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STRATEGIES FOR

Combating Mental Health Challenges in Injured Employees

mitchell | genex | coventry

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Executive Summary

When someone gets hurt on the job, the workers' compensation system is often adept at zeroing in on an injury and delivering timely care. But that well-intentioned focus on a patient's physical bruises can make it easy to miss the mental ones, which might be harder to spot. The old way of thinking was that when psychological issues enter the picture, claim costs spin out of control and return-to-work delays soar.

That perception has gradually diminished over the past decade as professionals see the benefits of a more holistic approach to healing. Psychosocial factors such as isolation, post-traumatic stress, and depression can be a direct result of an injury or arise during the recovery process. However, a good number of injured employees also come into the workers' compensation system with preexisting mental health conditions, whether diagnosed or not.

To achieve the best possible outcomes and get someone back to work with minimal delay, it's wise to focus on the whole person, including the mental health toll the episode may have on the injured employee. Failing to do so risks treating only part of an injury and achieving an insufficient recovery. It is equally important to evaluate the situation from a clinical perspective, review the medications a person is taking, and ensure they are being treated by the appropriate providers.

This eBook is a compilation of mental-health related articles written by subject matter experts at Enlyte. It acts to provide a comprehensive approach to addressing mental health challenges in workers' compensation with the end goal of identifying and meeting the needs of the injured employees we serve.

CHAPTER 1

The Case Manager's Role in Addressing Mental Health Challenges

To Best Treat an Employee's Injury, Look for a Broken Spirit, Not Just a Broken Bone

By Tammy Bradly
Vice President, Clinical Product Development
Coventry

Experience makes clear that numerous forces push and pull at employees after they are injured on the job. These are baseline factors, such as quality of care and timeliness of care, and they play enormous roles in laying out the courses of an employee's recovery. Yet the more we dig into claims and into the research, the more we understand that less-apparent variables can also tilt the direction many cases take.

One study revealed the likelihood of injured employees being treated for depression was 45 percent greater compared with employees who were not injured. And getting hurt on the job brings a heightened risk of mental hardship. A group of researchers found people who were injured at work were more likely to become depressed than those who were hurt outside of work. The researchers surmised that worries about reduced income, for example, might be partly to blame. They also noted, not surprisingly, that increased severity correlated with a higher likelihood of depression.

Of course, there are other cognitive factors beyond depression that can help drive the speed and scope of recovery. One is employees' trust—or lack thereof—that their employers will do right by them. And it's not only trust in managers and employers that matters: For injured employees, having trust in adjusters, case managers, and, of course, providers is also important in shaping the trajectories of their recoveries.

It's clear that actions such as working to identify mental-welfare concerns and fostering trust can bring value. To those ends, there are approaches adjusters can take right away to limit the drag that poor mental health can inflict on an employee's recovery. One method is to take a step back and ask questions related to the employee's state of mind and overall well being.

The likelihood of injured employees being treated for depression was 45 percent greater compared with employees who were not injured.

These aren't the only inquiries that might be necessary, of course, though they illustrate some of the considerations that can come into play for adjusters trying to assess where an employee stands on the path to recovery. It's wise to be on the lookout for when there is more going on with an injured employee than the extent of the physiological injuries might suggest.

There is ample reason for concern. Because much of the nation's workforce is already rattled by a host of worries and strains, mental health considerations are looming larger than ever over the welfare of employees, even those who haven't suffered a physical injury.

It's well understood that employees have been feeling stress stack up for years now. One study conducted before the pandemic found that for some employees so-called job strain—low levels of control over their work and high demands—was "strongly" associated with moderate to severe levels of suicidal thoughts.

These types of punishing workplace landscapes, and the stress they yield, had emerged well before the coronavirus began spiriting around the globe and disrupting nearly every aspect of daily life. Now, in the U.S., COVID-19 restrictions, widespread layoffs, school closures, and social unrest are creating one big pressure cooker.

Many employees are feeling it. A late-June 2020 snapshot of the mental state of U.S. adults from the Centers for Disease Control & Prevention revealed that younger adults, racial and ethnic minorities, essential workers, and unpaid adult caregivers reported suffering "disproportionately worse" states of mental health as well as higher substance misuse and increased thoughts of suicide.

While the global rate of suicides has fallen for decades, the rate in the U.S. has jumped 35 percent since 1999. It now stands at the highest age-adjusted rate since 1941, according to 2018 data, the latest available.

Difficult economic times tend to fan the problem. During the Great Recession more than a decade ago, the suicide rate rose between 1 and 1.6 percent for every percentage point increase in unemployment. That's worrisome given the job cuts this time are more severe.

Virtually overnight, the virus touched off an unprecedented jump in unemployment claims and ended the country's longest-ever economic expansion. Never had so many people in the U.S. been thrown out of work at once. While the jobless rate has yet to reach some of the direst predictions from the Federal Reserve and other forecasters, only about half of jobs have re-materialized. Some industries, such as the airlines and live entertainment, could take years to recover, if they do. Indeed, the number of laid-off individuals whose job losses became permanent jumped to a seven-year high in September 2020.

The blows to mental wellbeing we're seeing in 2020 extend beyond the impossible-to-quantify fallout of suicides. Even less-severe strains on mental welfare make it more likely that employees will get hurt and suffer longer when they do. Stress, particularly when it's chronic, can lead to distractedness and can heighten comorbid conditions such as elevated blood pressure. A high degree of worry can likewise cut into productivity, reduce job satisfaction, and likely even cause brain damage.

Sadly, the mental health challenges dogging many U.S. workers aren't likely to subside when the virus does. In fact, the effects of trauma tend to linger in populations long after the source of the distress fades.

That has disquieting implications for the future. The pandemic is likely to widen already yawning gaps in the U.S. between those who require mental health interventions and those who get them.

Similarly, the pandemic's role as stress multiplier could further harm injured employees and only underscores a need to lower the hurdles they face. Failing to deal with the mental health lesions that can accompany physical injuries can prolong suffering. In addition, inaction on tackling employees' mental challenges makes it more likely those who are injured will develop chronic pain. That means the employees who don't get the help they need could be facing years of discomfort, which, in turn, can further erode mental wellbeing.

This is why it's imperative that adjusters and case managers consider the whole person and scan for behaviors that could signal an injured employee is having trouble managing the attendant stress of an injury. As with the need to ask questions about mental wellness from the start, it's important to routinely look for signs that mental health challenges are beginning to bubble up.

Asking these types of questions regularly can help indicate whether an employee might be enduring a mental health condition such as depression, which can hurt the chances for a successful return to work. And taking action to identify potential barriers is important because we know the longer employees are away, the less likely they are to return at all.

For complex claims, in particular, case managers can use techniques and tools such as active listening and behavioral coaching to facilitate improvement and boost the likelihood of a successful return to work. We know these methods can promote success. A review of research pointed to the apparent benefits of tools such as rehabilitation programs and psychosocial interventions in getting injured employees back on the job.

At first, the mental and emotional components to a recovery might appear squishier and perhaps even secondary to the employee's ongoing physical needs. Yet waiting to go back and sweep up the mental health aspects of an injury well after strains begin to emerge can jeopardize the pace and degree of recovery. Instead, by looking at the whole person from the outset, it's possible to help an injured employee grapple with some of the forces taxing mental welfare.

Assessing an Employee's Path to Recovery

- ☐ How does the injury affect the employee's overall well-being?
- ☐ If the person is unable to work, how is that impacting recovery?
- ☐ Is the fallout from the injury creating problems at home, perhaps with family?
- ☐ Is the employee experiencing feelings of isolation from coworkers or friends?
- ☐ Does the employee appear less confident about making a speedy recovery and getting back to work?
- ☐ Does the employee appear to be turning to self-destructive behaviors in an attempt to cope?
- ☐ Is the employee receptive to recommendations for self-care and other means of promoting wellness?

Catastrophic Thinking Derails Injured Employee Recovery; Here's How to Manage It

By Mariellen Blue, RN, CCM
National Director, Case Management
Genex

Delayed recovery is a challenge coming to the forefront of workers' comp. It's defined as a lack of anticipated functional recovery in a medically reasonable period of time. Recently, many organizations have been seeking new ways—whether through telephonic or field case management services—to identify injured employees who are at risk for delayed recovery.

For years, we've used predictive modeling to identify cases that score high for delayed recovery, using factors like age, gender, and comorbidities, such as diabetes, obesity, smoking or substance abuse. These are proven biological factors that can lead to delayed recovery, and we've implemented clinical interventions to address them.

However, there are still many delayed cases that aren't attributable to these traditional biological factors. Today, the industry must delve deeper into cases and identify potential psychosocial issues that could be at the root of the reason why certain cases don't progress as expected.

Delayed Recovery: A Tale of Two Cases

Let's consider two individuals. Both are men of the same age with approximately the same health status. They hold the same position and sustain the same low-back injury. Neither individual has a comorbidity. On paper, the cases seem identical. However, each case results in significantly different outcomes.

Injured employees may not tell supervisors or doctors about their fears or family problems, but they may have built up enough rapport with case managers to share such information with them.

The first patient attends all of his medical appointments. His pain level gradually decreases, while his functionality improves. This individual returns to work within a reasonable period of time, slightly ahead of evidence-based guidelines.

Meanwhile, the second patient struggles. He has difficulty keeping his appointments. He seems to experience a higher level of pain. He's not compliant with his prescribed at-home exercise program.

The case soon exceeds typical treatment guidelines for this type of injury. The patient ends up staying on pain medication for a much longer period of time and is not experiencing the expected level of recovery. What factors make this second case different from the first?

Identifying Psychosocial Issues

Research over the past few decades has shown that psychosocial issues can have a significant impact on recovery rates. Having psychosocial issues doesn't mean individuals have a psychiatric disorder; instead, they may exhibit minor cognitive distortions, which relate to how they think and feel about a situation. These individuals are fine during the course of normal life, but when presented with an added stressor, like a painful work-related injury, they may experience a tense and fearful response.

Nurse case managers are uniquely positioned to recognize when cognitive, emotional, or social barriers may be at play. For example, injured employees may not tell supervisors or doctors about their fears or family problems, but they may have built up enough rapport with case managers to share such information with them.

In addition, nurse case managers are trained to listen for queues that may indicate cognitive distortions. For example, in talking with an injured employee, a nurse case manager may sense an exaggerated fearful response to pain.

There have been studies that show 64 percent of people who have low back pain are actually afraid to move. Since they're experiencing pain, they think that if they move—such as doing their prescribed home exercises—the condition will become worse, so they don't comply.

However, by remaining immobile, they become stiffer. Their muscles tighten up, and the pain might increase due to a lack of movement. This is condition is called "disuse syndrome" and as the name implies the individual may experience muscle atrophy from a lack of activity. Their initial fear—that pain will cause their condition to become worse—has become a self-fulfilling prophesy.

Recognizing Maladaptive Coping Strategies

Injured employees may exhibit other irrational fears. A WCRI study showed that people who had a fear of being fired due to their workplace injuries could experience a four-week increase in their average duration of disability. A big issue may be "catastrophic thinking," where injured employees may feel as if their injury is the end of their world. Their thoughts may go something like this: I have a low back injury. It's really painful. I'm never going to recover. I'm going to be disabled for the rest of my life, and I'll never be able to provide for my family again.

The fears create a snowball effect, becoming bigger and bigger in their minds. Nurse case managers will identify individuals with this type of mindset. For example, closely related to catastrophic thinking is a feeling of fateful injustice: If only I hadn't come to work that day, this never would have happened to me.

These expressed feelings often indicate maladaptive coping mechanisms. Perhaps these individuals have not had to develop positive adaptive behaviors to get them through a time of crisis or stress. Because of this, when something stressful happens, they become practically incapacitated by their own negative thoughts and fears.

Social factors can also contribute to an inability to cope. For example, an injured employee may have a difficult home life. This situation may not impact everyday life, but a weak social support system could fall apart in the face of an added stressor, like an injury.

Utilizing Questionnaires to Identify Psychosocial Risks

To pinpoint psychosocial issues, nurse case managers may use a patient questionnaire. An example of one that's used to identify delayed recover is the Örebro Musculoskeletal Screening Questionnaire (OMSQ). This short version uses 12 questions.

The questionnaire is filled out by the patient, and it collects information about how the person is feeling, if he or she can manage a daily routine, and it detects unhealthy perceptions or low social support.

OMSQ		
LOW RISK below **57** points	MEDIUM RISK between **57-72** points	HIGH RISK greater than **72** points

The OMSQ Short Form produces a score, which can then be used as a predictor for risk of delayed recovery or the potential for chronic symptoms, including delayed return to normal daily activities or work. A higher score indicates a higher risk. The resulting score would be categorized as follows:

Ideally, the questionnaire would be administered within the first 30 days of an injury or within the first two visits to a treating physician. If the injured employee has already exceeded treatment guidelines, the questionnaire can still be administered and can still be useful. But optimally, the earlier the risks are identified, the earlier that strategies can be applied to prevent a case from going off track. The risk factors could also be discussed with treating physicians, so they're aware of the non-medical issues affecting the patient. Physicians may decide to handle treatment differently. For example, they might prescribe cognitive behavioral therapy to help alleviate fears or other distorted thoughts.

The Role of Case Management

Nurses are trained to listen to what injured employees say, why they're saying it, and if they represent issues hindering their recovery. That's why they're often the ones to suggest a questionnaire be administered, although treating physicians may also request them.

Throughout a claim's duration, nurse case managers will encourage injured employees to take responsibility and play an active role in their own care and recovery. With added information from the questionnaire, they can better understand the underlying thoughts and feelings delaying progress.

Once high-risk cases are identified, nurses work with employers to aggressively utilize transitional or modified duty. It's important to get these individuals re-engaged in the work setting and have a return-to-work mindset as soon as possible.

Nurse case managers also work to reframe an injured employee's unhealthy thought process by establishing proper expectations: Yes, you're injured but you're going to gradually recover, and the pain will eventually go away. You'll actually make faster progress if you consistently perform your home exercises.

They also get injured employees to focus on function rather than pain. For example, they may set functional goals: Within two weeks, if you consistently attend your physical therapy appointments, you should be able to walk your dog again and take the stairs. And of course, case managers are also there to provide positive reinforcement: Fantastic! Look at the progress you've made!

In the end, the longer injured employees are out from work, the less likely they'll be able to return. That's why it's vital to catch psychosocial issues early, so injured employees can be provided with the cognitive behavioral tools they need to successfully cope with a stressful, painful injury, to comply with care, and not reach a state of delayed recovery.

Addressing Mental Health in the Workplace Using the Case Manager Approach

By Tom Kerr
Director of Communications
Genex

It may be surprising to learn that mental illness is one of leading causes of employee disability in the U.S. A recent study published by disability insurer Unum shows the true extent of the problem. Researchers surveyed 1,800 workers and reported 42 percent were aware of a colleague with a mental health issue. More than half—62 percent—said they had experienced a period where they have felt mentally unwell. Of 500 workers who had been diagnosed with a mental health issue, many said they had come to work while they had suicidal feelings.

Those are some hard numbers to swallow considering that work and purposeful activity have the greatest impact on moderating depression, building self-esteem, and negating idleness. As those in our industry know, workplace injuries can have a significant effect on mental health, which increases as an injured employee is out of the office.

That's why the case manager's role is so important in workers' comp, they often play the role of detective in discovering underlying problems that may delay a case. The injured employee often needs an advocate to help him or her get back to a normal routine. Case managers can play a key role in uncovering mental health related issues and in guiding the employee on their journey to recovery. Take for instance, the breadwinner who sustained a significant shoulder crush injury that kept him from doing purposeful activity until eight months later, when he was assigned to Genex case manager Julie Wilcox. The employee told Wilcox, he was suicidal with feelings that "the world gave up on him." Wilcox immediately put a plan into action that addressed these psychosocial factors and allowed the injured employee to receive the extensive shoulder surgery he needed to regain full function and return to work.

But how can managers and even co-workers help address mental health issues in the workplace? The stigma associated with mental health lingers and addressing the issue or even recognizing the symptoms related to mental health can be a challenge, but may not be as difficult as they seem. For instance, people with anxiety disorder may seem disorganized or scattered. They may show signs of stress, avoid social interactions, are irritable, avoid eye contact, and have nervous habits. Depressed employees may also seem scattered or absentminded. They may show indifference or have inappropriate reactions to coworkers. Often, they are isolated from team members, and lack confidence in their abilities.

There's a lot we can learn from case managers like Wilcox when it comes to addressing mental health in the workplace. One of the most important ones is simply through engagement. Normalizing the conversation about mental health and "checking in" on co-workers can go a long way in creating a healthier environment. In fact, some companies have established "mental health champions," employees who receive special training and encourage dialogue about mental health issues.

Another is to realize there is no one-size-fits all approach to managing depression and anxiety. Everyone has his or her own problems. A person's background, culture, and education level also play a role in how they're feeling. Employees should feel comfortable seeking help as soon as possible. Policies that protect against discrimination and those that provide adequate accommodations can go a long way.

And, while most of us aren't equipped to handle mental health issues in the workplace, we can offer resources to help. Many companies offer resources that are readily available, like employee assistance programs that assist individuals with emotional and substance use issues, interpersonal relationships and other problems that may be affecting their productivity.

In the end, a company's success is built on the employees who work there. Incorporating compassion, communication and comprehension strategies shouldn't be considered a nice thing to try but an important goal to meet in developing a successful corporate culture.

CHAPTER 2

Responding to Traumatic Events With Clinical Support

Not All Victims of Worksite Trauma Sustain Physical Injuries

By Tammy Bradly
Vice President, Clinical Product Development
Coventry

Anyone who has ever witnessed a traumatic event understands the mental anguish it can cause. You don't have to be physically injured to suffer a mental blow. But do we adequately care for or, for that matter, even acknowledge those unfortunate individuals who witness a catastrophic event? Too often the answer to both of those questions is no. It doesn't have to be this way. Addressing bystander trauma through crisis intervention can be good for employees and for the workplace.

Nine in 10 people in the U.S. will be exposed to at least one traumatic event in their lifetimes. For some, the events will carry lasting consequences. The estimated lifetime prevalence of post-traumatic stress disorder (PTSD) in the U.S. is 8.7 percent and for first responders such as paramedics, the rate is as high 20 percent.

Some of these traumatic events can unfold at work. Nearly two million American workers report having been victims of workplace violence each year. Even that large number understates the problem because many cases go unreported. Research has identified factors that might increase the risk of violence for employees in some situations. These include the situations in the graphic on the next page.

According to the Labor Department, violence and other injuries by persons or animals increased 23 percent to become the second-most-common fatal event in 2016. Workplace homicides increased by more than 80 cases to reach 500 in 2016. More than one-third of deaths were among older workers. Those age 55 and above suffered nearly 1,850 fatal injuries—the highest number for this group since reporting began in the early 1990s.

The numbers around workplace fatalities are sobering yet even those don't represent the full picture. For most every death, there are knock-on effects for those who are injured, for those involved and for those who simply witness these events. In workers' comp, we know what to do when someone is catastrophically injured. We can marshal an array of clinical resources to coordinate care for the injured employee. But oftentimes those who witness a catastrophic event without sustaining physical injury might be overlooked. Crisis intervention seeks to address the needs of those who are exposed to a critical event.

Depending on the jurisdiction, psych as a primary diagnosis may be considered compensable. Regardless, a traumatic event can disrupt the workplace. A psychological crisis is a response to a critical incident that might disrupt a person's psychological balance and usual coping mechanisms. Trauma can disrupt a worksite in many ways. Employees who witness a traumatic event may experience acute psychological crisis. An employee's response might vary depending upon factors such as their proximity to an incident or his ability to cope with stressful situations. A crisis situation at the worksite can reduce employees' motivation, hamper productivity, and even cause some people to leave a job. These effects can ripple through the organization. Chaos and disorganization can harm overall productivity if employees are unable to cope or are absent from work.

There are three common psychological reactions to a traumatic or crisis event:

- Eustress—This is the good stress that motivates the person to move forward.
- Distress—This is excessive stress though most people show resilience at this level of interference.
- Dysfunction—This is when a person is impaired to the point it affects his ability to perform normal activities of daily living.

FACTORS THAT INCREASE THE RISK OF WORKPLACE VIOLENCE

Working alone, in isolated areas, or in small groups

Working where alcohol is served

Working late at night

Working in areas with high crime rates

Exchanging money with the public

Certain occupations can face heightened risk as well. These include:

Delivery drivers

Health care professionals

Public service workers

Customer service agents

Law enforcement personnel

Is there anything we can do to support employees who witness a traumatic event? Can we, in some cases, prevent the normal distress reaction from developing into PTSD? The answer is yes.

The field of crisis intervention dates to World War I. However, the field of disaster mental health has been developing since the 1990s. In that time, groups including the American Red Cross and the Salvation Army, among others, have created disaster-response teams.

Critical Incident Stress Management (CISM) is a comprehensive, systematic, and multifaceted approach to managing traumatic stress within an organization or a community. It focuses on assisting both individuals and groups that have experienced a traumatic event. The goal is to mitigate the effects of a critical incident and assist employees in recovering as quickly as possible. Often referred to as psychological first aid, crisis intervention can be administered with small groups (e.g., debriefings) or with individuals. This allows employees to share their thoughts and feelings about an incident while a crisis interventionist watches for signs of stress and discomfort. This professional can then offer to hold one-on-one meetings with any employee who wishes to participate. Typically, it's best to limit individual meetings to one or two sessions. Anything more than that likely would require psychological intervention through the employer's employee-assistance program (EAP) or through a health plan and/or community resources.

Keep in mind that most individuals exposed to a traumatic event will need some level of intervention. Participation should be voluntary unless the individual displays maladaptive behavior or appears as though he may harm himself or others. And someone should not be required to talk about or relive an event unless she volunteers to do so. Being forced to do so can risk reintroducing the trauma.

The goal of any crisis intervention is to mitigate the harmful effect of traumatic stress, to provide support, and to offer encouragement in order to accelerate recovery. Doing so is not only the right thing to do. It also can mitigate losses to productivity at an individual and organizational level. And crisis intervention should seek to make appropriate referrals to qualified mental health professionals and other providers when indicated. If the needed resources are not available through an EAP or through an employer health plan, a referral should be made to community resources.

How PTSD is Affecting Return to Work

Excerpt from a podcast interview with
Mariellen Blue, RN, CCM
National Director, Case Management
Genex

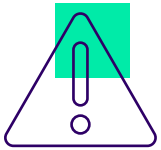
After a tragic accident or death, memories of the event can linger in the form of PTSD. Witnesses can be bombarded with nightmares that disrupt their sleep or flashbacks that leave them afraid to go near the site of the incident. The disease can be both physically and emotionally debilitating.

While PTSD has gained awareness as a mental health disorder that commonly affects soldiers and victims of violent crimes, injured employees can also be impacted by the disorder after catastrophic accidents.

"Looking at the workplace today, there are violent situations in the workplace, there are individuals that are exposed to catastrophic events, and PTSD, unfortunately, is a disorder that can go along with these types of events," said Mariellen Blue, national director of case management at Genex.

Even though most people who experience traumatic events will not develop PTSD, the condition still impacts about eight million adults a year. This means that nearly eight percent of all U.S. adults are affected by the condition at some point in their lives and women are twice as likely to experience PTSD than men, according to Blue.

"Most people who experience or witness a traumatic or catastrophic event will have some degree of difficulty coping, as well as experience feelings such as shock, denial, fear, nervousness, anger, hopelessness, and even guilt," Blue said.



Many PTSD patients experience severe physical and emotional distress when they're exposed to triggers that remind them of that traumatic event.

"Not everyone is going to develop PTSD. Most individuals are going to recover. They're not going to need any intense intervention."

For victims of PTSD, however, the symptoms don't ease with time. They get worse, lasting for months and even years after the accident.

As the symptoms worsen, they affect a patient's ability to function during day-to-day activities and can cause relationships to deteriorate, which can affect a patient's ability to return to work.

"For them, doing normal, ordinary tasks can become quite overwhelming, and the ability to develop and maintain relationships is often negatively impacted and there's also an increased risk of self injury behaviors, again, such as substance abuse, self mutilation, and even a high risk of suicide," Blue said.

A primary symptom of PTSD is deliberate avoidance of the accident site—a place where unwelcome memories often resurface. "[Many PTSD patients] experience severe physical and emotional distress when they're exposed to triggers that remind them of that traumatic event. For example, the anniversary of the event, passing the site of the event, and even things such as sights, sounds, or smells that were associated with that particular event," Blue said.

When the site of an accident is also a patient's place of employment, what was a daily workplace can turn into a personal site of turmoil. Despite this difficulty, Blue said that it is important for employees to focus on getting back to work in order to continue healing. "Research has shown that employees who are unable to return to work also experience more persistent PTSD symptoms," she said.

"Without clear strategies in place to assist in developing and facilitating a successful return-to-work plan, that individual can remain in a cycle where their PTSD symptoms are preventing them from returning to work, but their absence from work is negatively impacting their ability to overcome the PTSD symptoms."

In addition to delayed return to work, symptoms of PTSD can also interfere with an employee's ability focus, make it difficult for them to stay awake during the workday, and cause them to lash out at co-workers.

Blue advises workers' compensation case managers to know the symptoms of PTSD and to educate their employees on the condition after a traumatic event. "Unfortunately, there is a stigma with PTSD, and the best way I can describe it is that people tend to fear what they don't understand.," Blue said.

"Case managers are in a really unique position to recognize risk factors and symptoms of PTSD in the individuals that they're working with and to assist them with getting the right diagnosis and the proper treatment."

Knowing the factors that put employees at a higher risk of PTSD is one way that case managers can spot the issue early on in a patient's treatment.

Blue noted that a history of trauma or abuse, dealing with additional emotional stress after the event and working in high stress jobs, like the military or as an emergency responder, can all increase the likelihood of developing PTSD.

If a case manager thinks an employee is suffering with PTSD after a traumatic event, it's important to open a dialogue with both the patient and their physician to make a plan for treatment.

"It's important to remember that everyone is different, and PTSD affects people differently, so a treatment plan that works for one person may not work for everybody," Blue said.

"The case manager can work with the patient and their mental health care professional to find and coordinate the best treatment for their symptoms as well as provide that ongoing education and support to that individual."

Blue also recommended that having patients visit to the site of the accident before returning to work can be beneficial. She said that allowing flexible schedules and providing additional training can also help employees suffering from PTSD overcome any memory issues they may have.

"The goal of treatment for PTSD is to reduce the physical and emotional symptoms, improve daily functioning and help that individual better cope with the traumatic event that triggered the disorder," she said.

Jumpstart the Recovery Process and Promote Positive Outcomes with Crisis Intervention

An interview with Coventry crisis response case manager **Eleanor Armstrong-Head**

To gain deeper insight into how crisis intervention works, we talked with Eleanor Armstrong-Head, a crisis intervention case manager, to discuss how the proper response after a traumatic worksite incident jumpstarts the recovery process and promotes positive outcomes. Here is an excerpt from the discussions:

Q: Intervening after a traumatic event is challenging work. What skills or tools make a crisis intervention case manager successful?

Eleanor: We have our standard protocol for conducting the intervention and I always review that before going in. But the one thing I've found to be very true—and I've been doing this for over 10 years—it's very important to be your true self. When you're with a group of people who lost a coworker, for example, you need to be genuine to establish trust and engagement or it won't work.

Q: That's true. I imagine reading from a script or seeming like you're taking a formulaic approach would make it harder to establish trust with the folks you're meeting with. And we know building trust and making a connection is critical to helping people recover from an incident and get back to their best performance at work and in life. But making a connection can be easier said than done. Do you find it difficult to get groups of employees to talk after a traumatic incident?

Eleanor: Well, before a session begins, I try to observe group dynamics (who is hanging out with who), what's their body language, what's the energy in the room with the group. Are they nervous? Are they scared? Are they looking at the floor? Who is the leader of the group? Then I begin to react as the discussion unfolds.

These employees felt heard; they felt like someone understood. It's the ability to shift and meet them at their needs.

Recently, I had a large group of folks. I separated the employees who spoke only Spanish from the English speakers. I also speak Spanish, so I met with that group while a colleague met with other group. I brought some snacks to keep it casual. Then I just observed who they were looking at the most—who the unofficial spokesperson was for the group. We started talking and they began to open up. I listened to their belief systems. I learned that there was going to be a massive walkout of the Hispanic male community at that employer. I pressed them a little more and realized they had a spiritual belief that they could still see their former coworker in the area around the equipment where the fatality occurred. At work, people often are afraid to speak about religion. Crisis intervention allowed us to get to this place and talk about their faith and their superstitions.

We also had an employer that allowed it. They were willing to be creative and responsive to get to a better outcome. They brought in a Catholic priest to bless the site. Before that, there had been a lot of absenteeism. It took a lot of listening and observation. Then you take them through the steps of crisis intervention. Active listening and observing body language are key. These employees felt heard; they felt like someone understood. It's the ability to shift and meet them at their needs. There was not one walkout. The manager said it was an extraordinary turnaround among the employees.

Q: That's amazing and, I imagine, not what the employer expected. But expecting the unexpected makes sense because a critical incident can take many forms. What are some of the types of calls you get?

Eleanor: I had a client who was working at a convenience store. She was cleaning the bathroom and was dumping the trash when she stepped on a syringe; she was afraid she had contracted HIV. I worked with her for a few sessions to help her through that until her medical tests came back negative. Then I had another case where a frequent guest at a hotel took his own life in his car in the parking lot. I provided counseling for the hotel staff that found him. Another time I worked with a highway crew working overnight that saw an accident involving a two-car collision and one driver died immediately. Then another car hit some of the crew members and injured two of the employees very badly. In all these cases, people often feel like they will never un-see it. But I explain that it won't always feel as intense as it does right now.

In another case, I had one young woman working at a convenience store who was robbed on her shift. The attacker was caught and then released. I conducted telephonic counseling with her. She returned to work and at the end of her first day back she called me at 4 a.m. to say she'd gotten through her shift and was doing better.

Q: That's quite a variety. What are some of the signs you see that someone might be struggling more than he, or she lets on?

Eleanor: Many times, you'll see people who are self-medicating—drinking, taking medication, whatever is handy. Some will go to a doctor to say they aren't sleeping but not tell the doctor about this tragic incident at work, so it's not diagnosed properly. We educate the employer to look for signs and identify those that would be at risk for developing more issues. These might include witnesses to an incident or those that didn't engage in our initial session.

Q: How do you know your efforts are working?

Eleanor: I focus on active listening and empathetic responding. The best scenario is where the group starts talking to each other. That happened in a session with a group of managers not too long ago. They took the ball from me and were communicating with each other. That was a

I had one manager say he didn't know so much could be done in one afternoon. They're just surprised by how much can come from this and how much people can be helped by debriefing.

great sign that they would be able to support each other and their crew after I was gone. I told them when we started that these are techniques you can use when dealing with your crew. So, it's education for the management team as well. It's providing them with the tools they need.

Q: What are some of the mistakes you see employers make following an incident?

Eleanor: Employers do make mistakes. They're human, too. Sometimes their reaction is, "Get out of here and go back to work." They just want to keep everyone else out of the area where an incident occurred. They're meaning well and want to take their employees away from a bad situation. Preparedness can help employers know what to do when something happens rather than just reacting without a plan.

Q: Have you seen employers miscalculate how widespread the fallout is from an incident?

Eleanor: Yes, I would say probably on every crisis intervention I've had. In one case, we had a projection for a maximum 10 people participating and it turned out to be almost double what the management thought. I had 100 percent participation. Honestly, we got so many letters and calls from that employer and so much praise for how much help our solution provided. The manager was literally searching to see what he could do. He was actually a nurse; he just had no idea that this kind of crisis intervention existed. I always do a follow-up call with the employer to get their feedback. I had one manager say he didn't know so much could be done in one afternoon. They're just surprised by how much can come from this and how much people can be helped by debriefing. They're seeing people smile again. It's one of the things that I love about my job. I love being able to help who I can help for as long as I can help them and get them going in the right direction.

Q: That's fantastic. It must feel great to help traumatized employees though I imagine it's also difficult to interact with employees so soon after a workplace incident. Is that the case?

Eleanor: Yes. These cases are so difficult but also rewarding for me as a case manager. It's something where you know within a very short amount of time you've made an impact. You take away something from every case that you have, and you learn how to do something a little better and you learn different approaches for reaching people. Everybody comes out of it a little changed. The one thing I would say from a case management perspective is don't go into this lightly. It does take a lot out of you, but it can give you some of the most satisfying moments of your work. It's one the hardest things I've ever done but it's one of the best things I've ever done. I truly believe it's a great service.

CHAPTER 3

Breaking Down Mental Health Myths

What COVID-19 is Teaching Us About Mental Health

By Tom Kerr
Director of Communications
Genex

Americans have come a long way in better understanding and appreciating mental health and its important role in maintaining activities of daily living. This is especially true now, as we struggle to cope with a pandemic that has just started to loosen its grip on our way of life.

Pandemic Anxiety, Depression and Isolation Gives Us a Taste of What Employees Face in Overcoming a Work Injury

A third of Americans showed signs of clinical anxiety or depression in the early months of the COVID-19 pandemic and two-thirds of adults report more stress now compared with this time last year, living with anxiety, depression, loss, isolation and fear has become a major problem for many. For those of us in the workers' comp industry, we're getting a taste of the psychosocial effects many injured employees face during their recovery.

And perhaps stepping in those shoes may help the industry further recognize the need for psychosocial intervention and retire old stigmas regarding mental health and claims management. *Risk and Insurance (R&I)* recently published an encouraging article focused on the 7 Mental Health Myths—and Why They Matter in Workers' Comp. The detailed piece features leading industry experts who discuss the most common misconceptions regarding mental health in our industry that, when not correctly addressed, lead to delays in claim duration and return to work.

Uncovering the Myths

Chief among these is that psychosocial concerns need only be addressed in those injured employees with preexisting mental health disorders. As Mariellen Blue, National Director of Case Management Services at Genex, points out in the article even minor injuries can bring on symptoms of anxiety and depression in otherwise mentally stable individuals. So much so, that some psychologists have nicknamed this type of adjustment disorder "broken bone depression."

Another long-standing myth in workers' comp is that mental health concerns drive up claims costs and delay return to work. However, as Blue notes in the *R&I* article, though there is often a connection between high claims costs, delayed return to work and mental health, many of those who subscribe to this myth have the connection backwards. Depression isn't causing the inability to return to work; it's the inability to return to work that causes the depression. "Work really defines who you are as a person. It gives you purpose in life. When that's taken away from you, depression is something that can set in," Blue said in the article.

Early Recognition Leads to Better Coping

Which leads to another myth referenced in the piece, that mental health can't be approached from a preventative standpoint. In fact, early case management intervention has been successful in better addressing mental health concerns early on so injured employees can receive a true severity score to determine what needs to be addressed throughout the claim.

"Case managers often play a role, similar to a detective, in discovering what underlying problems there may be that could be delaying the claim," Blue told *R&I*.

And, as coronavirus continues to ramp up anxiety and psychosocial concerns in injured employees, Blue says that early case management intervention can make all the difference in the world in closing claims on time. During this pandemic, we've seen numerous examples of how case managers helped address anxious workers' concerns to ensure they continue to progress through their claims.

So, as we all continue to adapt to an uncertain and, often, fearful world, we've begun to walk that mile in the injured employee's shoes. Here's hoping we complete this journey with a better understanding of how much mental health impacts overall health and well-being.

CHAPTER 4

Access to the Right Providers at the Right Time

In Tough Times, Injured Employees Require More Mental Health Supports

By Kate Farley-Agee
Vice President, Network Products
Coventry

Mental health challenges present numerous hurdles for injured employees even in "normal" times. Now, because of the extraordinary fallout from the pandemic, it's imperative to ensure that injured employees obtain access to high-quality mental health assistance when it's needed.

For years now, we've understood that anxiety and depression can threaten an injured employee's recovery. Often, these pernicious inflictions don't creep up until well after a physical injury occurs. This stealthy advance can make these conditions hard to identify and difficult to treat. Yet before the novel coronavirus began pummeling the physical and mental welfare of so many people, it was possible, if ill-advised, to take a wait-and-see approach when considering mental health options for an injured employee who showed signs of unease. We have come to understand this no longer works.

Now, the collective gut punch delivered by the pandemic has made it necessary to devote added attention and resources to identify and treat behavioral-health challenges before they risk upending an injured employee's recovery. To further that goal, it's helpful to examine how successful models of care incorporate mental health aspects from the start.

It's wise to turn to a strong network that has deep bench strength. This is important because finding the right provider and gaining timely access to that provider is key to helping injured employees deal with mental health hurdles if such challenges begin to arise.

23%

of members with mental health or substance use disorders drive 60 percent of overall medical spending.

This is critical because we continue to develop a better understanding of the often-inextricable links between physical and mental soundness. For example, one study of more than 15,000 retirees pointed to anxiety and depression as posing similar—and sometimes greater—risks for poor health outcomes than obesity and smoking.

There is ample evidence that mental health assistance can play an important role in an employee's recovery. Where things get less clear is determining what behavioral-health interventions an injured employee needs to achieve success returning to work.

One fundamental question centers on the type of provider. In workers' compensation, behavioral health providers often include psychiatrists, psychologists, and professional counselors.

Beyond looking at the type of provider, it's critical to understand the level of care needed to promote a strong recovery. This includes questions about whether a treatment will be outpatient, or, though rare, inpatient. Here are some of the distinctions we often see in workers' comp:

- Inpatient hospitalization
- Partial hospitalization
- Intensive outpatient care
- Outpatient counseling
- Medication management

Looking a little closer at some of these variations, interventions such as inpatient hospitalization obviously represent acute care whereas partial hospitalization might be limited to day treatment. Next, intensive outpatient care stands as a still-lighter touch, perhaps with three hours of treatment three to five evenings per week. Outpatient counseling and medication management each have their place as well in helping injured employees combat mental health concerns. Often, talk therapy can serve as an appropriate first-line treatment when mental health obstacles emerge.

Of course, none of these interventions—provider types, treatment settings, or treatments themselves—exist in a vacuum. Today, injured employees are facing the added strains of seeking recovery under the pall of a global pandemic. This compounded stress can impinge on employees' recoveries by stirring unease about physical and financial well-being, among other concerns.

At the same time, the breadth and scale of the pandemic, not seen in a century, also raises sometimes-difficult questions about compensability. After all, if most everyone is feeling stressed, is an injured employee forced to bear a heavy mental load because of an injury or simply because these are stressful days?

There are several questions adjusters might consider asking to navigate to an answer:

- Did symptoms begin to emerge before or after the injury occurred?
- Did the injury exacerbate any mental strains the employee was already facing?
- Was the injured employee seeking treatment for mental health challenges prior to the injury?
- Are the difficulties linked to fallout from the injury, including decreased income, loss of contact with coworkers, or challenges associated with recovering at home or in a facility?

The nature of mental health ailments can make it difficult to uncover clear-cut ties between an initial incident and subsequent bouts with conditions such as anxiety and depression. That's why it's helpful for adjusters and case managers to reach for proven tools such as active listening and recurring engagement with an injured employee. These conversations can help adjusters both better answer questions about compensability and help direct injured employee toward the most appropriate treatments.

It's possible and even probable that getting hurt on the job amid a pandemic could bore further into an employee's mental wellbeing than it otherwise might. Working and living in a heightened state of strain for an extended duration makes it more likely that an employee could become injured in the first place. And unrelenting stress can likewise make recovery harder. It's also evident that the exogenous fault lines that grew to define 2020—worries about contagion, the economy, and society at large, among others—could make anxiety and depression more likely to follow when an injury occurs.

There are other ways the pandemic malaise could eat away at an employee's mental wellbeing. Fear of retaliation might keep someone from raising a hand to report an injury. Perhaps the employee feels gratitude about still having a job in the first place and doesn't want to appear unappreciative. Or it could be that the employee fears direct retribution or even a soft reprisal such as losing favor with management. It's likewise possible an injured employee might worry about being subsequently targeted if layoffs were to occur.

Given the financial and operational difficulties many employers are facing, it's little surprise that some employees might not want to rock the proverbial boat. This is the case for a segment of employees even in less economically perilous times. A 2013 survey by Findlaw.com, a legal-information clearinghouse, found nine percent of workers didn't report a workplace injury for fear of retaliation such as being fired or passed over for promotion. Now, with the U.S. economy staggering under the weight of coronavirus disruptions, it's possible more employees would be reluctant to reveal injuries.

Difficult times can require adjusters and case managers to do a little more looking under the hood of a claim to try and anticipate where an injured employee's case might be headed. This might mean examining the medications providers are prescribing or the types of treatments providers are seeking. By applying a bit more scrutiny to some of these aspects of a claim, adjusters and case managers might be able to tell when mental health challenges could threaten to complicate an employee's rebound and return to work.

Even for employees who aren't injured, mental health constraints such as depression can do enormous damage. In fact, about one-quarter of the U.S. workforce suffers from depression and these employees are out from work twice as often and they have five times the "lost productive time" of other employees. The cost to personal wellbeing is plainly severe. The same is true in monetary terms: A review of U.S. insurance claim data by the consultancy McKinsey reveals that the 23 percent of members with mental health or substance-use disorders drive 60 percent of overall medical spending.

Put another way, behavioral-health issues and physical issues often go hand-in-hand. The same McKinsey also found that people with behavioral-health conditions suffer two to six times the frequency of concurrent physical conditions compared with those who don't struggle with these challenges.

Challenges around access appear only likely to grow in the U.S. and, indeed, throughout the world. Paradoxically, as some mental health advocates have noted, some states hemmed in by financial difficulties arising from the pandemic are reducing the money they set aside for mental health treatments just as demand is spiking. Other states, desperate for space to treat patients contagious with COVID-19, the disease caused by the coronavirus, have shuttered or taken over behavioral health facilities.

While the outlook for treatment access remains worrisome, some mental health professionals hope the societal inequities and shortcomings highlighted by the crisis will lead to further innovations in delivering care such as using telemedicine to reach far-flung patients. The need is great. More than half of counties in the U.S. don't have a psychiatrist and nearly two-thirds have a shortage of mental health providers.

There are other potential benefits for injured employees that could grow out of a broader need across society for mental health interventions. One is a further breakdown in the stigma that too often surrounds mental illness. An employee already straining under physical maladies related to an injury can then suffer a cruel secondary blow—one tied to the shame that struggles with anxiety, depression, and stress can render. If more people recognize how commonplace mental health trials are, then perhaps more employees will ask for help. Similarly, perhaps more employees will understand how physical pain, social isolation, financial worries, and other everyday concerns can conspire to throw up sizable barriers to mental well-being.

What's Causing the Rise of Psychological IMEs in Workers' Comp?

Transcript from a podcast interview of
Donna Bradshaw
Vice President of IME Services
Genex

Independent Medical Exams (IMEs) are often thought of as a way to obtain an impartial opinion regarding the treatment of a physical injury. Though psychological IMEs are less common, they're sometimes just as imperative in helping an injured employee stay on track with the treatment protocol. For more on this, we've invited Genex's Donna Bradshaw to talk about it.

Q: What are some reasons a psychological IME might be performed?

Donna: Well, time to time, you might get a report, whether it be from the employee, from a treating provider, perhaps from a co worker or management of some psychologic, psychiatric, or cognitive issues that might impact an individual's ability to safely and efficiently perform their work functions.

For example, we've seen a co worker being verbally and/or physically abusive, maybe severely bullying another employee. All of those may cause symptomatology which could result in requiring a mental health IME.

Q: Who conducts a psychological IME?

Donna: Typically, psychologists perform these types of IMEs. And as psychologists, their designations are often a doctorate in PsychologyNIH or PhD. So normally, you'll see these types of physicians administering the tests and doing the IMEs, and then, also rendering their opinion on the test results.

As soon as you can identify the potential need for appropriate diagnostic treatment and care, the sooner the individual can be returned to a higher level of functioning and a potential return to work.

Q: When in the rehabilitation process would a psychological IME be ordered and who would order it?

Donna: Different jurisdictions and/or policies have varying requirement timelines in which an IME can be ordered. So, it would be dependent on the jurisdiction and/or policy, if applicable. However, typically, the workers' compensation carrier, the employer, or possibly the treating provider, would be the ones that would request or order this type of examination.

Q: Post-traumatic stress disorder is becoming more recognized as something that should be addressed when a catastrophic workplace event occurs, is it also a diagnosis that's being addressed more often in IMEs?

Donna: Yes, we have definitely seen an increase in this type of request. And of interest is the fact that this type of IME is the second most common requested in the disability arena.

I know we're talking about workers' compensation, but I just think it's interesting that this type of IME is really high up there when dealing with disability concerns. You know, also the wars in Afghanistan, Iraq, the 9/11 attack on the twin towers, the ever increasing mass shootings, they have dramatically increased the study of post traumatic stress disorder, which is leading us to a better understanding of the impact that it actually has on the individual as well as the community—the different risk factors that are out there, the assessment, the treatment. So, the study is really giving us a good handle on not only how to identify but how to treat this diagnosis.

Post traumatic stress disorder is also currently on the rise in veterans, women, and children. And again, some of that can be attributed to these mass shootings that we're seeing which seem to be becoming a part of our daily life.

Q: When might a provider order an IME for PTSD?

Donna: Providers would order an IME if their patient were to report or display some type of criteria that meet the DSM 5 diagnostic requirements for PTSD. The DSM 5 has a list of criteria that will point to that specific diagnosis, such as the individual either reporting or displaying a stressor, which would be a threatened death, a threatened serious illness, possible sexual violence.

And the criterion is intrusive symptoms and those can be identified as nightmares, flashbacks, upsetting memories, holding trauma related thoughts or feelings. Definitely a decrease in an interest in activities, negative thoughts about the world, about oneself, risky and destructive behavior, irritability and/or aggression are really kind of high up on the list of the criteria.

And then you have to look at the symptoms, you know—how long have these symptoms lasted? And if they have persisted for more than one month that is definitely one of the criteria, and whether or not the symptoms create distress and functional impairment within the individual and ensuring that the symptoms are not related to any type of medication side effects, substance abuse, or perhaps even another physical illness.

Q: What's the goal of performing an IME for PTSD?

Donna: Well, the goal would be to objectively confirm or refute a diagnosis of PTSD. And the psychologist that does the testing will want to analyze the testing results in comparison with standard test response.

They'll interpret the testing results to determine the severity of the individual's impairment to determine if the level of impairment due to PTSD requires workplace activity restrictions or limitations, perhaps to obtain recommendations for appropriate or further treatment, a prognosis, and basically to determine whether or not the employee is capable of performing the essential requirements of their position.

Q: What's involved in conducting a PTSD IME?

Donna: Well, IMEs for PTSD, especially if you're doing extensive neuropsychological testing, sometimes are done over a two day period because they are so psychologically intensive and they're time intensive.

So, what happens is there's an in person interview with the individual which will include medical, family, personal, educational, military background, work history and then there will be discussion of inciting events. Possibly the provider, the practitioner will want to have follow up phone calls with families or friends or co workers if permitted, or management if permitted, so that they can corroborate the information. That can only happen if the employee had signed a release of information which allows the provider to do so.

And then they would normally have a battery of neuropsychological testing which will have multiple, embedded validity factors. So, those types of tests can include the MMPI 2 which is the Minnesota Multiphasic Personality Inventory, the CAP 5 which is the Clinician Administered Post Traumatic Stress Disorder Scale which was designed expressly for the DSM 5, the PCL 5 which is the Post Traumatic Stress Disorder Checklist for the DCM 5, and then the MCMI 3 which is the Millon Clinical Multiaxial Inventory.

Those are typically the tests that we will see for a provider to perform a full mental status IME that will focus in on psychological functional ability.

Q: And with the extensive testing involved and the stigma associated with mental health, are some injured employees reluctant to have a PTSD IME performed?

Donna: Absolutely, and a lot of times, it is the individual who balks at the two day testing. You know, they don't want to give their time, especially over that two day time period, it can be five hours one day, five hours the next day.

It all depends on how quickly the provider can get to the testing, how quickly the interview process goes. You want to make sure that you're gathering all the information that you need so that when it comes time to prepare the report that you have all the data available to you. So, because it's an interview process coupled with testing, it's not something that can be done quickly.

Also, interestingly enough, because you're dealing with psychological questions, and especially with the MMPI, they can be somewhat intense questions that might make a person uncomfortable to answer. So, you want to go slowly through those things so that they don't feel rushed.

And you're again, gathering all the information that you need and giving the individual the time to address the questions as they come through.

Q: How do providers help ease those concerns?

Donna: Well, I guess it's because this will give the ability to determine if the treatment that's being rendered is appropriate, if additional treatment would be more appropriate, and current treatment would be more appropriate, as well as giving the individual a prognosis and a timeframe that they can work within.

So, there's multifactorial points that go into this. It is beneficial to the individual to get the treatment needed to resolve the issue at hand.

Q: Has there been a reluctance to order IMEs for PTSD or is becoming more common?

Donna: Ironically enough, the answer to that question is both, there is some reluctance, but yeah, we do see more and more coming through.

Historically, there's been reluctance mainly due to the associated costs. These are not inexpensive exams. They are relatively expensive, especially if you're talking a two day exam. So that sometimes holds people back from ordering them.

However, from the psychiatric and the psychological arena, these types of impairments are becoming more common and recognized, and the use of this neuropsychological testing in the form of an IME is definitely increasing because it does give you objective data. Whereas, going to see a counselor or just talking it through with a psychologist or psychiatrist doesn't necessarily provide objective data. The testing provides more objective data for us to work with, and again, to determine treatment recommendations, to determine functional ability and, ultimately, whether or not the individual is capable of functioning in their position.

Q: Do you think PTSD testing after a catastrophic event will become more integrated in the IME process going forward?

Donna: Absolutely, especially when one considers the current societal stressors. As soon as you can identify the potential need for appropriate diagnostic treatment and care, the sooner the individual can be returned to a higher level of functioning and a potential return to work. And this of course will reduce lost-time which is what we are looking for, to get the individual back to work and functioning in society.

CHAPTER 5

Pharmaceutical Support for Mental Health

Mind Over Matter: Addressing Mental Health Comorbidity with Pharmaceutical Treatment

By Dr. Mitch Freeman, Pharm.D.
Chief Clinical Officer
Mitchell Pharmacy Solutions

"Mind over matter" is a familiar saying suggesting the potential of "will" to manage or overcome a physical challenge or to persevere beyond expectations. We understand our minds to be powerful agents of will, but how does mental health comorbidity play into a workers' compensation or auto injury recovery? When a person struggles to cope with a physical injury and a host of other life issues, how might recovery be hampered? Alternatively, how can a healthy mindset help with recovery?

Mental health is demonstrated to have a large impact on a person's ability to cope with and recover from a workplace or auto injury—especially when pain is also involved. Let's look at how mental state affects health and recovery outcomes and how your pharmacy program might aid in managing mental health issues.

The Mind-Body Connection

Disease comorbidity, or the presence of more than one disease or condition in one person at the same time, is generally associated with worse health outcomes, greater complexity of clinical management and related costs. Comorbidity of chronic pain and major depression is especially complex, often contributing to delayed recovery and increased costs.

The operating crosswalk from pain or injury to depression and vice versa is clear in a study from Harvard Health. "People with chronic pain have three times the average risk of developing psychiatric symptoms—usually mood or anxiety disorders—and depressed patients have three times the average risk of developing chronic pain." A similar study looking at the link between depression and chronic pain adds to this: "Clinical studies have

85%

of patients with chronic pain are affected by severe depression

revealed that chronic pain, as a stress state, often induced depression and that up to 85% of patients with chronic pain are affected by severe depression." In an auto accident, rates of depression post-injury can be particularly prevalent. A study in the Social Psychiatry and Psychiatric Epidemiology journal states, "A review of psychiatric morbidity following motor vehicle injury found that the rates of depression across studies ranged between 21 and 67%."

Mental health comorbidity, like major depression and anxiety, are among the most frequently occurring with pain, significantly impacting full recovery and return to work. In a study of more than 7,000 workers' compensation claims from Harbor Health Systems, depression and mental health comorbidity increased claim durations, medical costs, temporary total disability days and rates of litigation.

Whether in a workers' compensation or auto casualty claim, the relationship between mental health and recovery outcomes that these stats describe are particularly important to observe. Not only can the physical experience of pain cause mental stress and contribute to depression, but the recovery process, including new routines, life changes, financial burdens and PTSD can all exacerbate the perception of physical pain. Harvard Health states, "Pain slows recovery from depression, and depression makes pain more difficult to treat; for example, it may cause patients to drop out of pain rehabilitation programs." Many other studies of patients with depression and comorbid pain also speak to diminished pain treatment success and prognoses.

On the other hand, a positive or healthy mindset can also help with recovery from a physical injury. Compelling examples of the power of the mind-body connection exist in athletic performance optimization and its impact on placebo effect in clinical trials.

First, there is a measurable impact of state-of-mind in the healing process (as was explored in the antithesis above). A National Institutes of Health meta-analysis study on Optimism and Physical Health showed that, "optimism was a significant predictor of health outcomes or markers." Additionally, there have been extensive studies on the benefits of mindfulness, cognitive behavioral therapy, and meditation to support positive mind-body healing and pain management. For example, "the recent evidence-based clinical practice guidelines from the American College of Physicians (ACP) gave a strong recommendation" for treating lower back pain with acupuncture and mindfulness-based stress reduction (NIH). It is believed that when stress is reduced, inflammation is also reduced—leading to healing.

Secondly, the mind can have an impact on the intensity of the symptoms a person feels. In an interesting study using virtual reality gaming, burn injury pain was reduced by up to 50% more than drugs alone. According to Jeannie Sperry, a psychologist who co-chairs

the division of addictions, transplant, and pain at Mayo Clinic, "'Acute pain is generated in the peripheral nervous system, which conducts danger signals to the brain. From there, the brain determines whether it'll experience the pain signals or ignore them,' Sperry said. 'In the case of chronic pain, that system has gone awry,' Sperry said. 'Without training your brain to turn down the alarm system, the alarm keeps going off all the time.'" Luckily, as Harvard Medical School reports, "Research suggests that because pain involves both the mind and the body, mind-body therapies may have the capacity to alleviate pain by changing the way you perceive it."

Can Pharmaceuticals Support Both Pain Management & Mental Health Comorbidity?

Treatment for pain and mental health comorbidity are necessarily complex and multi-layered. So how can we help support both by acknowledging the power of the mind-body connection and supporting the recovery process from all angles?

Data from Mitchell Pharmacy Solutions suggests that antidepressant prescribing is on the rise in workers' compensation, with utilization in retail and mail order settings increasing 12.5% from 2019 to 2020 and percent of total drug costs in claims rising to 11.3% from 10.5%.

Interestingly, studies have suggested that drugs typically used for mental health management may be effective at treating pain, (e.g. antidepressants—Duloxetine and Venlafaxine) and vice versa. This is likely because these conditions share biochemical "messengers" (neurotransmitters), anatomic and physiologic pathways.

Harvard Health suggests, "Almost every drug used in psychiatry can also serve as a pain medication. Relieving anxiety, fatigue, depression, or insomnia with mood stabilizers, benzodiazepines, or anticonvulsants will also ease any related pain. The most versatile of all psychiatric drugs, the antidepressants have an analgesic effect that may be at least partly independent of their effect on depression since it seems to occur at a lower dose." As always, medications should be considered on a claim-by-claim basis taking into account what is best for the patient.

Other studies have found that opioids may have a limited positive effect on mental health comorbidity in treatment up to a certain point and in certain patients. However, opioids used for longer treatment courses are also linked to negative effects, especially with long-term use, with one study finding that "patients taking opioids for 31–90 days were found to be at an 18% higher risk for depression than those taking opioids for 1–30 days. Additionally, depression may prolong the duration of opioid use."

Studies of other "non-traditional" substances for use in mood disorders and pain, including ketamine, psilocybin, ayahuasca and others known to affect cognition, perception and mood are in early progress. Keep an eye out for our upcoming Drug of the Month article to learn more.

Overall, no single treatment or "silver bullet" is apparent in the management of injury, pain and mood. Pharmaceuticals offer one important tool supporting relief of an injury in which treatment of the wounded spirit and wounded body helps injured patients recover.

Mental Health Considerations for the Workers' Compensation and Auto Casualty Industries

The complicated, working interrelationship of mind and body expressed simply by "mind over matter" reminds us that we are more than the sum of our parts. The best management of a workplace or auto injury for fullest recovery, return to work and living may be inextricably attached to the sum of externalities in one's whole life picture. Viral pandemics, physical injury, loss of work, and financial and family stresses all contribute to a person's ability to heal mentally and physically.

Although many approaches to recovery focus on healing the physical injury, the inseparable mind-body connection in healing may, in some instances, necessitate a more holistic approach.

Psychedelics as Medicines?

By Dr. Mitch Freeman, Pharm.D.
Chief Clinical Officer
Mitchell Pharmacy Solutions

Are psychedelics the next "miracle" drug to treat mental health issues?

Recent movements calling for the decriminalization of drugs like psilocybin might suggest that. As mental health management becomes increasingly important in our lives and in claims management, there has been renewed interest in psychedelic drugs.

Although psychedelics have no current medical use and are not approved for any mental health treatments, recent research suggests that the drugs may be able to play a positive role in treating various mental health-related ailments. For that purpose, we will outline the current understanding of psychedelics and where they could possibly fit into treatment in the future.

Do Psychedelics Have Potential for Medical Use?

Psychedelics are recognized in the long history of various cultures, many of which ascribed mystic, religious or spiritual significance. In the U.S., a period of counterculture experimentation in the late 1950's and '60's led to a public perception that the drugs are dangerous and prompted controlling legislation. The U.S. banned the hallucinogen LSD and psilocybin in 1970 under the Controlled Substances Act and assigned Schedule I, flagging them as substances having a high potential for abuse and no accepted medical use. However, similar to how marijuana became decriminalized and then legalized on the state level, some states are considering decriminalizing psychedelics as well.

Many psychedelics are botanicals, derived from mushroom, cactus or vine species; more recent compounds are the products of laboratory synthesis. Lysergic Acid Diethylamide (LSD), Psilocybin, Ayahuasca and Dimethyltryptamine (DMT) are among the subjects of recent study that have yielded some encouraging early reports in treatment-resistant depression, addictions, PTSD and "end of life" care that remain to be more fully validated.

Psilocybin (or "magic mushrooms") in particular is the subject of renewed interest. A November 2020 study from Johns Hopkins revealed that two doses of psilocybin, in conjunction with supportive psychotherapy, "produced rapid and large reductions in depressive symptoms, with more participants showing improvement and half of study participants achieving remission through the four-week follow-up." An additional Johns Hopkins study from 2016 found that treatment with psilocybin along with psychological support "significantly relieved existential anxiety and depression in people with a life-threatening cancer diagnosis.

Interestingly, the researchers point out that the effect of treatment with psilocybin was "four times larger than what clinical trials have shown for traditional antidepressants on the market," suggesting that psilocybin could be more effective in treating mental health issues, especially considering the inconsistent effectiveness of antidepressant medications. Although the study was small, the findings are fascinating:

"For the entire group of 24 participants, 67% showed a more than 50% reduction in depression symptoms at the one-week follow-up and 71% at the four-week follow-up. Overall, four weeks post-treatment, 54% of participants were considered in remission – meaning they no longer qualified as being depressed."

A few studies of psychedelics revealed that the drugs have a low likelihood for long-term dependence, addiction or increased mental health treatment. Unfortunately, a full understanding of their pharmacology, safety and effectiveness is limited by the scarcity of sound clinical research. There is still much to learn about the sources, defined constitution of the active product, neurochemistry, dose-response relationships and other critical clinical performance dimensions of psychedelics that would guide their safe and effective use.

MDMA, or ecstasy (also a Schedule I drug), has also garnered recent buzz in the news, with people talking about its potential to help with severe PTSD that has not responded to other treatments. A 2019 study of patients with PTSD found that 54% of patients who were treated with MDMA therapy no longer fit the criteria for PTSD two months after the experiment versus 23% in the control group. After a year, that number rose to more than 2/3 of the group. Although these results are promising, there is still little research into the positives and negatives of MDMA use for PTSD or other mental health treatments.

As interest continues to build for the potential medical use of psychedelics (and even marijuana for PTSD treatment), we expect studies to continue, hopefully revealing more about their uses and side effects.

Psychedelics, Public Perception, and the Future of Treatment

Despite potentially promising results, psychedelics have a long way to travel from their public perception to medical credibility. A visit to "psychedelic" in the dictionary offers a large number of definitions and descriptions, most of which are less related to their use as medicines than to music, art or even fashion design. Visual and auditory hallucinations, intensification of awareness and sensory perception, disorganized thought, loss of coordination, euphoria, anxiety, panic and paranoia are among the reported effects. However, less is understood or discussed about the treatment potential for disorders that remain a challenge to the current pharmacopeia, like clinical depression, persistent anxiety, addiction disorders and PTSD.

For now, the potential of better treatments on the horizon is exciting. The ability to treat mental health challenges effectively is vital in the management of workers' compensation, especially when mental health can have a significant influence on perceptions of pain and recovery. As states continue to consider the benefits and drawbacks of decriminalization, we will keep you updated on changes.

Medications Used for Mental Health Conditions in Workers' Compensation

By Dr. Mitch Freeman, Pharm.D.
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Antidepressant Medications

Brand Name	Generic Name	Indication	Other Use(s)
Cymbalta	Duloxetine	Depression	Neuropathic Pain
Wellbutrin	Bupropion	Depression	Smoking Cessation
Effexor	Venlafaxine	Depression	Neuropathic Pain
Desyrel	Trazodone	Depression	Promote sleep
Remeron	Mirtazapine	Depression	Promote sleep
Lexapro	Escitalopram	Depression	Anxiety
Zoloft	Sertraline	Depression	Anxiety
Prozac	Fluoxetine	Depression	Anxiety
Elavil	Amitryptiline	Depression	Neuropathic Pain

Anxiolytic (Antianxiety) Medications

Brand Name	Generic Name	Indication	Other Use(s)
Xanax	Alprazolam	Anxiety	Panic disorder
Ativan	Lorazepam	Anxiety	Seizure disorder
BuSpar	Buspirone	Anxiety	
Valium	Diazepam	Anxiety	Seizure disorder, spasm
Serax	Oxazepam	Anxiety	Acute alcohol withdrawal
Tranxene	Clorazepate	Anxiety	Seizure disorder

Antipsychotic Medications

Brand Name	Generic Name	Indication	Other Use(s)
Abilify	Aripiprazole	Schizophrenia, Bipolar disorder	Treatment resistant Depression
Seroquel	Quetiapine	Schizophrenia, Bipolar disorder	Treatment resistant Depression
Zyprexa	Olanzapine	Schizophrenia, Bipolar disorder	Treatment resistant Depression
Risperdal	Risperidone	Schizophrenia, Bipolar disorder	Treatment resistant Depression
Serax	Oxazepam	Anxiety	Acute alcohol withdrawal
Tranxene	Clorazepate	Anxiety	Seizure disorder

Other CNS Medications

Brand Name	Generic Name	Indication	Other Use(s)
Provigil	Modafinil	Wakefulness – Narcolepsy	Sleep Apnea, Shift Work Sleep Disorder

Closing

Ultimately, it's clear that, in most cases, injured employees require a host of support systems that will enable them to see their health restored and allow them to return to work. Only by viewing the whole person can employers, adjusters, case managers, and providers hope to help injured employees achieve the best-possible outcomes. Part of this task involves reviewing the mental health difficulties that an injured employee might be facing. Once an obstacle is identified, it's imperative to address their needs in a timely fashion, to break down any barriers or stigmas associated with getting help, and turn to a network of accomplished providers to help the injured employee vanquish these mental health complications and return to health and productivity.

About Our Contributors

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Tammy Bradly is vice president of clinical product development for Coventry. Bradly is a certified case manager with more than 25 years of comprehensive industry experience through service delivery, operations management, and product development. She holds several national certifications, including certified case manager (CCM), certified rehabilitation counselor (CRC), certified program disability manager (CPDM), and critical incident stress management (CISM).

Donna Bradshaw is vice president, operations of IME Services at Genex Services. With more than 30 years of experience, Bradshaw has been responsible for writing operational plans to meet various state regulatory requirements, as well as securing and maintaining URAC Core V3 Accreditation. In her current position, she is responsible for overseeing Genex's IME branch offices where she develops and implements policies and procedures to increase operational efficiencies and effectiveness.

Kate Farley-Agee oversees Coventry's national broad-based provider network and state-certified managed care organizations across the country. She also leads Coventry's Network Quality Management and Improvement department, Network Paneling and Reporting, and Network Performance groups. Farley-Agee has more than 20 years' experience in the health care industry with an emphasis in network development and leadership.

Melanie Izzo is director of product marketing at Genex, where she is responsible for creating and implementing the company's clinical marketing initiates and providing sales and product strategy and direction. She has 20 years of experience developing and executing effective marketing, product and communications programs in the workers' compensation and professional services industries.

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Tom Kerr is director of communications at Genex, where he's responsible for leading and managing marketing communication content and strategies, including strategic content, media/public relations and social media platforms. He also serves as host of the popular industry podcast, Inside Workers' Comp. Additionally, Kerr is a frequent speaker at workers' compensation trade conferences and served as editor at Merion Publications for 18 years, where he launched 10 news magazines, including those directed to C-level health care executives, nurses and occupational therapists.

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