

A Clinician's Summary of the Expert Guidelines on the Diagnosis and Treatment of Post-traumatic Stress Disorder in Emergency Service Workers

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Published February 2018

Endorsed by the Royal Australian and New Zealand College of Psychiatrists



Introduction

In Australia, there are over 80,000 full time emergency workers who perform a vital role in protecting and providing emergency assistance to other citizens. They may be police officers, fire fighters or ambulance personnel, or belong to a volunteer organisation such as the State Emergency Service (SES) or Rural Fire Service. There is increasing awareness that there may be mental health consequences of the cumulative trauma exposure and organisational stress experienced by many emergency service workers. Around one in 10 emergency service workers have symptoms consistent with post-traumatic stress disorder (PTSD), with similar high rates of depression and generalised anxiety symptoms. These mental health problems can cause many emergency service workers to lose their work, their family and their wellbeing.

However, this doesn't need to be the case. There is now a range of effective treatments for PTSD and with early diagnosis and good quality care, many emergency service workers can recover. While there is cause for optimism, it also needs to be acknowledged that diagnosing and treating mental health problems amongst emergency service workers can be complicated.

The Black Dog Institute has recently published evidence-based guidelines on how PTSD should be diagnosed and treated amongst emergency service workers.¹ These guidelines, which were peer reviewed and approved by the Royal Australian and New Zealand College of Psychiatrists, are intended to sit alongside and complement the broader NHMRC Australian Guidelines for the Treatment of Acute Stress Disorder and Post-traumatic Stress Disorder.² This summary is designed to provide clinicians with a brief overview of these expert guidelines to help with their day-to-day management of emergency service workers.

1. Harvey SB, Devilly G, Forbes D, Glozier N, McFarlane A, Phillips J, Sim M, Steel Z, Bryant R (2015). Expert Guidelines: Diagnosis and treatment of post-traumatic stress disorder in emergency service workers. Sydney: Black Dog Institute.

2. Phoenix Australia - Centre for Posttraumatic Mental Health (2013). Australian guidelines for the treatment of acute stress disorder & posttraumatic stress disorder. Melbourne, Victoria: Phoenix Australia.

How to diagnose PTSD

PTSD describes a severe and persistent stress reaction after exposure to a traumatic event or a series of traumatic events. A prerequisite is that an individual must be exposed to threatened or actual death or serious injury to themselves or others, including the repeated or extreme exposure to the adverse events as typically occurs with emergency workers. PTSD comprises four major clusters of symptoms:

1. Re-experiencing symptoms, including intrusive memories, flashbacks, and nightmares.
2. Avoidance symptoms, including active avoidance of thoughts and situational reminders of the trauma.
3. Negative cognitions and mood associated with the traumatic event, such as an inability to remember important details about the event or persistent unusual ideas about the cause or consequence of the traumatic experience.
4. Arousal symptoms, including exaggerated startle response, insomnia, irritability and concentration difficulties.

The latest version of the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, requires that symptom(s) from each of these clusters be present for more than one month and be associated with significant distress or impairment in social, occupational, or other important areas of functioning.

It is important to remember that many of these symptoms are common after exposure to trauma and can also be part of a normal response to trauma. Many emergency service personnel may have some of these symptoms, but this does not necessarily mean they are suffering from PTSD.

It is also useful for clinicians to realise that **emergency workers with PTSD may present in different ways to civilians**, and may describe a gradual build-up of distress and symptoms over a prolonged period of time, rather than a sudden onset of symptoms after one isolated event. Further, these symptoms can fluctuate over time, and typically worsen at times of stress.

Many emergency service workers may be reluctant to admit mental health symptoms out of fear for their career or concerns over stigma. Conversely, there is also evidence that symptoms can be misinterpreted if assessment relies too heavily on self-report symptom inventories. Therefore, clinicians assessing an emergency worker for possible PTSD should not commence their assessment with self-report tests but rather ask open-ended questions about any problems the emergency worker may be experiencing, and should look for all clusters of symptoms. Asking about mental health symptoms using a third party open questioning technique can help, for example “Lots of people working in your job have difficulty coping with things from time to time. Has that happened to you?”

What other disorders should you be considering?

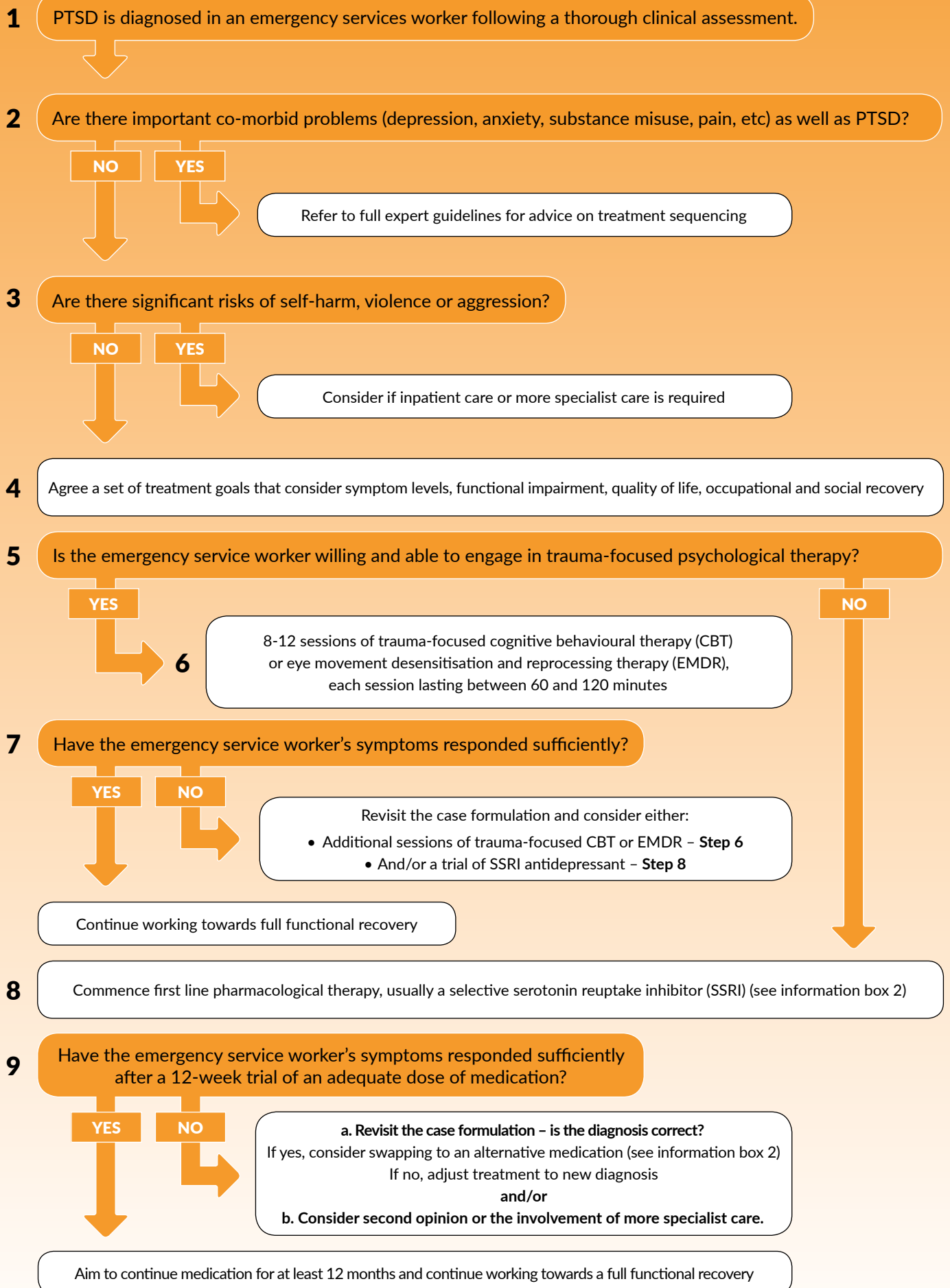
PTSD symptoms, particularly when long standing, rarely exist in isolation. When assessing emergency service workers it is important to consider the possibility of diagnoses other than PTSD. Other problems, such as **depression, generalised anxiety disorder, alcohol abuse or illicit drug use** are common amongst emergency service workers, but are sometimes misdiagnosed as PTSD. In recent years, there has also been increasing evidence of the importance of physical health symptoms, particularly pain, amongst those with PTSD.

Legal Disclaimer

This document is a general guide to appropriate practice, to be followed only subject to the practitioner's judgement in each individual case and in combination with the full Expert Guidelines on the Diagnosis and Treatment of Post-traumatic Stress Disorder in Emergency Service Workers.

The guidelines are designed to provide information to assist decision making but they do not override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient. Health professionals must be mindful of new evidence as it becomes available.

Suggested steps for the treatment of PTSD in emergency service workers



Treating emergency service workers with PTSD

Once a diagnosis of PTSD is established, effective, evidence-based treatments should be commenced as soon as possible. The selection of the correct treatment or collection of treatments for any individual will depend on a range of individual factors, such as duration of symptoms, presence of comorbidity, prominence of different symptoms clusters, the patient's ability to consider psychological concepts, and patient preference. The vast majority of emergency service workers with PTSD can be treated as outpatients.

However, PTSD is associated with an increased risk of suicide, so it is essential that the risks of **self-harm** and **violence** are considered and if there are significant risks, other options, such as inpatient care, need to be considered.

Prior to commencing any treatment for PTSD, there should be an agreed set of **treatment goals**, which consider symptom levels, functional improvement, quality of life and occupational and social recovery.

Information box 1

What is 'trauma-focused psychological therapy'?

There are two types of trauma-focused psychological therapy that we know are more effective than other types of psychological treatment for PTSD: trauma-focused cognitive behavioural therapy (CBT) and eye movement desensitization and reprocessing therapy (EMDR).

When used in PTSD, CBT should have two main components:

1. The cognitive component of therapy should aim to help individuals identify, challenge and modify distorted thoughts
2. The behavioural aspect of therapy should utilise prolonged imaginal and in vivo exposure to confront their memory of the trauma-related events in a gradual and supported manner.

In practice, a course of trauma-focused CBT for PTSD will usually involve the patient being led through a series of exercises in which the traumatic event and its aftermath are imagined and described, with particular focus on the level of negative emotion and arousal generated. As with all CBT, homework assignments allow progress to continue outside of regular session times. Special consideration should always be given to patient safety in the context of imaginal exposure to traumatic events and care taken to ensure that the patient is fully recovered from the experience before leaving the safety of the consulting room.

Eye movement desensitisation and reprocessing (EMDR) is a specific form of treatment for PTSD. During EMDR therapy a patient is asked to repeatedly focus on trauma-related thoughts, experiences and memories while following the movement of a therapist's finger across their field of vision. It is proposed that this dual attention facilitates the appropriate processing of the traumatic event. EMDR therapy has evolved over time and now includes many components that would be considered core aspects of trauma-focused CBT.

Many counsellors or therapists may offer emergency service workers other types of therapy, such as supportive counselling, relaxation therapy or 'tapping therapy'. These may have some temporary benefits, but we know they are not as effective as the two types of trauma-focused psychological therapy described above and they should not be used as an alternative to these evidence-based approaches.

Information box 2

What medication can be helpful in PTSD?

First-line pharmacological therapy

- Selective serotonin reuptake inhibitors (SSRIs) have been shown in multiple trials to be an effective treatment of the core symptoms of PTSD and should be considered first-line pharmacological treatment.
- Other types of antidepressant medication, particularly serotonin-noradrenaline reuptake inhibitors (SNRIs) and mirtazapine, also have been found to be effective treatments for PTSD.

Second-line pharmacological therapy

- The alpha-adrenergic antagonist prazosin can reduce the symptoms of arousal and re-experiencing (e.g. nightmares) in those with PTSD.
- Atypical antipsychotics (such as risperidone, olanzapine or quetiapine) can be used as augmenting agents when first-line pharmacological treatments have not been effective.
- Benzodiazepines should only be used for short-term (less than 4 weeks) relief of severe anxiety, insomnia or as part of a planned alcohol withdrawal regimen.

Information box 3

What about returning to or remaining at work?

Occupational recovery should be considered from the very beginning of treatment. There should be an expectation that most emergency workers with PTSD can gain benefits from appropriate treatment.

While a period away from operational duties may be required, clinicians should consider the possibility of adjusted duties and partial return to work as ways of promoting recovery and reducing the risk of long-term sickness absence. All emergency workers who are absent from work due to PTSD should be offered work-focused interventions, such as work-focused exposure therapy, in addition to standard symptom-focused treatment. Depending on the nature of the trauma exposure and PTSD, some personnel may need to resume on a period of alternate duties because direct re-exposure to particular events may be overly distressing.

In general, emergency workers can safely return to operational duties once their symptoms have improved, even while still undertaking treatment (including medication). When an emergency worker who has had PTSD returns to work, it should be agreed how their symptom levels will be monitored and what type of symptom recurrence should prompt a re-assessment.

What to do if an emergency worker with PTSD is not getting better

- Consider whether PTSD is still the primary diagnosis. Sometimes the symptoms of another disorder, such as depression or anxiety, may become more obvious once PTSD symptoms have been treated
- Ask about alcohol or substance misuse, which may be preventing the expected recovery
- Ensure there are no additional physical health problems
- Ask about any ongoing stressors or other barriers to recovery
- Consider the use of second-line therapies or a combination of different evidence-based treatments
- Ask for a second opinion from someone with expertise in PTSD and the mental health of emergency service workers.

Useful links for clinicians

Free downloads of the full Expert Guidelines on the Diagnosis and Treatment of Post-traumatic Stress Disorder in Emergency Service Workers can be obtained from the Black Dog Institute's website.

www.blackdoginstitute.org.au/fullptsdguidelines

Phoenix Australia's Centre for Post-Traumatic Mental Health provides a range of training programs for clinicians treating those impacted by trauma. Their website also contains free downloads of the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder.

www.phoenixaustralia.org

The Royal Australian College of General Practitioners (RACGP) has an active Learning Module (ALM) focused on recognising and treating common mental health problems following disaster and trauma. It can be accessed via the gplearning website.

www.gplearning.racgp.org.au

The International Society for Traumatic Stress Studies (ISTSS) website has a collection of assessment tools including interview protocols and self-report questionnaires. The website also provides information about how to use each scale and some non-English translations.

www.istss.org

The Australian Society for Traumatic Stress Studies (ASTSS) provides a forum for extending the understanding, prevention and treatment of major stress and trauma within the Australasian region, and for promoting mental health, resilience and post-traumatic growth.

They host regular meetings across Australia and disseminate up-to-date information about trauma treatments.

www.astss.org.au

The UNSW Traumatic Stress Clinic provides a free assessment and treatment service for former and current emergency service workers based in NSW.

www.traumaticstressclinic.com

Online trauma-focused cognitive behavioural therapy programs are offered by a number of providers, including This Way Up (www.thiswayup.org.au) and MindSpot (www.mindspot.org.au).

Useful links to recommend to patients

Information about normal recovery after trauma can be obtained from the website of Phoenix Australia's Centre for Post-Traumatic Mental Health.

www.phoenixaustralia.org

Information about PTSD and the different types of treatment available can be obtained from the Black Dog Institute's website.

www.blackdoginstitute.org.au

The Beyondblue website has information on a range of mental health problems and details about their program focused on first responders.

www.beyondblue.org.au



Funding declaration



EML (Employers Mutual Limited), a claims manager that provides workers insurance claims management services to a number of Australian emergency service organisations, funded the development of the full expert guidelines. The funder's role in the development of these guidelines was agreed in legal contract co-signed by the University of New South Wales and EML. This contract clearly sets out that the authors of these guidelines had full academic independence and that while EML provided funding to support the development of these guidelines, they did not influence the final report conclusions in any way.

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As a claims manager, EML group companies manage workplace personal injury claims nationally across a range of industries, including those with increased exposure to psychological stress and trauma such as the Emergency and Health Services. This summary forms part of our National Psychological Injury Service Offering which aims to better support those psychologically injured as a result of their work.

The full expert guidelines were authored by A/Prof S Harvey, A/Prof G Devilly, Prof D Forbes, Prof N Glozier, Prof A McFarlane AO, A/Prof J Phillips AM, Prof M Sim, Prof Z Steel and Prof R Bryant. They underwent independent peer review via the Royal Australian and New Zealand College of Psychiatrists Practice and Partnerships Committee. They were also reviewed by a range of emergency service organisations and by emergency service workers' peer support services.