NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline scope

Post-traumatic stress disorder: management

Topic

This guideline will update the NICE guideline on post-traumatic stress disorder: management (CG26) as set out in the surveillance review decision.

The guideline will be developed using the methods and processes outlined in Developing NICE guidelines: the manual.

For more information about why this guideline is being developed, and how the guideline will fit into current practice, see the context section.

Who the guideline is for

- People with post-traumatic stress disorder (PTSD) (including complex PTSD), people at risk of PTSD, families and carers of people with PTSD and the public.
- Practitioners involved in recognising PTSD and in caring for people with PTSD. These include the following: GPs, psychiatrists, clinical psychologists, practitioner psychologists, psychological wellbeing practitioners within IAPT (improving access to psychological therapies) services, mental health nurses, community psychiatric nurses, social workers, practice nurses, first responders who respond to an emergency, occupational therapists, other physicians, midwives, health visitors and psychological therapists.
- Practitioners in non-health sectors who are involved in providing services for people at risk of or who have PTSD. These may include practitioners who work in the criminal justice and education sectors and in non-government organisations.

- People with responsibility for planning services for people with a diagnosis of PTSD and their families and carers. These include directors of public health, NHS trust managers and managers in clinical commissioning groups.

NICE guidelines cover health and care in England. Decisions on how they apply in other UK countries are made by ministers in the Welsh Government, Scottish Government, and Northern Ireland Executive.

Equality considerations

NICE has carried out an equality impact assessment during scoping. The assessment:

- lists equality issues identified, and how they have been addressed
- explains why any groups are excluded from the scope.

The guideline will look at inequalities relating to gender, sexual orientation, gender reassignment, age, homelessness, refugees and asylum seekers, illegal immigrants, undocumented workers and failed asylum seekers, people with neurodevelopmental disorders, people with coexisting conditions, and people who are critically ill. The guideline committee will be sensitive to the different approaches to PTSD among people of different family origins and cultures, and be aware of the issues of both internal and external social exclusion.

1 What the guideline is about

1.1 Who is the focus?

Groups that will be covered

- Adults, children and young people at risk of or with PTSD.
- Family members and carers of people with PTSD: the guideline will recognise their role in the treatment and support of people with PTSD.

- Adults, children and young people with PTSD who have coexisting conditions, such as drug and alcohol misuse, common mental health disorders or personality disorders.

1.2 Settings

Settings that will be covered

- All NHS and social care commissioned services where care is provided for people at risk of or with a diagnosis of PTSD.

Settings that will not be covered

- Theatres of military conflict.

1.3 Activities, services or aspects of care

We will look at evidence on the areas listed below when developing the guideline, but it may not be possible to make recommendations on all the areas.

Key areas that will be covered

Areas from the published guideline that will be updated

1 Psychological and psychosocial interventions for the prevention and treatment of PTSD

2 Pharmacological interventions for the prevention and treatment of PTSD. Note the guideline recommendations will normally fall within licensed indications; exceptionally, and only if clearly supported by evidence, use outside a licensed indication may be recommended. The guideline will assume that prescribers will use a medicine's summary of product characteristics to inform decisions made with individual patients.

3 Principles of care for all people with PTSD

4 Support for families and carers

5 Practical and social support

6 Care for people with coexisting conditions

Areas that will not be covered

Areas from the published guideline that will not be updated

1 Recognition

2 Assessment

3 Language and culture

4 Disaster planning

Recommendations in areas that are not being updated may be edited to ensure that they meet current editorial standards, and reflect the current policy and practice context.

Areas not covered by the published guideline or the update

1 Inoculation interventions for people who may be at risk of experiencing, but have not experienced, a traumatic event

1.4 Economic aspects

We will take economic aspects into account when making recommendations. We will develop an economic plan that states for each review question (or key area in the scope) whether economic considerations are relevant, and if so whether this is an area that should be prioritised for economic modelling and analysis. We will review the economic evidence and carry out economic analyses, using an NHS and personal social services (PSS) perspective, although economic analyses will attempt to incorporate wider costs associated with the care of people with PTSD in other settings (for example, schools, immigrant and refugee centres, and the criminal justice system) if appropriate cost data are identified.

1.5 Key issues and draft review questions

While writing this scope, we have identified the following key issues, and key questions related to them:

1 Psychological and psychosocial interventions for the prevention and treatment of PTSD

1.1 For children and young people at risk of PTSD, do specific psychological or psychosocial interventions result in a clinically important reduction of PTSD symptoms or prevention of PTSD, reduction of symptoms of a coexisting condition, improved functioning, improved quality of life and/or adverse effects when compared with other interventions, treatment as usual, waitlist control or no intervention?

1.2 For children and young people with clinically important post-traumatic stress symptoms, do specific psychological or psychosocial interventions result in a clinically important reduction of PTSD symptoms, reduction of symptoms of a coexisting condition, improved functioning, improved quality of life and/or adverse effects when compared with other interventions, treatment as usual, waitlist control or no intervention?

1.3 For adults at risk of PTSD, do specific psychological or psychosocial interventions result in a clinically important reduction of PTSD symptoms or prevention of PTSD, reduction of symptoms of a coexisting condition, improved functioning, improved quality of life and/or adverse effects when compared with other interventions, treatment as usual, waitlist control or no intervention?

1.4 For adults with PTSD, do specific psychological or psychosocial interventions result in a clinically important reduction of PTSD symptoms, reduction of symptoms of a coexisting condition, improved functioning, improved quality of life, and/or adverse effects when compared with other interventions, treatment as usual, waitlist control or no intervention?

2 Pharmacological interventions for the prevention and treatment of PTSD

2.1 For children and young people within 3 months of a traumatic event, do specific pharmacological interventions result in a clinically important reduction of PTSD symptoms or prevention of PTSD, reduction of symptoms of a coexisting condition, improved functioning, improved quality of life and/or adverse effects when compared with other interventions or placebo?

2.2 For children and young people with clinically important post-traumatic stress symptoms, do specific pharmacological interventions

result in a clinically important reduction of PTSD symptoms, reduction of symptoms of a coexisting condition, improved functioning, improved quality of life and/or adverse effects when compared with other interventions or placebo?

2.3 For adults within 3 months of a traumatic event, do specific pharmacological interventions result in a clinically important reduction of PTSD symptoms or prevention of PTSD, reduction of symptoms of a coexisting condition, improved functioning, improved quality of life, and/or adverse effects when compared with other interventions or placebo?

2.4 For adults with PTSD, do specific pharmacological interventions, result in a clinically important reduction of PTSD symptoms, reduction of symptoms of a coexisting condition, improved functioning, improved quality of life, and/or adverse effects when compared with other interventions or placebo?

3 Principles of care for all people with PTSD

3.1 For adults, children and young people with clinically important post-traumatic stress symptoms, what factors should be taken into account in order to provide optimal care, coordination of care and access to care?

4 Support for families and carers

4.1 What practical and social support is needed and preferred by families and carers of people with PTSD?

5 Practical and social support

5.1 What practical and social support should be made available by healthcare practitioners and others to people with PTSD?

6 Care for people with coexisting conditions

6.1 Should treatment for PTSD differ depending on whether or not the person has a coexisting condition, and what is the best way to address any differences when delivering and coordinating care?

1.6 Main outcomes

The main outcomes that will be considered when searching for and assessing the evidence are:

1 Symptoms of PTSD
2 Recovery from PTSD
3 Relapse
4 Personal, social, educational and occupational functioning
5 Quality of life
6 Acceptability of the intervention
7 Adverse effects of treatment
8 Symptoms of and recovery from a coexisting condition
9 Experience and views of practical and social support

2 Links with other NICE guidance, NICE quality standards, and NICE Pathways

2.1 NICE guidance

NICE guidance that will be updated by this guideline

- Post-traumatic stress disorder: management (2005) NICE guideline CG26

NICE guidance about the experience of people using NHS services

NICE has produced the following guidance on the experience of people using the NHS. This guideline will not include additional recommendations on these topics unless there are specific issues related to post-traumatic stress disorder:

- Patient experience in adult NHS services (2012) NICE guideline CG138
- Service user experience in adult mental health (2011) NICE guideline CG136
- Medicines adherence (2009) NICE guideline CG76

NICE guidance that is closely related to this guideline

Published

NICE has published the following guidance that is closely related to this guideline:

- Antenatal and postnatal mental health: clinical management service guidance (2015) NICE guideline CG192
- Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care (2015) NICE guideline NG26
- Looked-after children and young people (2015) NICE guideline PH28
- Domestic violence and abuse: multi-agency working (2014) NICE guideline PH50
- Antisocial behaviour and conduct disorders in children and young people: recognition and management (2013) NICE guideline CG158
- Antisocial personality disorder: prevention and management (2013) NICE guideline CG77
- Common mental health problems: identification and pathways to care (2011) NICE guideline CG123
- Rehabilitation after critical illness in adults (2009) NICE guideline CG83
- Substance misuse interventions for vulnerable under 25s (2007) NICE guidance PH4

In development

NICE is currently developing the following guidance that is closely related to this guideline:

- Severe mental illness and substance misuse (dual diagnosis) - community health and social care services NICE guideline. Publication expected November 2016.
- Mental health of adults in contact with the criminal justice system NICE guideline. Publication expected February 2017.
- Child abuse and neglect NICE guideline. Publication expected September 2017.

2.2 NICE quality standards

NICE quality standards that may need to be revised or updated when this guideline is published

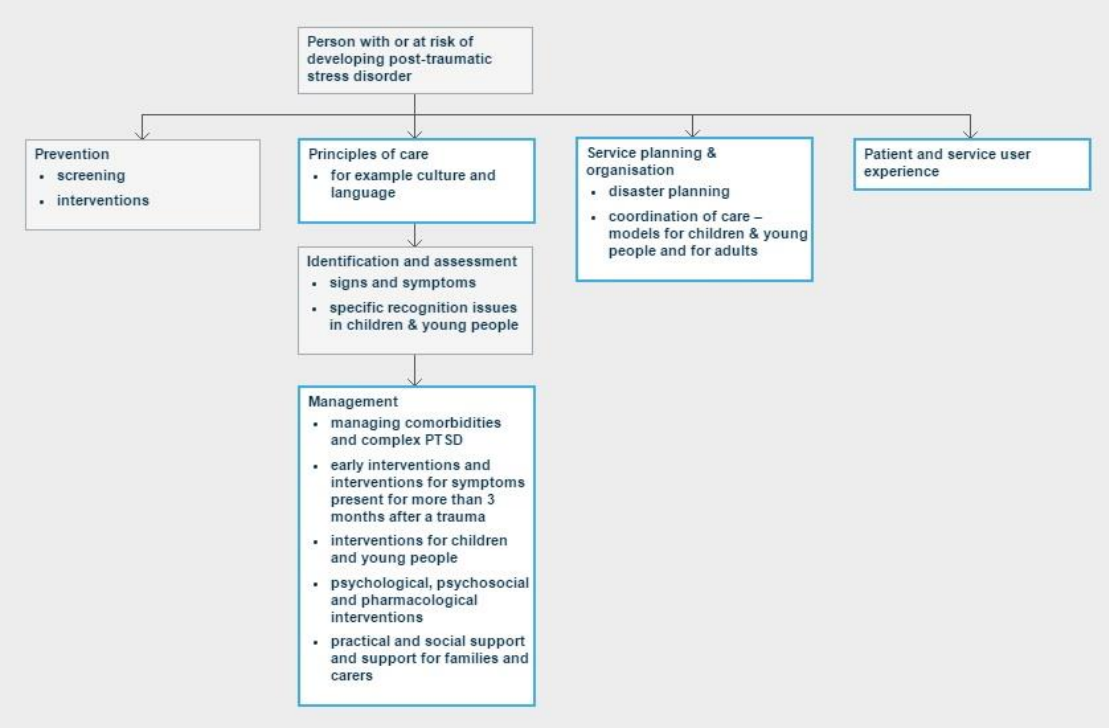
- Anxiety disorders (2014) NICE quality standard 53

2.3 NICE Pathways

NICE Pathways bring together all related NICE guidance and associated products on a topic in an interactive topic-based flow chart.

There is a live pathway for post-traumatic stress disorder: http://pathways.nice.org.uk/pathways/post-traumatic-stress-disorder

When the revised guideline is published, the recommendations will be incorporated into a revised pathway. An outline, based on the scope, is included below. It will be adapted and more detail added as the recommendations are written during guideline development.



3 Context

3.1 Key facts and figures

Post-traumatic stress disorder (PTSD) develops after a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. PTSD can affect people of all ages, including children and young people. The estimated population prevalence in adults in the UK is 2.6% in men and 3.3% in women. Around 25–30% of people experiencing a traumatic event are thought to go on to develop PTSD. Some groups of people are at an increased risk, for example first responders, military personnel, refugees and people who have experienced interpersonal violence or sexual assault. These groups may first come into contact with non-specialist or charitable services, such as Rape Crisis.

It is recognised that symptoms of PTSD are significantly under-reported, and that many people who experience clinically significant symptoms will not seek support. PTSD symptoms commonly occur alongside anxiety, depression and substance misuse problems. In this context PTSD symptoms are often overlooked, and remain untreated, in people who do access mental health services. Symptoms can be chronic, associated with significant impairment of adaptive functioning and have a negative impact on interpersonal relationships. In children and young people symptoms such as sleeping difficulties may be reported rather than the symptoms of re-experiencing or avoidance commonly reported by adults. It is therefore difficult to accurately estimate the burden of disease.

3.2 Current practice

The care pathway has changed significantly since the original NICE guideline on PTSD (CG26) was published in 2005. Care for adults is now provided primarily through the 209 IAPT (improving access to psychological therapies) services in the UK; people with PTSD comprised 1.2% of IAPT referrals in 2014–15. If care cannot be provided by IAPT services, people may be referred into community mental health services or, for those who are too

unwell to be cared for in the community, inpatient mental health services. Care for children and young people with identified PTSD is provided through Tier 3 or specialist CAMHS (child and adolescent mental health services). Children and young people with symptoms such as sleep difficulties that may in fact be undiagnosed PTSD will typically be treated within Tier 2 CAMHS.

Access to services is a significant concern for people with PTSD, as there are currently long waiting times across England for psychological interventions. In 2014–15, 38.1% of people referred to IAPT services with identified PTSD waited more than 28 days for their first appointment.

Trauma-focused cognitive behavioural therapy (CBT) and EMDR (eye movement desensitisation and reprocessing) therapy are the most common treatments for PTSD symptoms in adults. Trauma-focused CBT is recommended for children and young people in the current NICE guideline, and is widely used. In some services play therapy is also used for younger children, although this is not currently recommended by NICE.

The current NICE guideline recommends the use of psychological interventions before pharmacological interventions. There are concerns that people may not receive a sufficient 'dose' of the chosen psychological intervention. For example, an audit in 2009 found that only 11% of GPs reported that their patients with PTSD were receiving the recommended 8–12 sessions of trauma-focused CBT or EMDR therapy. Additionally, the current guideline recommends treating substance misuse problems before addressing PTSD symptoms, but information gathered as part of the guideline surveillance review reported that parallel treatment models have now been developed.

3.3 Policy, legislation, regulation and commissioning

Legislation, regulation and guidance

The updated PTSD guideline will provide up-to-date recommendations on the management and treatment of PTSD. It may help to inform important changes to relevant legislation, regulatory frameworks and statutory or professional

guidance from professional bodies relating to caring for people with PTSD, including the Mental Health Act 1983 and the Mental Capacity Act 2005. The guideline is particularly relevant to the Children Act 1989, since PTSD in children is often underdiagnosed, and may have resulted from neglect or maltreatment in the home and lead to a requirement of care by the state. The guideline will address the care of high-risk groups such as refugees and people in the military, and will add value to the Human Rights Act 1998 and the Armed Forces Covenant.

Commissioning

PTSD services for the adult population and CAMHS services for children and young people are commissioned primarily by clinical commissioning groups (CCGs). In some areas funding for Tier 2 CAMHS services is provided through a joint arrangement between the local authority and the NHS. For people with treatment-resistant PTSD or complex presentations there are also national specialist services commissioned by NHS England. Service provision for co-occurring substance misuse problems varies. In some areas this is commissioned and provided within the same service, but this is not always the case.

Most community mental health services for veterans (veteran mental health services) are commissioned centrally by the Department of Health. They are provided by NHS trusts organised into local networks, who work collaboratively with providers such as Combat Stress and the Royal British Legion in some cases. The Veterans and Reserves Mental Health programme is commissioned by the Ministry of Defence but is provided in collaboration with the NHS.

Specialist inpatient mental health services for serving military personnel are commissioned by the Ministry of Defence and provided by 8 NHS trusts. The main costs for treatment within this group are for psychological interventions and for people with complex or treatment-resistant presentations who need more intensive care.

4 Further information

This is the final scope, incorporating comments from registered stakeholders during consultation.

The guideline is expected to be published in August 2018.

You can follow progress of the guideline.

Our website has information about how NICE guidelines are developed.