**NOTE TO USER: This template is intended to give your clinic a head start on developing its own SOP for this topic. The template can quickly be adapted to fit your clinic’s needs, dropping content you do not need and adding anything you feel is relevant. Note that there are several highlighted areas, which should be addressed as you customize this template for your clinic.**

**Subject:** Standard Operating Procedure (SOP) for sub-clinic for PTSD within the [Behavioral Health Clinic] at [Medical Center].

**Purpose:** To establish a sub-clinic for PTSD within the clinic where patients receive a DoD/VA recommended EBP for their conditions.

**References:** [Add any clinic SOPs or Operating Instructions should be referenced in this document]

**1. Objectives.**

1.1. To provide DoD/VA recommended EBPs to as many PTSD patients as possible.

1.2. To provide EBP services in a timely manner (e.g., minimal wait times).

**2. Responsibilities.**

**2.1.** [Clinic Manager] has the overall responsibility for the provision of services and their method of delivery. He/she will determine staffing hours for the clinic population to receive recommended first-line EBP treatments.

**2.2.** [Clinical/Staffing Supervisors] will work with the clinic manager to coordinate staffing schedules. They will support and reinforce the procedures below at leadership, staff, and supervision meetings.

**2.3.** [Providers] are responsible for following the procedures as outlined below.

2.4 [Sub-Clinic Coordinator] can be a designated behavioral health technician that will help to track referrals and availability of providers assigned to the sub-clinic for PTSD. They can also help with scheduling or booking appointments for patients receiving care from the sub-clinic for PTSD.

**3. General.**

**3.1.** The clinic has established a sub-clinic for PTSD. This sub-clinic will be composed of a sub-set of clinic providers who will provide most, but not all, psychotherapy for PTSD patients within the clinic.

**4. Procedures.**

**4.1. Provider list**: The clinic will maintain a list of providers who are in the sub-clinic. These providers are selected by the Clinic Manager and will meet the following qualifications:

**4.1.1.** Trained in one of the DoD/VA EBPs for PTSD.

**4.1.2.** Have sufficient experience in treating PTSD cases with the EBP.

**4.1.3**. Willing to use an EBP as a primary mode of therapy, maintaining fidelity to the treatment protocol.

**4.1.4.** Note that not all providers who meet these qualifications will be included in the sub-clinic, as it will be considered a select group. The clinic manager will determine which providers are rotated in and out of the sub-clinic.

**4.2.** **Provider Templates:** The clinic leadership team will monitor provider templates to ensure that providers in the sub-clinic for PTSD have appropriate number of follow-up appointments.

**4.2.1.** For providers practicing Prolonged Exposure or similar treatments that suggest 90-minute sessions, templates will allow a sufficient number of slots to allow for these longer sessions.

**4.2.2.** Providers will ideally be able to see most PTSD cases weekly or every other week to facility rapid recovery and fidelity to the protocol

**4.3.** **Assigning Intakes**: New referrals who likely have PTSD will preferentially be routed to the sub-clinic providers.

**4.3.1.** While not all new cases will be assigned exclusively to the sub-clinic, the aim is to have most new patients routed to this group of providers.

**4.3.2.** New referrals that mention PTSD or probable PTSD should be booked into an intake with one of the providers from the sub-clinic.

**4.3.2.1.** In cases where the referral information was incorrect (e.g., the patient does not have PTSD), the provider can decide whether they will keep the case or refer to another provider outside of the sub-clinical.

**4.3.2.2.** Clinic staff will err on the side of assigning new referrals with probable PTSD to intakes with sub-clinic providers. This practice may be adjusted if sub-clinic providers run low on intake slots, in which case the referrals who are more questionable should be routed to general clinic providers and then referred to the sub-clinic if found to have PTSD (see below).

**4.3.3.** If a provider outside the sub-clinic completes an intake on a case and determines the patient has PTSD, they should consider referring the case to the sub-clinic.

**4.4.** **Limited referrals to the sub-clinic for PTSD from within the clinic**: Patients who have been seen by another clinic provider may be referred to a provider within the sub-clinic; however, this will happen in the following manner:

**4.4.1.** The referring provider will contact the sub-clinic coordinator (\_\_\_\_\_\_\_\_\_\_) to ask about availability for referral. Providers should not simply book a patient into the next available follow-up with a sub-clinic provider.

**4.4.2.** The sub-clinic coordinator will help locate a provider with availability and see that the patient is booked for an EST. Note, this type of case should not be put into an intake slot within the sub-clinic.

**4.4.3.** Once booked into the sub-clinic, the PTSD patient will be offered a course of an EBP, delivered by a sub-clinic provider.

**4.4.4.** Note that this is not a transfer of care, and thus the primary provider retains overall responsibility for the case. The sub-clinic provider will provide the EBP and document this care, but other administrative and clinical needs (e.g., crisis walk-ins, memos to command, medical boards, etc.) will remain under the primary provider.

**4.4.5.** The primary provider should consider following up with the patient every few weeks during the EBP treatment.

**4.5. Documentation**: Providers with the sub-clinic should use templates that adequately describe the interventions they are using and allow other providers to easily determine that an EBP is being used.

**4.6.** **Assessing Outcomes**: All providers within the sub-clinic treating PTSD cases should be administering the PCL at regular intervals.

**4.6.1.** This data helps with treatment planning, instilling hope and demonstrating progress that the patient can see, and helps the clinic meet DoD standards.

**4.6.2.** PTSD cases should therefore complete a PCL every (Xth) visit.

**4.7.** **Managing Patients who decline EBP treatment**: In general, if approached correctly, most patients will prefer to receive a therapy which has a larger evidence base so that makes it more likely they will recover. There will be patients who hold negative views about a particular therapy and refuse to attempt it.

**4.7.1.** If a patient refuses to try one EBP, they should be encouraged to attempt another EBP they do not have a bias against. For example, if a patient refuses EMDR, consider PE or CPT.

**4.7.2.** If a patient who is being seen within the sub-clinic refuses to initiate or continue with an EBP treatment, the following steps should be considered:

**4.7.2.1.** Providers attempt to motivate the patient to attempt one of the EBPs that are offered within the sub-clinic, using a motivational interviewing approach.

**4.7.2.2.** Patients who consistently decline an EBP may need to be referred to another provider outside of the sub-clinic.

**4.8. Communication**: In order for the PTSD sub-clinic to function, active lines of communication must remain open. The following items should happen to ensure smooth functioning.

**4.8.1.** Sub-clinic providers communicate their caseload levels and template needs (e.g., if more 90 minute slots are needed)

**4.8.2.** When a sub-clinic provider is delivering a course of care for a different primary provider’s patient, they will chart after each session and will let the primary provider know about emergencies. The primary provider should read through the EBP session notes to remain aware of patient progress.

**4.8.3.** All providers (EBP and non-EBP) will clearly communicate the time-limited nature of treatment within the clinic.

1. Point of contact for this SOP: POC name, title, phone number, and email address.