not work for another.

Abderholden brought information from the NIMH and the VA National Center for PTSD. Russell asked Anita Hess to send this information to the workgroup.

Kim Olson asked Abderholden whether the research gives guidance about the length of time for treatment or at what point a different type of treatment should be considered if treatment is not working. Abderholden said probably not, it depends on the individual. How quickly the individual gets treatment makes a difference and it can take a long time for some people to get out of a full-blown cycle of PTSD. Complementary therapies and peer support can be really helpful in treatment. Meditation and yoga can play a huge role in recovery and reducing the anxiety that comes along with PTSD. Acupuncture, therapy dogs, nutrition and physical exercise can be helpful as well.

Dr. Ernest Lampe asked who would be appropriate to deliver therapy for PTSD. Abderholden replied most mental health professionals would be appropriate, but there are people who specialize in PTSD to whom patients should be referred. Talk therapy is fine, but specific training in cognitive behavioral therapy (CBT) might be better. Sometimes patients are more comfortable talking to therapists of the same sex or race because of the difficult subject matter. Lampe asked specifically about training and certifications. Abderholden said this is more difficult in the mental health area; for example, a licensed clinical social worker might not get a certificate of training in CBT. Certificates are not given out like they are in other fields.

Abderholden said it is important to be flexible because research about PTSD is happening all the time.

b) Brian Gould, M.D.

Dr. Brian Gould, psychiatrist, Courage Kenny Institute, presented to the workgroup via phone conference. He noted he had sent written comments for the workgroup to review before the meeting. He was asked by Russell to address how psychiatrists are medicating PTSD. Gould

described how the drugs mentioned in the APA guidelines are very limited. His comments explain how a psychiatrist who is thoroughly trained on the literature in this area might treat a patient with PTSD.

Gould has seen patients responding to many kinds of drugs and none of them are very effective overall. However, psychiatrists have gotten better at matching a type of medication with the patient's symptoms. Anti-hypertension drugs are very effective for many patients with PTSD, because they calm down the over-arousal symptoms. The VA pioneered this but, in the past few years, it has been adopted by general psychiatry. Gould stated that when treating PTSD it is important to recognize individual factors rather than statistical best practices and also to take note of emerging treatments.

Gould stated his written comments contain the Harvard algorithm to demonstrate multiple drugs are considered appropriate for treatment of PTSD. He likes the algorithm's approach of starting broadly and then, if symptoms remain refractory, getting more specific using less common, more aggressive medications.

Wolfe asked if there was something the workgroup should be looking at about the issue of misdiagnosis. Gould replied that people throw around the terms ADHD, depression, anxiety and PTSD in an imprecise way. An emotional reaction to something bad does not constitute PTSD. DSM-V and CAPS provide clearly specified criteria for PTSD, but sometimes practitioners apply them loosely. That is a problem of the field that cannot be solved by regulation.

Dr. John Sutherland added that clinicians are not following the DSM-V criteria like they should, including criteria A. Clinicians are also not using instruments to validate their subjective opinions. CAPS is the gold standard. The PCL-5 and PSSR-5 are screening instruments that have good concurrent validity with CAPS. Another screening instrument often used with prolonged exposure therapy protocol is the PTCI-36, which is used in most research studies.

Baker asked if it would decrease misdiagnosis to require the initial diagnosis of PTSD to be made by a licensed psychologist or psychiatrist. Sutherland replied it is not necessarily a good idea. A clinician (MSWs or LPCCs) with specific training in PTSD can be trained to do the assessment just as well as any doctor. Laura Zajac noted the statute requires the diagnosis of PTSD be made by a licensed psychologist or psychiatrist to be a compensable work injury. Zajac stated the workgroup does not have authority to make a statutory change. Baker pointed out that post-diagnosis, the patient could treat with one of these other clinicians.

Baker asked Gould at what point he would insert medication therapy as opposed to just behavioral therapy or counseling. Gould said medication and psychotherapy are in no way competitive with each other. If you have a biological dysregulation, psychotherapy can enhance the healing process. But if you use a medication to re-normalize the dysregulation, it will be faster and more specific. Gould stated not all patients want to be medicated, but if they are open to the idea, they will be in a better position to use psychotherapies. He said there is no reason to hold off on the medication if it has a reasonable possibility of being effective. The

psychotherapy treatment can go on concurrently with the medication therapy. Sutherland agreed.

c) Dr. R. John Sutherland, ABPP

Dr. John R. Sutherland's training has been through the VA and the National Center for PTSD. He is trained in prolonged exposure (PE) therapy and cognitive processing therapy (CPT), and is one of the few national trainers in the PE therapy protocol. He sees patients with PTSD and teaches related courses at the University of Minnesota. Sutherland recommended a book, *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies*, edited by Foa, Keane, Friedman and Cohen. Much of the research Sutherland cites is from this book.

Sutherland said that in 1993, the literature started to point to short-term cognitive behavioral therapies (CBT) as being very effective for PTSD. These are effective in eight to 15 sessions, depending on the protocol. Short-term CBT treatments are about promoting safe confrontation via exposure to trauma reminders and modifying dysfunctional cognition. These approaches can be broken down into exposure and cognitive therapy procedures. In 2008, the Institute of Medicine recommended the exposure therapy procedures over the cognitive approaches because they were more effective. Sutherland explained exposure therapy is a *type* of CBT that reduces dysfunctional anxieties and cognition by encouraging patients to confront trauma-related fears or memories. Sutherland said during PE or EMDR, patients visualize the problem, and (in the case of PE) talk about it, so they are not fearful of the memory. PE is 85 to 90 percent effective.

Sutherland explained that processing the memory gets at the dysfunctional cognitions that have the patients feeling shame, blame and guilt. Patients are engaged in real-life situations. An example is asking the patient to go to Walmart, because PTSD patients do not like crowded situations. Patients then realize Walmart is not dangerous. These treatments are not effective if a patient doesn't engage and do the homework or if the therapist is not an experienced, well-trained clinician. Sutherland stated EMDR is similar to PE, but the dose of exposure is not as high. EMDR has a 75 percent effectiveness rate. CPT is the other evidence-based treatment. The focus is on cognition, in the areas of self-esteem, trust, power and control, intimacy and one other area. The VA Medical Center has pushed PE, CPT and (more recently) EMDR for treatment of PTSD.

Olson asked what to expect in terms of relapse and subsequent treatment. Sutherland replied most people don't relapse. For PE, there is a 6 percent relapse rate after five to 10 years. Patients are told what to do if their symptoms are triggered, to prevent relapse. In rare cases where relapse occurs, patients sometimes go back to their clinicians for a few sessions of PE, but then they are better. CPT has a 20 percent relapse rate. Sutherland is not aware of research about the relapse rate for EMDR. The best treatment protocol depends on the patient.

Baker asked how to decide when therapy should end. Sutherland replied that with PE protocol and CPT, a pre-test is given using the PCL-5, PSSR-5, PTCI-36 or PHQ-9. For research, CAPS is

used because it is the gold standard. These instruments are given every other week until treatment is completed. Even without using the instruments, Sutherland said he can tell by around session eight or nine the patient is better. Sutherland has treated 500 to 600 patients and said he is comfortable with these treatments because he knows they work.

Lampe asked at what point, if any, a complete psychological evaluation would be needed to determine if there is a co-morbidity. Sutherland likes to determine treatment based on a full, standard diagnostic assessment that looks at depression, mania, general anxiety disorder, obsessive compulsive disorder, PTSD, cognitive impairment, alcohol and substance use, and nicotine dependence.

Baker asked if a different type of treatment should be used if the patient is not improving. Sutherland replied there are two reasons why PTSD continues and those are: avoidance; and negative cognitions and confidence. If a clinician allows the patient to avoid talking about the trauma, that will prolong the PTSD symptoms. The patient must go through the pain to get better. Sutherland noted PE and CPT work very well with substance use. The substance use is treated with medication. However, benzodiazepines are counterproductive and must be reduced for therapy to work, because the medications reduce the fear and anxiety instead of the patient learning how to do that on their own.

Gould asked how Sutherland sees the use of psychotropic drugs with these therapies. Sutherland said selective serotonin reuptake inhibitors (SSRIs) work very well. When therapy and medication are compared, therapy works better than medication alone. But using both medication and therapy will help get the patient better faster.

Olson asked Sutherland about the problem of secondary gain. Sutherland acknowledged this is a problem with service-connected disability benefits in the VA. He said it is important for well-trained clinicians to do the assessment. A cue that a patient may not have PTSD occurs when the patient wants to tell every single detail of their story, because PTSD patients avoid talking about the trauma.

Lampe asked about non-cooperative patients. Sutherland replied that motivational interviewing is helpful, as well as explaining the rationale for the treatment and why it’s in the patient’s best interest. But, ultimately, the patients have to be willing to do the treatment and decide they want to get better.

Adjournment

Baker thanked everyone for attending. The next workgroup meeting is from noon to 1 p.m., Sept. 13. The hope is there will be draft rule language to review.