NSMHA Contract Memorandum 2006-002

Date: June 12, 2006

To: Jess Jamieson, President APN and CEO, Compass Health
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Michael Watson, Lake Whatcom RTC
Andy Byrne, Whatcom Counseling and Psychiatric Center
Thomas MacIntyre, Catholic Community Services Northwest
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Janelle Sgrignoli, Snohomish County Human Services
Tom Robinson, Volunteers of America

From: Chuck Benjamin, Executive Director

Subject: New Guidelines

The Board of Directors approved the PTSD Guidelines, June 8, 2006, Motion #06-051. You will find a copy attached for your convenience.

Quality Management Committee approved the PTSD Guidelines, October 20, 2005, and Quality Management Oversight Committee approved the PTSD Guideline, October 26, 2005.

Please ensure that these guidelines are implemented or revised at your agency within sixty days. The guidelines will be posted on the NSMHA website.

cc: Heather Fennell, Compass Health
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Contract File

Posttraumatic Stress Disorder DSM-IV-TR codes 309.1, 308.3)	
Diagnostic Features	**Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**1. Post Traumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.** **Criterion A) The person's response to the event must involve intense fear, helplessness, or horror.** **Criterion A-2) The characteristic symptoms resulting from the exposure to the extreme trauma include persistent re-experiencing of the traumatic event.** **Criterion B) Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness.** **Criterion C) Persistent symptoms of increased arousal** **Criterion D) The full picture must be present for more than 1 month** **Criterion E) Disturbance must cause clinically significant distress or impairment in social, occupation, or other important areas of functioning** **Criterion F) Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in concentration camp, natural or manmade disasters, severe auto accidents, or being diagnosed with a life-threatening illness. Multi-generational trauma among both mainstream and minority cultures also needs to be assessed and considered.**
Treatment Guidelines	**1. Initial and periodic psychiatric screening to determine need for consultation, evaluation and/or medications.** **2. Treatment plan includes interventions consistent with the level of risk for self-harm.** **3. Acute PTSD will require active treatment during this acute phase of PTSD may help to reduce the otherwise high risk of developing chronic PTSD.** **4. Chronic PTSD Long-term symptoms may need longer and more aggressive treatment and are likely to be associated with a higher incidence of comorbid disorders.** **a. The most Common Co-morbid Disorders in a Patient with PTSD:** **i. Substance abuse or dependence** **ii. Major depressive disorder** **iii. Panic disorder/agoraphobia** **iv. Generalized anxiety disorder** **v. Obsessive-Compulsive Disorder** **vi. Social Phobia** **vii. Bipolar Disorder** **viii. Personality Disorders, especially Borderline** **5. Patients presenting with the co-morbid disorders of major depression, bipolar disorder, panic disorder, social phobia, obsessive-compulsive disorder, psychotherapy should be combined with medication from the start of therapy.** **6. Patients presenting with co-morbid substance abuse, treatment or both substance abuse and PTSD should be provided simultaneously. Serous consideration should also be given to postponing treatment for PTSD until substance abuse problems have been treated first.** **7. Medication visits should occur as often as clinically indicated and medically necessary for the duration of treatment.** **8. Case management services may be helpful for coordination and family support and advocacy.** **9. Brief Descriptions of the Most Recommended Psychotherapy techniques** **i. Relaxation training** **ii. Breathing retraining** **iii. Positive thinking and self-talk** **iv. Assertiveness training** **v. Anxiety management**

	vi. Thought stopping vii. Cognitive therapy viii. Exposure therapy ix. Imaginal exposure x. In vivo exposure xi. Psychoeducation 10. Individual and/or group psychotherapy can be provided to promote mood stabilization and provide skill building and support. 11. Education about the illness, incidence and treatment options are important. Family members and significant others may be included in this process whenever appropriate and possible. 12. Varied employment strategies including prevocational and supported employment to assist clients ready to pursue employment. 13. Co-occurring disorder treatment as indicated. 14. Crisis planning focusing on early signs of decompensation, safety and management strategies. 15. Because of the chronic nature of the disorder, treatment may be long term. Relapse prevention should be included in treatment planning. 16. Residential Treatment/Housing/Crisis beds for those requiring 24 hour care or access to appropriate community-based housing. 17. Inpatient services for acute stabilization as necessary.
Optimal Outcome of Treatment	**The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.**
References	**DSM IV-TR** **The Expert Consensus Guideline Series Treatment of Post-Traumatic Stress Disorder, Consultation with Edna Foa, Ph.D., Jonathan R.T. Davidson, MD, Allen Frances, M.D., Ruth Ross, M.A.Journal of Clinical Psychiatry** **VA/DoD Practice Guideline for Management of PTSD and Acute Stress Reaction Module**