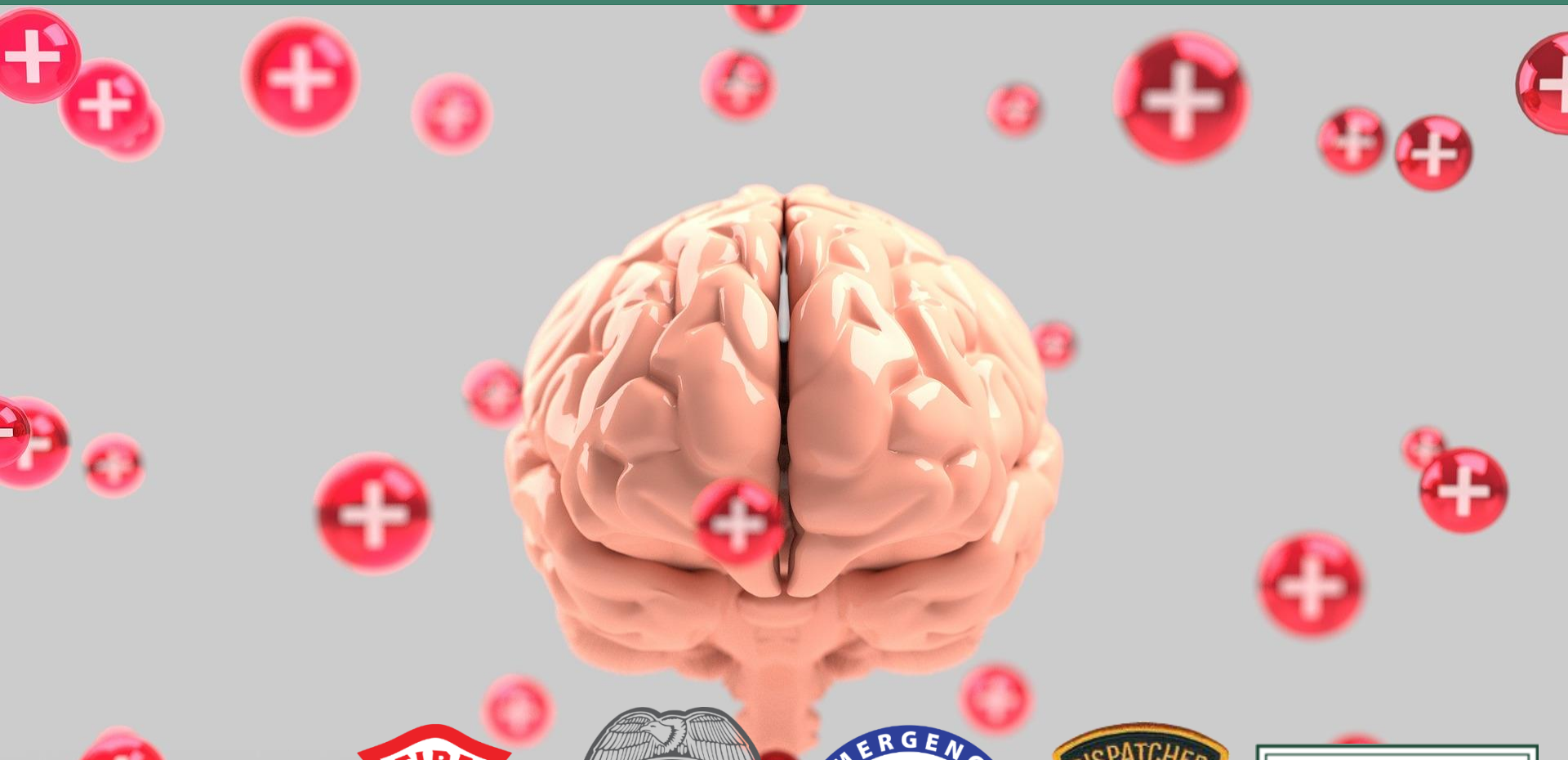
First Responder Training for Providers:
Diagnostic Considerations



MINES & ASSOCIATES
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First Responder Training for Providers: Diagnostic Considerations

Summary

1. Primary diagnoses seen in First Responder assessments
2. Mental Health and Substance Abuse co-morbid considerations
3. Co-morbid physical/mental health issues
4. ADA/FMLA/Disability Implications
5. EAP models and Treatment

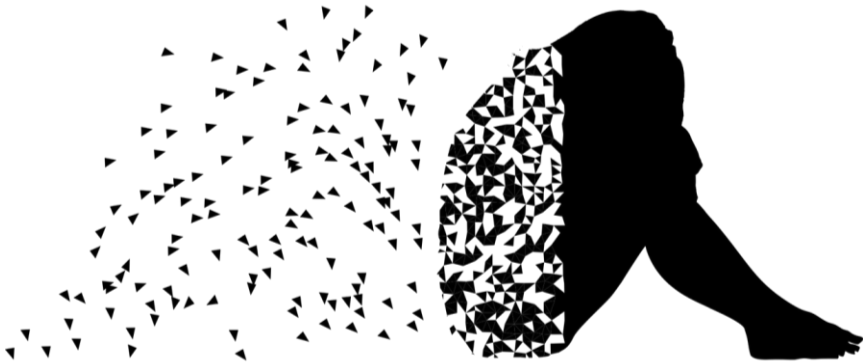
Depression 296.20-36 (F32.0-33.42)

A. **Five (or more)** of the following symptoms have been present during the same 2-week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

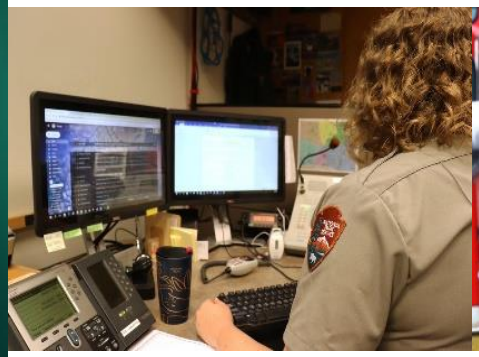
B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.



Trauma and Stressor-Related Disorders

Trauma- and Stressor-Related disorders include disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion. These include posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders as the focus for this training.



Acute Stress Disorder 308.3 (F43.0)

A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the event(s) occurred to a close family member or close friend. Note: In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse).

Note: This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). Note: In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Acute Stress Disorder Continued

Negative Mood

5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative Symptoms

6. An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
7. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

Avoidance Symptoms

8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
9. Efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal Symptoms

10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
12. Hypervigilance.
13. Problems with concentration.
14. Exaggerated startle response.

Acute Stress Disorder Continued

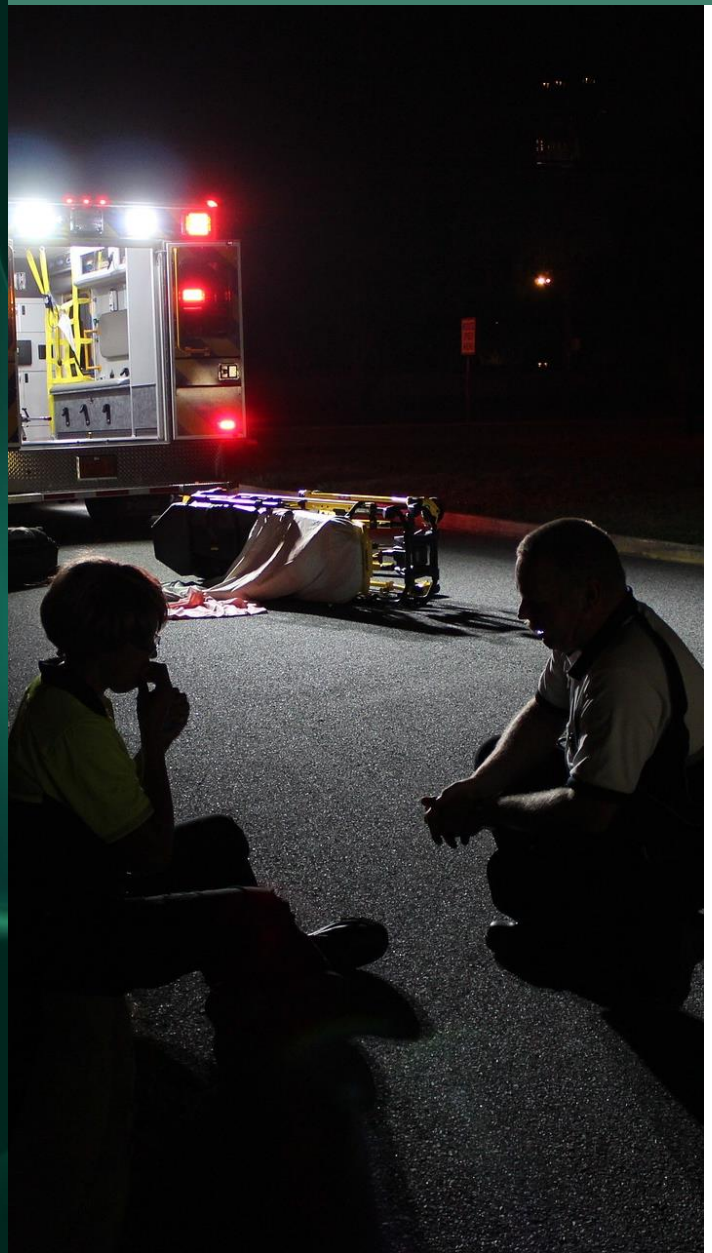
C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.

Note: Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

Post Traumatic Stress Disorder 309.81 (F43.10)



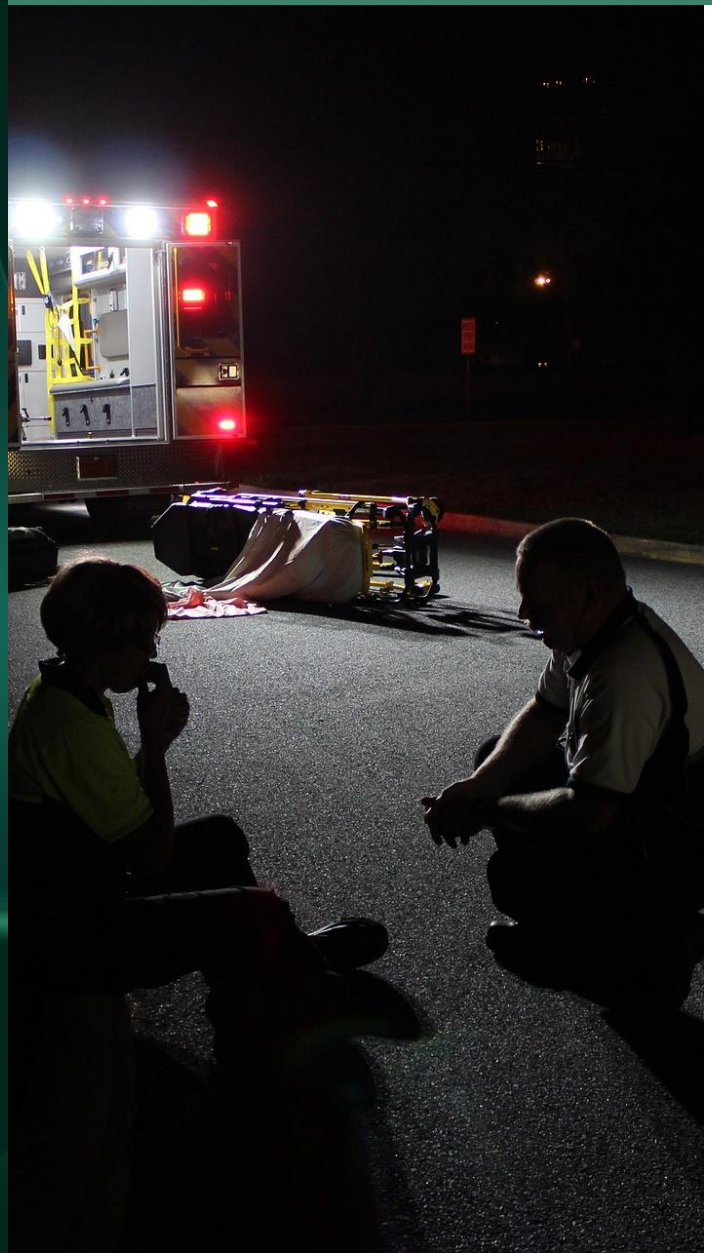
Post Traumatic Stress Disorder (Adults Criteria for this presentation)

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
    1. Directly experiencing the traumatic event(s).
    2. Witnessing, in person, the event(s) as it occurred to others.
    3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
    4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains: police officers repeatedly exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
    1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
    2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
    3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
    4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
    5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

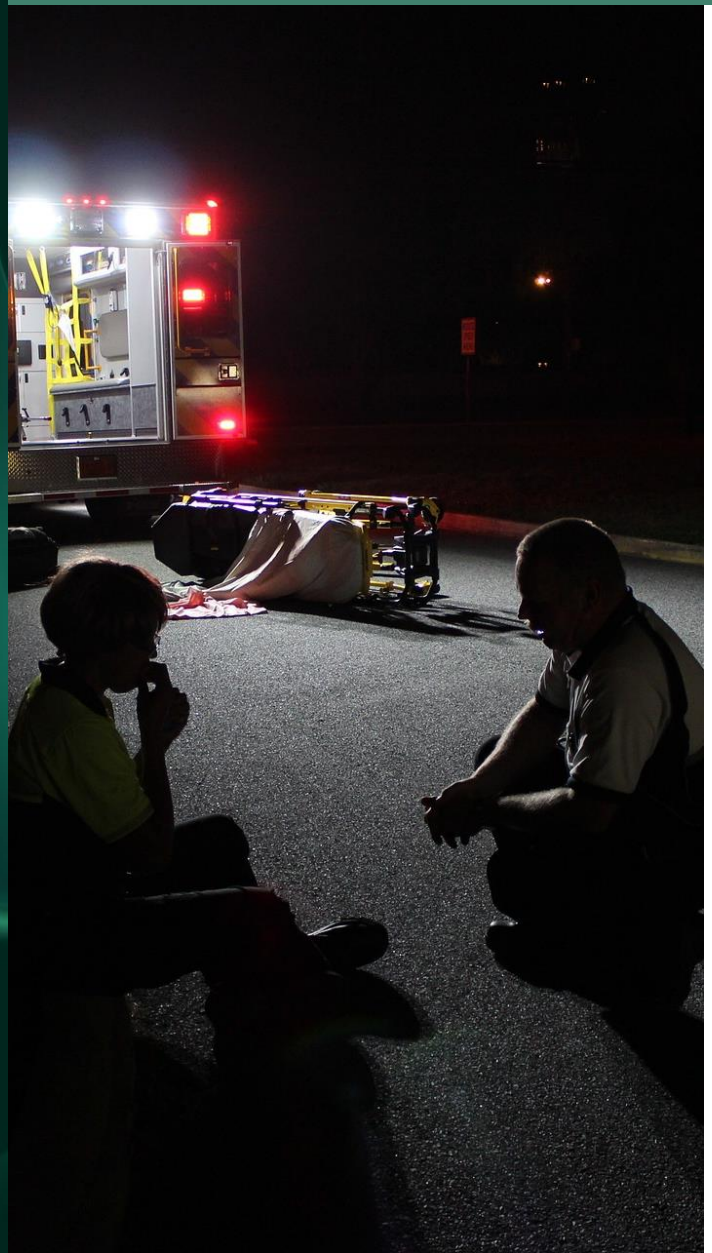
Post Traumatic Stress Disorder Continued



C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
   1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
   2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” ‘The world is completely dangerous,” “My whole nervous system is permanently ruined”).
   3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
   4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
   5. Markedly diminished interest or participation in significant activities.
   6. Feelings of detachment or estrangement from others.
   7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Post Traumatic Stress Disorder Continued



E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
    1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
    2. Reckless or self-destructive behavior.
    3. Hypervigilance.
    4. Exaggerated startle response.
    5. Problems with concentration.
    6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition

Specify whether:
With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:
    1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
    2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:
With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Adjustment Disorders 309.0-4, 9 (F43.20-25)

Diagnostic Criteria

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
B. These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:
    1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
    2. Significant impairment in social, occupational, or other important areas of functioning.
C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.
D. The symptoms do not represent normal bereavement.
E. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

Specify whether:

309.0 (F43.21) With depressed mood: Low mood, tearfulness, or feelings of hopelessness are predominant.
309.24 (F43.22) With anxiety: Nervousness, worry, jitteriness, or separation anxiety is predominant.
309.28 (F43.23) With mixed anxiety and depressed mood: A combination of depression and anxiety is predominant.
309.3 (F43.24) With disturbance of conduct: Disturbance of conduct is predominant.
309.4 (F43.25) With mixed disturbance of emotions and conduct: Both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct are predominant.
309.9 (F43.20) Unspecified: For maladaptive reactions that are not classifiable as one of the specific subtypes of adjustment disorder.

Substance Use Disorders

- Encompass 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens (with separate categories for phencyclidine [or similarly acting arylcyclohexylamines] and other hallucinogens); inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants (amphetamine-type substances, cocaine, and other stimulants); tobacco; and other (or unknown) substances.
- For the purposes of this training, the focus will be on substance use disorders and not substance induce disorders.

Substance Use Disorders

- The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.

- Overall, the diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance.

- To assist with organization. Criterion A criteria can be considered to fit within overall groupings of *impaired control, social impairment, risky use, and pharmacological criteria*.

Alcohol Related Disorders

Alcohol Use Disorder Diagnostic Criteria

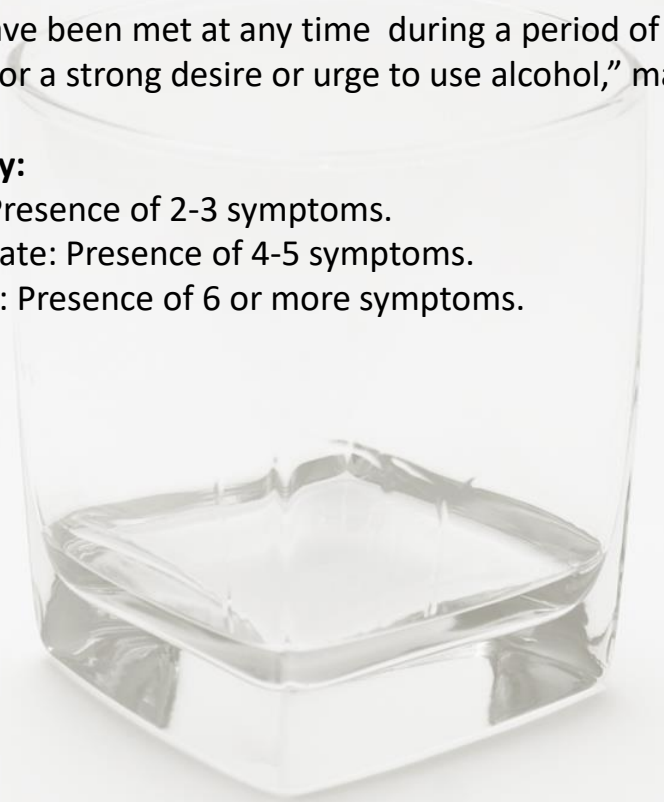
A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by **at least two** of the following, occurring within a 12-month period:
   1. Alcohol is often taken in larger amounts or over a longer period than was intended.
   2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
   3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
   4. Craving, or a strong desire or urge to use alcohol.
   5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
   6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
   7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
   8. Recurrent alcohol use in situations in which it is physically hazardous.
   9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
   10. Tolerance, as defined by either of the following:
      a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
      b. A markedly diminished effect with continued use of the same amount of alcohol.
   11. Withdrawal, as manifested by either of the following:
      a. The characteristic withdrawal syndrome for alcohol (refer to Criteria A and B of the criteria set for alcohol withdrawal,
      b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Alcohol Related Disorders

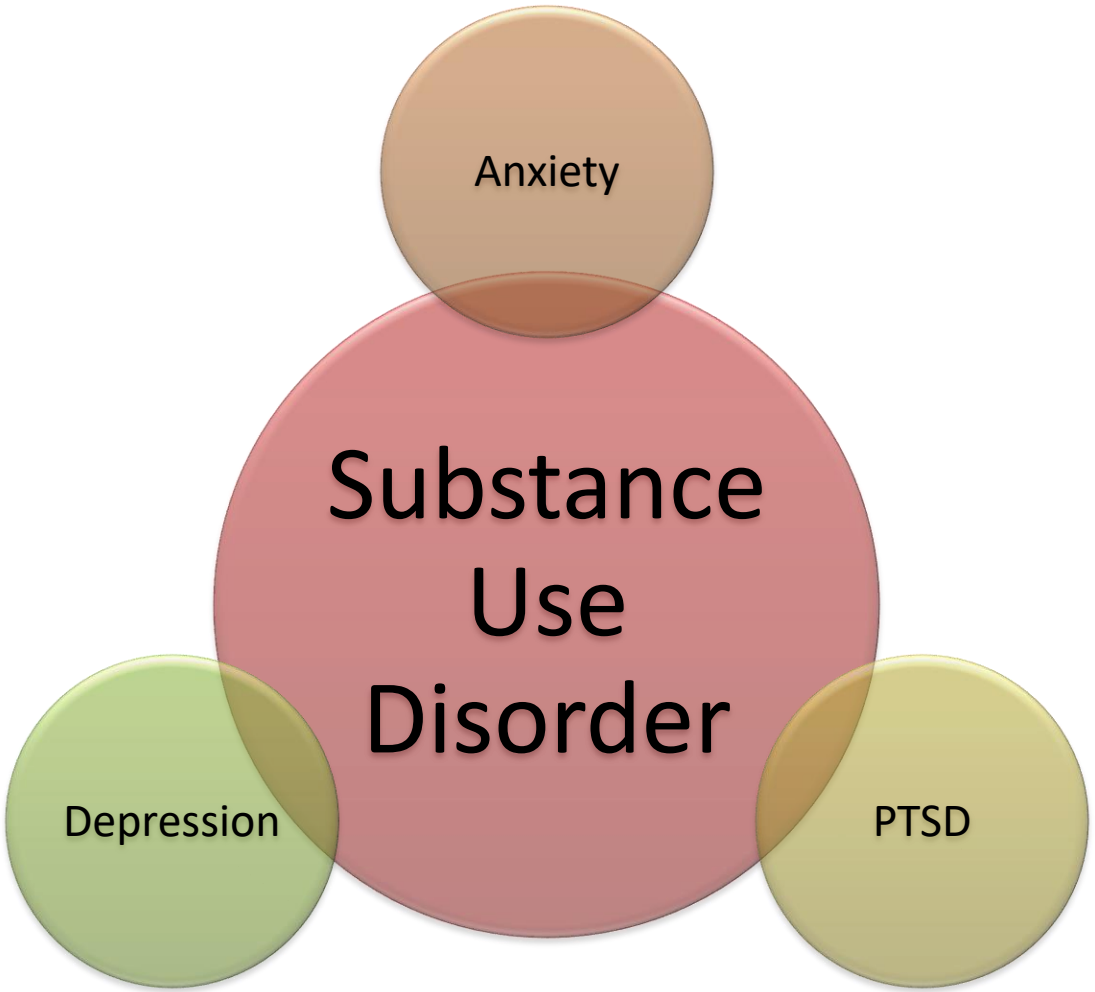
Specify:
If In early remission: After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, “Craving, or a strong desire or urge to use alcohol,” may be met).

In sustained remission: After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, “Craving, or a strong desire or urge to use alcohol,” may be met).

Specify current severity:
305.00 (FI 0.10) Mild: Presence of 2-3 symptoms.
303.90 (FI 0.20) Moderate: Presence of 4-5 symptoms.
303.90 (FI 0.20) Severe: Presence of 6 or more symptoms.



Co-Morbid Mental Health & Substance Use Disorder Considerations

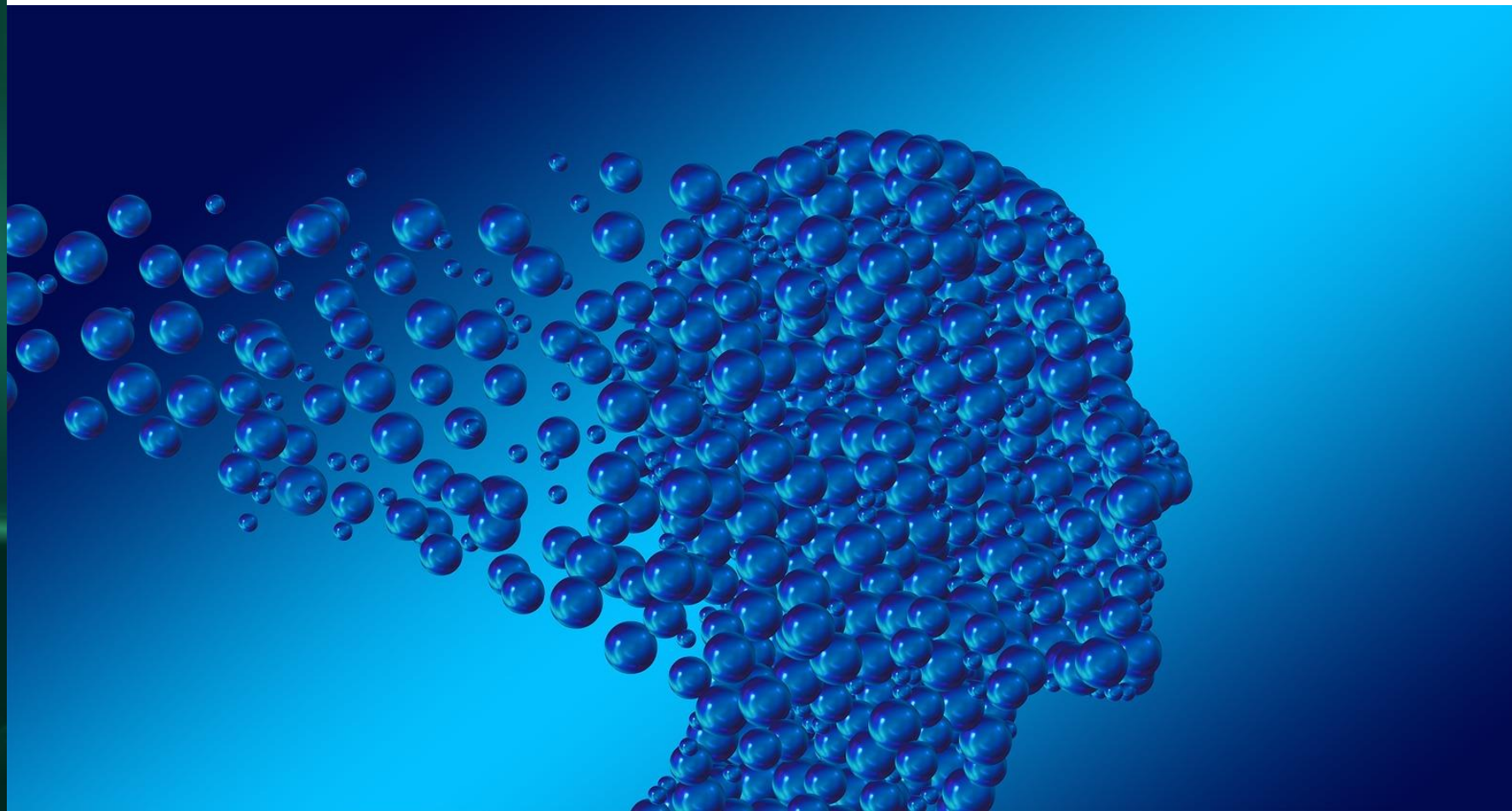


Co-Morbid Physical & Mental Health Considerations

- Chronic Illnesses (Diabetes, Metabolic Syndrome, Heart Disease, Asthma) and MH/SUD Complications
- Acute Medical Issues (Heart Attack, Injury, Cancer) and MH/SUD

ADA: Psychological Assessments of Functioning

- The array of broad psychological diagnostic categories that may require accommodations is large
  - Such as Depressive Disorders…



Psychological Considerations

In ADA and FMLA Accommodation Requests

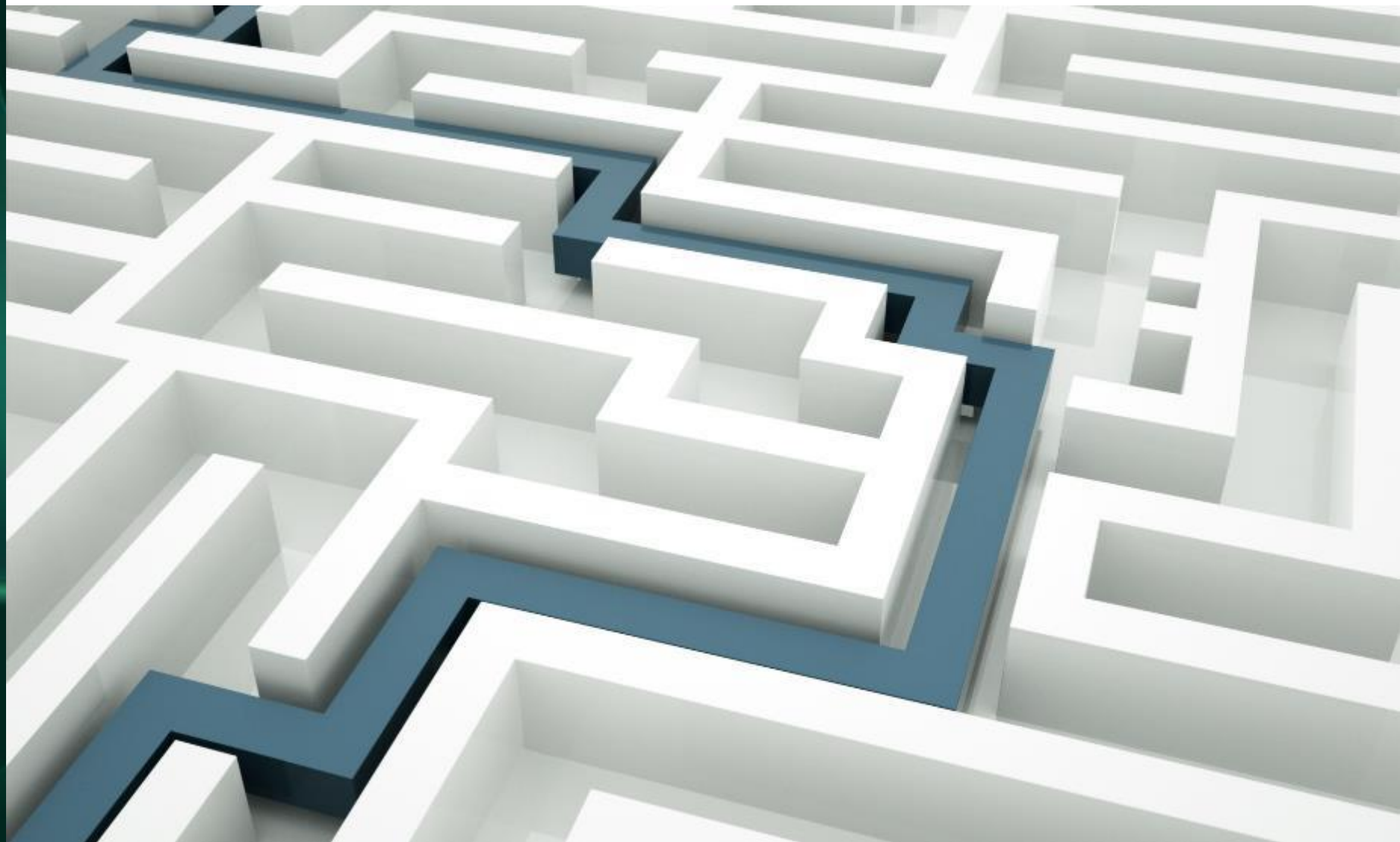
- **How does the employer determine what is a reasonable accommodation for a mental health ADA request?**
- **In addition, how does the employer manage FMLA requests related to mental health illnesses?**
  - What psychological functioning needs accommodation?
  - How many ways can this accommodation occur?
  - What is the impact of the accommodation on the work group/coworkers?
  - How best can this be addressed with the work group so everyone understands and is on the same page without violating the employee's privacy?
  - Who best can assess the accommodation needs?

Mental Health Professionals

- What are your methods?
- Validity and Reliability of your methods?
- Assess workplace as well as rely on employee-self report?

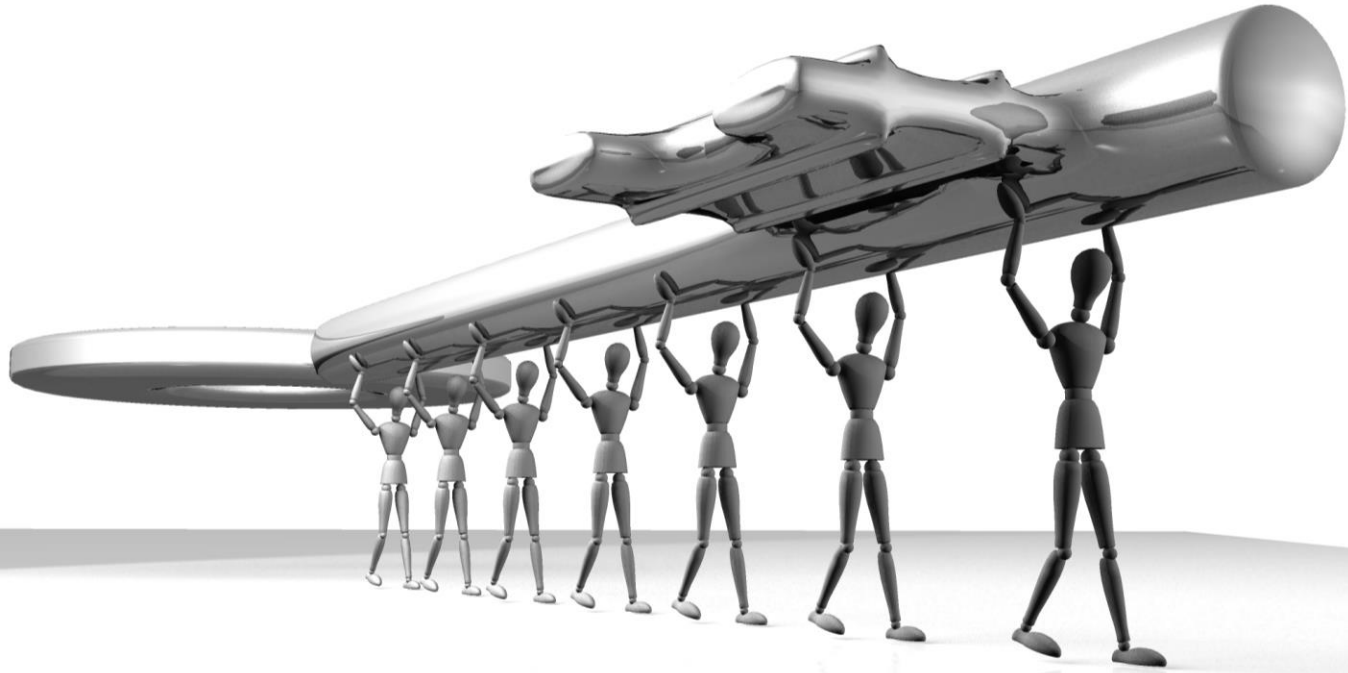
Common Barriers To Successful Treatment

EAP, Insurance, Self-Pay

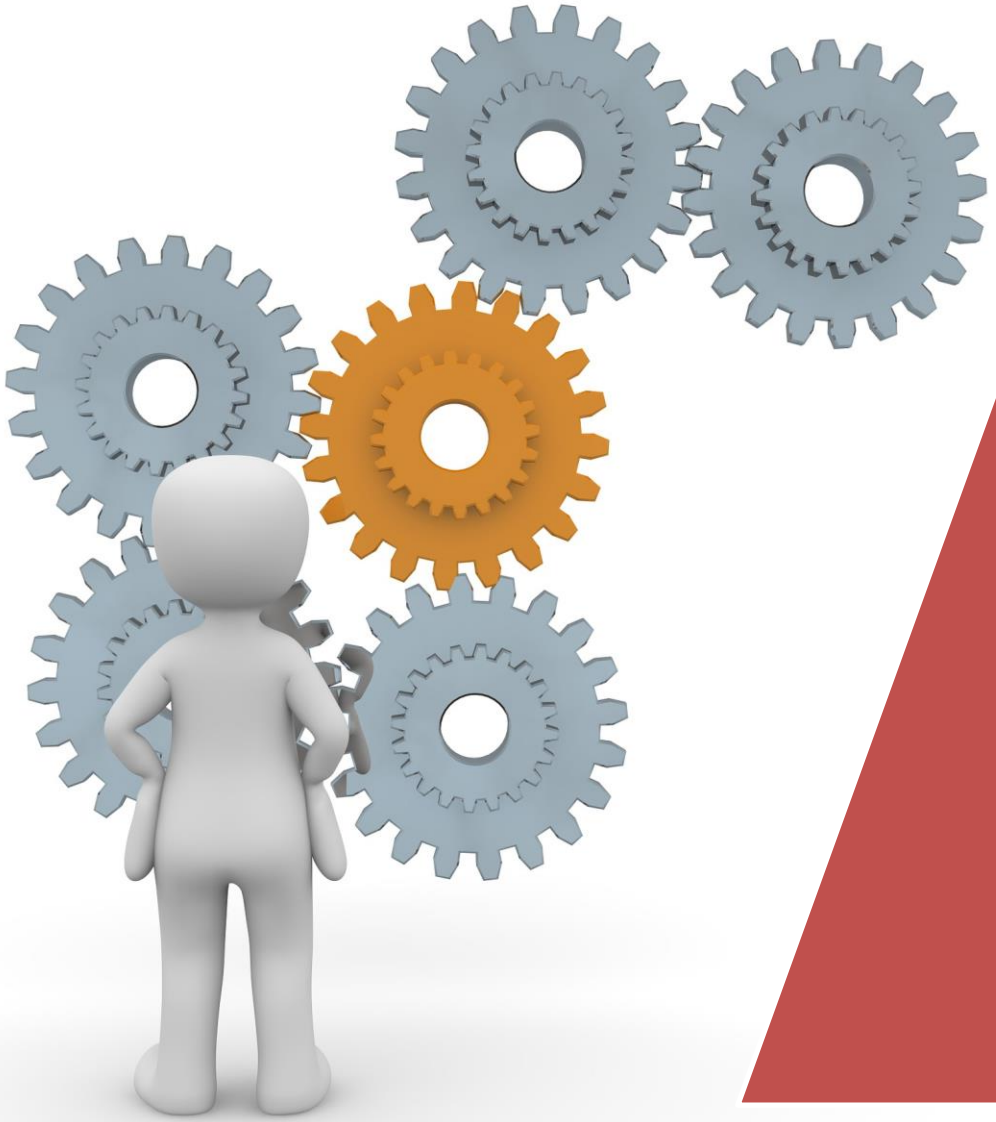


Common Barriers To Successful Treatment

Consultation and Supervision



Complexities and Additional Services

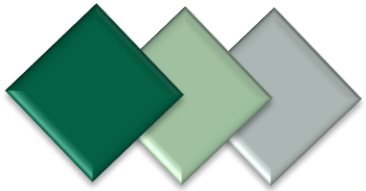


- Phobias
- Situational Anxiety
- When is a FR not safe to work?
- Post Offer Assessments and Fit for Duty Evaluations

Questions or Comments?

Contact providerinfo@minesandassociates.com for more information, comments, questions, or requests for resources mentioned in this presentation.

THANK YOU!!!



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