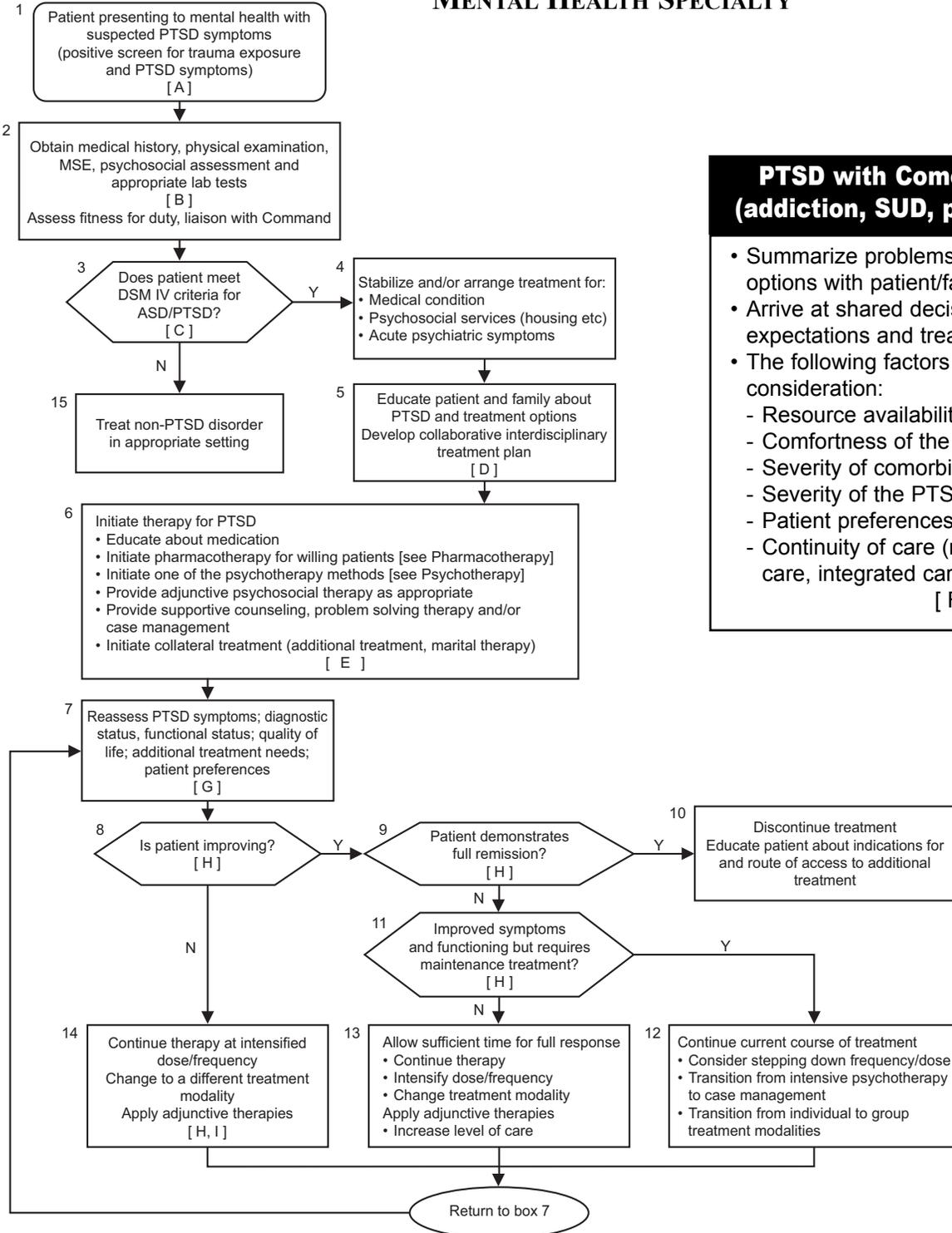


VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF POST TRAUMATIC STRESS

Module C Summary

MENTAL HEALTH SPECIALTY



PTSD with Comorbid Symptoms (addiction, SUD, psychosis, bipolar)

- Summarize problems and discuss treatment options with patient/family
 - Arrive at shared decision regarding goals, expectations and treatment options
 - The following factors should be taken into consideration:
 - Resource availability
 - Comfortness of the provider
 - Severity of comorbid symptoms
 - Severity of the PTSD
 - Patient preferences and pressing concerns
 - Continuity of care (mental health, primary care, integrated care, vet centers, other)
- [F]

ANNOTATIONS

A. Patient Presenting To Mental Health With Suspected PTSD Symptoms,

RECOMMENDATIONS

Assessment in Mental Health Specialty

1. Mental health clinicians should obtain a comprehensive diagnostic assessment that includes, but is not limited to, the symptoms that characterize PTSD (see DSM IV, 1994).
2. Routine use of self-administered checklists may ensure systematic, standardized and efficient review of the patient's symptoms and history of trauma exposure (see Appendix C [PCL-C]).
3. The assessment should also include review of other salient symptoms (guilt, dissociation, derealization, depersonalization, reduction in awareness of surroundings) that impact on treatment decisions. Structured psychiatric interviews, such as the clinician administered PTSD scale (CAPS), may be considered.

For discussion see CORE Module Annotation D, and Module B – Management of ASD and PTSD in Primary Care Annotations A and B

B. Obtain Medical History, Physical Examination, MSE, Psychosocial Assessment, And Appropriate Lab Tests

See Module B: Management of ASD & PTSD in Primary Care, Annotation D, E and F

C. Does Patient Meet DSM-IV Criteria For ASD/PTSD?

OBJECTIVE

Diagnose ASD/PTSD by DSM-IV criteria

RECOMMENDATIONS

1. Diagnostic criteria should be documented in the medical record

D. Educate Patient And Family About Treatment Options; Develop Collaborative And Interdisciplinary Treatment Plan

See Module B: Management of ASD & PTSD – Primary Care, Annotation H

E. Initiate Therapy For PTSD

See Intervention Module

F. PTSD With Other Comorbid Symptoms (Addiction, SUD, Psychosis, Bipolar) [Sidebar]

See Module B: Management of ASD & PTSD in Primary Care, Annotations I and J

G. Reassess PTSD Symptoms; Diagnostic Status, Functional Status; Quality Of Life; Additional Treatment Needs; Patient Preferences

Assess patient status following therapeutic intervention to determine future direction

RECOMMENDATIONS

1. Follow-up status of patients with PTSD should be monitored at least every three months. Use interview and questionnaire methods to assess PTSD symptoms and function.
 - Diagnostic status and symptom severity
 - Functional status/health-related quality of life
 - Psychosocial treatment needs
 - Patient preferences
 - Therapy adherence
 - Adverse treatment effects

H. Follow-Up In Mental Health

RECOMMENDATIONS

1. If patient does not improve or status worsens, consider one of the following treatment modification options:
 - Continued applications of the same modality at intensified dose and/or frequency
 - Change to a different treatment modality
 - Apply adjunctive therapies
 - Increase level of care (e.g., referral facility, partial hospitalization, inpatient hospitalization, residential care)
 - Consider a referral to adjunctive services for treatment of comorbid disorders or behavioral abnormalities (e.g., homelessness, domestic violence or aggressive behavior)

2. If patient demonstrates partial (insufficient) remission, consider one of the following treatment modification options:
 - Continue the present treatment modality to allow sufficient time for full response
 - Continue applications of the same modality at intensified dose and/or frequency
 - Change to a different treatment modality
 - Apply adjunctive therapies
 - Increase level of care (e.g., referral facility, partial hospitalization, inpatient hospitalization, residential care)
 - Consider a referral to adjunctive services for treatment of comorbid disorders or behavioral abnormalities (e.g., homelessness or domestic violence)
3. If patient demonstrates improved symptoms and functioning but requires maintenance treatment:
 - Continue current course of treatment
 - Consider stepping down the type, frequency, or dose of therapy
 - Transition from intensive psychotherapy to case management contacts
 - Transition from individual to group treatment modalities
 - Discuss patient status and need for monitoring with the primary care provider
 - Consider a referral to adjunctive services for treatment of comorbid disorders or behavioral abnormalities (e.g., homelessness or domestic violence)
4. If patient demonstrates remission from symptoms and there are no indications for further therapy:
 - Discontinue treatment
 - Educate the patient about indication and route of future care access
 - Monitor by primary care for relapse/exacerbation

Patient does not improve or status worsens:

Reassessment of patients' clinical status may occasionally show that symptoms and/or functional status is failing to improve or is deteriorating in a sustained way. It is important to determine that this static or deteriorated state is not simply the result of a major life crisis unrelated to the therapy being administered.

The clinician must next determine if a patient's unimproved clinical status reflects a temporary exacerbation of symptoms expected to occur in the course of treatment that will ultimately prove to be effective. For example, it is common for patients undergoing exposure therapy to experience some brief distress or symptom exacerbation during initial phases of treatment where they focus on emotions associated with traumatic memories. In this case, it is important to reassure patients about the natural course of recovery through treatment, assist them in coping with symptoms, and enlist them in the decision to continue with the current method of treatment. Increasing session contacts and or increasing the dose of medications may provide support needed to alter the outcome of treatment.

If the clinician and patient agree that the current treatment regimen is ineffective, then a collaborative decision can be made to switch to a different modality. Some patients find exposure therapy too distressing and may need to postpone that type of intervention, in favor of using an approach that is more easily tolerated (e.g., cognitive therapy and symptom management approaches).

Another approach is to hold the course of a current therapy, which may appear ineffective, but apply adjunctive treatments (see PTSD Interventions) There is no empirical evidence that supports the effectiveness of combination treatments for PTSD. However, there is clinical consensus that some treatments can act synergistically (e.g., combining coping skills and symptom management approaches with exposure-based treatments).

Clinicians should consider changing the treatment plan by increasing the level of care offered to patients. Levels of care for PTSD vary in intensity, including infrequent visits administered in outpatient clinics, partial hospital programs, specialized inpatient PTSD programs, PTSD residential care programs and domiciliarys, and acute inpatient hospitalization. Patients who fail to progress in outpatient treatment may benefit from a temporary transition to a higher level of care, followed by return to outpatient management after greater stabilization of symptoms have been achieved.

Often, progress in PTSD treatment may be compromised by a concurrent behavioral disorder (e.g., domestic violence), life crisis (e.g., homelessness), or uncontrolled substance use disorder. Referral to ancillary clinical services should be considered for patients for whom these problems emerge during the course of treatment, as identified upon reassessment.

Patient demonstrates improved symptoms and functioning but requires maintenance treatment:

Treatment may also lead to slight or moderate improvement that nonetheless leaves the patient with significant distress and impairment in functioning. If patient demonstrates partial (insufficient) remission, consider one of the following treatment modification options:

- Continue the present treatment approach to allow sufficient time for full response. This option might be worth considering when a treatment involves acquisition of skills (e.g., cognitive restructuring or anxiety management). In such a case, it is possible that the patient may be in the process of learning the skill, with the full impact of therapy dependent on increased practice and skill mastery. Or treatment may not have yet yielded its maximum potential effect because of limited patient compliance. Steps taken to increase adherence to treatment prescriptions may accelerate responsiveness to the intervention.
- If the moderate level of improvement obtained is less than would be expected, given what is known about the patient and the treatment modality, a change to a different treatment approach may be indicated.
- A move to an increased level of care may be warranted. For example, if current functioning remains poor despite some symptom improvement or the patient stands to experience major consequences for failure to improve more rapidly (e.g., marital separation), it may be desirable to move from outpatient care to a higher level of care (e.g., residential care).
- Improvement in PTSD symptoms may be inhibited by the presence of untreated additional problems, such as substance abuse or exposure to domestic violence. In such situations, it is important to initiate services for these problems in order to

improve the capacity of the PTSD treatment to effect change.

When symptoms and other trauma-related problems show significant improvement, the options include the following:

- Discontinue treatment
- Continue the course of treatment as is
- “Step down” to a treatment requiring less intensive resources.

Clinician judgment, based on discussion with the patient, will be the basis of such a decision.

- When therapy has resulted in clinically significant improvement, but the improvement in functioning is recent and of limited duration, a continuation of existing type and intensity of treatment may be indicated if the clinician judges that time is required for the patient to continue practicing new skills or to otherwise consolidate treatment gains. This will be especially true if the clinician judges that a reduction in level of therapeutic support would threaten treatment gains.
- If treatment has produced clear benefit, but the patient is continuing to show treatment gains week-by-week, it may also be helpful to maintain the treatment as is, in hopes of continued improvement. For many patients, some level of continuing care may be indicated after more intensive help has produced improvements. A step-down to less resource-intensive help can often be accomplished by changing treatment type (e.g., from individual psychotherapy to periodic group support), reducing frequency of contact (e.g., from once-per-week to twice-per-month contact) or reducing treatment dose (e.g., medication).
- If treatment has resulted in significant reductions in PTSD, but related problems (e.g., anger, social isolation, guilt) have shown little change, it will be important to consider adding treatment components to address those problems or referring the patient for additional services.

Patient demonstrates remission from symptoms:

When the patient demonstrates remission from symptoms and there are no indications for further therapy, it is time to discontinue treatment. Discontinuation of treatment may be anxiety-provoking for some patients, who have

come to depend on the therapist. If this is the case, it may be helpful to discontinue treatment by using the step-down approach noted above, and gradually moving toward termination. Whether treatment is ended gradually or more quickly, it is important to educate the patient about expected levels of continuing symptoms, indicators of relapse or need for future care and ways of accessing care should the need arise. The patient can be encouraged to talk with his or her primary care provider about the treatment experience and enlist help in monitoring improvement.

I. Referral

Treat symptoms, support function, and alleviate suffering in those patients with PTSD who are unwilling, unable or unsuitable for treatment in a mental health setting.

RECOMMENDATIONS

1. Evaluate psychosocial function and refer for psychosocial services, as indicated. Available resources include, but are not limited to: chaplains, pastors, family support centers, exceptional family member programs, VA benefit counselors, occupational or recreational therapists, Vet Centers, and peer-support groups.
2. Provide case management, as indicated, to address high utilization of medical resources.
3. Consider psychotherapeutic interventions as appropriate for level of training and available resources.
4. For patients with severe symptoms or coexisting psychiatric problems consider referrals to:
 - Specialized PTSD programs
 - Specialized programs for coexisting problems and conditions

- Partial psychiatric hospitalization or “day treatment” programs
- Inpatient psychiatric hospitalization

Patients with persistent mental health symptoms and needs may benefit from a range of assistance strategies provided by a range of disciplines. In addition to the usual general health and mental health specialists, available resources include, but are not limited to, case-management, chaplains, pastors, family support centers, exceptional family member programs, VA benefits counselors, vocational counselors, occupational or recreational therapy, Vet Centers, and peer-support groups.

In the primary care setting, appropriate encouragement of patients to obtain a mental health referral is important even if patients are initially hesitant or reluctant to seek it. Mental health referral options include outpatient psychology, social work or psychiatry clinics, depending on local resources and policies.

In specialty mental health settings, patients may be referred to specialized PTSD programs or programs that focus treatment on important coexisting problems, such as substance use disorder programs or programs for domestic violence or sexual assault/abuse. Depending on the level of associated disability, complexity of medication regimen and level of threat to self or others, patients with persistent PTSD symptoms and needs may require inpatient or partial psychiatric hospitalization.

Providers referring from either the primary or specialty mental health setting should consider the need for case-management to ensure that the range of patient needs is addressed and that follow-up contact is maintained.