Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care

NICE guideline

First draft for consultation, July, 2004

If you wish to comment on the recommendations, please make your comments on the full version of the draft guideline.
Contents

Key recommendations for implementation..................................................4

1 Guidance ........................................................................................................6
  1.1 Post traumatic stress disorder ...........................................................6
  1.2 The symptoms of PTSD .................................................................6
  1.3 Recognition of PTSD .................................................................7
  1.4 Recognition in primary care ............................................................7
  1.5 Recognition in general hospital settings ............................................9
  1.6 Screening after a major disaster and for programme refugees ...........9
  1.7 Specific recognition issues for children ...........................................10
  1.8 Assessment and coordination of care ..............................................10
  1.9 Support to families and carers .......................................................11
  1.10 Practical support and social factors ..............................................12
  1.11 Language and culture .................................................................12
  1.12 Care for all people with PTSD ....................................................13
  1.13 The treatment of PTSD ...............................................................15
  1.14 Chronic PTSD ............................................................................16
  1.15 Drug treatment ............................................................................18
  1.16 Chronic disease management .....................................................20
  1.17 Children ..................................................................................20
  1.18 Disaster planning .......................................................................21

2 Notes on the scope of the guidance ..........................................................23

3 Implementation in the NHS ......................................................................24
  3.1 In general .....................................................................................24
  3.2 Audit ............................................................................................24

4 Research recommendations ......................................................................24

5 Full guideline ............................................................................................24

6 Related NICE guidance ...........................................................................25

7 Review date ..............................................................................................25

Appendix A: Grading scheme .....................................................................26

Appendix B: The Guideline Development Group ........................................28
Appendix C: The Guideline Review Panel .......................................................... 30
Appendix D: Technical detail on the criteria for audit ........................................ 32
Key recommendations for implementation

Initial response to trauma

The systematic provision, to individuals who have experienced a traumatic event, of brief, single-session interventions (often referred to as de-briefing) that focus on the traumatic incident should not be routine practice when delivering services for those who have been exposed to such an incident.

Where symptoms are mild and have been present for less than 4 weeks after the trauma, watchful waiting, as a way of managing the difficulties presented by individual suffers, should be considered by healthcare professionals. A follow-up contact should be arranged within 1 month.

Psychological interventions

Trauma-focused cognitive behavioural therapy should be considered for those with severe post-traumatic symptoms or with severe post-traumatic stress disorder (PTSD) in the first month after the traumatic event.

All PTSD sufferers should be offered a course of trauma-focused psychological treatment (cognitive behavioural therapy [CBT] or Eye Movement Desensitization and Reprocessing [EMDR]). These treatments are usually given individually on an outpatient basis.

Children and adolescents

Trauma-focused cognitive behavioural therapy, delivered either individually or in groups that typically comprises at least four sessions of up to 90 minutes in duration should be considered for children and adolescents with severe symptoms of PTSD within 1 month of the traumatic event.

Children and adolescents with PTSD, including those who have suffered sexual abuse, should be offered a course of trauma-focused cognitive
behavioural therapy adapted as needed to suit their age, circumstances and level of development.

**Drug treatments**

Drug treatments for PTSD should not be used as a routine first-line treatment (in primary or secondary care) in preference to a trauma-focused psychological therapy.

Drug treatments (paroxetine, tricyclic antidepressants [TCAs] or mirtazapine) should be considered for the treatment of PTSD when a sufferer expresses a preference to not engage in trauma-focused psychological treatment.

**Screening for PTSD**

For all people who have been involved in a major disaster, consideration should be given (by those responsible for coordination of the disaster plan) to the routine use of a brief screening instrument for PTSD at 1 month post-disaster.
The following guidance is evidence based. The grading scheme used for the recommendations (A, B, C or good practice point [GPP]) is described in Appendix A. A summary of the evidence on which the guidance is based is provided in the full guideline (see Section 5).

1 Guidance

1.1 Post traumatic stress disorder

PTSD develops following a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. PTSD does therefore not develop following those upsetting situations that are described as “traumatic” in everyday language, e.g., divorce, loss of job, or failing an exam. PTSD is a disorder that can affect people of all ages.

1.2 The symptoms of PTSD

The most characteristic symptoms of PTSD are re-experiencing symptoms. PTSD sufferers involuntarily re-experience aspects of the traumatic event in a very vivid and distressing way. These includes flashbacks in which the person acts or feels as if the event were recurring; nightmares; and repetitive and distressing intrusive images or other sensory impressions from the event. Reminders of the traumatic event arouse intense distress and/or physiological reactions. In children, re-experiencing symptoms may take the form of re-enacting the experience, repetitive play or frightening dreams without recognisable content.

Avoidance of reminders of the trauma is another core symptom of PTSD. This includes people, situations or circumstances resembling or associated with the event. People with PTSD often try to push memories of the event out of their mind and avoid thinking or talking about it in detail, particularly about its worst moments. On the other hand, many ruminate excessively about questions that prevent them from coming to terms with the event, e.g., about why the event happened to them, about how it could have been prevented, or about how they could take revenge.
PTSD sufferers also experience symptoms of **hyperarousal** including hypervigilance for threat, exaggerated startle responses, irritability, and difficulty concentrating and sleep problems. Others with PTSD also describe symptoms of **emotional numbing**. These include inability to have any feelings, feeling detached from other people, giving up previously significant activities, and amnesia for significant parts of the event.

Symptoms of PTSD often develop immediately after the traumatic event but in some (less than 15% of all sufferers) the onset of symptoms may be delayed. Sufferers with PTSD may not present for treatment for months or year after their onset despite the considerable distress experienced. Nevertheless PTSD is a treatable disorder even when problems present many years after the traumatic event. Assessment of PTSD can, however, present significant challenges as many people avoid talking about their problems even when presenting with associated complaints.

### 1.3 Recognition of PTSD

Effective treatment of PTSD can only take place if the disorder is recognised. In some cases, for example following a major disaster, specific arrangements to screen people at risk may be considered. For the vast majority with PTSD opportunities for recognition and identification come as part of routine health care interventions, for example following an assault or an accident for which physical treatment is required or when a person discloses domestic violence or a history of child sexual abuse. Identification of PTSD in children presents particular problems but is improved if children are asked about their experiences directly.

### 1.4 Recognition in primary care

Post-traumatic stress disorder (PTSD) can present with a range of symptoms most commonly in adults in the form of very vivid, distressing memories of the event or flashbacks (otherwise known as intrusive or re-experiencing symptoms). However, at times, the most prominent symptoms may be avoidance of trauma-related or general social contacts. It is important when recognising and identifying PTSD to ask specific questions in a sensitive
manner about both the symptoms and traumatic experiences. Between 25 and 30% of people experiencing a traumatic event may go on to develop PTSD.

1.4.1 PTSD may present with a range of symptoms (including re-experiencing, avoidance, hyperarousal, depression, emotional numbness, drug or alcohol misuse and anger) and therefore when assessing for possible PTSD, members of the primary care team should ask whether or not patients with such symptoms have suffered a range of traumatic experiences (which may have occurred many months or years before) and give specific examples of traumatic events (for example, assaults, rape, road traffic accidents and childhood sexual abuse).

[GPP]

1.4.2 General practitioners and other members of the primary care team should be aware of traumas associated with the development of PTSD. These include not only single events such as assaults or road traffic accidents, but also domestic violence and child sexual abuse. [GPP]

1.4.3 For patients with unexplained physical symptoms who are repeated attendees to primary care, members of the primary care team should consider asking whether or not they have experienced a range of traumatic events, and specific examples of traumatic events should be given (for example, assaults, rape, road traffic accidents and childhood sexual abuse). [GPP]

1.4.4 When seeking to identify possible PTSD, members of the primary care team should consider asking specific questions to adults about re-experiencing (including flashbacks and nightmares) or hyperarousal (including an exaggerated startle response or sleep disturbance). For children, particularly younger children, consideration should be given to asking the child and/or their parents about sleep disturbance or significant changes in sleeping patterns. [C]
1.5 Recognition in general hospital settings

Many people attending for medical services in a general hospital settings may have experienced traumatic events. This may be particularly so in accident and emergency departments, orthopaedic and plastic surgery clinics. For some people with PTSD, this may be the main point of contact with the healthcare system and the opportunity that this presents for the recognition and identification of PTSD should be taken.

1.5.1 PTSD may present with a range of symptoms (including re-experiencing, avoidance, hyperarousal, depression, emotional numbness and anger) and therefore when assessing for possible PTSD, members of secondary care medical teams should ask patients with such symptoms whether they have suffered a range of traumatic experiences and give specific examples of traumatic events (for example, assaults, rape, road traffic accidents and childhood sexual abuse). [GPP]

1.6 Screening after a major disaster and for programme refugees

Many individuals involved in a major disaster will suffer both short- and long-term consequences of their involvement. Although the development of single-session de-briefing is not recommended (see Section 10.1.1.3), screening of all individuals should be considered by the authorities responsible for developing the local disaster plan. Similarly, the vast majority of people who are involved in a refugee programme will have experienced major trauma and may benefit from a screening programme.

1.6.1 For all people who have been involved in a major disaster, consideration should be given (by those responsible for coordination of the disaster plan) to the routine use of a brief screening instrument for PTSD at 1 month post-disaster. [C]

1.6.2 For all programme refugees and asylum seekers maintained as a group in a special centre where there is a duty of care, consideration should be given (by those responsible for management of the refugee
programme) to the routine use of a brief screening instrument for PTSD as part of the initial refugee healthcare assessment. This should be a part of any comprehensive physical and mental health screen. [C]

1.7 Specific recognition issues for children

Children, particularly those under 8 years of age, may not complain directly of PTSD symptoms, such as re-experiencing or avoidance. Instead children may complain of problems sleeping. It is vital therefore that all opportunities for identifying PTSD in children should be taken. Questioning the children as well as parents or guardians will also improve the recognition of PTSD. PTSD is common (up to 30%) in children following attendance at accident and emergency departments for a traumatic injury. Accident and emergency staff should take the opportunity to inform patients of the risk of their child developing PTSD following accident and emergency attendance for a traumatic injury and advise them on what action to take.

1.7.1 When assessing a child or adolescent for possible PTSD, healthcare professionals should ensure that they separately and directly question the child about the presence of PTSD symptoms. They should not rely on the parent or guardian as the sole informant in any assessment. [GPP]

1.7.2 When a child who has been involved in a traumatic event is treated in an accident and emergency department, accident and emergency staff should inform the parents or guardians of the possibility of the development of PTSD, briefly describe the possible symptoms (for example, sleep disturbance nightmares, difficulty concentrating and getting very irritable) and suggest that they contact their GP if the symptoms persist beyond 1 month. [GPP]

1.8 Assessment and coordination of care

1.8.1 For people with PTSD presenting in primary care, GPs should take responsibility for the initial assessment and the initial coordination of
care. This includes the determination of the need for emergency medical or psychiatric assessment. [C]

1.8.2 Assessment of PTSD sufferers should be conducted by competent individuals and be comprehensive, including physical, psychological and social needs and a risk assessment. [GPP]

1.8.3 Patient preference should be an important determinant of the choice among effective treatments. PTSD sufferers should be given sufficient information about the nature of these treatments in order to make an informed choice. [C]

1.8.4 Where management is shared between primary and secondary care, there should be clear agreement among individual healthcare professionals on the responsibility for monitoring patients with PTSD. This agreement should be in writing (where appropriate, using the Care Programme Approach [CPA] and should be shared with the patient and, where appropriate, their families and carers. [C]

1.9 Support to families and carers

Families and carers have central role in support of people with PTSD. However, depending on the nature of the trauma and its consequences, many families may also need support for themselves. Healthcare professionals should be aware of the impact of PTSD on the whole family.

1.9.1 In all cases of PTSD, healthcare professionals should consider the impact of the traumatic event on all family members and, where necessary, assess this impact and consider providing appropriate support. [GPP]

1.9.2 Healthcare professionals should ensure that the families of PTSD sufferers are fully informed about common reactions to traumatic events, including the symptoms of PTSD and its course and treatment. [GPP]
1.9.3 In addition to the provision of information, family and carers may be informed of self-help groups and support groups and encouraged to participate in such groups where they exist. [GPP]

1.9.4 When a family is affected by a traumatic event, more than one family member may suffer from PTSD. If this is the case, healthcare professionals should ensure that the treatment of all family members is effectively coordinated. [GPP]

1.10 Practical support and social factors

Practical and social support can play an important part in facilitating a person’s recovery from PTSD, particularly in the immediate aftermath of the trauma. Healthcare professionals should be aware of this and facilitate access to such support when people present with PTSD.

1.10.1 Healthcare professionals should identify the need for appropriate practical and social support and advocate for the meeting of these needs. [GPP]

1.10.2 Healthcare professionals should consider offering help in or advice to PTSD sufferers or relevant others on how the continuing threats related to the traumatic event may be ameliorated or removed. [GPP]

1.10.3 Healthcare professionals should normally only consider providing trauma-focused psychological treatment when the sufferer considers it safe to proceed. [GPP]

1.11 Language and culture

People with PTSD treated in the NHS come from diverse cultural and ethnic backgrounds – some have no or limited English. Nevertheless, all should be offered the opportunity to benefit from psychological interventions. This can be achieved by the use of interpreters and bicultural therapists. In all cases, healthcare professionals must familiarise themselves with the cultural background of the sufferer.
1.11.1 Where differences of language or culture exist between healthcare professionals and PTSD sufferers, this should not be seen as an obstacle to the provision of effective trauma-focused psychological interventions. [GPP]

1.11.2 Where language or culture differences present challenges to the use of trauma focused psychological interventions in PTSD, healthcare professionals should consider the use of interpreters and bicultural therapists. [GPP]

1.11.3 Where a PTSD sufferer has a different cultural or ethnic background from that of the treating healthcare professionals, the healthcare professionals must familiarise themselves with that cultural background. [GPP]

1.12 Care for all people with PTSD

PTSD is a treatable condition that responds to a variety of effective treatments. All treatment should be backed by proper information to sufferers about the likely course of such treatment. A number of factors, which are described below, may modify the nature, timing and course of treatment.

1.12.1 Interventions across all conditions

1.12.1.1 When a diagnosis of PTSD has been established and a treatment plan agreed, PTSD sufferers should receive information about common reactions to traumatic events, including the symptoms of PTSD and its course and treatment. [GPP]

1.12.1.2 Healthcare professionals should not delay or withhold treatment for PTSD because of court proceedings or applications for compensation. [C]

1.12.1.3 Healthcare professionals should acknowledge that many PTSD sufferers are anxious about and can be avoidant of engaging in treatment. Healthcare professionals should also recognise the challenges that this presents and respond appropriately, for example,
by following up PTSD sufferers who miss scheduled appointments.  
[C]

1.12.1.4 Healthcare professionals should treat PTSD sufferers with an atmosphere of respect, trust and understanding, and keep technical language to a minimum. [GPP]

1.12.2 Comorbidities

1.12.2.1 When a patient presents with PTSD and depression, consider treating the PTSD first, as the depression will often improve with successful treatment of the PTSD. [C]

1.12.2.2 For PTSD sufferers whose assessment identifies a high risk of suicide or harm to others, healthcare professionals, clinical management should concentrate on management of the risk in the first instance. [C]

1.12.2.3 For PTSD sufferers who are so severely depressed that this makes initial psychological treatment of PTSD very difficult (e.g. as evidenced by extreme lack of energy, concentration and inactivity or high suicide risk), healthcare professionals should treat the depression first. [C]

1.12.2.4 For PTSD sufferers with drug or alcohol dependence or in whom alcohol or drug use may significantly interfere with effective treatment, then healthcare professionals should treat the drug or alcohol problem first. [C]

1.12.2.5 PTSD sufferers with comorbid personality disorder may benefit from trauma-focused psychological interventions, but healthcare professionals should consider extending the duration of treatment. [C]

1.12.2.6 Patients who have lost a significant other due to an unnatural or sudden death should be assessed for PTSD and traumatic grief. In most cases, healthcare professionals should treat the PTSD first. [C]


\textbf{1.13 The treatment of PTSD}

\subsection*{1.13.1 Early interventions}

A number of sufferers with PTSD may recover with no or limited interventions. However, without effective treatment, many people may develop chronic problems over many years. The severity of the initial traumatic response is a reasonable indicator of the need for early intervention, and treatment should not be withheld in such circumstances.

\textit{Watchful waiting}

1.13.1.1 Where symptoms are mild and have been present for less than 4 weeks after the trauma, watchful waiting, as a way of managing the difficulties presented by individual suffers, should be considered by healthcare professionals. A follow-up contact should be arranged within 1 month. [C]

\textit{Immediate psychological interventions for all}

As described elsewhere, practical support delivered in an empathetic manner is important in promoting recovery for PTSD, but it is unlikely that a single session of a psychological intervention will be helpful.

1.13.1.2 All health and social care workers should acknowledge the psychological impact of traumatic incidents in their immediate post-incident care of survivors. [GPP]

1.13.1.3 The systematic provision, to individuals who have experienced a traumatic event, of brief, single-session interventions (often referred to as de-briefing) that focus on the traumatic incident, should NOT be routine practice when delivering services for everyone who has been exposed to such an incident. [B]

\textit{Interventions for acute PTSD}

Acute PTSD refers to PTSD in the first 3 months after the traumatic event. Brief psychological interventions (five sessions) may be effective if treatment
starts within the first month after the event. Beyond the first month, the
duration of treatment is similar to that in chronic PTSD.

1.13.1.4 Trauma-focused cognitive behavioural therapy should be offered for those with severe post-traumatic symptoms or with severed PTSD in the first month after the traumatic event. [B]

1.13.1.5 Trauma-focused cognitive behavioural therapy should be offered to people who present with PTSD within 3 months of a traumatic event. [A]

1.13.1.6 The duration of the trauma-focused cognitive behavioural therapy should normally be 8–12 sessions, but if the treatment starts in the first month after the event, fewer sessions (about five) may be sufficient. When the trauma is discussed in the treatment session, longer sessions than usual are usually necessary (for example, 90 min). Treatment should be regular and continuous (usually at least once a week) and should be delivered by the same person. [B]

1.13.1.7 Drug treatment may be considered in the acute phase of PTSD for the management of sleep disturbance. In this case, antidepressant medication (paroxetine, TCAs and mirtazapine) should be used in preference to other medication, for example benzodiazepines, as this may reduce the likelihood of causing dependence. [C]

1.13.1.8 Non-trauma-focused interventions such as relaxation or non-directive therapy, which does not address traumatic memories, should NOT routinely be offered to people who present with PTSD symptoms within 3 months of a traumatic event. [B]

1.14 Chronic PTSD

Most patients presenting with PTSD have had the problem for many months, if not years. The interventions outlined below are effective in treating such individuals and duration of the disorder does not itself seem an impediment to benefiting from effective treatment provided by competent healthcare professionals.
1.14.1 Psychological interventions

1.14.1.1 All PTSD sufferers should be offered a course of trauma-focused psychological treatment (cognitive behavioural therapy or Eye Movement Desensitization and Reprocessing). These treatments are usually given individually on an outpatient basis. [A]

1.14.1.2 Trauma-focused treatment should be offered to PTSD sufferers regardless of the time that has elapsed since the trauma. [B]

1.14.1.3 The duration of trauma-focused psychological treatment should normally be 8–12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are usually necessary (for example, 90 min). Treatment should be regular and continuous (usually at least once a week) and should be delivered by the same person. [B]

1.14.1.4 When PTSD sufferer has experienced multiple traumatic events, traumatic bereavement or chronic disability resulting from the trauma, or has significant comorbid disorders or social problems, healthcare professionals should consider extending the duration of treatment beyond 12 sessions. [C]

1.14.1.5 Treatment should be delivered by competent individuals who have received appropriate training. These individuals should receive appropriate supervision. [C]

1.14.1.6 For some PTSD sufferers, it may initially be very difficult and overwhelming to disclose details of their traumatic events. In these cases, healthcare professionals should consider devoting several sessions establishing a trusting therapeutic relationship and emotional stabilisation before addressing the traumatic event. [C]

1.14.1.7 Non-trauma-focused interventions such as relaxation or non-directive therapy, which does not address traumatic memories, should not routinely be offered to people who present with chronic PTSD. [B]
1.14.1.8 For those sufferers from PTSD who have no or only limited improvement with a specific trauma-focused psychological treatment, healthcare professionals should consider the following options:

- an alternative form of trauma-focused psychological treatment
- the augmentation of trauma focused psychological treatment with a course of pharmacological treatment. [C]

1.14.1.9 When PTSD sufferers request other forms of psychological treatment (e.g. stress management, supportive therapy/non-directive therapy, hypnotherapy or psychodynamic therapy), they should be informed that there is as yet no convincing evidence for a clinically important effect of these treatments on PTSD. [GPP]

### 1.15 Drug treatment

1.15.1 Drug treatments for PTSD should not be used as a routine first-line treatment (in primary or secondary care) in preference to a trauma-focused psychological therapy. [A]

1.15.2 Drug treatments (paroxetine, TCAs or mirtazapine) should be considered for the treatment of PTSD where a sufferer expresses a preference not to engage in a trauma-focused psychological treatment. [B]

1.15.3 Drug treatments (paroxetine, TCAs or mirtazapine) should be offered to PTSD sufferers who cannot start a psychological therapy because of serious ongoing threat of further trauma. [C]

1.15.4 Drug treatments (paroxetine, TCAs or mirtazapine) should be considered for PTSD sufferers who have gained little or no benefit from a course of trauma-focused psychological treatment. [C]
1.15.5 Antidepressant medication should be used in preference to other medication, for example benzodiazepines, in the management of sleep disturbance, as this may reduce the likelihood of causing dependence. This may be particularly helpful in the immediate aftermath of a trauma or whilst a person is awaiting psychological treatment. [C]

1.15.6 Drug treatments (paroxetine, TCAs or mirtazapine) for PTSD should be considered as an adjunct to psychological treatment where there is significant co-morbid depression or severe hyperarousal that significantly impacts on a sufferer’s ability to benefit from psychological treatment. [C]

1.15.7 When a sufferer with PTSD has not responded to a drug treatment and further drug treatment is considered, this should generally be with a different class of antidepressant or involve the use of adjunctive olanzapine. [C]

1.15.8 When a sufferer with PTSD has responded to drug treatment, it should be continued for at least 6–12 months before gradual withdrawal. [C]

**General recommendations regarding drug treatment**

1.15.9 PTSD sufferers started on antidepressants should be seen on a regular basis and carefully monitored for side effects and efficacy. [GPP]

1.15.10 Before starting treatment, all PTSD sufferers who are prescribed antidepressants should be informed about potential side effects and discontinuation symptoms. [C]

**Recommendations regarding discontinuation symptoms**

1.15.11 All PTSD sufferers prescribed antidepressants should be informed that, although the drugs are not associated with tolerance and craving, discontinuation symptoms may occur on stopping, missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but occasionally can be severe. [C]
1.15.12 Prescribers should normally gradually reduce the doses of antidepressants over a 4-week period, although some people may require longer periods. Fluoxetine can usually be stopped over a shorter period. [C]

1.15.13 If discontinuation symptoms are mild, practitioners should reassure the patient and arrange for monitoring. If symptoms are severe, the practitioner should consider reintroducing the original antidepressant (or another with a longer half-life from the same class) and reduce gradually while monitoring symptoms. [C]

1.16 Chronic disease management

1.16.1 Chronic disease management models should be considered for the management of people with chronic PTSD who have not benefited from a number of courses of effective treatment. [C]

1.17 Children

Children present particular problems with the identification of PTSD (see previous section). The treatments for children with PTSD are less well developed but emerging evidence provide an indication to effective interventions.

1.17.1 Early intervention

1.17.1.1 Trauma-focused cognitive behavioural therapy, delivered either individually or in groups, that typically comprises at least 4 sessions of up to 90 minutes duration should be considered for children and adolescents with severe symptoms of PTSD within 1 month of the traumatic event. [B]

1.17.2 Chronic PTSD

1.17.2.1 Children and adolescents with PTSD, including those who have suffered sexual abuse, should be offered a course of trauma-focused
cognitive behavioural therapy adapted as needed to suit their age, circumstances and level of development. [B]

1.17.2.2 The duration of trauma-focused psychological treatment for children and adolescents with chronic PTSD should normally be 8–12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are usually necessary (for example, 90 min). Treatment should be regular and continuous (usually at least once a week) and should be delivered by the same person. [C]

1.17.2.3 Drug treatments should not be routinely prescribed for children and adolescents with PTSD. [C]

1.17.2.4 Where appropriate, families should be involved in the treatment of PTSD in children and adolescents. However, treatment programmes for PTSD in children and adolescents that consist of parental involvement alone are unlikely to be of any benefit for PTSD symptoms. [C]

1.17.2.5 When considering treatments for PTSD, parents and, where appropriate, children and adolescents should be informed that there is at present no good evidence for the efficacy of other forms of treatment of PTSD apart from trauma-focused psychological interventions in children and adolescents such as widely used play therapy, art therapy or family therapy. [C]

1.18 Disaster planning

Health and social services have responsibility for organising the appropriate social and psychological support for those affected by disasters.

1.18.1 All disaster plans should make provision for a fully coordinated psychosocial response to the disaster. Those responsible for developing the psychosocial aspect of the plan should ensure it contains provision for immediate practical help, means to support the role of the affected
communities in caring for all those involved in the disaster and the provision of specialist mental health, evidenced-based assessment and treatment services. All healthcare workers involved in a disaster plan, should have clear roles and responsibilities, agreed in advance. [GPP]
2 Notes on the scope of the guidance

All NICE guidelines are developed in accordance with a scope document that defines what the guideline will and will not cover. The scope of this guideline was established at the start of the development of this guideline, following a period of consultation; it is available from www.nice.org.uk/ [NICE will add URL]

This guideline is relevant to PTSD sufferers, to their carers, and to all healthcare professionals involved in the help, treatment and care of PTSD sufferers. These include the following.

- Professional groups who share in the treatment and care for people with a diagnosis of PTSD, including psychiatrists, clinical psychologists, mental health nurses, community psychiatric nurses, social workers, practice nurses, secondary care medical staff and paramedical staff, occupational therapists, pharmacists, paediatricians, other physicians, general medical practitioners and family/other therapists.

- Professionals in other health and non-health sectors who may have direct contact with or are involved in the provision of health and other public services for those diagnosed with PTSD. These may include prison doctors, the police and professionals who work in the criminal justice and education sectors.

Those with responsibility for planning services for people with a diagnosis of PTSD and their carers, including directors of public health, NHS trust managers and managers in primary care trusts.

The guidance does not specifically address treatments that are not normally available on the NHS.
3 Implementation in the NHS

3.1 In general

Local health communities should review their existing practice in the treatment and management of PTSD against this guideline. The review should consider the resources required to implement the recommendations set out in Section 1, the people and processes involved and the timeline over which full implementation is envisaged. It is in the interests of PTSD sufferers that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly.

This guideline should be used in conjunction with the National Service Framework for Mental Health, which is available from www.doh.gov.uk/nsf/mentalhealth.htm.

3.2 Audit

Suggested audit criteria are listed in Appendix D. These can be used as the basis for local clinical audit, at the discretion of those in practice.

4 Research recommendations

The following research recommendations have been identified for this NICE guideline, not as the most important research recommendations, but as those that are most representative of the full range of recommendations. The Guideline Development Group’s full set of research recommendations is detailed in the full guideline produced by the National Collaborating Centre for Mental Health (see Section 5).

[To be included in second consultation draft.]

5 Full guideline

The National Institute for Clinical Excellence commissioned the development of this guidance from the National Collaborating Centre for Mental Health. The
Centre established a Guideline Development Group, which reviewed the evidence and developed the recommendations. The full guideline *PTSD (post-traumatic stress disorder): the management of PTSD in primary and secondary care* is published by the National Collaborating Centre for Mental Health; it will be available from its website (www.rcpsych.ac.uk/cru/nccmh.htm), the NICE website (www.nice.org.uk) and on the website of the National Electronic Library for Health (www.nelh.nhs.uk). [Note: these details will apply to the published full guideline.]

The members of the Guideline Development Group are listed in Appendix B. Information about the independent Guideline Review Panel is given in Appendix C.

The booklet *The Guideline Development Process – An Overview for Stakeholders, the Public and the NHS* has more information about the Institute’s guideline development process. It is available from the Institute’s website and copies can also be ordered by telephoning 0870 1555 455 (quote reference N0472).

6 Related NICE guidance

None

7 Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.
Appendix A: Grading scheme

The following guidance is evidence based. All evidence was classified according to an accepted hierarchy of evidence that was originally adapted from the US Agency for Healthcare Policy and Research Classification (see Box 1). Recommendations were then graded A to C based on the level of associated evidence. This grading scheme is based on a scheme formulated by the Clinical Outcomes Group of the NHS Executive (1996).

**Box 1: Hierarchy of evidence**

<table>
<thead>
<tr>
<th>Level</th>
<th>Type of evidence</th>
<th>Grade</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials</td>
<td>A</td>
<td>At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level I) without extrapolation</td>
</tr>
<tr>
<td>IIa</td>
<td>Evidence obtained from at least one well-designed controlled study without randomisation</td>
<td>B</td>
<td>Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level I evidence</td>
</tr>
<tr>
<td>IIb</td>
<td>Evidence obtained from at least one other well-designed quasi-experimental study</td>
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<tr>
<td>III</td>
<td>Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies</td>
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<tr>
<td>IV</td>
<td>Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities</td>
<td>C</td>
<td>Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV) or extrapolated from level I or II evidence. This grading indicates that directly</td>
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<td>applicable clinical studies of good quality are absent or not readily available</td>
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<tr>
<td><strong>GPP</strong></td>
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</tbody>
</table>

Appendix B: The Guideline Development Group

**Dr Jonathan Bisson** (Co-Chair, Guideline Development Group)
Consultant Liaison Psychiatrist, Cardiff and Vale NHS Trust

**Mrs Pamela Dix**
PTSD Sufferer Representative

**Professor Anke Ehlers** (Co-Chair, Guideline Development Group)
Professor of Experimental Psychopathology, Institute of Psychiatry, Kings College London

**Mrs S Janet Johnston, MBE**
Clinical Director, Ashford Counselling Service
Retired Senior Social Worker Kent County Council
Founder of the Dover Counselling Centre

**Mr Christopher Jones**
Health Economist, The National Collaborating Centre for Mental Health

**Ms Rebecca King**
Project Manager, The National Collaborating Centre for Mental Health

**Ms Rosa Matthews**
Systematic Reviewer, The National Collaborating Centre for Mental Health

**Mr Andrew Murphy**
PTSD Sufferer Representative

**Ms Peggy Nuttall**
Research Assistant, The National Collaborating Centre for Mental Health

**Mr Cesar De Oliveira**
Systematic Reviewer, The National Collaborating Centre for Mental Health

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Camden and Islington Mental Health and Social Care Trust

**Professor David Richards**
Professor of Mental Health, University of York

**Dr Clare Taylor**
Editor, The National Collaborating Centre for Mental Health

**Dr Stuart Turner**
Consultant Psychiatrist, Capio Nightingale Hospital
Chair of Trustees, Refugee Therapy Centre and Trustee, Redress
DRAFT FOR FIRST CONSULTATION

Honorary Senior Lecturer, Royal Free and University College Medical School, London

Ms Heather Wilder
Information Scientist, The National Collaborating Centre for Mental Health

Professor William Yule
Professor of Applied Child Psychology, Institute of Psychiatry, King’s College London
Appendix C: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring its quality. The Panel includes experts on guideline methodology, healthcare professionals and people with experience of the issues affecting patients and carers. The members of the Guideline Review Panel were as follows.

<table>
<thead>
<tr>
<th>Member</th>
<th>Area of expertise/experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Chaand Nagpaul</td>
<td>Clinical practice</td>
</tr>
<tr>
<td>GP, Stanmore</td>
<td></td>
</tr>
<tr>
<td>Dr Marcia Kelson</td>
<td>Patient and carer issues</td>
</tr>
<tr>
<td>Director, Patient Involvement Unit for NICE, London</td>
<td></td>
</tr>
<tr>
<td>Mr John Seddon</td>
<td>Patient and carer issues</td>
</tr>
<tr>
<td>Patient Representative</td>
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</tr>
<tr>
<td>Professor Kenneth Wilson</td>
<td>Methodology</td>
</tr>
<tr>
<td>Professor of Psychiatry of Old Age and Honorary Consultant Psychiatrist, Cheshire and Wirral Partnership NHS Trust</td>
<td></td>
</tr>
<tr>
<td>Professor Shirley Reynolds</td>
<td>Clinical practice</td>
</tr>
<tr>
<td>Professor of Clinical Psychology, School of Medicine, Health Policy and Practice, University of East Anglia, Norwich</td>
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</tr>
<tr>
<td>Dr Roger Paxton</td>
<td>Implementation</td>
</tr>
<tr>
<td>R&amp;D Director, Newcastle, North Tyneside and Northumberland Mental</td>
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</tr>
</tbody>
</table>
Appendix D: Technical detail on the criteria for audit

Possible objectives for an audit

One or more audits could be carried out in different care settings to ensure that:

- individuals with PTSD are involved in their care
- treatment options, including psychological interventions, are appropriately offered and provided for individuals with PTSD.

People who could be included in an audit

A single audit could include all individuals with PTSD. Alternatively, individual audits could be undertaken on specific groups of individuals such as:

- people with a specific type of PTSD, (for example, to study early intervention
- a sample of patients from particular populations in primary care.

Measures that could be used as a basis for an audit

Please see tables overleaf.
<table>
<thead>
<tr>
<th><strong>Criterion</strong></th>
<th><strong>Standard</strong></th>
<th><strong>Exception</strong></th>
<th><strong>Definition of terms</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Brief, single-session interventions (de-briefing)</strong>&lt;br&gt;The systematic provision, to individuals who have experienced a traumatic event, of brief, single-session interventions (often referred to as de-briefing) that focus on the traumatic incident should not be routine practice when delivering services for those who have been exposed to such an incident.</td>
<td>100% of victims of trauma should not be offered single-session interventions (often referred to as de-briefing).</td>
<td>None</td>
<td>Operational policies of relevant organisations should contain copies of relevant protocols and implementation plans, which specify that single-session debriefing should not be routinely provided.</td>
</tr>
<tr>
<td><strong>2. Watchful waiting</strong>&lt;br&gt;Where symptoms are mild and have been present for less</td>
<td>100% of patients identified as suffering from PTSD who are</td>
<td>Individuals who are offered the follow up but who, for personal</td>
<td>The notes should indicate that the healthcare professional</td>
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</table>
than 4 weeks after the trauma, watchful waiting, as a way of managing the difficulties presented by individual suffers, should be considered by healthcare professionals. A follow-up contact should be arranged within 1 month. Not offered or who decline an active intervention should have arranged a follow-up contact within 4 weeks. Or practical reasons, are not able to attend within 4 weeks. Responsible has discussed the need for follow up and an arrangement has been made for a contact to be made.

<table>
<thead>
<tr>
<th>3. Trauma-focused cognitive psychological treatment for acute PTSD</th>
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<tbody>
<tr>
<td>Trauma-focused cognitive behavioural therapy should be considered for those with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event.</td>
</tr>
<tr>
<td>100% of PTSD sufferers with severe post-traumatic symptoms or with severe PTSD seen within 1 month of the traumatic event should be considered for trauma-focused CBT.</td>
</tr>
<tr>
<td>Those who request or have taken up the offer of another intervention.</td>
</tr>
<tr>
<td>The notes should indicate that the patient was informed of the possibility of trauma-focused CBT. The notes should record if the patient completes a full course of the treatment.</td>
</tr>
<tr>
<td>4. Trauma-focused psychological treatment for chronic PTSD</td>
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<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>All PTSD sufferers should be offered a course of trauma-focused psychological treatment (CBT or EMDR). These treatments are usually given individually on an outpatient basis.</td>
</tr>
<tr>
<td>100% of PTSD sufferers with chronic PTSD should be considered for trauma-focused psychological treatment.</td>
</tr>
<tr>
<td>Those who request or have taken up the offer of another intervention.</td>
</tr>
<tr>
<td>The notes should indicate that the patient was informed of the possibility of trauma-focused psychological treatment.</td>
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</table>

<table>
<thead>
<tr>
<th>5. Trauma-focused CBT for children and adolescents with PTSD</th>
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<tbody>
<tr>
<td>Cognitive behavioural therapy, delivered either individually or in groups, that typically</td>
</tr>
<tr>
<td>100% of child and adolescents with severe post-traumatic symptoms seen within 1 month</td>
</tr>
<tr>
<td>Those who request or have taken up the offer of another intervention.</td>
</tr>
<tr>
<td>The notes should indicate that the patient was informed of the possibility of trauma-focused psychological treatment.</td>
</tr>
</tbody>
</table>
comprises at least 4 sessions of up to 90 minutes in duration should be considered for children and adolescents with severe symptoms of PTSD within 1 month of the traumatic event.

of the traumatic event should be considered for trauma-focused CBT.

intervention.

CBT.
The notes should record if the patient completes a full course of treatment.

### 6. Trauma-focused cognitive behavioural therapy for chronic PTSD in children and adolescents

Children and adolescents with PTSD, including those who have suffered sexual abuse, should be offered a course of trauma-focused cognitive behavioural therapy adapted as needed to suit their age,

100% of child and adolescents with PTSD should be offered a course for trauma-focused CBT.

Those who request or have taken up the offer of another intervention.

The notes should indicate that the patient was offered trauma-focused CBT.

The notes should record if the patient completes a full course of treatment.
circumstances and level of development. Cognitive behavioural therapy should be considered for those with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event.

7. Drug treatments for PTSD

Drug treatments for PTSD should not be used as a routine first-line treatment (in primary or secondary care) in preference to a trauma-focused psychological therapy.

Drugs should not routinely be used in the treatment of PTSD. The option of trauma-focused psychological treatment should be considered.

Exceptions include:

a. patients who refuse psychological treatment
b. patients who have not responded to psychological interventions
c. patients who have

The notes should indicate for all patients in receipt of medication that they were considered for psychological interventions and the reason that this was not taken up — the exceptions set out in this audit apply.

The notes should record if the
### 8. Drug treatments for PTSD when a patient declines psychological interventions

Drug treatments (paroxetine, TCAs or mirtazapine) should be considered for the treatment of PTSD when a sufferer expresses a preference to not engage in a trauma-focused psychological treatment.

<table>
<thead>
<tr>
<th>Drugs should be considered in the treatment of PTSD where a sufferer declines the offer of trauma-focused psychological treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
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</tbody>
</table>

The notes should indicate for all patients who declined psychological interventions that the option of prescribing appropriate medication was considered. The reason that this was not taken up should be recorded in the notes.
9. Disaster screening

For all people who have been involved in a major disaster, consideration should be given (by those responsible for coordination of the disaster plan) to the routine use of a brief screening instrument for PTSD at 1 month post-disaster.

<table>
<thead>
<tr>
<th>100% of patients who have been involved in a major disaster should be screened at 1 month post-event.</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of patients receiving GSH should be offered a follow-up appointment.</td>
</tr>
<tr>
<td>Those who refuse to participate in the screening or who are not contactable despite reasonable efforts by those responsible for the screening.</td>
</tr>
<tr>
<td>which should also record if the patient completes a full course of treatment.</td>
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</tbody>
</table>

Operational policies of relevant organisations should contain copies of relevant protocols and implementation plans that specify the requirement for screening. Where screening occurs, records should be reviewed to establish the numbers screened.
Calculation of compliance

Compliance (%) with each measure described in the table above is calculated as follows.

Number of patients whose care is consistent with the criterion

\[\text{Criterion} \times \text{Exception} \times 100\]

\[\text{Number of patients to whom the measure applies}\]

Clinicians should review the findings of measurement, identify whether practice can be improved, agree on a plan to achieve any desired improvement and repeat the measurement of actual practice to confirm that the desired improvement is being achieved.