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TURNING THE TIDE:

How Risk and Claims Leadership Are Reversing the PTSD and Disability Crisis Among First Responders

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TURNING THE TIDE:

How Risk and Claims Leadership Are Reversing the PTSD and Disability Crisis Among First Responders

BY JOSEPH SOUSA, CITY OF SAN DIEGO;
DR. TOMER ANBAR, INSTITUTES OF HEALTH &
DAVID PICONE, SAN DIEGO FIRE DEPARTMENT (RETIRED)



A CRISIS ROOTED IN SERVICE AND THE PATH TOWARD RECOVERY

Every day across America, firefighters, police officers, sheriffs, and emergency medical personnel step into danger without hesitation. They are the ones we call in our darkest hours when natural disasters tear through communities, violent crimes shatter lives, and industrial accidents and other tragedies bring chaos and fear. In those moments, they stand between order and catastrophe. But when the sirens fade and the crowds disperse, the danger does not end. For the first responders who confront such devastation, the invisible and insidious impact lingers, etching itself into their memories and their bodies alike. These silent wounds, too often met with indifference or buried in bureaucracy, can shatter the sacred bond of trust with the agency they believed would protect them, leaving them with a profound sense of betrayal.

WHAT DO YOU WANT TO DO?

It is no secret that more first responders die from suicide than in the line of duty (Heiman, et al, 2018). Nor is it a surprise that Post Traumatic Stress Disorder (PTSD), brain injuries, chronic pain, sleep disorders, and substance use have reached epidemic levels in this workforce. What is far less understood, however, is how these conditions are perpetuated, not only by trauma itself, but by the system of care and compensation designed to help.

Delayed or denied access to treatment, denied claims, and adversarial processes are not just bureaucratic hurdles, but rather biological insults that perpetuate disability. They are betrayals that wound both body and soul.

Still, there is hope. Across the country, a new movement is emerging. Led not only by clinicians, this transformation is also being spearheaded by risk managers and claims professionals as they step into a powerful new role and become healers through system leadership.

First responders operate in high-stakes environments that demand rapid decision-making and emotional suppression. Over time, these demands can conflict with deeply held values, leading to what clinicians describe as moral injury. Whether it is being unable to save a child, using force under duress, or seeing a colleague fall, these experiences can rupture one's inner world.

Yet, the trauma does not end at the scene. When workers are denied care or are forced to prove their suffering through adversarial claims processes, it creates a feeling of organizational betrayal, a profound secondary wound inflicted at an extremely vulnerable time. This betrayal corrodes trust, deepens isolation, and reinforces the belief that "no one has my back."

It is not just a psychological issue. Psychoneuroimmunology (PNI) research shows that moral injury and chronic stress disrupt the body's most vital systems, including immune function, cardiovascular regulation, and hormone balance. Elevated levels of cortisol, suppressed natural killer (NK) cell activity, and pro-inflammatory cytokines are common among traumatized responders. These biological changes are not only linked to PTSD and chronic depression, but they are also associated with contributing to the causation of cancer, autoimmune diseases, and accelerated aging.

When injured first responders are trapped in cycles of denied care, untreated trauma, or fragmented treatment, it creates a perfect storm for long-term disability. The consequences are staggering, and those impacted can experience intensified PTSD symptoms, chronic pain and central sensitization; sleep dysfunction and cognitive impairment; substance use and suicidality; and increased cancer, cardiovascular, and chronic disease risk. In short, delays in treatment not only delay recovery but also biologically deepen the damage and trauma.

THE SOLUTION: TRANSDISCIPLINARY BIOPSYCHOSOCIAL THERAPEUTIC COMMUNITIES

Reversing this trajectory requires more than individual therapy or medication. It demands system-wide transformation, including innovative clinical models that treat the whole person.

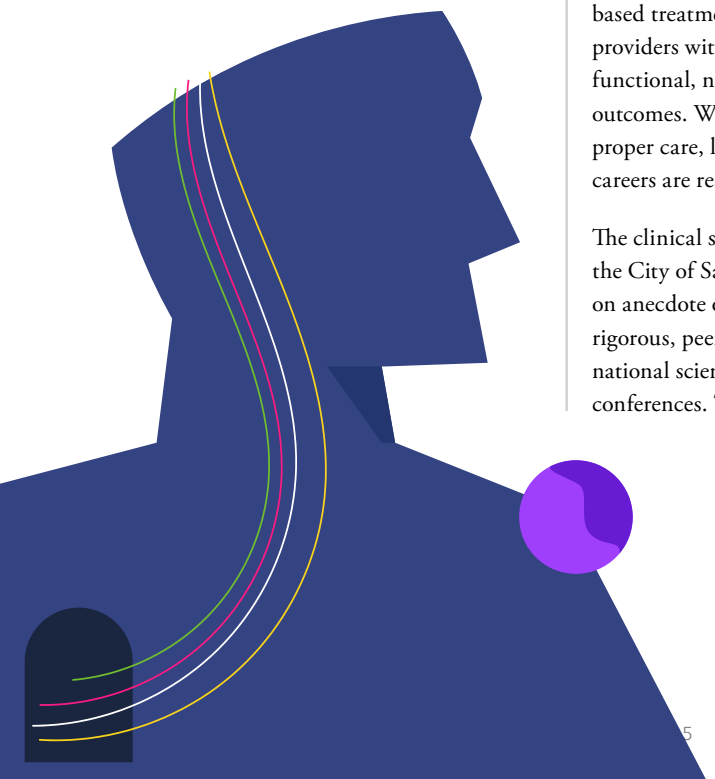
Enter the Transdisciplinary Biopsychosocial Therapeutic Community (TBTC) model. Developed by Institutes of Health (IOH) and implemented in partnership with munici-

palities like the City of San Diego, this model provides an integrated platform where physical medicine and rehabilitation (PM&R) physicians, psychologists, neurologists, psychiatrists, pain and rehabilitation specialists, addictionologists, sleep experts, peer mentors, clinical nutritionists and researchers work in unison to rebuild health from the inside out.

Unlike siloed care, the TBTC model recognizes that PTSD can often be intertwined with undiagnosed brain injuries. Moreover, chronic pain and insomnia amplify trauma responses and impede recovery. Substance use, as a maladaptive coping mechanism, can further complicate the situation and contribute to neurobiological dysregulation.

The TBTC approach heals through structured daily programming, community trust, and biologically informed care that restores nervous system regulation, immune resilience, and psychosocial identity. It is a living model of psychoneuroimmunology in action.

Nowhere is this model more powerfully demonstrated than in the City of San Diego's workers' compensation department. Under the leadership of forward-thinking claims professionals, the city has built a new standard of care that is trauma-informed, data-driven, and outcomes- focused.



Instead of routing first responders through generic networks, the City of San Diego's claims team became trained in recognizing first responder trauma. They built trusted referral pathways with physically vetted clinical programs. These actions ensured patients received rapid access to multi-disciplinary care with facilities demonstrating proven outcomes.

The results were overwhelmingly positive and exceeded expectations. Partnering with IOH and employing the TBTC model, the City of San Diego achieved the following:

- 93.6% of treated first responders with complex PTSD no longer met diagnostic criteria post-treatment.
- 93.6% returned to full duty or modified work.

The City of San Diego workers' compensation team also noted significant reductions in opioid use, polypharmacy, and disability duration. Additionally, clinically validated improvements were also achieved in sleep, cognition, emotion regulation, and pain. These results did not happen by accident but rather because risk leadership aligned with clinical excellence.

While the most overlooked heroes in this recovery revolution may not wear uniforms, they are on the frontlines of healing every day. Risk managers and claims professionals are in the best position to ensure early recognition and referral; approve integrated, evidenced-based treatment plans; direct care to vetted providers with proven results; and track functional, not just symptomatic, recovery outcomes. When these professionals choose the proper care, lives are saved, costs are reduced, careers are restored, and families are preserved.

The clinical success of the partnership between the City of San Diego and IOH is not based on anecdote or aspiration, but rather on rigorous, peer-reviewed research presented at national scientific and occupational medicine conferences. These studies document not only statistically significant improvements in PTSD, pain, and return-to-work outcomes but also illuminate why the TBTC model is producing unprecedented results for injured first responders.

REVERSING PTSD AND DISABILITY IN FIRST RESPONDERS

A study titled "Systematically Reversing Post-Traumatic Stress Disorder and Disability Among First Responders Through a Biopsychosocial Occupational Medicine Program" analyzed treatment outcomes for 62 San Diego first responders treated at IOH (Powell et al., 2025a). The results were groundbreaking:

- 93.6% of patients who completed at least the median number of program hours no longer met diagnostic criteria for PTSD at the end of care.
- 93.6% of the same group had returned to work, compared to only 64.5% among those with lower engagement.
- Each doubling of program hours was associated with a 50% decrease in the odds of persistent PTSD and two times higher likelihood of return-to-work.

These outcomes are not just exceptional. They redefine what is possible in workers' compensation care.

FUNCTIONAL RESTORATION AND MENTAL HEALTH

The TBTC model was further validated in the study "Improving Mental Health by Restoring Physical Health: Addressing Chronic Pain and Behavioral Health Issues Through a Functional Restoration Program" (Powell et al., 2025b). Among 336 patients:

- Each doubling of program participation significantly improved carrying and overhead lift capabilities.
- Increased program hours led to statistically significant reductions in clinically meaningful pain, anxiety, and somatic complaints.
- Odds of clinically significant pain and anxiety dropped by 26% and 23%, respectively, for each doubling of participation.

The TBTC approach heals through structured daily programming, community trust, and biologically informed care that restores nervous system regulation, immune resilience, and psychosocial identity. It is a living model of psychoneuroimmunology in action.

This research confirms that physical recovery and psychological healing are mutually reinforcing when addressed in an integrated way.

TREATING PAIN AS A GATEWAY TO BEHAVIORAL RECOVERY

In the study "Treating Psychosocial Barriers in Patients with Traumatic Brain Injuries in a Transdisciplinary Biopsychosocial Therapeutic Community Model" (Powell et al., 2025d), IOH researchers evaluated 149 patients receiving multidisciplinary TBTC-based care.

- When patients with at least the median number of program hours were compared to patients with fewer than the median number of program hours, patients had significantly (p<0.01) lower physical component summary (PCS) scores at treatment completion if they completed at least the median number of program hours.
- Adjusted analysis found that longer treatment duration was significantly associated with lower likelihood of clinically relevant pain catastrophizing at completion (odds ratio: 0.66; 95% confidence interval: 0.47-0.93).
- There was an average reduction in PCS scores of 35% across all patients. For patients who completed above the median hours, there was a 42% reduction.

This study highlights that a biopsychosocial approach to care has a significant impact on psychosocial barriers to recovery as well as clinical symptoms, allowing for improved self-efficacy, a primary driver in perceived disability and healthcare utilization.

IMPROVING FUNCTION AND REDUCING PERCEPTION OF DISABILITY FOR SUSTAINED RECOVERY

A fourth study, "Reducing Disability in Patients with Traumatic Brain Injuries via a Transdisciplinary Biopsychosocial Therapeutic Community Model Occupational Medicine Program," examined 187 patients across TBTC sites (Powell et al., 2025c). Key insights included:

- Doubling hours of program participation was significantly associated with improved activities of daily living (ADL) function, reduced depression and perceived disability.
- Improvements on the Oswestry Disability Questionnaire (ODQ), 22% on average.
- 30% Increase in ADL function on average.
- 21% reduction in depressive symptoms as measured on the Beck Depression Inventory (BDI).

These outcomes demonstrate that treating psychosocial factors concurrently with physical and cognitive deficits results in significant improvements in both ADL and psychological functioning. According to research, psychosocial factors have a greater impact on chronicity than do clinical findings. Reduced perceptions of disability improve self-efficacy and self-management, leading to reduced dependence on the healthcare system and better long-term functional outcomes.

Presented at major medical and occupational health conferences in 2025, these four independent studies underscore the scientific evidence for the efficacy of the TBTC model. When first responders are immersed in a recovery environment that addresses trauma, pain, sleep dysfunction, substance misuse, and relational trust simultaneously, they do not just stabilize; they recover. They return to their jobs, their families, and their sense of identity.

These outcomes are only possible when risk and claims managers, working in alignment with department leadership and evidence-based clinical providers, commit to the model, vet the clinics, and clear the path to timely, coordinated care.

Outcomes like those achieved through the partnership between the City of San Diego and Institutes of Health do not happen by chance. They are not the result of luck, branding, or one-time heroics. They are the predictable by-product of deliberate, strategic alignment between those responsible for managing organizational risk and those responsible for the lives that risk management is meant to protect.

In workers' compensation, risk managers and claims administrators are often seen as gatekeepers. But when aligned with chiefs, department leaders, and outcome-proven care providers, they become enablers of recovery. This alignment is not just a procedural necessity; it is a moral and operational imperative.

Too often, first responders are sent to providers selected from large medical provider networks (MPNs) or generic vendor networks, without any verification of their ability to reverse PTSD, treat brain injury, or address complex pain. Strategic systems do not settle for that.

The real difference is not just in having the right clinic or the right treatment model but rather in clearing the path so that care can happen at the right time, in the right way, with the right team.

Under the City of San Diego program, clinics are physically visited, medically verified, and performance vetted. The risk team knows where they are sending injured workers. They understand the philosophy, the protocols, and, most importantly, the outcomes. That is how confidence is built. That is how lives are saved.

The first few weeks following an injury or traumatic event are critical. Delayed authorization, siloed evaluations, or adversarial utilization reviews (URs) often push first responders into isolation, pain, and demoralization. The longer the delay, the more entrenched the dysfunction becomes.

But when risk leaders, claims personnel, and clinical partners collaborate from Day 1, the opposite happens. Early screening detects PTSD, brain injury, or comorbid substance use disorder (SUD) before they escalate. Fast-tracked referrals get patients into function-first programs immediately. These actions, alongside coordination with chiefs and supervisors, build a culture of care rather than confrontation. This kind of early, team-based activation is what prevents chronicity and enables transformative recovery.

Another defining factor in the City of San Diego's success has been the willingness of departmental chiefs, including fire, police, lifeguard, and others, to engage directly in the recovery infrastructure. When chiefs understand the care model, trust the providers, and remain engaged with the claims process, the results are remarkable. The leadership and support of chiefs help first responders feel valued, not discarded. Referrals come with leadership endorsement rather than fear. The result is department morale improves as word spreads that "this system actually works."

Chiefs are more than commanders; they are cultural architects. When they align with risk and claims teams, they create systems where care is not delayed, dignity is not denied, and disability is not inevitable.

The City of San Diego model does not rely on hope or anecdotes. It runs on data, reviewed regularly by risk leadership and clinical teams alike. Among the City's key performance indicators are the percentage of patients returning to work, resolution rates of PTSD and chronic pain, reductions in polypharmacy and unnecessary surgeries, and time to medical maximum improvement and cost savings.

By integrating data dashboards and continuous feedback loops, the system self-corrects, improves, and proves its value with every case. This creates mutual accountability—a rare yet powerful dynamic—in the world of injury care.

The real difference is not just in having the right clinic or the right treatment model but rather in clearing the path so that care can happen at the right time, in the right way, with the right team.

That means risk managers are trained in trauma-informed decision-making; claims professionals are empowered to fast-track proven care; chiefs sit at the table and say, "My people deserve better, and I will lead the way"; and clinical providers understand that healing is a system function, not just a treatment outcome. When that alignment occurs, the tide turns. PTSD resolves. Disability declines. Trust is rebuilt. And most importantly, lives and careers are saved.

Joseph Sousa is Workers' Compensation Manager for the City of San Diego; Dr. Tomer Anbar is the CEO of Institutes of Health in San Diego; and David Picone is Battalion Chief, Health & Wellness Specialist with the San Diego Fire Department (Retired).

REFERENCES:

American College of Occupational and Environmental Medicine [ACOEM]. (2024). ACOEM clinical practice guidelines: Chronic pain. Retrieved from https://www.acoem.org

American College of Occupational and Environmental Medicine [ACOEM]. (2024). ACOEM clinical practice guidelines: Post-traumatic stress disorder. Retrieved from https://www.acoem.org

California Department of Industrial Relations, Division of Workers' Compensation. (2021). Annual Report. Retrieved from https://www.dir.ca.gov/dwc

Gatchel, R. J., Reuben, D. B., Dagenais, S., Turk, D. C., Chou, R., Hershey, A. D., … & Horn, S. D. (2014). Research agenda for the prevention of chronic pain and its impact: Report of the National Institutes of Health Pain Consortium Research Task Force. The Journal of Pain, 15(2), 92–100. https://doi.org/10.1016/j.jpain.2013.10.007

Heiman, M, Dill J, Douglas, R. The Ruderman White Paper on Mental Health and Suicide of First Responders, Ruderman Family Foundation, April 2018.

Powell, A. C., Dawson, G., & Anbar, T. (2025, April). Improving mental health by restoring physical health: Addressing chronic pain and behavioral health issues through a functional restoration program [Poster presentation]. American Academy of Pain Medicine Annual Conference, Austin, TX.

Powell, A. C., Sousa, J., Picone, D., Dawson, G., & Anbar, T. (2025, May). Systematically reversing post-traumatic stress disorder and disability among first responders through a biopsychosocial occupational medicine program [Poster presentation]. American Occupational Health Conference, American College of Occupational and Environmental Medicine.

Powell AC, Dawson G, Anbar T. Reducing Disability in Patients with Traumatic Brain Injuries via a Transdisciplinary Biopsychosocial Therapeutic Community Model Occupational Medicine Program. Poster presented at: American Society of Pain & Neuroscience Annual Conference; 2025 July 17-20; Miami, FL.

Powell AC, Dawson G, Anbar T. Treating Psychosocial Barriers in Patients with Traumatic Brain Injuries in a Transdisciplinary Biopsychosocial Therapeutic Community Model. Poster presented at: PainWeek National Conference; 2025 Sep 2-5; Las Vegas, NV.

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2022). Trauma-informed care in behavioral health services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801.

Yehuda, R., Flory, J. D., Southwick, S., & Charney, D. S. (2006). Developing an agenda for translational studies of resilience and vulnerability following trauma exposure. Annals of the New York Academy of Sciences, 1071(1), 379–396.