NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Centre for Clinical Practice

Review of Clinical Guideline (CG26) – The management of PTSD in adults and children in primary and secondary care

Background information

Guideline issue date: 2005

2 year review: 2007 (Update not required after review of evidence)

6 year review: 2011

National Collaborating Centre: Mental Health

Review recommendation

- The guideline should not be updated at this time.

Factors influencing the decision

Literature search

1. From initial intelligence gathering and a high-level randomised control trial (RCT) search clinical areas were identified to inform the development of clinical questions for focused searches. Through this stage of the process 110 studies were identified relevant to the guideline scope. The identified studies were related to the following clinical areas within the guideline:
    - Predictors of post-traumatic stress disorder (PTSD) and screening for the disorder
    - Early interventions for PTSD in adults
    - Psychological treatment of PTSD in adults

- Pharmacological and physical interventions for PTSD in adults
- Children and young people with PTSD

2. No new evidence was identified in these areas which would change the direction of current guideline recommendations.

3. From initial intelligence gathering, qualitative feedback from other NICE departments, the views expressed by the Guideline Development Group, as well as the high-level RCT search, additional focused searches were also conducted for the following clinical areas:
    - Screening and diagnosis
    - Health economics: initiation of treatment

4. No conclusive new evidence was identified through the focused searches which would change the direction of current guideline recommendations relating to health economics: initiation of treatment screening and diagnosis. In addition, an ongoing update of the Diagnostic and Statistical Manual of Mental Disorders (to version DSM-V) was identified through the review process. However, this is currently undergoing field testing and is not expected to be published until May 2013 therefore it is not possible to determine what impact the revised DSM will have on the guideline recommendations relating to screening and diagnosis at this time.

5. Several ongoing clinical trials related to the recommendations (publication dates unknown) were identified focusing on psychological and pharmacological interventions for treatment of PTSD.

Guideline Development Group and National Collaborating Centre perspective

6. A questionnaire was distributed to GDG members and the National Collaborating Centre (NCC) to consult them on the need for an update of the guideline. Four responses were received with respondents highlighting relevant new literature relating to areas of the guideline

including diagnosis of PTSD, narrative exposure therapy in children, cognitive behavioural therapy (CBT) based interventions and internet therapy.

7. Ongoing research relevant to the guideline was highlighted by GDG members including emerging work on mass interventions after disasters and war and additional studies of trauma-focused CBT in routine clinical practice.

8. This feedback contributed towards the development of the clinical questions for the focused searches.

Implementation and post publication feedback

9. In total 101 enquiries were received from post-publication feedback, most of which were routine. Key themes emerging from post-publication feedback included psychological and pharmacological treatments for PTSD.

10. Feedback from the NICE implementation team indicated that there is low recognition of PTSD in primary care. This feedback contributed towards the development of the clinical question relating to screening and diagnosis of PTSD for the focused search.

Relationship to other NICE guidance

11. NICE guidance related to CG26 can be viewed in Appendix 1.

Summary of Stakeholder Feedback

Review proposal put to consultees:
The guideline should not be updated at this time.
The guideline will be reviewed again according to current processes.

12. In total 15 stakeholders commented on the review proposal recommendation during the two week consultation period. The table of stakeholder comments can be viewed in Appendix 2.

13. Seven stakeholders agreed with the review proposal and six disagreed with the review proposal. Two stakeholders did not state a definitive decision.

14. The stakeholders that disagreed with the review proposal commented that:
    - There is new literature available on pharmacological treatment of PTSD since the guideline was published. However, although new evidence was identified through the review of the guideline relating to pharmacological treatment of PTSD in adults, heterogeneity across the studies was evident relating to comparators used and reported results. Taking study heterogeneity into account, we feel that the identified new evidence is unlikely to update the current guideline recommendations relating to drug treatments for PTSD at this time.
    - There have been steps forward in terms of the non-pharmacological management of sleep since the original guidelines were written. However, through the in-house review of the PTSD guideline we did not identify any studies which specifically focused on non-pharmacological management of sleep. In terms of pharmacological management, two small studies were identified which indicated that prazosin treatment increased total sleep time and reduced trauma-related nightmares in people with PTSD. However, we feel that it would be pertinent to await further evidence, particularly on the benefits, harms and cost-effectiveness of this treatment, before updating the guideline recommendation. This area will be examined again in the future review of the guideline.
    - It would be helpful to patients, clinicians and commissioners to have fuller guidance in relation to specific populations where it exists (such as veterans, refugees and asylum-seekers, people with PTSD

to childhood sexual abuse, traumatic bereavement or significant co-morbidity). However, the guideline scope covers adults and children of all ages, who meet, or are at risk of PTSD. As such, the interventions covered in the guideline are relevant for all children and adults presenting with PTSD to the NHS. In addition, the guideline currently provides special consideration to the role and links with other organisations that play a key part in delivering care (particularly in the immediate aftermath of traumatic events) for those at risk of PTSD within specific populations of ex-military personnel, refugees and survivors of disasters.

- Art therapy is a well recognised treatment modality in the management of PTSD. However, through the review of the guideline no RCTs relating to art therapy as an intervention for PTSD were identified. The use of art therapy for the management of PTSD will be examined in the future review of the guideline.

15. During consultation, stakeholders suggested new areas to consider in a future update of the guideline including:
    - Complex presentations of PTSD
    - Emotional freedom techniques and trauma incident reduction for management of PTSD

Anti-discrimination and equalities considerations

16. No evidence was identified to indicate that the guideline scope does not comply with anti-discrimination and equalities legislation. The original scope is inclusive of adults and children of all ages with or at risk of PTSD.

Conclusion

17. Through the process no areas were identified which would indicate a significant change in clinical practice. There are no factors described above which would invalidate or change the direction of current guideline recommendations.

18. An ongoing update of the Diagnostic and Statistical Manual of Mental Disorders (to version DSM-V) was identified. However, this is currently undergoing field testing and is not expected to be published until May 2013 therefore it is not possible to determine what impact the revised DSM will have on the guideline recommendations at this time.

19. The PTSD guideline should not be considered for an update at this time

Relationship to quality standards

20. This topic is not currently being considered for inclusion in the scope of a quality standard.

21. This topic is not currently being considered as a proposed core library topic.

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Centre for Clinical Practice
December 2011

Appendix 1

The following NICE guidance is related to CG26:

Guidance	Review date
CG123: Common mental health disorders: identification and pathways to care, 2011.	To be reviewed: 2014.
CG113: Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults, 2011.	To be reviewed: 2014.
CG91: The treatment and management of depression in adults with chronic physical health problems (partial update of CG23), 2009.	To be reviewed: 2012.
CG90: Depression: the treatment and management of depression in adults (update), 2009.	To be reviewed: 2012.
CG31: Obsessive compulsive disorder, 2005.	Guideline reviewed in 2011 and not recommended for an update.
CG28: Depression in children and young people: identification and management in primary, community and secondary care, 2005.	Guideline reviewed in 2011 and not recommended for an update.

Appendix 2

National Institute for Health and Clinical Excellence

Post-Traumatic Stress Disorder
Guideline Review Consultation Comments Table
24 October – 7 November 2011

Stakeholder	Agree with proposal not to update?	Comments	Comments on areas excluded from original scope	Comments on equality issues	Responses
Lancashire Care NHS Foundation Trust	Disagree	I do feel that a review in terms of recommended medication would be valuable. There is more literature out there now and the choice could be widened I am certain. I would be in favour of a review earlier than 2014.			Thank you for your comment. New evidence was identified relating to pharmacological treatment of PTSD in adults. However, heterogeneity across the studies was evidence relating to comparators used and reported results. In addition, generally the medications identified (apart from paroxetine and sertraline) do not currently have a UK license for use in PTSD. Taking study heterogeneity into account, we feel that the identified new evidence is unlikely to update the current guideline recommendations relating to drug treatments for

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					PTSD at this time. This area will be examined again in the future review of the guideline.
Lancashire Care NHS Foundation Trust	Disagree	The original guidance did not deal with complex PTSD. Many of the patients seen within secondary mental health services have complex developmental trauma in the background and then experience of traumatic events in adulthood This group of clients is not well catered for in the current guidance and – as a result – suggestions regarding numbers of sessions can be often be short of the mark			Thank you for your comment. The current guideline states the following relating to complex PTSD: • The NICE guideline focuses on the treatment of PTSD, as there is as yet little research on the treatment of 'enduring personality changes after catastrophic experience'. It is, however, recognised that many PTSD sufferers will have at least some of the features of this disorder or the corresponding concept of 'disorders of extreme distress not otherwise specified' (DESNOS) (complex PTSD). The guideline therefore takes into account that these features need to be considered when treating PTSD sufferers. However, the

Stakeholder	Agree with proposal not to update?	Comments	Comments on areas excluded from original scope	Comments on equality issues	Responses
					guideline does not apply to individuals with a diagnosis of 'enduring personality changes after catastrophic experience' rather than PTSD. Through an assessment of abstracts, no studies were identified which focused on complex PTSD. This area will be examined in a future review of the guideline.
Lancashire Care NHS Foundation Trust	Disagree	There have been significant steps forward in terms of the non-pharmacological management of sleep since the original guidelines were written			Thank you for your comment. Through the in-house review of the PTSD guideline we did not identify any studies which specifically focused on non-pharmacological management of sleep. In terms of pharmacological management, two small studies were identified which indicated that prazosin treatment increased total sleep time and reduced trauma-related nightmares in people with PTSD. However, we feel that it would be pertinent to await further

Stakeholder	Agree with proposal not to update?	Comments	Comments on areas excluded from original scope	Comments on equality issues	Responses
					evidence, particularly on the benefits, harms and cost-effectiveness of this treatment, before updating the guideline recommendation. This area will be examined again in the future review of the guideline.
Lancashire Care NHS Foundation Trust	Not sure	Waiting till 2014 would mean that the next DSM will have been published and the revision will have the chance to take account of any changes			Thank you for your comment.
Lancashire Care NHS Foundation Trust	Disagree	Given the development of IAPT and also the increase in profile of PTSD and veterans' issues it may be helpful to review the cost assumptions as well as the guideline. We have fed back (via the NICE field team) additional comments regarding the costing tool.			Thank you for your comment. No issues relating to cost assumptions were identified through the review of the guideline. However, your comments will be raised with the implementation team. Through the guideline review, we conducted a focused literature search to identify evidence determining whether there are any significant additional costs associated with intervening early or later in the course of PTSD. However, we did not identify any literature relating to this clinical

Stakeholder	Agree with proposal not to update?	Comments	Comments on areas excluded from original scope	Comments on equality issues	Responses
					question. This area will be examined again in the future review of the guideline.
Disaster Action		There is a continuing issue about identification of those at risk of developing PTSD following a traumatic incident, diagnosis and appropriate referral within primary care. We appreciate that this issue is noted in the consultation document. We are not aware if it is within the remit of the review to consider what can be done further to encourage understanding within primary care. Anecdotal evidence from members of Disaster Action is that GPs do not pick up signs and symptoms. Disaster Action strongly recommends that even if the decision is not to review the guideline at this time, NICE should at least issue a press release noting that a review was considered, highlighting the ongoing issue around primary care. Improvement to the 'mood' of those with a PTSD diagnosis is referred to in the evidence. Disaster Action members would suggest that improvement in a sense of well being should be considered a successful, at least partial, outcome for such people, even if the symptoms of PTSD remain. The benefits and potential risks of contact and membership of self-determining support groups have not been addressed by studies or trials to date. Anecdotally, Disaster Action's experience is that such activity can be beneficial for those affected by trauma, whether or not there has been			Thank you for your comment. The guideline makes recommendations on recognition of PTSD and screening for the disorder. Failure to follow the guideline recommendations is a local implementation issue. Implementation support is provided by NICE to facilitate implementation of the guideline. In addition, once the review decision for the PTSD guideline is finalised this will be placed onto the website along with all the related documents.

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		a PTSD diagnosis. The place of psychological, psychosocial, first aid is not mentioned within the review. While there are some studies that consider the impact of information/.education on the outcome for those exposed to trauma, have there been any studies around social support that includes practical support and information? In this instance, we are referring to information about, for example, a criminal investigation and the circumstances of the trauma, and support through the process. The experience of our members is that the aftermath of an incident can exacerbate their feelings if this is not handled in an appropriate, needs-based manner. Essentially, we are of the view that an individual's psychological well being (whether with or without a PTSD diagnosis) cannot be considered in isolation from the overarching set of circumstances. (This is an extension of the experience of those referred to in a domestic abuse setting in quoted evidence.)			Through the review of the guideline we did not identify studies focusing on social support including practical support and information. This area will be examined again in the future review of the guideline.
Disaster Action		Although reference 127 refers to the diagnostic accuracy of the TSQ following the London bombings, it is not clear whether the conclusions, recommendations and evidence gathered from the London bombings screen and treat programme have been considered within the consideration of evidence.			Thank you for your comment. The studies included in the consultation document relating to screening and diagnosis of PTSD were selected if they used a reference standard for PTSD and reported outcomes relating to diagnostic test

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					accuracy. As such, we included the reference: Brewin CR, Fuchkan N, Huntley Z et al. (2010) Diagnostic accuracy of the Trauma Screening Questionnaire after the 2005 London bombings. Journal of traumatic stress 23:393-398. We did not identify any additional studies relating to the London bombings which reported outcomes of diagnostic test accuracy.
Disaster Action		On page 29, statement: 'Drug treatments for PTSD should not be used as a routine first-line treatment for adults (in general use or by specialist mental health professionals) in preference to a trauma-focused psychological therapy.' This statement might be at odds with the findings referred to, concerning, for example, the efficacy of medication that successfully helps those with a PTSD diagnosis to sleep better.			Thank you for your comment. Through the in-house review of the PTSD guideline two small studies were identified which indicated that prazosin treatment increased total sleep time and reduced trauma-related nightmares in people with PTSD. However, we feel that it would be pertinent to await further evidence, particularly on the benefits, harms and cost-effectiveness of this treatment, before updating the guideline recommendation. This area will

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					be examined again in the future review of the guideline.
Disaster Action		Is there evidence concerning the impact of different forms of treatment on those who may have suffered brain damage as a result of a traumatic injury, as well as having a PTSD diagnosis? Is it known whether a combination of drug therapy and CBT, for example, would be a helpful form of treatment?			Thank you for your comment. Through an assessment of abstracts we did not identify any studies focusing on treatment among people who have suffered brain damage and been diagnosed with PTSD. New evidence was identified relating to combined pharmacological/psychological treatment of PTSD in adults. However, heterogeneity across the studies was evident relating to comparators used and reported results. Taking study heterogeneity into account, we feel that the identified new evidence is unlikely to update the current guideline recommendations. This area will be examined again in the future review of the guideline.
Disaster Action		Anecdotal evidence from individuals indicates successful use of combined prolonged exposure			Thank you for your comment. This area will be examined

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		therapy and CBT.			again in the future review of the guideline.
Association for the Advancement of Meridian Energy Techniques (AAMET)	Important update required	Q: For people with PTSD, does any psychological treatment confer any advantage over any other psychological treatment' This section in the draft consultation document concludes that the evidence base for interventions other than EMDR and trauma-focused CBT is still small, and therefore there is no basis as yet for an update of the guideline. This is not correct. The study by Karatzias et al (2011) [1], which compares emotional freedom techniques (EFT) favourably with EMDR for the treatment of PTSD should be cited as new evidence that has come to light since the review in 2007. Omission of this information would be misleading, leaving clinicians with the impression that only trauma-focused CBT and EMDR show clear evidence of efficacy for the treatment of PTSD. EFT is a widely used, cheap and easy to apply treatment, readily available to interested clinicians and as a self-help tool. For brief further information on this point see here: http://www.eftdevon.co.uk/EFT_for_trauma_PTSD.php and http://www.eftdevon.co.uk/EMDR.php			Thank you for providing the reference by Karatzias et al. This small-scale RCT compared eye movement desensitization and reprocessing (EMDR) and emotional freedom techniques (EFT) for posttraumatic stress disorder. However, we feel that this is not sufficient evidence to draw a conclusion at this time. This area will be examined again in the future review of the guideline.
Association	Important	Mention is made on page 10 of the lack of evidence			Thank you for providing the two

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for the Advancement of Meridian Energy Techniques (AAMET)	update required	for the efficacy of EMDR for PTSD for combat veterans. By contrast, the RCT by Church et al (2010) [2] clearly demonstrates the efficacy of EFT for such applications. Again, it would be an omission not to include at least a reference to this in the 2011 update. References: 1 Karatzias, T., Power, K., Brown, K., McGoldrick, T., Begum, M., Young, J., Loughran, P., Chouliara, Z. and Adams, S. (2011) A Controlled Comparison of the Effectiveness and Efficiency of Two Psychological Therapies for Posttraumatic Stress Disorder - Eye Movement Desensitization and Reprocessing vs. Emotional Freedom Techniques *J Nerv Ment Dis, 199: 372-378* 2 Church, D., Hawk, C., Brooks, A., Toukolehto, O., Wren, M., Dinter, I. and Stein, P. (2010) Psychological trauma in veterans using EFT (emotional freedom techniques): a randomized controlled trial *Poster session at the 31st Annual Meeting and Scientific Sessions of the Society of Behavioral Medicine, Seattle, 7–10 April 2010.* www.stressproject.org/documents/ptsdfinal1.pdf, September 2010. *Further research is in Press but the abstract is*			references by Church et al. However, as one reference is a conference abstract and the other is awaiting publication these references do not meet our inclusion criteria as the aim of this review is to consider new evidence published since the publication of the guideline. However, this area will be examined again in the future review of the guideline.

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		available here: http://www.energypsych.org/displaycommon.cfm?an=1&subarticlenbr=288 *The Effect of Emotional Freedom Techniques (EFT) on Stress Biochemistry: A Randomized Controlled Trial. Dawson Church, PhD, Foundation for Epigenetic Medicine. Garret Yount, PhD, California Pacific Medical Center (CPMC) Research Institute Audrey Brooks, PhD, Psychology Department, University of Arizona at Tucson.* Journal of Nervous and Mental Disease*, (2011), in press.* *This is not directly a RCT relating to PTSD but provides evidence of the effect of EFT on stress physiology and an objective indicator of the effect of EFT.*			
Association for the Advancement of Meridian Energy Techniques (AAMET)	Important update required	Further to our earlier stakeholder comments proforma, I have just received from an American counterpart organisation, ACEP, the attached Powerpoint summarising research into EFT, much of which relates to PTSD. You will see from slide 36 for example that in the 2010 RCT (Church & Hawk) comprising 59 veterans suffering PTSD with 30 assigned to an EFT treatment group and 29 to Waiting list control group, post treatment 90% of the EFT treatment group no longer met criteria for PTSD vs 4% of the control group. These are impressive results that suggest the potential to relieve a great deal of suffering amongst a most			Thank you for providing a presentation summarising research into EFT. The presentation provides several references relating to PTSD: • Church, 2010. The Treatment of Combat Trauma in Veterans Using EFT (Emotional Freedom Techniques): A Pilot Protocol.

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		deserving population. Also, see slide 39 - the US military at Reed Army Medical Centre has begun a 120-subject longitudinal study comparing EFT, CBT and usual PTSD care. Please consider the emerging and promising research into EFT for PTSD. It is worthy of mention in the guideline; this would help a great many sufferers.  56794 - updated by AAMET.doc  CAIET Conference. ACEP Research Com			Traumatology 16(1): 55-65. • Sakai et al., 2010. Treatment of PTSD in Rwandan child genocide survivors using thought field therapy. International Journal of Emergency Mental Health 12(1): 41-49. However as the studies compared different interventions and included different populations we feel that this is insufficient evidence to warrant an update of the guideline as this time. However, this area will be examined again in the future review of the guideline.
Nottinghamshire Healthcare	Agree	Agree that it is better to wait for further evidence before fully revising the guideline.			Thank you for your comment.

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NHS Trust					
Traumatic Stress Service (SWLSTG)	Disagree	The review of the more recent evidence clearly supports the current recommendations regarding the effective treatments for PTSD, namely Trauma-focused CBT and EMDR. However, it would be helpful to patients, clinicians and commissioners to have fuller guidance in relation to specific populations (such as veterans, refugees and asylum-seekers, people with PTSD to childhood sexual abuse, traumatic bereavement or significant co-morbidity) where it exists.			Thank you for your comment. The guideline scope covers adults and children of all ages, who meet, or are at risk of PTSD. As such, the interventions covered in the guideline are relevant for all children and adults presenting with PTSD to the NHS. Although the guideline currently provides special consideration to the role and links with other organisations that play a key part in delivering care (particularly in the immediate aftermath of traumatic events) for those at risk of PTSD within specific populations of ex-military personnel, refugees and survivors of disasters.
Traumatic Stress Service (SWLSTG)		In addition to assisting patients and clinicians, in the current economic climate, more detailed guidance regarding groups likely to need more than 12 treatment sessions would be extremely helpful.			Thank you for your comment.
Southern Health NHS Foundation Trust	I agree that there is not a requiremen	The request for comments was passed to me with only 4 days notice prior to deadline, am unsure if this was our Trusts delay or from original source, so apologies for these very rushed comments as a	Interested to know if in the future 'NICE' are planning to move away from the	It may be therefore that if guidelines were more inclusive of different research	Thank you for your comment. The NICE Guidelines Manual 2009 suggests that a review

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	t to update guidance at this time due to the research papers presented.	result of this limited time.	reliance on RCT's when, (particularly in the trauma field), such methodological approaches are felt by many clinicians and researchers to be less relevant and transferable to the 'coalface' of actual patient care working? As suggested by researchers such as Hawker, Durkin and Hawker (2010); Deahl, Scrinivasan, Jones, Thomas, Neblett, & Jolly, (2000); BPS (2002) and Stehl, Kazah, Alderfer et al (2009) for example.	methodology there may be a resulting change in the direction of future guidelines and their recommendations and thus make them actually more 'useable' in day to day clinical practice.	question relating to an intervention is usually best answered by a randomised controlled trial (RCT), because this is most likely to give an unbiased estimate of the effects of an intervention. The Centre for Clinical Practice Guidelines Manual update will be available for stakeholder consultation in January 2012. We would welcome your comments on the review process at this time.
Southern Health NHS Foundation Trust			I do feel a review should take place after the publication of the DSM-V as this may well have a bearing on the guidance NICE recommends. Particularly if the		Thank you for your comment. This area will be examined again in the future review of the guideline

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			planned 1 (4) concerning repeated exposure to aversive events is included (e.g., first responders collecting body parts; police officers repeatedly exposed to details of child abuse).		
Southern Health NHS Foundation Trust		I do feel strongly that when the guidelines are reviewed in full, changes should be made as to the clarity of chapter 7 to make obvious that that psychological debriefing/CISM (as originally intended) was and is not intended as preventing (or as a treatment for) PTSD but as a crisis support strategy.			Thank you for your comment. This information will be considered when the guideline will be updated in the future.
Southern Health NHS Foundation Trust		This appears to have been omitted - Pharmacotherapy in post-traumatic stress disorder: evidence from randomized controlled trials Sullivan, Gregory M; Neria, Yuval Current Opinion in Investigational Drugs, vol. 10, no. 1, pp. 35-45, January 2009			Thank you for providing the reference by Sullivan et al. This reference was identified through our high-level RCT search but did not meet our inclusion criteria as, from an assessment of the abstract, it is not a systematic review. This area will be examined again in the future review of the guideline
RCPCH	Yes	We agree			Thank you for your comment.

Stakeholder	Agree with proposal not to update?	Comments	Comments on areas excluded from original scope	Comments on equality issues	Responses
British Association of Art Psychotherapists	Agree with proposal but Disagree at the exclusion of Art therapy as a well recognised treatment modality in the management of PTSD	1) Although post traumatic stress disorder (PTSD) in children has been extensively studied during the past 15 years, little research exists regarding the efficacy of treatment interventions. This report describes an outcome-based art therapy research project currently conducted at a large urban hospital trauma center. Included are the theoretical rationale and overview of an art therapy treatment intervention called the Chapman Art Therapy Treatment Intervention (CATTI) designed to reduce PTSD symptoms in pediatric trauma patients. Used in this study, the CATTI was evaluated for efficacy in measuring the reduction of PTSD symptoms at intervals of 1 week, 1 month, and 6 months after discharge from the hospital. An early analysis of the data does not indicate statistically significant differences in the reduction of PTSD symptoms between the experimental and control groups. However, there is evidence that the children receiving the art therapy intervention did show a reduction in acute stress symptoms. The Effectiveness of Art Therapy Interventions in Reducing Post Traumatic Stress Disorder (PTSD) Symptoms in Pediatric Trauma Patients Linda Chapman MA, ATR-BC[a], Diane Morabito RN, MPH[a], Chris Ladakakos PhD[b], Herbert Schreier MD[b] & M. Margaret Knudson MD[a]			Thank you for providing the reference by Chapman et al. Through an assessment of the abstract we feel that this is insufficient evidence to warrant an update of the guideline at this time. However, the use of art therapy for the management of PTSD will be examined in the future review of the guideline.
British Association	Agree with proposal	2) Describes an art therapy program designed as an alternative treatment modality for Vietnam			Thank you for your comment.

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of Art Psychotherapists	but Disagree at the exclusion of Art therapy as a well recognised treatment modality in the management of PTSD	veterans who were dealing 15 yrs later with the psychological sequelae of combat. The 5 ways in which the Ss' dualistic approach to self-representation manifested itself artistically are presented. Ss' conscious and unconscious attempts to integrate the opposite aspects of the self symbolically are described. (PsycINFO Database Record (c) 2010 APA, all rights reserved) Symbolic expression in post-traumatic stress disorder: Vietnam combat veterans in art therapy. Golub, Deborah			Through the review of the guideline no RCTs relating to art therapy as an intervention for PTSD were identified. However, the use of art therapy for the management of PTSD will be examined in the future review of the guideline.
British Association of Art Psychotherapists	Agree with proposal but Disagree at the exclusion of Art therapy as a well recognised treatment modality in the management of PTSD	3) Both psychosocial and medication management have been recommended, alone and in combination, for children and adolescents suffering from posttraumatic stress disorder (PTSD). Empirical evidence favors cognitive-behavioral psychotherapy over other forms of psychotherapy; support for medication management is weak at best. Eye movement desensitization and reprocessing may or may not prove useful, and treatments such as art therapy, psychodynamic psychotherapy, or group therapy, are supported by anecdotal evidence but cannot on this basis be recommended as 1st-line treatments for pediatric PTSD. There currently is no empirical evidence regarding the optimal length of the treatment with psychotherapy or medication. Children and adolescents with PTSD would likely benefit from treatment focused on PTSD symptomatology. Recommendation ratings are presented for several			Thank you for your comment. Thank you for supplying the references by Cohen et al., 2000. However this reference does not meet our inclusion criteria as we only consider studies published from 2004 onwards as the aim of this review is to consider new evidence published since the publication of the guideline. However, the interventions that you have mentioned will be examined in the future review of the guideline.

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		different treatments. Treatment of children and adolescents. Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies. Cohen, Judith A.; Berliner, Lucy; March, John S. Foa, Edna B. (Ed); Keane, Terence M. (Ed); Friedman, Matthew J. (Ed), (2000)			
British Association of Art Psychotherapists	Agree with proposal but Disagree at the exclusion of Art therapy as a well recognised treatment modality in the management of PTSD	4) Pediatric and young adult renal transplant recipients may experience feelings of depression and emotional trauma. A study was conducted to (1) determine the prevalence of depression and emotional trauma and (2) assess the utility of the Formal Elements of Art Therapy Scale (FEATS). Sixty-four renal transplant recipients, 6–21 yr of age, were evaluated using self-report measures (CDI and Davidson) and art-based assessments. Subject art was analyzed by art therapists using seven of the 14 elements of the (FEATS), to assess depression. Unlike CDI and Davidson self-report testing, all patients were able to complete the art-based directives. When self-report measures and art-based assessments were combined, 36% of the study population had testing results consistent with depression and/or post-traumatic stress. The FEATS assessments identified a subset of patients who were not identified using the self-report measures. There was a correlation between CDI and Davidson scores ($p < 0.0001$), Davidson scores correlated with hospital days ($p = 0.05$), and			Thank you for providing the reference by Wallace et al., 2004. Through an assessment of the abstract we feel that this is insufficient evidence to warrant an update of the guideline at this time. However, the use of art therapy for the detection of PTSD will be examined in the future review of the guideline.

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		FEATS correlated with height Z score (p = 0.04) and donor type (p = 0.01). Patients who required psychological interventions including antidepressant therapy, psychological counseling and psychiatric hospitalization during the year after the study were identified as depressed. Sensitivity for FEATS and CDI were 22 and 50% respectively. The results suggest that while art therapy may be of utility in the identification of pediatric and young adult transplant recipients who are suffering from depression, FEATS analysis appears to lack sufficient sensitivity to warrant its use in this population. Study of other quantitative art-based assessment techniques may be warranted. The use of art therapy to detect depression and post-traumatic stress disorder in pediatric and young adult renal transplant recipients. Jo Wallace[1], Peter D. Yorgin[2], Richard Carolan[1], Heather Moore[1], Jaime Sanchez[2], Amir Belson[2], Lisa Yorgin[2], Cyd Major[2], Laura Granucci[2], Steve Alexander[2], Doris Arrington[1]			
Firestress Solutions	Disagree. Clinical Area 3. See: Valentine, P. V. & Smith, T. E. (2001). Evaluating	Traumatic Incident Reduction (TIR) was found to significantly reduce PTSD symptoms in a sample of incarcerated women compared to controls and over time (1-week and 3-month follow-ups).  TIR for NREPP final-jd.pdf	Traumatic Incident Reduction (TIR) is a manualised, standardised procedure that can be taught to non-clinically trained practitioners in a week. As a single-		Thank you for supplying the references by Smith et al., 2001 and the research review on Traumatic Incident Reduction (TIR). However these references do not meet our inclusion criteria as we only consider studies published from 2004 onwards as the aim

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	Traumatic Incident Reduction (TIR) Therapy with female inmates: A randomized controlled clinical trial. *Research on Social Work Practice, 11* (1), 40-52.		session protocol it offers additional economic benefits to multiple-session approaches to treatment.		of this review is to consider new evidence published since the publication of the guideline. However, TIR will be examined in the future review of the guideline.
Firestress Solutions	Disagree. Clinical Area 3.	In this PTSD sample TIR was found to improve outcomes compared to no treatment			Thank you for your comment. Through the review of the guideline no literature relating to TIR for PTSD was identified. However, TIR will be examined in the future review of the guideline.
Firestress Solutions	Disagree. Clinical Area 3.	Advantage over other treatments: In this PTSD sample TIR was found to confer reductions in depression, anxiety and improved self-perceptions.			Thank you for your comment. Through the review of the guideline no literature relating to TIR for PTSD was identified. However, TIR will be examined

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					in the future review of the guideline.
Firestress Solutions	Disagree. Clinical Area 3.	Advantage over other treatments: Reductions and improvements were reported relative to controls, following treatment and over time (3 month follow-up).			Thank you for your comment. Through the review of the guideline no literature relating to TIR for PTSD was identified. However, TIR will be examined in the future review of the guideline.
Firestress Solutions	Disagree. Clinical Area 3.	Advantage over other treatments: Treatment condition was a single session of TIR.			Thank you for your comment. Through the review of the guideline no literature relating to TIR for PTSD was identified. However, TIR will be examined in the future review of the guideline.
UKPTS	Disagree	We have had comments from approx. 20 of our members with a very clear theme. The guidelines do need updating for the following reasons. There are a small number of trials of more complex PTSD (Cloitre et al) and these should be reviewed. Brief Eclectic Therapy is included with CBT, this is			Thank you for your comment. The current guideline states the following relating to complex PTSD: • The NICE guideline focuses on the treatment of PTSD, as there is as yet little research on the treatment of 'enduring

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		wrong and misleading. There is one trial of EFT (which is being widely used) Power et al. There are more drug trials. Clinicians are desperate for more guidance on the treatment of non straightforward PTSD, even guidance on how poor the evidence is would be of help.			personality changes after catastrophic experience'. It is, however, recognised that many PTSD sufferers will have at least some of the features of this disorder or the corresponding concept of 'disorders of extreme distress not otherwise specified' (DESNOS) (complex PTSD). The guideline therefore takes into account that these features need to be considered when treating PTSD sufferers. However, the guideline does not apply to individuals with a diagnosis of 'enduring personality changes after catastrophic experience' rather than PTSD. Through an assessment of abstracts, no studies were identified which focused on complex PTSD. This area will be examined in a future review of the guideline. Through the review of the

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					guideline no evidence was identified relating to EFT or brief eclectic therapy as interventions for management of PTSD. These interventions will be examined in the future review of the guideline. In terms of drug trials, new evidence was identified relating to pharmacological treatment of PTSD in adults. However, heterogeneity across the studies was evidence relating to comparators used and reported results. In addition, generally the medications identified (apart from paroxetine and sertraline) do not currently have a UK license for use in PTSD. Taking study heterogeneity into account, we feel that there is insufficient new evidence to warrant an update of the current guideline recommendations at this time.
Department of Health		I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.			Thank you for your comment.

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Association for Family Therapy and Systemic Practice (AFT)	Agree	Agree that there is not enough new evidence for changes in the guideline, but it may be helpful to consider a systemic approaches with families when appropriate in treating children and young people, for the next review: Field, A. and Cottrell, D. (2011): Eye movement desensitization and reprocessing as a therapeutic intervention for traumatized children and adolescents: a systematic review of the evidence for family therapists. Journal of Family Therapy. 33.4.374-388. A description of how this can be implemented follows this article: Pocock, D. (2011): The promise of EMDR in family and systemic psychotherapy: a clinical complement to Field and Cottrell. Journal of Family Therapy. 33.4.389-399.			Thank you for providing the references by Field and Cottrell, 2011 and Pocock, 2011. These studies were not identified through our review process as they were published in November 2011 (after our search cut-off date). Through an assessment of the abstracts we feel that this is insufficient evidence to warrant an update of the guideline at this time. However, the areas you have highlighted will be examined again in the future review of the guideline.
British Psychological Society	Disagree	The review consultation document does not mention the RCT by Kemp *et al* (2010), which found EMDR to be superior to wait-list control, nor does it mention the meta-analysis by Rodenburg *et al* (2009) which demonstrates the effectiveness of Eye Movement Desensitisation and Reprocessing (EMDR) for children and young people. Moreover, the section on pages 31-32 of the consultation document, *does* mention an RCT showing EMDR to be effective for children with PTSD (Ahmad et al 2007).			Thank you for your comment. Thank you for providing the references by Rodenburg et al., 2009 and Kemp et al., 2010. These references were identified through our high-level RCT search but did not meet our inclusion criteria as, from an assessment of the abstract, Kemp et al did not appear to be an RCT and Rodenburg et al did not describe the method of

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		The above evidence, published since the original guideline, (i.e. two RCTs and a meta-analysis), together with the RCTs by Jaberghaderi (2004) and Chemtob *et al* (2002) mentioned in section 9.6 of the original Full Guideline, warrants a deeper review of the evidence to ascertain whether EMDR should be recommended as an intervention for Children and Young People. References: Ahmad, A., Larsson, B. & Sundelin-Wahlsten, V. (2007) EMDR treatment for children with PTSD: Results of a randomized controlled trial. *Nordic Journal of Psychiatry, 61*,349-354. Cont'd/ ….. Chemtob, C. M., Nakashima, J. & Carlson, J. G. (2002). Brief treatment for elementary school children with disaster-related posttraumatic stress disorder: A field study. *Journal of Clinical Psychology*, *58*, 99–112. Jaberghaderi, N., Greenwald, R., Rubin, A., Zand, S.O. & Dolatabadi, S. (2004). A comparison of CBT and EMDR for sexually abused Iranian girls. *Clinical Psychology and Psychotherapy*, *11*, 358–368. Kemp, M., Drummond, P. & McDermott, B. (2010). A wait-list controlled pilot study of eye movement desensitization and reprocessing (EMDR) for children with post-traumatic stress disorder (PTSD)			meta-analysis used and how included studies were identified. Through the review of the guideline we identified one study on EMDR in children however we feel that this is insufficient evidence to warrant an update of the guideline at this time. As such, we concluded that it would be pertinent to await further evidence, particularly on the benefits, harms and cost-effectiveness of EMDR in children before considering an update of the guideline recommendations. This area will be examined again in the future review of the guideline.

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		symptoms from motor vehicle accidents. *Clinical Child Psychology and Psychiatry*. Available online at: http://ccp.sagepub.com/cgi/content/abstract/15/1/5 Accessed November 2011. Rodenburg, R., Benjamin, A., de Roos, C., Meijer, A. M. & Stams, G. J. (2009). Efficacy of EMDR in children: A meta-analysis. *Clinical Psychology Review, 29*, 599-606.			
British Psychological Society	Disagree	The recommendation in the original Full Guideline to offer trauma-focussed CBT to children and young people is graded B. Given that the review consultation document has identified additional RCTs evidencing the effectiveness of trauma-focussed CBT for children and young people with PTSD, a review of the guidelines would enable this to be upgraded if appropriate.			Thank you for your comment. Through the review of the guideline the identified new literature highlighted the beneficial effect of trauma-focused CBT as an intervention for PTSD in children and young people and therefore supports the current guideline recommendations. As such, we feel that this does not warrant an update of the guideline at this time.
British Psychological Society	Disagree	In the original Full Guideline, the recommendation to offer trauma-focused CBT to older children with severe PTSD symptoms in the first month is graded C (9.9.2.1). However in both the NICE Guideline (1.9.5.1) and the Quick Reference Guide (page 15),			Thank you for bringing this to our attention. This information will be passed to the relevant team for amending.

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		this same recommendation is graded B. Although this may simply be a typographic error, because of the contentious nature of early intervention, it is important to be absolutely clear about the level of evidence. A review of the guidelines would enable this anomaly to be corrected.			
RCN	Agree	Agree that the guideline should not be considered for an update at this time. Nothing significant has occurred to warrant this and the guideline is still fit for purpose for those individuals presenting with single trauma presentations.	The area that NICE has not addressed fully is complex trauma - those individuals who are victims of child sexual abuse or torture and asylum seekers with the former. This would be a useful review for NICE to undertake and make a clear distinction that there is a large difference between the two populations in their presentation and treatment needs. The latter group do not do well with 12-16 sessions of out-put		Thank you for your comment.. The current guideline states the following relating to complex PTSD: • The NICE guideline focuses on the treatment of PTSD, as there is as yet little research on the treatment of 'enduring personality changes after catastrophic experience'. It is, however, recognised that many PTSD sufferers will have at least some of the features of this disorder or the corresponding concept of 'disorders of extreme distress not otherwise specified' (DESNOS) (complex PTSD). The guideline

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			Trauma Focused Cognitive Behavioural Therapy (TFCBT) or Eye Movement Desensitization Reprocessing therapy (EMDR).		therefore takes into account that these features need to be considered when treating PTSD sufferers. However, the guideline does not apply to individuals with a diagnosis of 'enduring personality changes after catastrophic experience' rather than PTSD. Through an assessment of abstracts, no studies were identified which focused on complex PTSD. This area will be examined in a future review of the guideline.
British Association for Behavioural and Cognitive Psychotherapies (BABCP)	Agree	We welcome the thorough review of research relating to the assessment, prediction and treatment of PTSD since the first publication of the NICE guidelines in 2005. We commend the NICE expert review group for the comprehensive review and the scope and number of questions considered in relation to PTSD. An extensive range of studies were reviewed. These support the recommendation of trauma-focused psychological therapy, such as CBT and EMDR, for PTSD. The review also included a small number of studies, which investigated a new modality through which to	The original scope is inclusive of adults and children of all ages who meet or at risk of PTSD.	There was no evidence indicating a failure to comply with anti-discrimination and equalities legislation. Given the differing nature of traumatic events (e.g. rape / combat / torture), additional information regarding age, gender,	Thank you for your comment.

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		deliver treatment for PTSD, such as internet-based therapy, therapy via video teleconferencing, and the use of virtual reality as a therapy tool. However, these particular studies were few in number and more research is needed to evaluate the longer-term benefits, harms and cost-effectiveness of these approaches. Overall, we agree there is insufficient new evidence to update the current guidelines. We support the recommendation of trauma-focused psychological interventions, such as CBT, for the treatment of PTSD. We are aware that the DSM-IV is undergoing revision to version DSM-V and that the impact of this on the assessment and prediction of PTSD will need to be reviewed after May 2013.		socioeconomic status, ethnicity etc may be particularly useful for this clinical area in future revisions. Treatment developments for groups such as refugees and asylum seekers were discussed in the original guidelines but seemingly not in this document.	
BABCP		This work is warmly welcomed by BABCP and only minor comments that might improve clarity are given. P.6 Clinical Area 2; early interventions. There are two 'clinical questions': "For people exposed to trauma, do early pharmacological interventions improve patient outcomes compared to placebo?" and "For people exposed to trauma, do any early pharmacological interventions confer any advantage over any other pharmacological interventions?" (first column). However, there seems to be no summary of evidence regarding theses points in column 2. Please clarify (p.6-7)			Thank you for your comment. All the clinical questions cited in the guideline relating to the clinical area: Early interventions for PTSD in adults have been included within the table as they are related to that particular clinical area. However, only literature relating to psychological interventions was identified and has been summarised in the table.

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BABCP		The following point regarding early interventions would benefit from further clarification: P.8 Summary point 1 – states "trauma focussed cognitive behavioural therapy should be offered to those with severe post-traumatic symptoms or with severe PTSD **in the first month** after the traumatic event". However, the evidence on page 6 states "No psychological intervention could be recommended for routine use following traumatic events and that multiple session interventions may have an adverse effect on some individuals". Further, it seems that there is evidence under the subheading "Trauma focussed cognitive behavioural therapy" for CBT within 3 months but not 1 month in particular Therefore, it is unclear from the summary of evidence why trauma focused CBT is recommended to be offered in the first month in Summary point 1 above? Could this conclusion be better clarified in the text or amended as appropriate?			Thank you for your comment. Three RCTs were identified which indicated that trauma-focused cognitive behavioural therapy (CBT) within three months of a traumatic event was more effective than waiting list or supportive counselling conditions whilst a systematic review was unable to recommend an intervention for routine use following traumatic events. As our methodology for a review of the guideline involves an assessment of the abstracts as opposed to the full text paper we cannot determine exactly when the interventions described in the studies were administered. However, we concluded that, in general, the evidence supports the use of trauma-focused CBT as an early intervention for PTSD. Further information regarding how this recommendation was originally derived can be found in chapter 7 of the guideline. This area will be examined

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					again in a future review of the guideline.
BABCP		A similar point to that described above is also made in the summary on P.18: “Trauma focussed psychological treatment should be offered to PTSD sufferers regardless of the time that has elapsed since the trauma”. Does this mean from day 1? Please can this conclusion be better clarified in the text or the conclusion amended as appropriate?			Thank you for your comment. “Trauma focussed psychological treatment should be offered to PTSD sufferers regardless of the time that has elapsed since the trauma” is one of the recommendations presented in the guideline. Further information regarding how this recommendation was originally derived can be found in chapter 5 of the guideline.
BABCP		No new areas for research recommendations appear to have been considered, yet given the lack of updates to the guidelines this may be particularly relevant and aid the development of future guidelines. Implications that flow from the current document might include 1. Early interventions / preventative treatment strategies. 2. Treatments for refugees and asylum seekers 3. And so forth			Thank you for your comment. Through the review process we assessed the identified studies to determine whether they are relevant to the research recommendations presented in the guideline. No evidence that directly matched the guideline research recommendations was identified.

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BABCP	Agree	This is a good review of evidence pertaining to PTSD in children and adolescents. We felt that there were some additional papers to consider. Our comments below are directed at the relevant sections of the review document.			Thank you for your comment.
BABCP		*Clinical area 1: Predictors of PTSD and screening for the disorder* With respect to predictors of PTSD and screening for the disorder in children and adolescents, several highly pertinent papers are missed. Several groups have published papers on the validity of Acute Stress Disorder as a predictor of later PTSD (Bryant, Mayou, Wiggs, Ehlers, & Stores, 2004; Dalgleish et al., 2008; Kassam-Adams & Winston, 2004; Meiser-Stedman, Smith, Glucksman, Yule, & Dalgleish, 2008; Meiser-Stedman, Yule, Smith, Glucksman, & Dalgleish, 2005). In each instance ASD was found to be minimally useful as a predictor of PTSD, i.e. positive predictive rates are low, and the measure is insensitive to some chronic PTSD cases. Other screening instruments have been found to predict chronic PTSD cases. In particular the STEPP was produced based on analyses from a large sample of traffic accident survivors (Winston, Kassam-Adams, Garcia-Espana, Ittenbach, & Cnaan, 2003). However, the reliability of such instruments has not been replicated (Nixon, Ellis,			Thank you for your comment. Thank you for providing references relating to predictors of PTSD and screening for the disorder. These studies will be passed to the technical team responsible for updating the guideline in the future. As the update of the Diagnostic and Statistical Manual of Mental Disorders (to version DSM-V) is ongoing we feel that it would be pertinent to wait for the DSM-V to be published before an update is commissioned particularly as we do not know what impact the revised DSM will have on the guideline recommendations.

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		Nehmy, & Ball, 2010). Screening measures based on early symptoms counts are encouraging, e.g. the Child Revised Impact of Event Scale and the Child Trauma Screening Questionnaire (CTSQ)(Kenardy, Spence, & Macleod, 2006). The findings for the CTSQ, which shares the approach of the adult Trauma Screening Questionnaire (Brewin et al., 2002) on relying on screening for the presence of the ten PTSD reexperiencing and hyperarousal symptoms, are further supported by a large data set which also examined the effectiveness of examining these same ten symptoms (Dalgleish et al., 2008). There is also some evidence that including elevated heart rate with the CTSQ improves this predictive ability (Olsson, Kenardy, De Young, & Spence, 2008). Several studies have examined predictors of PTSD that are not included in the document (e.g. Meiser-Stedman et al., 2009; Stallard et al., 2007; Nixon et al., 2010). These papers are best summarised in a recent meta-analysis (Alisic et al., 2011). In summary, while the evidence for the CTSQ as an early screening measure is promising, there are no firm conclusions about screening measures at this time, and more research is needed.			
BABCP		*Clinical area 5: Children and young people with PTSD*			Thank you for your comment.

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		The Sijbrandij et al. (2007) study concerns adults (aged 18 upwards) and is therefore not relevant to this section. The Catani study (Catani et al., 2009) is comparing NET to another "active" treatment, so it is perhaps not fair to conclude that there was no beneficial effect observed. A further recent trial shows evidence of the equivalence of EMDR and CBT (de Roos et al., 2011). There are two further studies that have examined psychoeducation as a treatment or early intervention for PTSD. Kenardy et al., (2008) found that the provision of information booklets (relative to no intervention) significantly reduced anxiety symptoms, but not PTSD symptoms. Cox et al., (2009) examined whether an online information provision package would be effective as an early intervention. Again, the intervention improved anxiety symptoms, but not PTSD symptoms. These findings do not appear to substantially impact on the recommendations for the treatment of PTSD in children and adolescents, i.e. CBT remains the recommended treatment. However, EMDR and Narrative Exposure Therapy would appear to have greater warrant now. In light of the latest Scheeringa trial (2011) for trauma-focused CBT for young (i.e. preschool) children, it might also be helpful for the guidelines to stress that TF-CBT is an appropriate treatment in this age group.			We agree that the Sijbrandij et al., 2007 study should have been included in the section related to adults. Thank you for bringing this to our attention. This will be passed onto the relevant team for amending. In terms of our process for a review of the guideline we assess study abstracts although we are aware that the full publication will contain additional results and information. The current process is under development and will be out for consultation as part of the Centre for Clinical Practice Guidelines Manual update in January 2012. We would welcome your comments on the review process at this time. All the areas you have highlighted will be examined again in the future review of the guideline.

These organisations were approached but did not respond.

2gether NHS Foundation Trust
A Little Wish
Alder Hey Children's NHS Foundation Trust
All Wales Senior Nurses Advisory Group
Anglesey Local Health Board
Anxiety UK
ASSIST Trauma Care

Association for Improvements in the Maternity Services

Association of Child Psychotherapists, The
Association of Professional Music Therapists
Association of Therapeutic Communities
Avon and Wiltshire Mental Health Partnership NHS Trust
Barnsley Primary Care Trust
Birth Trauma Association
Black Women's Rape Action Project
Borderline UK LTD
Bradford District Care Trust
British Association for Counselling and Psychotherapy
British Association for Psychopharmacology

British Association of Critical Care Nurses

British Association of Music Therapy
British Association of Social Workers
British Geriatrics Society
British Medical Association
British Medical Journal
British National Formulary
British Paediatric Accident & Emergency Group

British Society of Rehabilitation Medicine
Camden and Islington NHS Foundation Trust
Camden Link
Care Quality Commission (CQC)
Central & North West London NHS Foundation Trust
Central Lancashire Primary Care Trust
Central London Community Healthcare
Centre for Trauma Studies/Traumatic Stress Services
Changed to British Paediatric Mental Health Group ..British Paediatric Psychology & Psychiatry Group
Cochrane Depression Anxiety and Neurosis Group
College of Mental Health Pharmacy
College of Occupational Therapists

Combat Stress
Community Psychiatric Nurses' Association
Contact
Co-operative Pharmacy Association
Counselling and Psychotherapy Trust
Coventry and Warwickshire Partnership Trust

Crisis
Critical Psychiatry Network
Cruse Bereavement Care
Department of Health
Department of Health, Social Services and Public Safety - Northern Ireland
Devon Partnership NHS Trust

Dorset Mental Health Forum
Dorset Primary Care Trust
East London NHS Foundation Trust
Eastbourne District General Hospital
Eli Lilly and Company
EMDR UK and Ireland Association
EMDR Workshop Ltd
Equalities National Council
Faculty of Intensive Care Medicine
Faculty of Public Health

First Person Plural
Five Boroughs Partnership NHS Trust
Foreign and Commonwealth Office
George Eliot Hospital NHS Trust
GlaxoSmithKline
Gloucestershire LINk
Great Western Hospitals NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust

Hafal
Hafan Cymru
Hampshire Partnership NHS Trust
Health Quality Improvement Partnership
Healthcare Improvement Scotland
Hertfordshire Partnership NHS Trust
Human Givens Institute
Humber NHS Foundation Trust
Independent Healthcare Advisory Services
Independent Midwives Association
Janssen
Kent and Medway NHS and Social Care Partnership Trust
Leicestershire Partnership NHS Trust
Liverpool Primary Care Trust
Lundbeck UK
Maidstone and Tunbridge Wells NHS Trust
Manic Depression Fellowship - The Bipolar Organisation
Medicines and Healthcare products Regulatory Agency
Mental Health Foundation
Ministry of Defence
Moving Minds Ltd
National Childbirth Trust
National Clinical Guideline Centre
National Collaborating Centre for Cancer
National Collaborating Centre for Mental Health

National Institute for Health Research Health Technology Assessment Programme
National Institute for Mental Health in England
National Nurse Consultants in CAMHS forum
National Patient Safety Agency
National Public Health Service for Wales
National Treatment Agency for Substance Misuse
NCC Women & Childrens Health
Neurolink
NHS Connecting for Health
NHS Direct
NHS Herefordshire
NHS Milton Keynes
NHS North East Essex
NHS Plus
North Essex Mental Health Partnership Trust
North Staffordshire Combined Healthcare NHS Trust
North Yorkshire & York Primary Care Trust
Nottinghamshire Acute Trust

PERIGON Healthcare Ltd
Pfizer
Pilgrim Projects
POhWER
Pulse Doctors
Rethink Mental Illness
Richmond Fellowship

Rotherham Primary Care Trust
Royal Berkshire NHS Foundation Trust
Royal Brompton Hospital & Harefield NHS Trust
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of General Practitioners in Wales
Royal College of Midwives

Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Psychiatrists in Scotland
Royal College of Psychiatrists in Wales
Royal College of Radiologists
Royal College of Surgeons of England
Royal Pharmaceutical Society
Royal Society of Medicine
Royal West Sussex NHS Trust
Safeline
Scottish Intercollegiate Guidelines Network
SEE Pfizer - DO NOT USE Wyeth Pharmaceuticals
Sheffield Primary Care Trust
SIARI

Social Care Institute for Excellence
Society for Existential Analysis
Solvay
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Specialist Psychotherapy Services
St Mungo's
ST Solutions Ltd
Staffordshire Ambulance Service NHS Trust
Step4Ward Adult Mental Health
Suffolk Mental Health Partnership NHS Trust
Sure Start Ashfield
Sussex Partnership NHS Trust
Tees, Esk and Wear Valleys NHS Trust
The Association of the British Pharmaceutical Industry
The British False Memory Society
The Children's Trust
The College of Social Work
The Hindu Forum of Britain
The Northern Ireland Veterans Association
The Princess Alexandra Hospital NHS Trust
The Rotherham NHS Foundation Trust
The Survivors Trust
UK Specialised Services Public Health Network
UKSSD
Unite - the Union

United Kingdom Council for Psychotherapy
United Kingdom Psychological Trauma Society
United Lincolnshire Hospitals NHS
VBAC Information and Support

Victim Support
Welsh Government
Welsh Scientific Advisory Committee
West London Mental Health NHS Trust
Westmeria Healthcare Ltd
WISH - A voice for women's mental health
Women Against Rape
Worcestershire Acute Hospitals Trust
York Hospitals NHS Foundation Trust
York Stress & Trauma Centre
YoungMinds