THE ASSISTANT SECRETARY OF DEFENSE

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HEALTH AFFAIRS

22 Feb 12

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (M&RA)
COMMANDER, JOINT TASK FORCE NATIONAL CAPITAL REGION-MEDICAL

SUBJECT: Guidance for Providers Prescribing Atypical Antipsychotic Medication

Articles in popular media, and the concern of several national and military leaders in recent months, have raised the question of whether certain psychoactive medications are inappropriately prescribed for post-traumatic stress disorder (PTSD) and commonly comorbid conditions. Of greatest concern is the suspicion of the over-prescription of antipsychotic medications for PTSD. Service-wide, antidepressant use was little changed from Calendar Year (CY) 2002 to CY 2009. Service member (SM) prescription rates for atypical antipsychotics, however, increased tenfold, from 0.1 percent to 1.0 percent. Seroquel, an atypical antipsychotic, was prescribed to 1.4 percent of Army SMs and 0.7 percent of Marines in Fiscal Year 2010.

The increase in prescription rate of atypical antipsychotic agents may be attributed to many factors, including the following: the expected increase in use seen after the market release of any medication; the shift in prescribing practices from typical to atypical antipsychotics for bipolar and psychotic disorders; and the use of these medications for "off-label" indications, such as to assist in sleep dysfunction and irritability and/or anger. While off-label drug use is legal and has been an accepted and beneficial practice within the standard of care for many years, atypical antipsychotics are not U.S. Food and Drug Administration-approved treatments for anxiety disorders (including PTSD) or sleep disturbances. Providers should use caution when these agents are used as sleep aids in SMs struggling with substance use disorders, especially given the risk of such side effects as glucose dysregulation and cardiac effects. Providers should offer SMs the lowest risk medication and non-medication therapy options for their symptoms. The Military Health System continues its commitment to define practice boundaries and promulgate optimal prescribing and monitoring regimens by ensuring that Military Treatment Facility (MTF) Commanders' clinical training efforts include guidance for providers prescribing atypical antipsychotic drugs.

MTF Commanders and clinical leaders should be cognizant of the factors associated with the use of atypical antipsychotics and ensure that they have systems in place to monitor prescription and utilization patterns throughout their network, including the use of off-label atypical antipsychotics. MTF Commanders should consider the MTF Pharmacy and Therapeutics Committee's monitoring of providers who prescribe the most off-label antipsychotics and flag these providers for additional peer review. Policy restrictions might include restricting prescribing authority for atypical antipsychotics to psychiatrists only or

requiring that any use of atypical antipsychotics beyond 30 days require a psychiatrist's authorization.

The Military Health System remains committed to the highest quality care for SMs and is committed to ensuring the best possible use of atypical antipsychotic medications consistent with clinical judgment. Please report actions taken to implement this guidance within 60 days of the date of this memorandum.

A summary of PTSD treatment trends and the core learning objectives for provider training for use by the Military Departments are provided in the Attachment. The point of contact is CAPT Michael Colston, M.D. CAPT Colston may be reached at (703) 681-3611, or Michael.Colston@ha.osd.mil.

Jonathan Woodson, M.D.

cc:
Surgeon General of the Army
Surgeon General of the Navy
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Medical Officer of the Marine Corps
Director, Health and Safety, U.S. Coast Guard
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ATTACHMENT

PTSD

Treatment Trends

- Resilience training, non-pharmacological therapies, and medications are the core components of care for Service members who develop PTSD. There is an evidence base for the use of antidepressants (such as the FDA-approved medications Zoloft or Paxil, which clinically, are also anxiolytics) in PTSD treatment, and several other classes of medications are used to treat the condition. A multi-center DoD-VA study is due to assess medication effects in many classes. While recognizing differences in methodology and control group formulation, effect sizes in randomized, controlled trials of SSRIs have generally been smaller than those in psychotherapy trials.
- A VA-DoD Clinical Practice Guideline Update was completed in 2010. It updated algorithms for evaluation and treatment of traumatic stress in multiple settings, including combat and primary care. *(http://www.healthquality.va.gov/Post_Traumatic_Stress_Disorder_PTSD.asp)*
- Current evidence-based treatment of PTSD allows for a balance of medication and therapy options as clinically indicated. The Services are making consistent and sustained efforts to train clinicians in cognitive-behavioral therapy or exposure based therapies such as Prolonged Exposure Therapy or Cognitive Processing Therapy. Such therapies share benefits. They are well tested in military populations. Each is manualized, making it easier to foster competence in clinicians and fidelity to the treatment protocol. Importantly, briefer forms of exposure therapies are being tested, and initial results are promising.
- Training mandates, peer review and best practices, specialty leader communication with clinicians, numerous working groups, GME programs, and defense centers of excellence continue to focus questions and push gains in PTSD treatment on the training and research fronts.

Core Learning Objectives for Provider Training[1]

- Demonstrate the application of treatment models detailed in the 2010 DoD-VA Clinical Practice Guideline (CPG) for Management of Traumatic Stress (http://www.healthquality.va.gov/Post_Traumatic_Stress_Disorder_PTSD.asp)
- Understand that treatment of PTSD might include cognitive-behavioral or exposure-based elements, consistent with best practice standards, in patients who are amenable to therapy.
- Identify PTSD diagnostic criteria; co-morbid conditions; all first line strategies; and the algorithmic treatment model detailed in the 2010 DoD-VA CPGs.
- Demonstrate the application of treatment models detailed in the 2010 DoD-VA Clinical Practice Guideline for Management of Traumatic Stress.

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[1] Each MTF Commander is encouraged to implement provider training in the treatment of PTSD in addition to or within the context of training for providers prescribing antipsychotic drugs. Additional guidance for provider training regarding PTSD and Acute Stress Disorder is provided in the OASD/HA Memorandum, *Guidance for Mental Health Provider Training for the Treatment of PTSD and ASD,* 13 Dec 2010.