# Common Mental Health Presentations among Public Safety Personnel

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# Faculty/Presenter Disclosure

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- **Faculty:** Nadia Aleem, MD, MSc, FRCP; Psychiatrist

- **Relationships with financial sponsors:**
    - **Grants/Research Support:** Workplace Safety and Insurance Board (WSIB)
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    - **Patents**: Not applicable
    - **Other:** Employee of Centre for Addiction and Mental Health (CAMH), Trillium Health Partners

# Disclosure of Financial Support

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- **This program has received financial support from the Workplace Safety and Insurance Board (WSIB) in the form of an educational grant.**
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- **Potential for conflict(s) of interest:**
- None

# Mitigating Potential Bias

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- The information presented in this program is based on recent information that is explicitly "evidence-based".

- This Program and its material is peer reviewed and all the recommendations involving clinical medicine are based on evidence that is accepted within the profession; and all scientific research referred to, reported, or used in this CME/CPD activity in support or justification of patient care recommendations conforms to the generally accepted standards

# Learning Objectives

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By the end of this session, participants will be able to:

1. Identify the most common mental health concerns that PSP may present with in healthcare settings
2. Create a framework to distinguish the type and level of care that may be best suited to the PSP seen in treatment

# Diagnosis



- The DSM-I published in 1952
- The DSM-II published in 1968
- The DSM-III published in 1980
- The DSM-IV published in 1994
- The DSM-V published in 2013
- The DSM-V-TR published in 2022-2023

# Diagnosis



- Symptom description format
- Limited description of impairment in functioning
- Post-traumatic stress disorder (PTSD) and adjustment disorder have parameters around causality otherwise does not comment on causation

# Limitations

- Cultural limitations
- Overlap in symptoms
- Does not capture complexity
- Does not correspond with treatment

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# Prevalence of Diagnoses in PSP

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- It is estimated that 30% of first responders develop behavioural health conditions including, but not limited to, depression and [PTSD], as compared with 20% of the general population.

- Depression, PTSD, alcohol, drug use all higher than general population

# Prevalence

| | Total sample |
|---|---|
| PTSD (PCL-5) | 23.2 (1304) |
| Major depressive disorder (PHQ-9) | 26.4 (1419) |
| Generalized anxiety disorder (GAD-7) | 18.6 (975) |
| Social anxiety disorder (SIPS) | 15.2 (783) |
| Panic disorder (PDSS-SR) | 8.9 (439) |
| Alcohol use disorder (AUDIT) | 5.9 (292) |
| Any other self-reported mood disorder[a] | 1.7 (80) |
| Any positive screen for a mood disorder[b] | 29.0 (1460) |
| Any positive screen for an anxiety disorder[c] | 30.3 (1433) |
| Any positive screen for any mental disorder[d] | 44.5 (1998) |
| Total number of positive screens[d] | |
| 0 | 58.2 (2495) |
| 1 | 15.1 (648) |
| 2 | 8.7 (371) |
| 3 or more | 18.0 (771) |

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# Substance Use

- The prevalence of alcohol abuse in first responders can range from 16%- 40% (Milligan–Saville, et al., 2017; Jones, S., 2017; Utzon-Frank, N., et al., 2014).
  - Higher patterns of binge pattern use
  - Influence noted in peer behaviour and workplace culture
- Ruderman White Paper on Mental Health and Suicide of First Responders (2018), one research team examined drinking among female firefighters and found that 40% reported binge drinking during the previous month, and 16.5% of female firefighters who used alcohol

# Diagnosis and Intervention

# Depression vs PTSD vs Adjustment Disorder

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| DEPRESSION | PTSD | Adjustment Disorder |
| --- | --- | --- |
| Low mood and irritability | Low mood and irritability | Low mood and irritability |
| Loss of motivation | Loss of motivation | Loss of motivation |
| Difficulties with sleep | Difficulties with sleep | Difficulties with sleep |
| Change in view of self/low self esteem/guilt | Change in view of self/low self esteem/guilt | Change in view of self/low self esteem/guilt |
| Difficulties with Concentration | Difficulties with Concentration | Difficulties with Concentration |
| Changes in Energy * | | Changes in Energy * |
| Changes in Appetite * | | Changes in Appetite * |
| Hopelessness or suicidal ideation | | Hopelessness or suicidal ideation |
| Anxiety symptoms* | | **Anxiety Symptoms *** |

# Distinguishing by Stressor

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- Depression: not defined
- Adjustment: must be present but not defined
- PTSD : very clearly defined  as actual or threatened death, serious injury, or sexual violence. Stressful events not involving an immediate threat to life or physical injury such as psychosocial stressors are not considered trauma in this definition.
- Chronic vs Acute

# Diagnostic Complexity

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- Trauma exposure does not equate to a PTSD diagnosis
- Cannot predict based on type or volume of exposure
- Many other stressors contributing to illness (moral injury, burnout, organizational betrayal)

Stressful event (s)

Onset of Symptoms

Change in Functioning

# Diagnosis and Intervention

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- Lack of clarity of diagnosis can lead to a mismatch in treatment
- Assumption that main outcome of trauma exposure is PTSD
- Can be tempting to push a diagnosis to get access to care

# Level of Care

# Level of Care

- Functioning vs Severity
- Psychosocial supports/ability
- Preference/comfort

# Levels of Care

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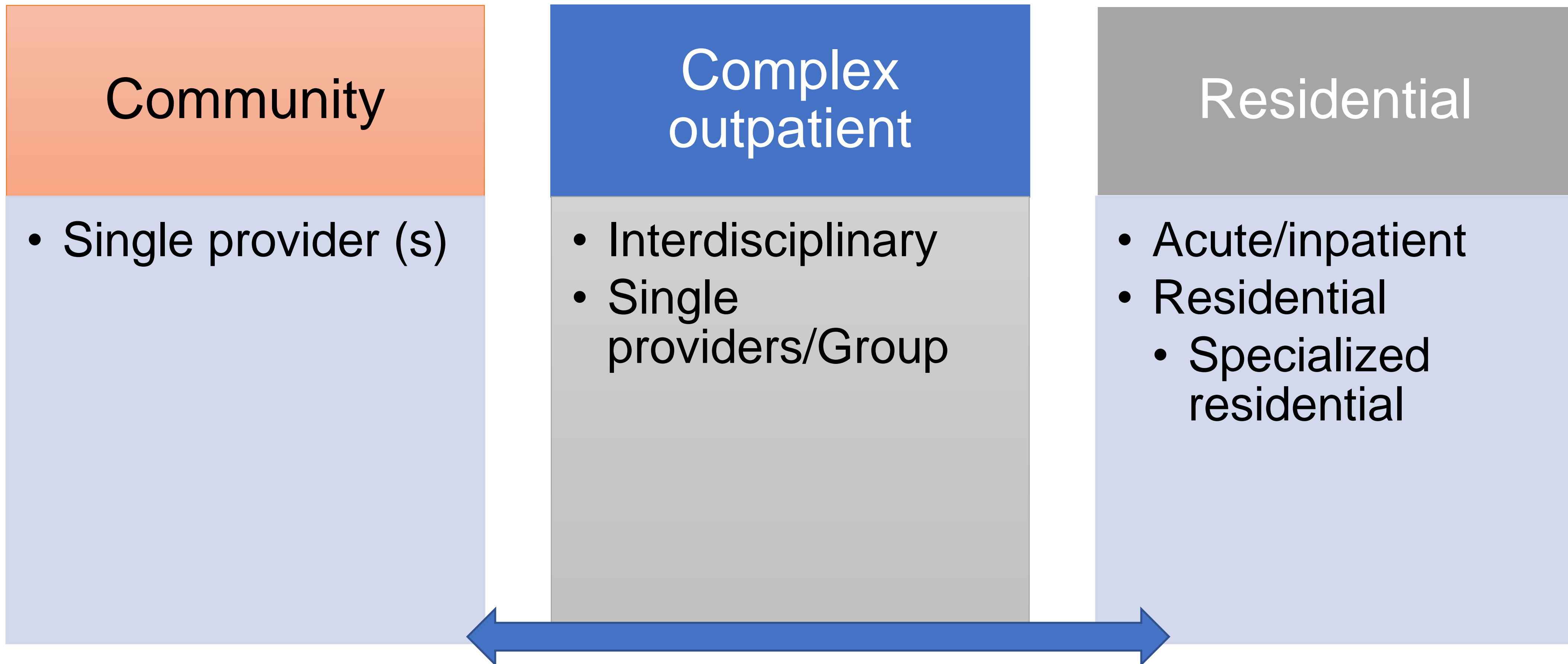

# Level of Care

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- Tend to present later with more complex presentation

- Treatment matching can be challenging
  - Underreporting/stigma
  - Access to complex care
    - Capacity
    - Funding

- Regular Evaluation and Re-evaluation – requires nimble systems of care

# Access

# Access to Care

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# Access to Care

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## Diagnosis Dependent

- Ontario Health Insurance Plan (OHIP), WSIB

## Employer Dependent

- Employee Assistance Program (EAP)

## Related to Workplace Injury (Attribution)

- WSIB

# Limitations

- Availability of diagnosis
- Time limited care
- Lack of specialized services
- Capacity

# Take Home Messages

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- Diagnosis is complex even if trauma is clear: Mood and anxiety disorders higher prevalence than PTSD
- Tend to present with high complexity including high levels of substance use, particularly alcohol
- Treatment matching to suit complexity can be challenging and require careful attention to:
    - Providing the correct diagnosis and matching intervention
    - Determining the correct level of care
    - Supporting access to treatment

# Contact for Questions

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