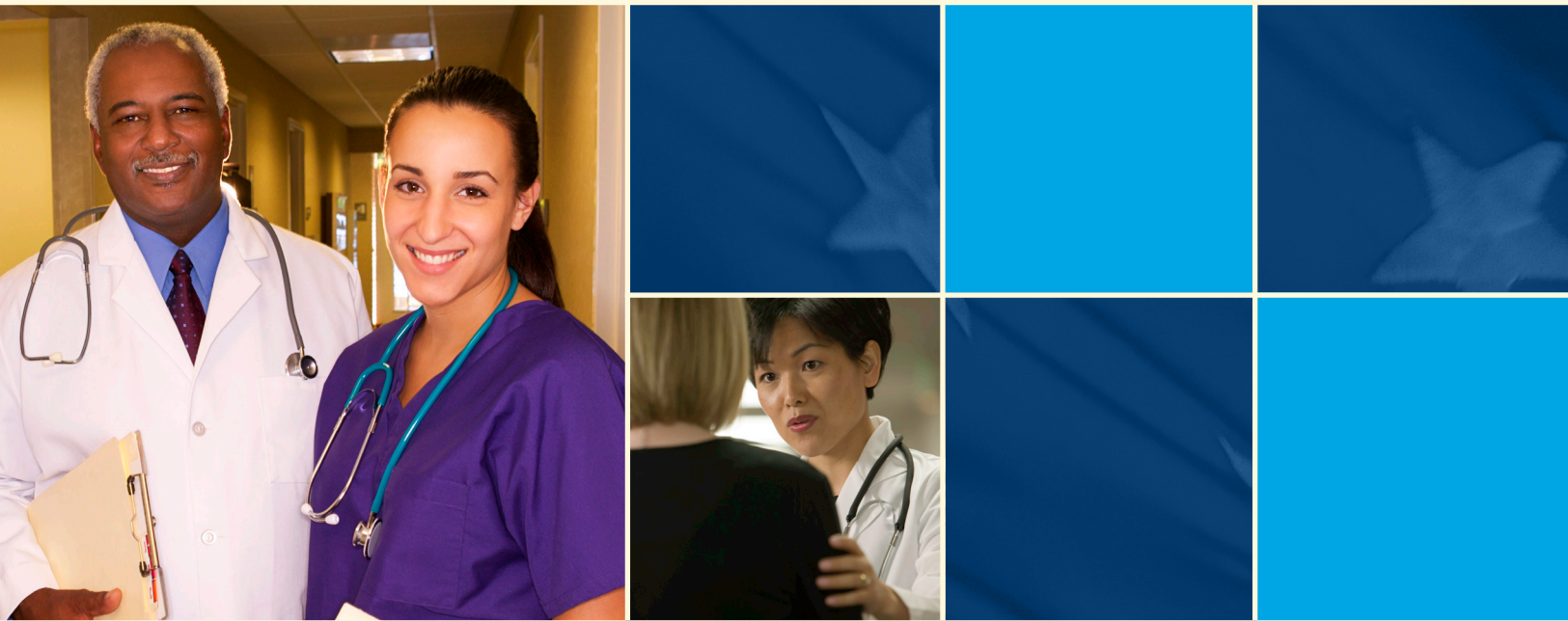




Implementing the 2010 VA/DoD Clinical Practice Guideline for Post-traumatic Stress: A Guide for Clinic Leaders





This tool is intended for use in conjunction with other essential resources including:

- *2010 VA/DoD Clinical Practice Guideline for the Management of Post-traumatic Stress and the Guideline Summary* healthquality.va.gov
- VA/DoD posttraumatic stress disorder (PTSD) clinical support tools including:
 - *Posttraumatic Stress Disorder Pocket Guide*
 - *VA/DoD Essentials for Posttraumatic Stress Disorder: Provider Tool*
 - *Understanding Posttraumatic Stress Disorder*
 - *Experiencing Posttraumatic Stress Disorder as a Family: A Survival Guide*

Clinical Support Tools are available at: <https://www.qmo.amedd.army.mil>



How Can this Guide Help Me?

As an administrator responsible for shaping clinical practices for service members and/or veterans, it is important to provide the highest quality of care appropriate to your treatment setting. The *2010 VA/DoD Clinical Practice Guideline for the Management of Post-traumatic Stress* makes numerous recommendations for care across the post-traumatic stress (PTS) spectrum including combat operational stress reaction (COSR), acute stress reaction (ASR), acute stress disorder (ASD), and acute and chronic PTSD.

The clinical practice guideline (CPG) recommendations can be challenging to implement for clinic managers and program administrators because some patients will experience only part of this PTS spectrum and others will progress through the entire range to develop a PTSD diagnosis. This tool provides practical “quick tips” that correspond with 10 focus areas drawn from the CPG. These straightforward and actionable tips are meant to improve patient outcomes, simplify efforts to implement key CPG recommendations, and encourage the use of evidence-based practices across the Department of Veterans Affairs (VA) and the Department of Defense (DoD).

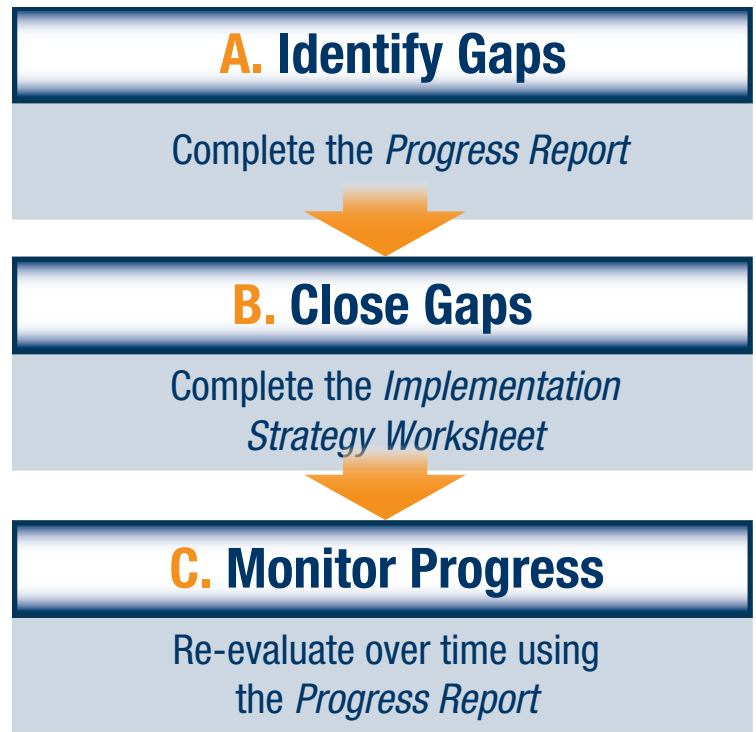
VA and DoD employees who use this information are responsible for considering all applicable regulations and policies throughout the course of care and patient education.

This Guide Will:

- Help you identify ways your clinic’s practices can be more consistent with CPG recommendations
- Describe concrete actions, *Quick Tips* and specific resources to help you improve practices at your clinic related to the PTS continuum of care
- Enable you to evaluate your clinic and help implement changes based on key recommendations from the CPG

Implementation Process

- Use the *Progress Report* to determine which practices within your clinic align with recommendations from the CPG.
- Next, use the *Implementation Strategy Worksheet* to prioritize the items in your implementation plan.
- Finally, use the *Progress Report* to continue to track your clinic's progress over time and identify areas that are incongruent with the CPG.



A: Identify Gaps

Complete the *Progress Report*

Complete the *Progress Report* on pages 3-7 to evaluate your clinic's practices in comparison to the CPG recommendations. The *Progress Report* is organized by topic areas from the CPG. It is designed to help you easily identify, and subsequently prioritize, practice gaps.

The *Progress Report* Can Be Used:

- As part of the three-step process outlined above
- As a stand-alone evaluation tool to identify areas where improvements are needed
- To re-evaluate your clinic over time
- As an education and/or discussion tool to help practitioners and front-line staff identify areas of practice that are inconsistent with the CPG

Use the descriptors on the scale below to help you respond to each item on the *Progress Report* (p. 3-7). Please note items are coded to the appropriate setting (i.e., some items may not be applicable to every setting).

| Never or Rarely | Some of the Time | Most of the Time |
|------------------------|----------------------|--------------------------|
| No process is in place | Inconsistent process | Well-established process |

Progress Report

2010 VA/DoD CPG for the Management of Post-traumatic Stress

Key: Primary Care^{PC} Specialty Care^{SC} Acute Care^{AC}
 Deployed/Operational Setting^{D/OS}

No designation indicates the item applies to all four settings

Progress Rating

| | | |
|-----------------|------------------|------------------|
| Never or rarely | Some of the time | Most of the time |
|-----------------|------------------|------------------|

1. Screening

| | | | | |
|----|---|--|--|--|
| 1. | Patients are screened using a validated instrument (e.g., PC-PTSD, PTSD Brief Screen, PCL-C) | | | |
| 2. | When PTSD symptoms are present, patients are screened for: <ul style="list-style-type: none"> Pre-existing medical conditions Coexisting psychiatric and medical conditions (e.g., substance abuse, depression, mild traumatic brain injury (mTBI)) Psychosocial problems (e.g., financial stressors, relationship issues, family conflict) Dangerousness to self or others | | | |
| | | | | |
| | | | | |
| | | | | |
| 3. | Patients with PTSD symptoms receive assessment for pre-, peri- and post-traumatic risk factors (see CPG Summary, p. 33 for a full list) | | | |

2. Assessment and Diagnosis

| | | | | |
|----|--|--|--|--|
| 4. | Patients (not currently receiving speciality care) with potential PTSD symptoms receive referral for a comprehensive clinical interview (e.g., CAPS) ^{PC, D/OS} | | | |
| 5. | Trauma survivors are assessed for: <ul style="list-style-type: none"> Sleep disturbance Anger/irritability Acute and chronic pain TBI Substance abuse | | | |
| | | | | |
| | | | | |
| | | | | |
| 6. | When possible, family members are included in the assessment process | | | |
| 7. | A diagnosis (or working diagnosis) of PTSD consistent with current DSM criteria is formulated before initiating treatments ^{PC, SC, D/OS} | | | |

^{PC}Care provided in a primary care setting, usually general medical care. Providers may seek consultation from specialty care resources, or in some cases transfer care to specialty care resources, but generally remain responsible for care integration and coordination, providing continuity and integration of health care services

^{SC}Care provided in a behavioral health or mental health clinic, including PTSD clinics (beyond general medical care)

^{AC}Care provided before general medical care or specialty care is available, often in the immediate aftermath of a trauma

^{D/OS}Care provided within a military setting in theater

No designation indicates the item applies to all four settings

3. Prevention

| | | | | |
|-----|---|--|--|--|
| 8. | For patients with significant early symptom levels, especially those meeting diagnostic criteria for ASD, providers consider early brief intervention (4 to 5 sessions) of cognitive-based therapies that includes exposure-based therapy, alone or combined with a component of cognitive re-structuring therapy | | | |
| 9. | Providers routinely provide reassurance to survivors of trauma that what they are experiencing is common | | | |
| 10. | Providers offer follow-up care or specific symptom management (e.g., pain, sleep, anger/irritability) to survivors who are symptomatic, but do not meet the diagnostic threshold for ASD or PTSD | | | |

4. Treatment and Management

| | | | | |
|-----|---|--|--|--|
| 11. | Clinical staff (not including primary care providers) are trained to provide one of the recommended evidence-based, trauma-focused psychotherapeutic interventions that include components of exposure, cognitive restructuring and/or stress-inoculation (e.g., prolonged exposure (PE), stress inoculation training (SIT), eye movement desensitization and reprocessing (EMDR) ^{SC, AC}). Note that 90-minute PE sessions are recommended by the CPG | | | |
| 12. | When the setting allows, patients with PTSD diagnosis are offered referrals to one of the evidence-based treatments ^{PC, AC, D/OS} | | | |
| 13. | Prescribing practitioners are trained on updated CPG for PTSD (2010) Guideline Summary recommendations (see CPG Summary, p. 46-48, 51-53 for updated prescribing recommendations) | | | |
| 14. | Patients diagnosed with PTSD and related conditions are: <ul style="list-style-type: none"> ▪ Evaluated for prescription of selective serotonin reuptake inhibitors (SSRIs) or serotonin norepinephrine reuptake inhibitors (SNRIs) as a first-line treatment ▪ Not prescribed benzodiazepines for PTSD, as they may cause harm ▪ Not prescribed atypical antipsychotics as monotherapy for PTSD, as they are not effective ▪ Not prescribed risperidone as adjunctive therapy for PTSD ▪ Not prescribed anticonvulsants as monotherapy for PTSD, as the existing evidence does not support their use ▪ Not prescribed prazosin as monotherapy for PTSD (prazosin may be used as an adjunctive treatment for nightmares) | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| 15. | When appropriate, behavioral health providers establish an ongoing relationship with primary care service ^{SC, AC, D/OS} | | | |

**Key: Primary Care^{PC} Specialty Care^{SC} Acute Care^{AC}
Deployed/Operational Setting^{D/OS}**

Progress Rating

| | | |
|-----------------|------------------|------------------|
| Never or rarely | Some of the time | Most of the time |
|-----------------|------------------|------------------|

No designation indicates the item applies to all four settings

5. Specific Symptom Management

| | | | | |
|-----|---|--|--|--|
| 16. | Non-pharmacological evidence-based interventions are offered to address specific symptoms, to include use of integrative medicine interventions (e.g., relaxation techniques, acupuncture, yoga, massage) | | | |
| 17. | There are programs available for referring PTSD patients who need anger management | | | |
| 18. | There are programs in place for PTSD patients who need referral, evaluation or therapy related to sleep problems | | | |
| 19. | Practitioners are educated to encourage patients to practice good sleep hygiene | | | |
| 20. | Clinicians are available and educated about how to evaluate patients with pain complaints or refer patients to pain management | | | |

6. Avoid Harm

| | | | | |
|-----|---|--|--|--|
| 21. | Patients are assessed for pre-existing psychiatric conditions (e.g., mood or anxiety disorders, substance use disorders (SUD), psychotic disorders) and for identification of high-risk individuals and groups | | | |
| 22. | With the exception of providing education, avoid routine single or multiple psychological interventions, such as debriefing or formal psychotherapy, for asymptomatic individuals | | | |
| 23. | Patients receive follow-up after acute interventions to determine their status, treatment response and new or additional risk factors that might impact recovery or treatment response | | | |
| 24. | Patients with PTSD symptoms receive safety and dangerousness assessment including assessment of current risk to self or others, as well as historical patterns of risk (e.g., suicidal/homicidal ideation, risk-taking behaviors, medical and psychiatric comorbidities) | | | |
| 25. | Patients with pre-existing psychiatric conditions are referred to behavioral health specialty care when indicated, or referred to an emergency department in consultation with behavioral health specialty care when indicated. Referrals that involve a military chain of command must be in compliance with Department of Defense Instruction 6490 series | | | |

**Key: Primary Care^{PC} Specialty Care^{SC} Acute Care^{AC}
Deployed/Operational Setting^{D/OS}**

Progress Rating

| | | |
|-----------------|------------------|------------------|
| Never or rarely | Some of the time | Most of the time |
|-----------------|------------------|------------------|

No designation indicates the item applies to all four settings

7. Patient and Family Education and Engagement

| | | | | |
|-----|--|--|--|--|
| 26. | The clinic has several educational tools related to PTSD and related conditions available to provide to patients and families (see <i>Resources</i> , p. 22 for web links to clinical support tools) | | | |
| 27. | Patients and family members (where appropriate e.g., where consent is given or as the setting allows) are: <ul style="list-style-type: none"> ▪ Involved in care and treatment planning in PTSD cases ▪ Offered educational interventions (e.g., verbal, written, other) ▪ Enlisted to support the PTSD treatment plan ▪ Provided with opportunities to submit feedback on their treatment experiences (e.g., focus groups, surveys, satisfaction ratings) | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

8. Referral, Reassessment and Follow-Up

| | | | | |
|-----|--|--|--|--|
| 28. | Patients are referred for specialty care appointments (e.g., pain, substance abuse, TBI, sleep or behavioral health) when indicated | | | |
| 29. | Providers perform a brief PTSD symptom assessment at each treatment visit | | | |
| 30. | Reassess treatment progress at least every 90 days using an evidence-based measure of PTSD symptomatology (e.g., PCL) | | | |
| 31. | Patients with complicated psychiatric or psychological presentations (e.g., co-occurring conditions) are referred to specialty care (e.g., behavioral health) | | | |
| 32. | Clinic has established relationships with clinical partners (e.g., primary care, pain clinic, chaplains, rehabilitative services) | | | |
| 33. | Clinic has procedures for tracking complex PTSD cases within and across departments (e.g., procedures are in place to reinforce appropriate referrals from primary care) | | | |

**Key: Primary Care^{PC} Specialty Care^{SC} Acute Care^{AC}
Deployed/Operational Setting^{D/OS}**

Progress Rating

| | | |
|-----------------|------------------|------------------|
| Never or rarely | Some of the time | Most of the time |
|-----------------|------------------|------------------|

No designation indicates the item applies to all four settings

9. Provide Adjunctive Services and Psychosocial Rehabilitation

| | | | | |
|-----|--|--|--|--|
| 34. | Practitioners regularly collaborate with appropriate adjunctive services (e.g., regular meeting times, memoranda of understanding, interdisciplinary team meetings): | | | |
| | ▪ Chaplaincy | | | |
| | ▪ OIF/OEF Program Managers | | | |
| | ▪ Case Managers | | | |
| | ▪ Vocational Rehabilitation | | | |
| | ▪ Vet Centers | | | |
| | ▪ TBI Service | | | |
| | ▪ Substance Abuse Clinic | | | |
| | ▪ Pain Management Clinic | | | |
| | ▪ Military Family Support Centers (e.g., Navy Fleet and Family Support Centers (FFSC), Air Force Family Support Centers (FSC), Army Community Service (ACS) Centers, Marine Corps Community Services (MCCS)) | | | |
| 35. | Patients have access to spiritual care when requested | | | |
| 36. | Providers facilitate access to social support and provide assistance to improve social functioning when indicated | | | |

10. Training and Supervision

| | | | | |
|-----|--|--|--|--|
| 37. | An ongoing PTSD training plan with identified goals specific to differences in specialty area is established (e.g., continuing medical education for prescribing practitioners, education on evidence-based treatments for psychotherapists) | | | |
| 38. | There is an established supervision and/or peer consultation capability within the PTSD treatment setting to support evidence-based practices | | | |
| 39. | Educational activities include ASD/PTSD treatment, skills practice, post-training supervision or peer consultation | | | |
| 40. | Discussion of the CPG is integrated into staff meetings and trainings | | | |
| 41. | Staff is given feedback on their progress towards evidence-based practice for PTSD (e.g., external consultation, internal peer consultation, consultation with outside resources such as trainers) | | | |
| 42. | Staff has access to the CPG and corresponding clinical support tools | | | |
| 43. | Practices are periodically reviewed for consistency with the CPG | | | |
| 44. | Practitioners are aware of national consultation resources (see p. 17, <i>Quick Tips for Referral</i>) | | | |



B: Close the Gaps

Review *Quick Tips* in this Section to Complete the *Implementation Strategy Worksheet*

Use your answers from the *Progress Report* to complete the *Implementation Strategy Worksheet* on the following page. Note that the recommendations included in this document pertain to both primary care and specialty care settings.

The checklists and *Quick Tips* that follow the worksheet (starting on p. 10) correspond to the *Progress Report* and can help you develop your implementation strategy and identify which areas are the top priorities in your clinic. Involve your entire health care team (and when appropriate, patients, families and other stakeholders) in the implementation process.

Focus your initial implementation strategy (use your clinic's process improvement policy) on items from the *Progress Report* that:

- **May cause harm (section six)**
- **Are marked either “never or rarely” or “some of the time”**
- **Can be easily implemented**
- **Involve items from the treatment and management medication section (section four, #14 specifically)**

Implementation Strategy Worksheet

| Key CPG Element | Gaps in Current Practice | Person Responsible for Action | Action to Close Gaps | Target Date to Complete |
|--|--------------------------|-------------------------------|----------------------|-------------------------|
| 1. Screening | | | | |
| 2. Assessment and Diagnosis of PTSD and Related Conditions | | | | |
| 3. Prevention | | | | |
| 4. Treatment and Management of PTSD and Related Conditions | | | | |
| 5. Specific Symptom Management | | | | |
| 6. Avoid Harm | | | | |
| 7. Patient and Family Education | | | | |
| 8. Referral, Reassessment and Follow-Up | | | | |
| 9. Provide Adjunctive Services and Psychosocial Rehabilitation | | | | |
| 10. Training and Supervision | | | | |

1. Screening

The CPG makes a number of screening recommendations across the PTS spectrum. Please refer to the CPG algorithm to optimize quality of care and clinical outcomes, and to identify critical decision points regarding screening, diagnosis, follow-up, treatment and referral.



Quick Tips for Screening

Within primary care, all new patients should be screened for symptoms of PTSD initially and then on an annual basis, or more frequently if clinically indicated (e.g., recent trauma exposure, history of PTSD).

Use validated instruments to screen for PTSD. The CPG references the following tools which have been validated and can be considered for use (see *Resources*, p. 22 for links to screening instruments):

- *Primary Care-PTSD (PC-PTSD) (not for specialty care)*
- *PTSD Checklist (PCL)*
- *PTSD Brief Screen*

Recognize that medical disorders or symptoms, behavioral health disorders and psychosocial problems commonly exist with PTSD. Screen for these during the evaluation and treatment of PTSD (e.g., TBI, substance abuse, depression, social problems, occupational difficulties). Refer patients with complicated comorbidities to specialty treatment (e.g., mood or anxiety disorders, SUD, severe personality disorders, psychotic disorders).

2. Assessment and Diagnosis of PTSD and Related Conditions

PTSD is frequently under-recognized and therefore often left untreated. Patients who are presumed to have symptoms of PTSD or who are positive for PTSD after the initial screening should receive a thorough assessment of their symptoms as well as a functional assessment to guide accurate diagnosis and appropriate decision-making. The assessment should include discussion to determine the presence or absence of:

- Other past trauma exposures in addition to the index trauma
- Existence of social supports and ongoing stressors
- Risk factors for developing PTSD (see CPG Summary, p. 33 for a full list)
- Suicidality and other high-risk behaviors (e.g., smoking, alcohol and/or drug abuse, unsafe weapon storage, dangerous driving, unsafe sexual activity)
- Psychosocial functioning (e.g., coping skills, life stress, financial resources, legal issues, psychiatric history)
- SUD, including nicotine dependence (recommended and offered cessation treatment for nicotine dependence)



Quick Tips for Assessment and Diagnosis of PTSD

Provide practitioners with clinical support tools such as:

- *Posttraumatic Stress Disorder Pocket Guide*
- *VA/DoD Essentials for Posttraumatic Stress Disorder: Provider Tool*

Consider using a validated, self-report screening instrument (e.g., the PCL) to promote systematic, standardized and efficient review of the patient's symptoms and history of trauma (see *Resources*, p. 22 for links to PDF forms and more information on evidence-based assessment and screening instruments).

Integrate templates (paper or electronic) consistent with the CPG into clinical records to help staff access evidence-based diagnostic, assessment and referral criteria and to aid in treatment planning.

3. Prevention

The CPG addresses both primary and secondary prevention. **Primary prevention** activities include efforts to support psychological resilience prior to trauma exposure through preparation and promotion of psychological hardiness. Identification of high-risk persons is also a primary prevention strategy which includes the type, frequency and duration of trauma as well as assessment of social support and stressors. **Secondary prevention** is used to identify individuals at risk for development of PTSD after trauma exposure through screening, identification of traumatic stress-related symptoms and an initial assessment of symptom severity.



Quick Tips for Prevention of PTSD

- Provide reassurance to survivors that what they are experiencing is common.
- Provide psychological first aid and ensure basic needs are met.
- Provide patient education (and family education when possible) about common reactions following trauma, coping strategies, as well as contact information, should symptoms emerge later.
- Consider evidence-based screening or comprehensive assessment with a behavioral health provider or representative from PTSD clinic, if available.
- Facilitate social support (e.g., consider family involvement in treatment).
- Manage specific symptoms (e.g., pain, sleep, anger).
- Ensure access to evidence-based cognitive-behavioral intervention for ASD.
- Triage and refer patients to appropriate services when necessary.

4. Treatment and Management of PTSD and Related Conditions

The choice of a specific approach should be based on the severity of the symptoms, clinician expertise and patient preferences. Treatment should be initiated after education, normalization and psychological first aid have been provided and after basic needs following trauma have been addressed, if symptoms are severe or persist.

Treatment of ASD and PTSD with Therapy

Practitioners who have been trained in the particular method of treatment should provide ASD and PTSD psychotherapies.

For ASD: Consider early brief intervention (four to five sessions) of cognitive-based therapy that includes components of prolonged exposure or cognitive restructuring therapy for patients with significant early symptom levels, especially those meeting diagnostic criteria for ASD.

For PTSD: Patients should be offered one of the evidence-based, trauma-focused psychotherapeutic interventions that include components of exposure, cognitive restructuring, relaxation/stress modulation and psychoeducation.

Patient preferences along with provider recommendations should drive the selection of treatment interventions in a shared and informed decision-making process.

Treatment of ASD and PTSD with Medication

It is highly recommended that you consult the **2010 VA/DoD CPG, Guideline Summary (p. 46-48, 51-53)** for prescribing recommendations and when appropriate consult the DoD policies and guidance for the most up-to-date prescribing information. These recommendations will help you provide appropriate training for physicians and other prescribing practitioners. Additional recommendations for prescribing for specific PTS or PTSD symptoms (e.g., sleep, pain, anger, irritability) should also be reviewed. Medication should be used in conjunction with psychotherapy in some cases.

Evidence suggests that if identification of PTSD takes place early, quick referral to treatment may shorten the severity of functional impairment.



DOs and DON'Ts of Evidence-based Prescribing for PTSD and ASD

(consult CPG Summary, p. 46-47, 51-53 for the most up-to-date information)

DO:

- **Do** assess whether the patient has access to and is adhering to current medications as prescribed.
- **Do** offer patients diagnosed with PTSD SSRIs or SNRIs if not contraindicated.
- **Do** consider mirtazapine, nefazodone, tricyclic antidepressants (amitriptyline and imipramine), or monoamine oxidase inhibitors (phenelzine) for treatment of PTSD with appropriate prescribing cautions.
- **Do** recommend adjunctive treatment with prazosin for sleep/nightmares (Note: Prazosin is not recommended as a monotherapy for PTSD).
- **Do** consider short courses of medication (< six days) targeted for specific symptoms (e.g., sleep disturbance, management of pain, irritation, excessive arousal or anger).
- **Do** consider interventions such as relaxation and breathing techniques. These can be used to address specific symptoms such as sleep, pain, hyperarousal and anger.
- **Do** educate patients about medication side effects.

DON'T:

- **Don't** prescribe benzodiazepines in PTSD management as it **MAY CAUSE HARM. Strongly recommend against the use of benzodiazepines for prevention of ASD or treatment of PTSD.**
- **Don't** prescribe guanfacine or anticonvulsants (e.g., tiagabine, topiramate, valproate) as monotherapy in the management of PTSD.
- **Don't** prescribe prazosin as a monotherapy in the management of PTSD – the existing evidence does not support the use of prazosin as a monotherapy in the management of PTSD.
- **Don't** prescribe bupropion, buspirone, trazadone, anticonvulsants or typical or atypical antipsychotics as monotherapy in the management of PTSD – the existing evidence does not support their use for PTSD. Typical antipsychotics have unknown benefit in PTSD.
- **Don't** prescribe risperidone as adjunctive therapy for PTSD – there is insufficient evidence to recommend for or against the use of other atypical antipsychotics as an adjunctive therapy for the treatment of PTSD.
- **Don't** prescribe a sympatholytic or an anticonvulsant as an adjunctive therapy for treatment of PTSD – there is insufficient evidence to support their use.

Complementary and Alternative Medicine (CAM):

There is insufficient evidence to recommend CAM approaches as first-line treatments for PTSD. However, providers may consider referral for alternative care modalities to address patient symptoms, consistent with available resources and resonant with patient belief systems. Providers should discuss the evidence and effectiveness, risk and benefits of different options, and ensure that the patient is appropriately informed. The CPG makes the following recommendations:

- CAM approaches that facilitate a relaxation response (e.g., yoga, acupuncture, massage) may be considered for adjunctive treatment of hyperarousal symptoms, although there is no evidence that these are more effective than standard stress inoculation techniques.
- CAM approaches may be considered as adjunctive approaches to address some comorbid conditions (e.g., acupuncture for pain).
- CAM may facilitate engagement in medical care and may be considered in some patients who refuse evidence-based treatments.

5. Specific Symptom Management

Patients with PTSD who experience clinically significant symptoms, including chronic pain, insomnia or anxiety, should receive symptom-specific management interventions. The CPG makes recommendations about the following symptoms which are common in patients presenting with PTSD:

- Sleep disturbance
- Pain
- Irritability, severe agitation or anger

Sleep Disturbance: Survivors of trauma may not complain directly about PTSD symptoms, such as re-experiencing or avoidance, which may affect sleep. Instead, they may complain of “sleeping problems” (e.g., nightmares, insomnia). Therefore, it is important to ensure that processes are in place to assess for and identify PTSD at multiple encounters within the continuum of care. When seeking to identify PTSD, the primary care team should ask specific questions about sleep problems.



Quick Tips for Management of Sleep Disturbance

- Encourage patients to practice good sleep hygiene.
- Offer cognitive-behavioral therapy for insomnia.
- Consider *adjunctive* treatment for nightmares using prazosin (prazosin is not recommended as a monotherapy for PTSD).
- Significant changes in sleep patterns should trigger re-assessment to rule out worsening or onset of new comorbid conditions.

Pain: Chronic pain and PTSD frequently co-occur. People with both PTSD and chronic pain tend to have greater distress and impairment compared to those with only one of these conditions, and assessment and treatment of co-occurring conditions are more complicated. It is important to assess for pain (acute and chronic) in the examination of patients with ASD or PTSD and to consider how pain symptoms and PTSD symptoms influence one another.



Quick Tips for Pain Management

- Assess for pain in patients with PTSD; assessment should include evaluation of the effect of pain on function, pain-related disabilities and interferences with daily activities.
- Use a 0-10 scale to rate pain.
- When appropriate, discuss potential use of non-pharmacological evidence-based modalities such as biofeedback.
- Discuss use of cognitive-behavioral therapy for pain management.



Irritability, Severe Agitation or Anger: To improve treatment effectiveness, clinicians need to assess veterans' and service members' anger, aggression and alcohol use. Clinicians should be aware that patients who struggle with anger issues often experience troubled relationships or legal problems.



Quick Tips for Management of Irritability, Severe Agitation or Anger

- **Avoid prescribing benzodiazepines.**
- Make the distinction between perceived anger and expressed aggression.
- Consider referral to specialty care for counseling, anger management, or training in exercise and relaxation techniques.
- Promote sleep and relaxation.
- Promote enjoyable activities especially with family and loved ones.
- Address pain.
- Consider SSRIs/SNRIs; secondarily, consider low-dose anti-adrenergics.
- Assess carefully for substance abuse.



6. Avoid Harm

The 2010 VA/DoD CPG for the Management of PTS and the 2010 VA/DoD CPG for the Management of PTS Guideline Summary provide a number of evidence-based recommendations to help practitioners avoid harm to patients. As you review your *Progress Report* (p. 3-7) and complete your *Implementation Strategy Worksheet* (p. 9), use the checklist below to prioritize items that involve the potential for harm and consider where training of staff is needed (specific recommendations regarding pharmacological treatments are found in the “DOs and DON’Ts of Evidence-based Prescribing for PTSD and ASD,” p. 12).



2010 VA/DoD CPG for the Management of PTS Guideline Summary Recommendations for Preventing Harm to Patients

- In operational settings, assess service member’s functional status, document symptoms of combat operational stress reaction (COSR), and consider the service member’s role, functional capabilities and the complexity and importance of their job.
- Follow up to determine patient status after acute intervention; follow-up should include assessment of treatment response (e.g., worsening, dangerousness, maladaptive coping, deterioration of function).
- Help to ensure basic needs are met and provide psychological first aid.
- Routine single or multiple psychological interventions beyond education for trauma survivors who exhibit no symptoms are NOT effective and may be harmful.
- Routine debriefing or formal psychotherapy has shown no evidence for benefit to asymptomatic individuals and may be harmful.
- Assess patients for pre-existing psychiatric conditions to identify high-risk individuals and groups (see CPG Summary, p. 33 for a full list of pre-, peri- and post-traumatic risk factors).
- Follow up to determine emergence of any new or additional risk factors (e.g., poor social support, loss of resources, poor coping skills).
- All patients with PTSD should be assessed for safety and dangerousness, including current risk to self or others, as well as historical patterns of risk.
- Refer patients with pre-existing psychiatric conditions to behavioral health specialty care. When a military chain of command is the originating source of a referral or of an emergency command consultation, ensure process is in compliance with DoD 6490 series.
- When assessing trauma exposure, the clinician must consider the patient’s ability to tolerate the recounting of traumatic material since it may increase distress or exacerbate PTSD symptoms.



7. Patient and Family Education and Engagement

The goal of patient and family education is to promote engagement in care, shared decision-making and participation in evidence-based treatment.

Some topics to address when providing patient and family education include:

- PTSD symptoms
- Comorbidity with other symptoms
- Consequences of exposure to trauma
- Practical ways of coping
- The nature of treatment
- Process of recovery

Profound social impairment can result from having PTSD and can impact relationships with close friends and family. For this reason, education, as well as supplemental couples or family treatment, is frequently recommended in addition to individual treatment. The CPG for PTS does not recommend for or against family or couples therapy as a first-line treatment for PTSD. Either may be considered in managing conflict or family disruption, increasing support or improving communication.



Quick Tips for Providing Patient and Family Education

- Ensure that your clinic has several PTSD education tools to distribute to patients and families. VA/DoD clinical support tools include:
 - *Understanding Posttraumatic Stress Disorder*
 - *Experiencing Posttraumatic Stress Disorder as a Family: A Survival Guide*
- Utilize available materials such as pamphlets, brochures, websites and mobile applications (e.g., PTSD Coach for patients and family members, [ptsd.va.gov](https://www.ptsd.va.gov)).
- Involve patients and families (with patient consent) in treatment planning.
- Manage patient expectations about PTSD symptoms and/or treatment.
- Use motivational interviewing to encourage patients and families to use evidence-based treatments.
- Provide support groups for families and encourage family involvement in care.
- Educate staff to provide brief educational interventions related to seeking help (e.g., stigma) and encourage patients to seek evidence-based treatment.
- Provide patients with emergency contact numbers for local resources.
- When patients demonstrate remission, educate them about indications for future access to care should symptoms recur.

8. Referral, Reassessment and Follow-Up

Veterans and service members with PTSD are frequently challenged by co-occurring diagnoses and/or problems in addition to multiple psychosocial stressors. Therefore, the CPG stresses the importance of creating a collaborative environment that provides coordinated care seamlessly across disciplines, with all available resources enlisted to promote patient welfare.



Quick Tips for Referral

- Provide adequate opportunities to establish collaboration and integration between resources (e.g., ongoing multidisciplinary treatment planning, involving the patient in treatment planning, interdisciplinary meetings).
- Establish protocols for tracking complex, high-intensity patients or patients at high-risk for harm to self or others.
- Ensure that patients are provided appropriate contact information to access the clinic where they can receive care.
- Establish appropriate referral or consultation guidelines coordinating the care provided to patients across multiple treatment teams (e.g., pain, TBI, PTSD).
- Ensure provider awareness of national resources for consultation (e.g., National Center for PTSD, Center for Deployment Psychology, Defense and Veterans Brain Injury Center, Deployment Health Clinical Center, inTransition Program).



Quick Tips for Reassessment and Follow-Up

- Perform a brief PTSD symptom assessment at each treatment visit.
- Consider using validated PTSD symptom measures, such as the PCL.
- For patients diagnosed with PTSD, conduct comprehensive reassessment and evaluation of treatment progress at least every 90 days or with greater frequency for those in active treatment. Specific areas of treatment focus should also be reevaluated by standardized outcome measures (e.g., substance abuse, depression).
- Track scores over time to create a longitudinal record of symptom severity (e.g., using PCL), help identify environmental precipitants of PTSD, and identify symptom worsening.
- Strongly consider an evidence-based measure of depression symptomatology (e.g., PHQ-9).
- Obtain detailed contact information from patients and families to facilitate outreach and follow-up.
- Offer follow-up to:
 - Individuals who request it
 - Those at high-risk of developing adjustment difficulties following trauma

9. Provide Adjunctive Services and Psychosocial Rehabilitation

Some patients with chronic PTSD may develop persistent incapacitating problems as well as functional impairment (e.g., problems with work or daily activities). These patients may benefit from case management and psychosocial rehabilitation in order to generalize PTSD coping skills from the clinic to their home, work or community.

An integrated model which coordinates clinical and adjunctive services has the potential to reduce stigma associated with help-seeking. Meeting the physical, behavioral health and psychosocial needs of patients in a single setting with a multi-disciplinary care team is more efficient than obtaining care from multiple providers in different locations.

Adjunctive Problem-focused Methods and Services for PTSD

| If the Patient and Provider Together Conclude That the Patient: | Service or Training |
|---|--|
| Is not fully informed about aspects of health care needs and does not engage in high-risk behaviors (e.g., substance use) | Provide patient education |
| Does not have sufficient self-care and independent living skills | Refer to self-care or independent living skills training services |
| Does not have safe, decent, affordable or stable housing that is consistent with treatment goals | Consult with case management or social work |
| Does not have a family or network that is actively supportive and/or knowledgeable about treatment for PTSD | Implement family skills training |
| Is not socially active | Implement social skills training or discuss benefit of social support for PTSD treatment |
| Does not have a job that provides adequate income and/or fully uses his/her training and skills | Implement vocational rehabilitation training |
| Is unable to locate and coordinate access to services, such as those listed above | Consult with case management or social work |
| Desires spiritual support | Consult with chaplaincy and/or similar resources |

10. Training and Supervision

Most implementation plans will involve staff training. One of the primary goals of the CPG is to increase staff knowledge about the practices recommended in the guideline. As part of your initial evaluation, identify gaps in training at your clinic and consider establishing a training plan that ensures:

- CPG distribution to all staff
- Scheduled and protected time for providers to participate in PTSD-related training
- Supervision for providers, using either local subject matter experts or peer supervision approaches
- Education for staff on the CPG
- Identification of PTSD-related training resources, to include access to local experts, national and regional training initiatives and online continuing education resources
- Plans for long-term training of staff (current and incoming), along with opportunities for continuing education
- Procedures specific to your clinic related to PTSD treatment



Quick Tips to Implement Changes and Monitor Progress

- Identify current gaps in staff training and conduct basic training.
- Distribute CPG and CPG Summary Guidelines and corresponding PTSD clinical support tools to staff (see *Resources*, p. 22).
- Develop a list of items pertaining to the CPG that can be included for discussion at staff meetings, for example:
 - Management of specific symptoms.
 - Assessment of risk factors for ASD or PTSD.
 - Pharmacological treatment of PTSD and related conditions.
 - Referral procedures.
- Conduct continuing education refreshers for providers to be held at the clinic site.
- Establish procedures to help staff members learn the CPG and new procedures.
- Formulate policies that enable clinicians to apply evidence-based treatment management decisions.
- Hold meetings with clinic leaders and clinicians using the CPG to examine sample cases.
- Establish supervision and/or peer supervision procedures within the treatment setting.
- Provide ongoing support and incentives for staff to learn evidence-based treatments.
- Promote educational activities that focus on best practices and include skills practice and post-training peer supervision.
- Provide staff with feedback on their performance and provide reminders to staff about evidence-based practices.
- Identify appropriate online training materials and encourage use (see *Resources*, p. 22).
- Establish an ongoing education plan.
- Implement ways to prevent and assess for staff burnout.



C: Monitor and Re-evaluate Using the *Progress Report*

Use the *Progress Report* as a way of monitoring and communicating your progress towards goals. As you continue to compare your practices with the recommendations from the CPG, continue to adapt your implementation plan as you receive new information.

As you begin to implement changes:

- Focus your improvement efforts on the areas of the *Progress Report* (e.g., screening, assessment, treatment) where there are items marked “never or rarely” or “some of the time”
- Using your clinic’s process improvement procedures, use objective outcome measures to help quantify and determine whether you are making progress towards your goals
- Re-evaluate your progress after an established time period
- Continue using the *Progress Report* to evaluate whether your practices are improving; over time you should see more check marks in the “most of the time” column
- Seek patient and family input into the effectiveness of your programs and identify potential areas that need improvement

Utilize your clinic’s process improvement model when implementing CPG recommendations. You may find it useful to put an objective program evaluation system in place, which means you will need to determine how you will measure treatment outcomes related to the key focus areas within your clinic. You can utilize the data in conjunction with the *Progress Report* to continue to evaluate your program and make necessary adjustments to your procedures and processes.

For more information on process improvement and on choosing metrics to evaluate your program please refer to the following documents:

- *“Putting Practice Guidelines to Work in the Department of Defense Medical System: A Guide for Action”* (<https://qmo.amedd.army.mil>)
- *“Putting Clinical Practice Guidelines to Work in VHA”* (healthquality.va.gov)



Quick Tips

- Conduct a pre-change self-assessment using the *Progress Report*, p. 3-7.
- Use the *Progress Report* to prioritize implementation items and complete the *Implementation Worksheet* (p. 9).
- Establish metrics appropriate to your setting to monitor and track progress towards implementation goals.
- Establish a time frame to regularly monitor your progress.
- Make implementation goals a regular topic of discussion during staff and leadership team meetings.
- Utilize all stakeholders, including patients, families and front-line staff, to provide feedback, monitoring and supervision as appropriate.
- Ensure there is a plan for ongoing training and certification for staff.
- Be prepared to adapt your implementation plan based on feedback and monitoring.
- Commit necessary resources (e.g., human, financial, space, attention).
- Re-design clinic procedures and policies to promote use of evidence-based practice.



SUMMARY

Implementation of the 2010 VA/DoD CPG for PTS requires planning, teamwork and a sustained and focused effort. Commitment to the implementation process and fidelity to evidence-based practices for the treatment of PTSD and related conditions will facilitate the best possible treatment for service members and veterans across the DoD and VA.

Resources

Assessment Instruments:

ptsd.va.gov

Center for the Study of Traumatic Stress:

cstsonline.org

Clinical Practice Guidelines:

healthquality.va.gov

Clinical Support Tools:

<https://www.qmo.amedd.army.mil>

Posttraumatic Stress Disorder Pocket Guide: To Accompany the VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress

VA/DoD Essentials for Posttraumatic Stress Disorder: Provider Tool

Understanding Posttraumatic Stress Disorder

Experiencing Posttraumatic Stress Disorder as a Family: A Survival Guide

PTSD Coach Smart Phone APP and Breathe2Relax Smart Phone APP: t2health.org

Deployment Health Clinical Center:

<https://www.pdhealth.mil>

Example Policy Memorandum:

Department of the Navy; Chief of the Bureau of Medicine and Surgery; Implementation of the Post-deployment Health Clinical Practice Guideline, Example pdhealth.mil/BUMED_6450_implementation_of_post-deployment.pdf

Online Evidence-based Training Resources:

Evidence-based Clinical Practice Guideline, Quad-fold pamphlet, and National Center for PTSD homepage healthquality.va.gov

Center for Deployment Psychology Online Courses, deploymentpsych.org

RESPECT–Mil:

<https://www.pdhealth.mil/respect-mil>

United States Department of Veterans Affairs National Center for PTSD:

ptsd.va.gov

References

- Nicholas, W., Farley, D.O., Vaiana, M.E., & Cretin, S. (2001). Putting practice guidelines to work in the Department of Defense Medical System: A guide for action. Santa Monica, CA: RAND Corporation. Retrieved from: https://www.qmo.amedd.army.mil/general_documents/rand_document_4_01.pdf
- Putting Clinical Practice Guidelines to Work in VHA. Department of Veterans Affairs. (2010). Putting clinical practice guidelines to work in VHA. Retrieved from: healthquality.va.gov/VA_Manual.pdf



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