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Jacqueline Kurth
Manager, Medical Resource Office
Industrial Commission of Arizona
800 W Washington Ave, Suite 305
Phoenix, AZ 85007

Dear Ms. Kurth:

Thank you for allowing me to participate in the ODG review process. The purpose of this communication is to provide you with an opinion about the guidelines relevant to my specialty, psychiatry. I have the following comments:

1. With regard to, 311, Depressive Disorder Not Elsewhere Classified.
   A. Return-to-work best practice guidelines indicate time off for between no days and 56 days.
      1) Comment: This range of days is probably sufficient for most individuals suffering from a Major Depressive Episode. However, individuals who are a) Psychotic, b) Treatment refractory, or c) Have substantial personality disorders, are likely to require longer to return to work. Individuals with psychotic symptoms require additional medication manipulations and are slower to respond. Likewise, individuals with treatment-resistant depression may require multiple trials of antidepressant medication as well as ongoing psychotherapy in order to return to work, and may not return to work for up to six months in severe cases. Finally, individuals with concurrent personality disorders are likely to struggle to return to work, as personality disorders are typically aggravated by the disruption of being off of work, loss of income, or the disability/treatment administrative process. However, uncomplicated depressive conditions readily respond to treatment.
2. Initial Response to Presenting Complaint: Regarding the Mental Illness and Stress chapter, I have the following comments:
   A. Outline of treatment planning: With regard to general medical physicians administering in-house psychological testing, in my opinion, most primary care physicians are neither comfortable nor qualified for such testing, outside of basic depression and anxiety scales (such as the PHQ-9 and GAD-7). Those simple scales (for depression and anxiety) may be sufficient to initiate treatment. However, most general medical clinicians have limited experience with psychological testing or diagnostic interviews beyond this level.

B. With regard to referrals to a psychologist, I am unaware of community resources for obtaining psychological testing through occupational medical clinics, as written.

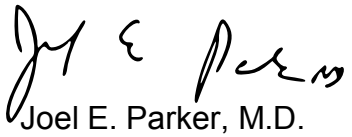
3. With regard to the mental health evaluation:
   A. The initial referral outside of the workers' compensation system seems prudent "given the difficulty in establishing a mental illness as work-related and the harmful health effects of involvement in workers' compensation." The causality point is well taken, as finding a relationship between an injury and a mental health condition is often complex. I generally do not see harmful health effects from involvement in the workers' compensation system for mental health conditions, outside of the possibility of aggravating a mental health condition due to the sometimes adversarial nature of the workers' compensation system. Regardless, initial evaluation outside of the system is appropriate.
   B. With regard to evaluation inside the workers' compensation system, I strongly agree that evaluations should occur on an independent basis (independent medical examinations) with the mental health specialist agreeing that they will not assume care. The "dual agency" of physicians who both evaluate and treat workers' compensation patients provides a built-in conflict of interest, and should be avoided, according to the Ethics Guidelines of the American Academy Psychiatry and the Law.
   C. Diagnosis: The importance of diagnosis, full utilization of the DSM-5 and the importance of psychological testing are all very appropriate comments.
4. With regard to treatment planning: With regard to a procedure summary for mental illness and stress, I have the following comments.
   A. The antidepressant comments are reasonable, appropriate, and comprehensive.
   B. With regard to antidepressants for treatment for PTSD, these comments are reasonable and appropriate. Of note, PTSD is not always a chronic disorder, and indefinite treatment may be excessive. Antidepressants may be needed for PTSD treatment for some period of time, but not necessarily indefinitely. Those recommendations appear to have come out of the Veterans Administration, where veterans are typically traumatized by combat, not workplace injuries.
   C. The comments for antidepressants/SSRIs versus tricyclics are reasonable. There are comments about Social Anxiety Disorder, which are not likely relevant to industrial injuries. Social Anxiety Disorder is typically a longstanding condition that begins in adolescence, and is not industrially related.
   D. The comments regarding atypical antipsychotics are very reasonable and appropriate. These medications are associated with substantial side effect burdens (chiefly weight gain, elevated blood lipids, and the development of pre-diabetes or diabetes) but are used extensively. In my review of medical records for numerous cases, I see limited documentation of informed consent for the use of these agents.
   E. The comments on benzodiazepines are reasonable and appropriate. The concerns about psychological and physical dependence, or frank addiction, as well as risk of overdose (especially when combined with opioids), and the risk of Alzheimer's disease, indicate substantial concerns about this class of agents.

F. The recommendations for bupropion as a first line treatment for Major Depressive Disorder, but not recommended for PTSD, is an appropriate, well-reasoned comment.
G. The Cognitive Behavioral Therapy recommendations are reasonable and appropriate. Of some note, however, is that this modality of psychotherapy can be somewhat difficult to access in the Arizona mental health marketplace. The recommendation for Cognitive Behavioral Therapy for depression, Panic Disorder, Post-Traumatic Stress Disorder, and general stress, is reasonable.
H. The recommendations for Dialectical Behavioral Therapy are reasonable, but treatment is geared primarily toward individuals with Borderline Personality Disorder, which as the DSM-5 requires it to be present by early adulthood, and is a non-industrial condition. Its use may be reasonable for industrially-aggravated pre-existing personality disorders, but is unlikely to be relevant to an industrially-related condition.
I. The exposure therapy recommended as an option for Post-Traumatic Stress Disorder section is very appropriate and related to many workplace injuries.
J. The recommendations for Eye Movement Desensitization and Reprocessing are reasonable as a recommended option.

In sum, the ODG Guidelines for the Mental Illness and Stress section are reasonable and appropriate, and are likely to be beneficial for use in Arizona.

Please contact me for questions.

Sincerely Yours,



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