Summary of PTSD Workshop

Equalities

- Sexual orientation
- Learning disabilities
- Homelessness
- Emergency services
- Failed asylum seekers in custody
- Age

Population

- Suggested co-morbidities to add
    - Psychosis *(trauma included in update of psychosis)*
    - Eating disorders
    - Body dysmorphia
    - Dissociation
- People with co-morbid dissociative disorder
- complex PTSD
- complex trauma
- highlight the range of people who might experience trauma
    - for example: rail services tend to focus company policies on drivers and do not necessarily include engineers, cleaners, etc.
- Special consideration for asylum seekers and unaccompanied child asylum seekers
- Migrant/Displaced populations
- Refugee care in custody
- Pregnant women
- Long term / ongoing trauma
- Prisoners
- Broaden torture to include cruel, inhuman or degrading treatment
- Individuals from military backgrounds/outside of the military health services remit
    - Carers and family members of personnel in the military
    - Ex-military personnel who are caught between NHS services and military health services
    - Military personnel in theatre
- Defence medical services
- Veterans and their family members/carers
- Victims of racist attacks
- Individuals, particularly young people, separated from their families
- Perinatal period
- Midwives, health visitors
- Physical comorbidities
- People who are mute as result of trauma

- Survivors of sexual abuse
- Survivors of physical and emotional abuse
- Prolonged abuse
- Developmental trauma

Settings

- Rape crisis centres, transport, child protective services? (or is this an implementation issue?)
- Military

Activities, service or aspects of care

- Recognition in relation to complex PTSD
- Issues of dissociative disorder
- Patients living in poverty
- Concern that assessment is not included
- Guideline should include access, recognition, timing of treatment
- Access to interventions/pathway is problematic

Key issues

<u>Interventions:</u>

- Body based therapies (e.g. yoga, breathing techniques)
- Should it be psychological or psychosocial?
- Looking at first 3 months implies a single event and the guideline should look at multiple/prolonged events
- Clarify draft RQ7 covers people at risk for PTSD and/or preventing the emergence of PTSD

<u>Psychological interventions:</u>

- Timescales between diagnosis and intervention
- Systematic interventions
- Group interventions
- Social interventions
- Family therapies

<u>Pharmacological interventions:</u>

- Keep in mind new mothers and the effect of medication on breast feeding women.

<u>Support for families and careers/ practical support and social factors:</u>

- Well-being of staff working with PTSD
    - Prevention
    - Trauma specific supervision
- Wider social circumstances may need considering
- Families of veterans
- Psychoeducation for families

- Coordination of care of military families; some family members cared for by NHS and military personnel are under the care of military service remit
- Consideration for therapists – secondary trauma measures
- Support for public body staff i.e. nurses, police officers , pre/post-traumatic event
- Dependents and risk to them

Psychosocial interventions:

- EDMR
- Number of treatments recommended need to be reviewed – usually 30+ sessions needed
- Medically holding individuals / medical containment – most individuals are not in one place long enough to receive adequate care
- Disorganised attachment (associated with complex PTSD)
- Pre and post-traumatic event measures
    - Pre- and post-traumatic event interventions for individuals who are otherwise healthy but may experience a traumatic event in their line of work
- Reduction of timeframe from referral to first session

Continuity of care:

- Peer support / Service user led organisations
- Clinicians should help link services / promote access to services
- Service users should have input into their own care
- Training for clinicians to recognise PTSD

Coordination of care:

- Include family members/carers in the treatment of individuals
- Information sharing – coordination of an individual's care to be shared across all treatment provides, family/carers etc. to prevent set-backs
- Health services working together
- Mental health awareness training to those in contact with people who are at risk of developing PTSD
- Training for GPs and primary care in assessment

Care for people with co-morbidities:

- Include recommendations to check changes in patients co-morbidities

Outcomes

- Suggested to remove the specific psychometrics
- Add maintenance, ideation/intent of suicide and harm to others to Outcome 2.
- Consider SALY as well as QALY
- Harm to others
- Changes in physical symptoms

GC constituency

The group suggested GC members in addition to those suggested by NICE:

- Broaden NGOs
- Domestic violence specialist
- Rape crisis centre workers
- Clinician with experience working with older adults
- Pharmacist
- Alternative therapist
- Commissioners
- Lay members:
    - Agreement that it is important to receive their feedback / input but there is concern about service users in this area and the amount of support that will be available
    - domestic violence survivor
    - grassroots organisation (for victims of rape, domestic violence)

- Criminal justice system personnel
- critical care
- Drug and alcohol specialist
- Neuropsychologist
- Psychological therapist (adult and children)
- Dual diagnosis specialist
- A specialist in dissociative disorders
- Community based commissioners
- Armed forces commissioners
- Professional in social services
- LGBT community member (re homosexual and transgender based violence)
- Victims of institutionalised abused by those in religious groups
- Allied health professionals

Additional considerations/ information

- Important to think about access, especially with refugees who may feel uncomfortable seeking help as they may fear it affects likelihood of asylum, etc.
- Barriers to engagement with an intervention
- Is recognition or treatment more important?
- Traumatic birth
- Misinterpretation of previous guideline may have led to some asylum seekers not receiving essential care
- Need to be mindful of terminology and language used in the update
- Clear statements as to which population groups are to be treated by the recommendations should be included
- Length of time between referral to first session can be 31 months

- Many individuals with PTSD suffer a series of traumatic events rather than a single traumatic experience – consideration for this to be accounted for when constructing recommendations
- WHO have developed a document setting out recommendations treating patients with PTSD in different populations across various countries
- If there is insufficient evidence for recommendations relating to complex PTSD/complex trauma request that this is stated in the guideline and a call for further research included
- Rec 1.4.1 in previous guideline isn't well implemented