Continuum Of Care Model For Traumatic Psychological Injury (TPI)

1. Scope: The term traumatic psychological injury refers to psychological or psychiatric disability caused by an exposure to work-related psychological trauma.

DSM diagnoses that you may see on file are: Acute Stress Disorder, Posttraumatic Stress Disorder (PTSD), Major Depressive Disorder, Adjustment Disorders, Panic Disorder, Specific Phobia, Other Specified Trauma- and Stressor-Related Disorder, Unspecified Anxiety Disorder.. You may also see other related terms used in reports (e.g., anxiety, depression, panic attacks, acute stress reaction).

Work-related psychological traumas are typically associated with motor vehicle collisions, falls, assaults, robberies, exposure to potentially fatal substances (e.g., infected blood), explosions, shootings, and other situations where actual or threatened death, serious injury, or sexual violence was directly experienced, witnessed, or learned about.

2. Service provision criteria: Services are typically provided if the injured worker has not returned to work, or if his/her work status is at risk due to the psychological symptoms related to the work-related trauma. The model is intended to be a guideline for our case managers, and as an adjunct to sound clinical judgment. Services are individualized to the circumstances of each patient, and will involve family members and employers where appropriate.

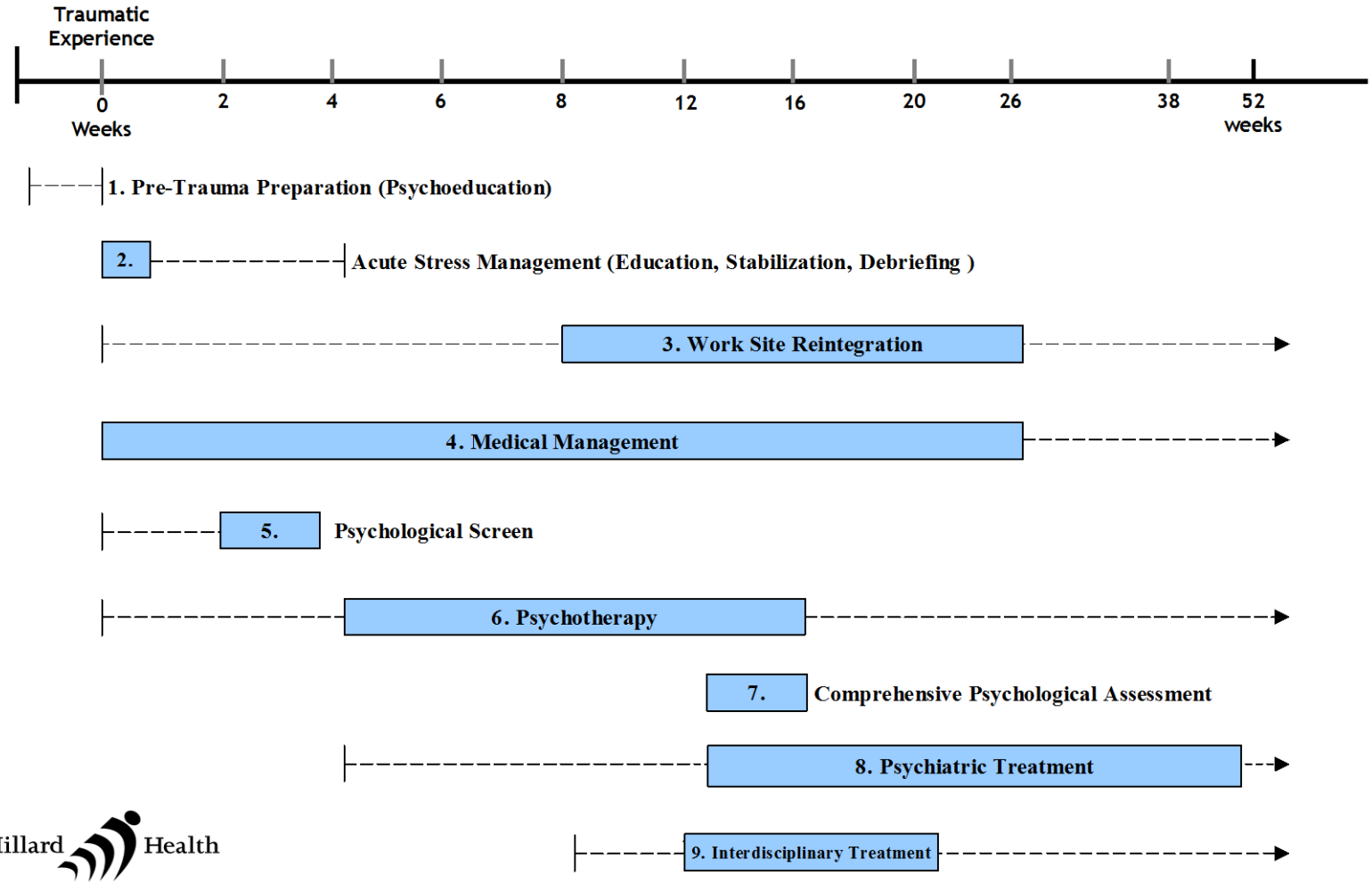
3. Service providers: Health professionals with training and experience with traumatic psychological injuries will provide services to our clients. Culturally competent health professionals who have experience working with first responders and have training and experience with traumatic psychological injuries will provide services to those workers with claims that meet the criteria for WCBs presumptive PTSD policy.

4. Treatment and Assessment Services:

- The model has principally been designed for the first 6 months after the work-related trauma.
- Solid lines represent the most likely times and durations for intervention. Dotted lines indicate possible times for intervention
- Time loss is a key 'trigger' for providing services, although services would also be offered if a person's psychological symptoms put their work status at risk.

5. Brief Description of Traumatic Psychological Injury Model: The model is shown next, followed by a brief description of the associated services.

Traumatic Psychological Injury
Continuum of Care Model



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Services within the Continuum of Care Model (CCM)

1. Pre-Trauma Preparation (prior to trauma):
This occurs before a trauma has happened. The focus is on educating people about normal and abnormal responses to stress, and providing information on how people can cope after a traumatic stressor. It is hoped that by demystifying the symptoms and treatment of trauma that people will report their symptoms more readily and attend treatment. It should be recognized that WCB has little involvement in providing this service, however, pre-trauma preparation may be offered by employers to workers in certain industries.

2. Acute Stress Management (within four weeks of trauma, or a soon as possible):
Services would include Critical Incident Stress Management (CISM). This includes psychoeducation, stress management training, and, if appropriate, may include a formal group or individual debriefing ('retelling of the incident'). Clients may be educated regarding 'stabilization' activities (e.g. getting their life back to together, and education regarding 'self-regulating' activities such as getting good sleep, exercise, nutrition). People in need of further services can be referred to their family physician for medications, or a screening/intake assessment. Again, this would typically be a service provided 'in house' by some employers following a traumatic incident.

3. Worksite Reintegration: Research has suggested that people should begin reintegration into the worksite by eight weeks post trauma. Return to work interventions might involve one or more of the following: (a) an appropriate, rapid return to full duties, (b) a gradual return to the same or modified employment, (c) supported employment, (d) a complete career change, (e) an interdisciplinary team (e.g., occupational therapy, psychologist, job coach, patient, employer).

4. Medical Management: This refers to medical interventions that might include medications to calm acute anxiety, control any physical pain, and assist with sleep. Currently Selective Serotonin Reuptake Inhibitors (SSRIs) are being recommended as a first line of treatment if acute stress symptoms have not abated by three weeks post trauma. Nonbenzodiazepine hypnotics are being recommended to address sleep concerns. Medical management also refers to physical-medical management of any physical injuries sustained in the traumatic incident. These services would be provided by the treating physician, or other specialists.

5. Psychological screening assessment (provided between two to four weeks post injury): This is performed by a psychologist when a client is off work, or when work is threatened. The purpose of the screen is to:

- Provide a provisional diagnosis
- Assess risk factors for poor outcome
- Triage service requirements (e.g. psychotherapy, further assessment)
- Provide a basis for treatment by the psychologist ('Assess and Treat' model)
- Generate a report of the assessment findings for case management approval of services (if required) and to provide recommendations and direction for the initial management of the claim

6. Psychotherapy (Duration: initial intake for about three months):
Psychotherapy is commonly the first line of intervention for single, work-related traumas. The choice of psychotherapeutic technique will depend on patient presentation and needs. The best evidence-based treatments are part of a category of treatment known as Cognitive-Behavioral

Therapy (CBT). Two forms of CBT that have been shown to be effective in the treatment of traumatic injuries include Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy. Eye Movement Desensitization & Reprocessing (EMDR) is another evidence-based treatment for acute and post-traumatic stress disorders, and can be considered a first line of treatment. Other therapies may be required depending on the client's presenting problems, these might include simple exposure therapy for driving phobias, and cognitive therapy for depression. Other physical therapies may be helpful for people with psychosomatic (stress-related) physical symptoms. The duration of the initial treatment sessions could be up to three months from the date of the initial assessment. Depending on the severity of the trauma and the client's status following the trauma, some individuals may not be ready for in-depth psychotherapy immediately following the trauma. Treatment might instead focus on stress management and lifestyle stabilization activities initially. Family members should be invited to be part of this process.

7. Comprehensive Psychological Assessment (usually conducted at about 12-16 weeks post trauma): This is conducted by a psychologist, and involves a detailed psychosocial assessment. This service is indicated if recovery is not occurring as expected, and/or if other complicating factors are suspected (e.g., pre-existing trauma, non-compensable personality factors). The assessment will investigate for co-morbid disorders and issues. A report will be generated which will address the following questions: the validity of the client's presentation, DSM diagnosis(es), relationship between the workplace incident and the diagnosis, fitness for work and work restrictions, and further treatment recommendations.

8. Psychiatric Treatment:
Psychiatric treatment may be indicated when there is evidence of:

More severe psychological/psychiatric symptoms
Co-morbid mental disorders
Persistent and non-remitting symptoms (following treatment)
A need for in-patient hospitalization (e.g., patient is acutely suicidal)
Medication side-effects that need to be addressed
Current psychotropic medication regime is not working

9. Interdisciplinary Treatment: Further treatments will depend on the results of the psychological assessment. Interdisciplinary Rehabilitation (IR) may be indicated when:

- A client has traumatic psychological injuries in addition to comorbid physical conditions (e.g., physical injury, deconditioning).
- A client may benefit from 'real life' exposure to reminders of the trauma in order to desensitize them. For instance, IR programs can provide supported exposure experiences to treat simple phobias (e.g., fear of heights), or can provide a supported preparatory period prior to a full or transitional return to work.
- An interdisciplinary approach is required to return the injured client to work (e.g., Occupational Therapist, Psychologist, Job Coach, Client, Employer).

Other services that can support the continuum of care:

1. Community-Based Follow-up
This can include:

- Counselling ‘booster’ sessions, or a tapering off of services
- Medications (e.g., continuation of antidepressants monitored by treating physician)
- Family support (e.g., family counseling)

2. Case Conference

- Involving client and their family, treating professionals and case manager
- May be helpful in cases of prolonged recovery
- Assists in developing a further management plan

3. In-patient program

This can include:

- In-patient admission to a hospital psychiatric ward for observation, stabilization and treatment
- Medical Assessment Program (MAP) for further in-patient assessment to determine barriers to recovery

4. Case Management

A core service that underlies the continuum of care