National Institute for Health and Care Excellence

Draft for consultation

Post-traumatic stress disorder: management (update)

[J] Evidence reviews on care pathways for adults, children and young people with PTSD

NICE guideline <number>

Evidence reviews

June 2018

Draft for Consultation

These evidence reviews were developed by National Guideline Alliance, hosted by the Royal College of Obstetricians and Gynaecologists

Disclaimer

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

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. All NICE guidance is subject to regular review and may be updated or withdrawn.

ISBN:

Contents

Care pathways for adults, children and young people with PTSD

This evidence report contains information on 1 review relating to care pathways for adults, children and young people:

- Review question 7.2 For adults, children and young people with clinically important post-traumatic stress symptoms, what are the aspects of a clinical care pathway that are associated with better outcomes?

Review question 7.2 For adults, children and young people with clinically important post-traumatic stress symptoms, what are the aspects of a clinical care pathway that are associated with better outcomes?

Introduction

CG26 identified a need to develop a pathway of care that offers prompt, evidence-based services in local communities, supported by specialist services for more refractory or complex problems. Although some progress has been made in this process, there is still some way to go. For instance, people with PTSD are currently under-represented in the population treated by the Improving Access to Psychological Therapies (IAPT) programme.

Methods and processes

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual; see the methods chapter for further information.

Declarations of interest were recorded according to NICE's 2014 and 2018 conflicts of interest policies.

Summary of the protocol (PICO table)

Please see Table 1 for a summary of the Participants, Intervention, Comparison, Outcomes (PICO) characteristics of this review.

Table 1: Summary of the protocol (PICO table)

Population	People with clinically important post-traumatic stress symptoms
Intervention	Care pathways (including continuity of care and informational continuity)
Comparison	Standard management strategy
Outcome	**Critical outcomes:** • Efficacy (PTSD symptoms/diagnosis) • Quality of life • Access to treatment • Uptake of treatment **Important outcomes:** • Healthcare utilization • Satisfaction, preference • Anxiety about treatment • Symptoms of a coexisting condition (including anxiety and depression)

PTSD=Post-Traumatic Stress Disorder

For full details see review protocol in Appendix A.

Methods and processes

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual; see the methods chapter for further information.

Declarations of interest were recorded according to policies.

Clinical evidence

No evidence was identified for this review question.

Method used to answer the review question in the absence of appropriately designed, high-quality research

The evidence base available for evidence review was anticipated to be, and indeed found to be extremely poor. No RCTs or systematic reviews were identified in the search. Consequently, the committee decided to adopt a formal method of consensus (the modified nominal group technique) to identify areas of agreement on which to base guidance (see Supplement 1-Methods Chapter for further detail).

Existing recommendations on important components of effective care pathways from NICE mental health guidelines (including: the previous PTSD guideline [CG26]; Common mental health problems: identification and pathways to care; and Mental health problems in people with learning disabilities: prevention, assessment and management) were used to develop the consensus questionnaire (see Appendix M). These components were adapted into 44 separate statements. In order to address different stages of the care pathway for people with PTSD, statements were divided into sections to address 5 aspects: (1) access; (2) engagement and uptake; (3) treatment and referral for treatment; (4) coexisting conditions; (5) care coordination and transitions.

Members of the committee were required to indicate their agreement with these statements by rating each statement in the consensus questionnaire on a 9-point Likert scale. Statements with greater than or equal to 80% agreement were used to inform drafting of recommendations (taking into account comments from the committee members). Statements where there was 60-80% agreement were redrafted based on the committee's comments and re-rated following the same procedure as in round 1. Statements with less than 60% agreement in round 1 were generally disregarded unless there were obvious and addressable issues identified from the comments.

Results from formal consensus exercise

The questionnaire was completed by 9 of the 11 committee members. Some members were unable to attend the relevant committee meeting. However, they had the opportunity to discuss the statements from the nominal group process and contributed to the subsequent recommendations. Percentage consensus values were calculated and comments collated, for each statement. The rankings and comments were then presented to the committee members and used to inform a structured discussion within the committee meeting. Generally, there was high agreement among the committee members however where there were statements with lower but still moderate agreement these were re-drafted to account for comments from the committee members and re-distributed in questionnaire form (round 2). Discussions following each round of ratings led to the development of recommendations in this area. A brief summary of the outcome of this process is depicted in Table 2 below. The full list of statements and

ratings can be found in Appendix N and a blank copy of the first and second round questionnaires can be found in Appendix M.

Table 2: Summary of nominal group technique process followed for the development of recommendations on aspects of the clinical care pathway for people with PTSD

Round 1		Round 2		No. of recommendations generated
Access				15 recommendations*
Level of agreement	Statements N (total=13)	Level of agreement	Statements N (total=3)	
High	9	High	1	
Moderate	3	Moderate	2	
Low	1	Low	0	
Engagement and uptake				
Level of agreement	Statements N (total=6)	Level of agreement	Statements N (total=2)	
High	3	High	0	
Moderate	2	Moderate	2	
Low	1	Low	0	
Treatment and referral for treatment				
Level of agreement	Statements N (total=10)	Level of agreement	Statements N (total=1)	
High	8	High	0	
Moderate	1	Moderate	0	
Low	1	Low	1	
Coexisting conditions				
Level of agreement	Statements N (total=4)	Level of agreement	Statements N (total=1)	
High	2	High	1	
Moderate	1	Moderate	0	
Low	1	Low	0	
Care coordination and transitions				
Level of agreement	Statements N (total=11)	Level of agreement	Statements N (total=1)	
High	9	High	0	
Moderate	1	Moderate	0	
Low	1	Low	1	

*Note. Levels of agreement: High=≥80% agreement; Moderate=60-80%; Low=<60% agreement. *Note that many of the recommendations include more than one of the statements integrated as bullet points*

Economic Evidence

No economic studies assessing the cost effectiveness of different care pathways for adults, children and young people with PTSD were identified. The search strategy for economic studies is provided in Appendix B.

Economic model

No economic modelling was conducted for this question because other topics were agreed as higher priorities for economic evaluation.

Resource impact

The recommendations made by the committee based on this review are not expected to have a substantial impact on resources. The committee's considerations that contributed to the resource impact assessment are included under the ‘Cost effectiveness and resource use’ in 'The committee's discussion of the evidence' section.

Clinical evidence statements based upon formal consensus ratings

Regarding access to services

The committee agreed that access should be promoted, and potential barriers removed, by:

- having clear and explicit criteria for entry to the service, and focusing on entry and not exclusion criteria
- minimising the need for transition between different services or providers
- having multiple means (including self-referral) to access the service and providing multiple points of access
- establishing clear links (including access and entry points) to other care pathways (including those for physical healthcare needs)
- delivering services flexibly, taking into account the person’s needs (including financial considerations, mobility needs or any anxieties about travel)
- modifying the method and mode of delivery of treatment interventions including technology (for example, text messages, email, telephone and computers), for people with PTSD who may find it difficult to, or choose not to, attend a specific service
- accommodating, where possible, service-user preference for a worker of a particular gender, or ethnic or cultural background
- not delaying or withholding treatment for PTSD because of court proceedings or applications for compensation
- providing information about the services and interventions that constitute the care pathway, including the range and nature of interventions, settings in which services are delivered, and how progress and outcomes are assessed
- providing information (to people with PTSD and their families and carers) about services in a range of languages and formats (visual, verbal and aural), available from a range of settings

Regarding engagement with, and uptake of, treatment

The committee agreed that uptake and engagement could be encouraged by:

- being aware that people with PTSD may be anxious about and avoid engaging in treatment, and use engagement strategies, for instance, following up people who miss scheduled appointments
- offering interventions in different settings (for instance, community centres)
- engaging families and carers in treatment, where appropriate, to inform and improve the care of the person with PTSD and meet the identified needs of the families and carers

Regarding treatment and referral for treatment

The committee agreed that the process of developing and agreeing a treatment plan could be optimised by:

- taking into account previous treatment history, associated functional impairment and the presence of any coexisting conditions
- taking into account any social or personal factors that may have a role in the development or maintenance of the disorder
- providing information about the nature, content and duration of any proposed intervention, including acceptability and tolerability and possible interactions with any current interventions
- providing information about common reactions to traumatic events, including the symptoms of PTSD and its course and treatment

Regarding coexisting conditions

The committee agreed that considerations regarding the sequencing of treatments when a person has a coexisting condition should be guided by some overarching principles as follows:

- When a person presents with PTSD and depression, the PTSD should usually be treated first, as the depression will often improve with successful treatment of the PTSD except where depression poses risks or is likely to interfere with engagement in treatment
- For people with PTSD who are so severely depressed that initial psychological treatment of PTSD is very difficult, the depression should be treated first
- For people with PTSD whose assessment identifies a high risk of suicide or harm to others, the management of this risk should be concentrated on first

Regarding care coordination

The committee agreed that care coordination could be facilitated by:

- planning transitions in advance
- involving families and carers in the planning of transitions
- giving consideration to any special requirements that may assist with a smooth transition between services (such as difficulties with changes to routine or anxiety about meeting new people)
- clarifying the roles and responsibilities of key people and services regarding the care of the person with PTSD
- ensuring that the referring organisation does not discharge a person with PTSD who needs ongoing care before another organisation has accepted the referral
- ensuring that all involved agencies communicate information clearly, both between services and with the person with PTSD and any key people involved (such as family members or carers)

The committee agreed that children and young people with PTSD who are within the care system should receive additional support when transitioning between settings.

The committee also agreed that people with PTSD who are admitted to hospital because of neurological or physical health problems should receive additional support during admission or discharge.

Economic evidence statements

No economic evidence on different care pathways for adults, children and young people with PTSD was identified and no economic modelling was undertaken.

Recommendations

1. **To support transitions when people with PTSD are moving between services:**
    - give the person information about the service they are moving to, including the setting and who will provide their care
    - ensure there is effective sharing of information between all services involved
    - involve the person and, where appropriate, their family or carers in meetings to plan the transition
    - address any worries the person has, for example about changes to their routine or anxiety about meeting new people.

2. **Provide additional support in line with NICE guideline on transition from children's to adults' services for young people using health or social care services and transition between inpatient mental health settings and community or care home settings :**
    - to children and young people with PTSD who are within the care system when they are transitioning between services or settings
    - during admission and discharge to people with PTSD who are admitted to hospital because of other mental or physical health problems.

3. **During transitions between services for people with PTSD who need ongoing care, the referring team should not discharge the person before another team has accepted the referral. [2018]**

4. **Promote access to services for people with PTSD by:**
    - providing a care model that is clear about the range of interventions and services offered and the people that may benefit, rather than prioritising reasons why services cannot be accessed
    - ensuring that methods of access to services take into account the needs of specific populations of people with PTSD, including migrants and asylum seekers.
    - minimising the need to move between different services or providers
    - providing multiple points of access to the service

- establishing clear links to other care pathways, including for physical healthcare needs
- offering flexible modes of delivery, such as using text messages, email, telephone or video consultation, or care in non-clinical settings such as schools or offices
- offering a choice of therapist that takes into account the person's trauma experience – for example they might prefer a specific gender of therapist
- using proactive person-centred strategies to promote uptake and sustained engagement.

5. **Do not delay or withhold treatment for PTSD because of court proceedings or applications for compensation. Discuss with the person the implications of the timing of any treatment to help them make an informed decision about if and when to proceed.**

6. **Provide information in both oral and written format and in line with recommendations in the NICE guidelines on service user experience in adult mental health and patient experience in adult NHS services.**

7. **Give information and support to people with PTSD (and their family members or carers as appropriate) covering:**
    - common reactions to traumatic events, including the symptoms of PTSD and its course
    - assessment, treatment and support options to help the person make an informed choice
    - care pathways for PTSD
    - where their care will take place.

8. **Be aware of the risk of continued exposure to trauma-inducing environments or factors for people with PTSD and minimise exposure to triggers that could risk exacerbating symptoms (for example, restraining someone or placing them in a noisy inpatient ward).**

9. **Involve family members and carers, where appropriate, in treatment for people with PTSD as a way to:**
    - inform and improve the care of the person with PTSD **and**
    - identify and meet their own needs as carers.

10. **When discussing treatment options with people with PTSD (and their family members or carers as appropriate):**
    - give them information about the aim, content, duration and mode of delivery of any proposed interventions, including acceptability, tolerability and any possible interactions with current interventions
    - take into account any previous treatment, associated functional impairment and any coexisting conditions
    - take into account any social or personal factors that may have a role in the development or maintenance of the disorder.

11. **Be aware that people with PTSD may be apprehensive, anxious and may avoid treatment or have difficulty developing trust. Engagement strategies could include following up when people miss appointments.**

12. **For people presenting with PTSD and depression:**
    - usually treat the PTSD first because the depression will often improve with successful PTSD treatment
    - treat the depression first if it might make psychological treatment of the PTSD difficult.

13. **Do not exclude people with PTSD from treatment based on comorbid drug or alcohol misuse.**

14. **For people with PTSD whose assessment identifies a high risk of suicide or harm to others, establish a risk management plan as part of initial treatment planning.**

Rationale and impact

Why the committee made the recommendations

There was not enough good evidence about access to care, developing care pathways and coordinating care, so the committee drew on sources from other mental health disorders describing pathways and systems that support access and engagement with care. Based on this information they used a formal consensus method to make recommendations on good practice.

Supporting transitions between services

The committee discussed strategies to improve care coordination and provide smooth transitions of care for people with PTSD. They agreed it was important to plan transitions in advance, involve families and carers, make sure everyone involved in the person's care is aware of their role and responsibility, and ensure that different services are communicating with each other, as well as with the person with PTSD. They noted that overall coordination and continuity of care could be achieved by having a key professional to oversee the whole period of care (as covered by recommendations 1.2.1 and 1.2.3). The committee also identified certain groups that might need extra support during care transitions.

Access to care

In the absence of good evidence the committee used formal consensus to recommend some key strategies for promoting access to care.

They also discussed evidence on delivering care more flexibly. Qualitative evidence showed that some people with PTSD prefer to have their treatment away from a clinical environment. There was also clinical evidence that some types of remote care (for example, computerised trauma-focused cognitive behavioural therapy and video consultation) can be as successful as face-to-face interventions. Based on this, the committee agreed that delivering care in more flexible ways, including by using non-clinical locations like schools or offices, would improve access. See evidence reviews H and I for the full committee discussion on this.

The committee noted that the evidence on using a stepped care approach was encouraging, but because only 1 study was identified they decided to recommend it as an area for further

research (see research recommendation 1). See evidence review I for the evidence and discussion on this

Planning treatment and supporting engagement

The committee agreed it was important to use a holistic approach when planning treatment with people who have PTSD, for example by thinking about all the different possible factors in their life that could be contributing to their continuing symptoms and taking into account whether any treatments have worked in the past. In the committee's opinion these were important points of good practice, along with providing information and support to help the person to make an informed choice about treatments.

Evidence review H has more evidence and discussion supporting recommendations on improving uptake and engagement.

People with PTSD and complex needs

There was a lack of evidence on care for people with PTSD and complex needs, including people with coexisting conditions such as depression or substance misuse, so the committee used a formal consensus method to agree some overarching principles. They agreed that substance misuse should not be a barrier to people accessing treatment for PTSD so services should not exclude people on this basis.

Evidence review D has more evidence and discussion supporting recommendations for people with PTSD and complex needs.

Impact of the recommendations on practice

These recommendations will help to improve the way in which care is provided and improve consistency between services. Any resource impact should be offset by time savings and efficiency benefits from improved care coordination and continuity.

Currently video consultation is not available everywhere so this recommendation could have a moderate impact on resources. However, it is expected to save resources in the future, in particular in remote areas where therapists need to travel further to deliver trauma-focused CBT in person.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

The committee considered the following outcomes as critical: PTSD symptom improvement on validated scales and prevention of PTSD (as measured by the number of people with a diagnosis or scoring above clinical threshold on a validated scale at endpoint or follow-up), quality of life, access to treatment and uptake of treatment. The committee considered healthcare utilization, satisfaction/preference, anxiety about treatment, and symptoms of a coexisting condition (including anxiety and depression) as important but not critical outcomes. This distinction was based on the primacy of preventing PTSD and of improving access to effective treatment and continuity of care, whilst acknowledging that broader measures may be indicators of a general pattern of effect.

The quality of the evidence

Benefits and harms

Because of the paucity of evidence, the committee used a formal consensus approach, which drew on NICE recommended care pathways for other mental health disorders, in order to determine strategies for improving access to care (informed by both current barriers and facilitators to care) and identify key components of effective care pathways. The consensus process clearly identified a number of strategies with strong support from the committee.

The committee endorsed a number of factors or attributes that could enhance access to services, and ameliorate some of the current barriers, with key facilitators including: multiple points of access and prioritisation of inclusion over exclusion criteria; clear links to other care pathways; minimising unnecessary transitions; offering flexible modes of delivery. Although not included in the original formal consensus questionnaire statements, the committee also noted that some groups, for instance migrants and asylum seekers, may experience specific barriers to access and agreed that the needs of specific populations should be carefully considered in order to promote equitable access to services. The committee discussed that care pathways should promote access to services for people with PTSD by supporting the integrated delivery of services across primary and secondary care. However, it was agreed that this statement was already covered by an existing recommendation (section 1.2 in the short guideline).

The committee agreed that uptake and engagement could be encouraged through: the use of engagement strategies that are informed by an awareness that people with PTSD may be anxious about and avoid engaging in treatment; offering interventions in different, non-clinical settings; engaging families and carers in treatment where appropriate. Furthermore, these good practice points were corroborated by the qualitative evidence review (see evidence report I).

The committee agreed that the process of developing and agreeing a treatment plan could be optimised by taking a holistic view of the person with PTSD (including consideration of previous treatment history, associated functional impairment, the presence of any coexisting conditions, and any social or personal factors that may have a role in the development or maintenance of the disorder). The committee also agreed that the provision of information (about both PTSD and available treatment options) was key to enable an informed decision about the most appropriate treatment. The committee discussed that patient preference should be an important determinant of the choice among effective treatments. However, it was agreed that this statement was already covered by existing treatment recommendations where additional options should be considered for people who do not want or have not been able to engage in the first-line treatment recommended (section 1.6 in the short guideline). The committee also considered that treatment should be delivered by competent individuals who have received appropriate training and are appropriately supervised. This was considered particularly important for non-manualised interventions. On this basis the committee agreed that this statement was already covered by existing recommendations that outline the content and format of first-line treatment (section 1.6 in the short guideline) and the recommendation for peer support groups that stipulates that groups should be facilitated by people with training and supervision (section 1.4 in the short guideline).

The committee agreed that considerations regarding the sequencing of treatments when a person has a coexisting condition should be guided by some overarching principles, for instance, given that coexisting depression often improves with successful treatment of the PTSD it is appropriate to prioritise the treatment of PTSD where this is possible. Although agreement was generally high for the statements in the formal consensus questionnaire, the

committee decided to discard the statement that for people with coexisting PTSD and substance misuse, the drug or alcohol problem should usually be treated first as there is some evidence for efficacy of integrated trauma-focused CBT and substance misuse interventions (see evidence report D). Based on consensus opinion that coexisting substance misuse is often a barrier to accessing treatment for PTSD, the committee agreed that it was important to recommend that services do not exclude people with PTSD from treatment based on comorbid drug or alcohol misuse.

The committee agreed that care coordination should be facilitated by planning transitions in advance, involving families members and carers, making sure everyone involved in care is aware of their roles and responsibilities, and ensuring clear communication between services involved in the transition and with the person with PTSD themselves. The committee also noted that some people with PTSD may require additional support when transitioning between care settings, including children and young people within the care system and people admitted to hospital because of other mental or physical health problems. The committee agreed that all efforts should be made to ensure the person with PTSD feels adequately supported during transitions and decided that this would be achieved by incorporating the key components above. The committee discussed that systems should be in place to provide for the overall coordination and continuity of care for people with PTSD, including designating a key individual to oversee the whole period of care. However, it was agreed that this statement was already covered by an existing recommendation (section 1.2 in the short guideline).

Cost effectiveness and resource use

No evidence on the cost effectiveness of different care pathways for adults, children and young people with PTSD was identified and no economic modelling was undertaken in this area. The committee made recommendations that reflect good practice in the area. The committee acknowledged that these recommendations will have a moderate resource impact as it is expected that more people with PTSD will access care, receive timely management and become better engaged with services. However, they expressed the view that the recommendations are likely to result in better clinical outcomes for people with PTSD and to prevent further downstream care costs that are incurred by this population when provision of appropriate treatment is delayed or when low engagement with treatment leads to suboptimal clinical outcomes. The committee expressed the view that the recommendations on supporting transitions between services will enable more effective delivery of care, improve care coordination and reduce variation in practice.

Other factors the committee took into account

In discussing transitions involving inpatient environments for the treatment of physical or mental health problems, including treatment of the PTSD itself. Lay members of the committee highlighted the potential for some care settings such as psychiatric inpatient units and general hospital wards to be very distressing for people with PTSD as loud noises, being restrained, or having invasive treatments can trigger flashbacks and other symptoms. Based on the potential for harm the committee judged it appropriate to make a recommendation based on informal consensus in order to raise awareness of potentially trauma-inducing environments or factors and minimise the risk of the patient becoming more distressed.

The following areas are the committee's equality considerations for the guideline and described as part of this evidence review:

- Intention to alleviate barriers or difficulties with access to services, and make particular reference to taking account the needs of specific populations of people with PTSD,

including migrants and asylum seekers is addressed in recommendation 1.3.1 (of the short guideline).

- the need to provide information in a way that addresses individual needs in terms of language, readability and applicability to different ethnic origins, or religions. In order to address this, the committee cross-referenced the relevant recommendations in the NICE guidelines on service user experience in adult mental health and patient experience in adult NHS services (recommendation 1.4.1 of the short guideline)
- additional support that may be required for people with PTSD who are admitted to hospital because of other mental or physical health problems, which addresses the needs of critically ill patients. This can be found in recommendation 1.3.1 (on the short guideline)

Appendices

Appendix A – Review protocols

Review protocols for "For adults, children and young people with clinically important post-traumatic stress symptoms, what are the aspects of a clinical care pathway that are associated with better outcomes?"

Topic	Organisation and delivery of care for people with PTSD
Review question(s)	RQ. 7.2 For adults, children and young people with clinically important post-traumatic stress symptoms, what are the aspects of a clinical care pathway that are associated with better outcomes?
Sub-question(s)	Where evidence exists, consideration will be given to the specific needs of: • women who have been exposed to sexual abuse or assault, or domestic violence • lesbian, gay, bisexual, transsexual or transgender people • people from black and minority ethnic groups • people who are homeless or in insecure accommodation • asylum seekers or refugees or other immigrants who are entitled to NHS treatment • people who have been trafficked • people who are socially isolated (and who are not captured by any other subgroup listed) • people with complex PTSD • people with neurodevelopmental disorders (including learning disabilities and autism) • people with coexisting conditions (drug and alcohol misuse, common mental health disorders, eating disorders, personality disorders, acquired brain injury, physical disabilities and sensory impairments) • people who are critically ill or injured (for instance after a vehicle crash)
Objectives	To identify the most effective care pathways for people with clinically important post-traumatic stress symptoms
Population	People with clinically important post-traumatic stress symptoms If some, but not all, of a study's participants are eligible for the review, where possible disaggregated data will be obtained. If this is not possible then the study will be included if at least 80% of its participants are eligible for this review.

Topic	Organisation and delivery of care for people with PTSD
Exclude	Trials of people with adjustment disorders Trials of people with traumatic grief Trials of people with psychosis as a coexisting condition Trials of people with learning disabilities Trials of women with PTSD during pregnancy or in the first year following childbirth Trials of adults in contact with the criminal justice system (not solely as a result of being a witness or victim)
Intervention	Care pathways (including continuity of care and informational continuity)
Comparison	Standard management strategy
Critical outcomes	Efficacy PTSD symptomology (mean endpoint score or change in PTSD score from baseline on a validated scale) Diagnosis of PTSD (number of people meeting diagnostic criteria for PTSD according to DSM, ICD or similar criteria) Quality of life (as assessed with a validated scale including the 36-item Short-Form Survey [SF-36], Health Status Questionnaire-12 and Warwick-Edinburgh Mental Well-being Scale [WEMWBS]) Access to treatment Uptake of treatment
Important, but not critical outcomes	Healthcare utilization Satisfaction, preference Anxiety about treatment Coexisting conditions (note that target of intervention should be PTSD symptoms): Symptoms of and recovery from a coexisting condition Self-harm Suicide
Study design	Systematic reviews
Include unpublished data?	Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline

Topic	Organisation and delivery of care for people with PTSD
	Conference abstracts and dissertations will not be included.
Restriction by date?	Publication limit 2000-current
Study setting	Primary, secondary, tertiary, social care and community settings. Treatment provided to troops on operational deployment or exercise will not be covered.
The review strategy	Reviews If existing systematic reviews are found, the committee will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the committee agrees that a systematic review appropriately addresses a review question, a search for studies published since the review will be conducted. Data Extraction (selection and coding) Citations from each search will be downloaded into EndNote and duplicates removed. Titles and abstracts of identified studies will be screened by two reviewers for inclusion against criteria, until a good inter-rater reliability has been observed (percentage agreement =>90% or Kappa statistics, K>0.60). Initially 10% of references will be double-screened. If inter-rater agreement is good then the remaining references will be screened by one reviewer. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). At least 10% of data extraction will be double-coded. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or the opinion of a third reviewer will be sought. Non-English-language papers will be excluded (unless data can be obtained from an existing review). Data Analysis A narrative synthesis of the evidence that addresses care pathways will be performed. If insufficient evidence is available then a formal consensus method (within the guideline committee) will be considered.
Notes	None

Appendix B – Literature search strategies

Literature search strategies for "For adults, children and young people with clinically important post-traumatic stress symptoms, what are the aspects of a clinical care pathway that are associated with better outcomes?"

Clinical evidence

Database: Medline

Last searched on: **Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R), Embase, PsycINFO**

Date of last search: 31 January 2017

#	Searches
1	*acute stress/ or *behavioural stress/ or *emotional stress/ or *critical incident stress/ or *mental stress/ or *posttraumatic stress disorder/ or *psychotrauma/
2	1 use emez
3	stress disorders, traumatic/ or combat disorders/ or psychological trauma/ or stress disorders, post-traumatic/ or stress disorders, traumatic, acute/ or stress, psychological/
4	3 use mesz
5	exp posttraumatic stress disorder/ or acute stress disorder/ or combat experience/ or "debriefing (psychological)"/ or emotional trauma/ or post-traumatic stress/ or traumatic neurosis/ or trauma/ or stress reactions/ or psychological stress/ or chronic stress/
6	5 use psyh
7	(railway spine or (rape adj2 trauma*) or reexperienc* or re experienc* or torture syndrome or traumatic neuros* or traumatic stress).ti,ab.
8	(trauma* and (avoidance or grief or horror or death* or nightmare* or night mare* or emotion*)).ti,ab.
9	(posttraumatic* or post traumatic* or stress disorder* or acute stress or ptsd or asd or desnos or (combat neuros* or combat syndrome or concentration camp syndrome or extreme stress or flashback* or flash back* or hypervigilan* or hypervigilen* or psych* stress or psych* trauma* or psycho?trauma* or psychotrauma*)).ti,ab.
10	or/2,4,6-9
11	*case management/ or clinical pathway/ or clinical protocol/ or *cooperation/ or *patient care/ or *health care delivery/ or *integrated health care system/ or *multihospital system/ or *patient care/ or *health care planning/ or *health care policy/ or *hospital management/ or *health care planning/ or *patient care planning/ or *program development/ or *resource allocation/
12	11 use emez
13	case management/ or clinical protocol/ or cooperative behavior/ or "continuity of patient care"/ or critical pathway/ or delivery of health care/ or delivery of health care, integrated/ or interprofessional relations/ or interinstitutional relations/ or multi-institutional systems/ or models, organizational/ or patient care team/ or patient centered care/ or community health planning/ or decision making, organizational/ or health care reform/ or health facility administration/ or health facility planning/ or health planning/ or health planning guidelines/ or health plan implementation/ or health resources/ or health services administration/ or exp health planning organizations/ or health systems plans/ or institutional management teams/ or national health programs/ or organizational innovation/ or patient care planning/ or planning

#	Searches
	techniques/ or program development/ or public health administration/ or regional health planning/ or regional medical programs/ or resource allocation/ or state health plans/
14	13 use mesz
15	exp case management/ or exp cooperation/ or exp "continuum of care"/ or exp health care delivery/ or exp integrated services/ or exp interdisciplinary treatment approach/ or exp teams/ or exp health care reform/ or exp treatment planning/ or exp resource allocation/
16	15 use psyh
17	(algorithm* or careplan* or care plan* or pathway* or ((care or treatment) adj3 (delivery or guideline* or program* or protocol*))).ti,ab.
18	(((assertive or proassertive) adj2 (communit* or outreach or treatment*)) or act model*).ti,ab.
19	((augment* or collaborat* or coordinat* or co ordinat* or enhanc* or holistic* or 69 integrat* or interdisciplin* or inter disciplin* or interagenc* or inter agenc* or interorganis* or inter organis* or interprofessional* or inter professional* or intraprofessional* or intra professional* or multiagenc* or multi agenc* or multidimension* or multi dimension* or multidisciplin* or multi disciplin* or multifacet* or multi facet* or multiprofessional* or multi professional* or multiple or shared or stepped or tiered or transdisciplin* or trans discliplin*) adj3 (approach* or care or healthcare or intervention* or manag* or model* or program* or psychotherap* or service* or system* or team* or therap* or treatment* or work*)).ti,ab.
20	(((care or case*) adj manag*) or managed care program* or (patient care adj (plan* or team*))).ti,ab.
21	(cluster adj3 health* adj3 social*).ti,ab.
22	((complex or organi?ational) adj intervention*).ti,ab.
23	((comprehensive adj2 (care or management or service or treatment)) or (managed adj (behavioral or behavioural) adj health) or (model* adj2 (approach* or care or consultation or integrated or service* or team* or treatment*))).ti,ab.
24	(co located team or co location or (joint service adj3 development) or linkwork* or multidisciplinary assessment or one stop shop or (pool* adj3 budget) or single assessment or strategic collaboration).ti,ab.
25	consultation liaison.ti,ab.
26	((contin* or coordinated or co ordinated or joint* or joined up or progression or seamless* or structured or uninterrupted) adj3 (care or healthcare or service*)).ti,ab.
27	(((continuous or integrated or joint or overlapping) adj commission*) or provider partnership*).ti,ab.
28	(continuity adj2 (care or healthcare)).ti,ab.
29	(((cooperative or co operative) adj behav*) or ((interpersonal or inter personal or interprofession* or inter profession* or interinstitution* or inter institution*) adj (work* or relation*))).ti,ab.
30	(flexible partnership* or (joint* adj3 working) or joined up partnership* or (partnership* adj3 working) or partnership project*).ti,ab.
31	(((horizontal or vertical) adj integrat*) or horizontal communication*).ti,ab.
32	(imhc or integrated psychiatry).ti,ab.
33	(integrat* adj3 health*).ti,ab.
34	((model* or pathway*) adj3 (approach* or care or healthcare or program* or psychotherap* or service* or specialit* or therap* or treatment*)).ti,ab.
35	((parallel or serial) adj2 (care or healthcare or model* or service* or therap* or treatment*)).ti,ab.

#	Searches
36	((premobile or pre mobile) adj3 (approach* or care or communit* or healthcare or program* or service* or therap* or treatment or work*)).ti,ab.
37	(system* adj2 care).ti,ab.
38	((deliver* or implement* or needs or organi* or plan* or utili*) adj3 (care or healthcare or model* or program* or service* or system*)).ti,ab.
39	or/12,14,16-38
40	meta analysis/ or "meta analysis (topic)"/ or systematic review/
41	40 use emez
42	meta analysis.sh,pt. or "meta-analysis as topic"/ or "review literature as topic"/
43	42 use mesz
44	(literature review or meta analysis).sh,id,md. or systematic review.id,md.
45	44 use psyh
46	(exp bibliographic database/ or (((electronic or computer* or online) adj database*) or bids or cochrane or embase or index medicus or isi citation or medline or psyclit or psychlit or scisearch or science citation or (web adj2 science)).ti,ab.) and (review*.ti,ab,sh,pt. or systematic*.ti,ab.)
47	46 use emez
48	(exp databases, bibliographic/ or (((electronic or computer* or online) adj database*) or bids or cochrane or embase or index medicus or isi citation or medline or psyclit or psychlit or scisearch or science citation or (web adj2 science)).ti,ab.) and (review*.ti,ab,sh,pt. or systematic*.ti,ab.)
49	48 use mesz
50	(computer searching.sh,id. or (((electronic or computer* or online) adj database*) or bids or cochrane or embase or index medicus or isi citation or medline or psyclit or psychlit or scisearch or science citation or (web adj2 science)).ti,ab.) and (review*.ti,ab,pt. or systematic*.ti,ab.)
51	50 use psyh
52	((analy* or assessment* or evidence* or methodol* or quantativ* or systematic*) adj2 (overview* or review*)).tw. or ((analy* or assessment* or evidence* or methodol* or quantativ* or systematic*).ti. and review*.ti,pt.) or (systematic* adj2 search*).ti,ab.
53	(metaanal* or meta anal*).ti,ab.
54	(research adj (review* or integration)).ti,ab.
55	reference list*.ab.
56	bibliograph*.ab.
57	published studies.ab.
58	relevant journals.ab.
59	selection criteria.ab.
60	(data adj (extraction or synthesis)).ab.
61	(handsearch* or ((hand or manual) adj search*)).ti,ab.
62	(mantel haenszel or peto or dersimonian or der simonian).ti,ab.
63	(fixed effect* or random effect*).ti,ab.
64	((pool* or combined or combining) adj2 (data or trials or studies or results)).ti,ab.
65	or/41,43,45,47,49,51-64
66	exp "clinical trial (topic)"/ or exp clinical trial/ or crossover procedure/ or double blind procedure/ or placebo/ or randomization/ or random sample/ or single blind procedure/

#	Searches
67	66 use emez
68	exp clinical trial/ or exp "clinical trials as topic"/ or cross-over studies/ or double-blind method/ or placebos/ or random allocation/ or single-blind method/
69	68 use mesz
70	(clinical trials or placebo or random sampling).sh,id.
71	70 use psyh
72	(clinical adj2 trial*).ti,ab.
73	(crossover or cross over).ti,ab.
74	(((single* or doubl* or trebl* or tripl*) adj2 blind*) or mask* or dummy or doubleblind* or singleblind* or trebleblind* or tripleblind*).ti,ab.
75	(placebo* or random*).ti,ab.
76	treatment outcome*.md. use psyh
77	animals/ not human*.mp. use emez
78	animal*/ not human*/ use mesz
79	(animal not human).po. use psyh
80	or/67,69,71-76
81	80 not (or/77-79)
82	or/65,81
83	10 and 39 and 82

Database: CDSR, DARE, HTA, CENTRAL

Date of last search: 31 January 2017

#	Searches
#1	MeSH descriptor: Stress Disorders, Traumatic this term only
#2	MeSH descriptor: Combat Disorders this term only
#3	MeSH descriptor: Psychological Trauma this term only
#4	MeSH descriptor: Stress Disorders, Post-Traumatic this term only
#5	MeSH descriptor: Stress Disorders, Traumatic, Acute this term only
#6	MeSH descriptor: Stress, Psychological this term only
#7	("railway spine" or (rape near/2 trauma*) or reexperienc* or "re experienc*" or "torture syndrome" or "traumatic neuros*" or "traumatic stress"):ti (Word variations have been searched)
#8	("railway spine" or (rape near/2 trauma*) or reexperienc* or "re experienc*" or "torture syndrome" or "traumatic neuros*" or "traumatic stress"):ab (Word variations have been searched)
#9	(trauma* and (avoidance or grief or horror or death* or nightmare* or "night mare*" or emotion*)):ti (Word variations have been searched)
#10	(trauma* and (avoidance or grief or horror or death* or nightmare* or "night mare*" or emotion*)):ab (Word variations have been searched)
#11	(posttraumatic* or "post traumatic*" or "stress disorder*" or "acute stress" or ptsd or asd or desnos or ("combat neuros*" or "combat syndrome" or "concentration camp syndrome" or "extreme stress" or flashback* or "flash back*" or hypervigilan* or hypervigilen* or "psych* stress" or "psych* trauma*" or psychotrauma* or psychotrauma*) or (posttrauma* or traumagenic* or "traumatic stress*")):ti (Word variations have been searched)

#	Searches
#12	(posttraumatic* or "post traumatic*" or "stress disorder*" or "acute stress" or ptsd or asd or desnos or ("combat neuros*" or "combat syndrome" or "concentration camp syndrome" or "extreme stress" or flashback* or "flash back*" or hypervigilan* or hypervigilen* or "psych* stress" or "psych* trauma*" or psychotrauma* or psychotrauma*) or (posttrauma* or traumagenic* or "traumatic stress*")):ab (Word variations have been searched)
#13	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12

Database: CINAHL PLUS

Date of last search: 31 January 2017

#	Searches
s52	s6 and s51
s51	s40 or s50
s50	s48 not s49
s49	(mh "animals") not (mh "human")
s48	s41 or s42 or s43 or s44 or s45 or s46 or s47
s47	ti (placebo* or random*) or ab (placebo* or random*)
s46	ti (single blind* or double blind* or treble blind* or mask* or dummy* or singleblind* or doubleblind* or trebleblind* or tripleblind*) or ab (single blind* or double blind* or treble blind* or mask* or dummy* or singleblind* or doubleblind* or trebleblind* or tripleblind*)
s45	ti (crossover or cross over) or ab (crossover or cross over)
s44	ti clinical n2 trial* or ab clinical n2 trial*
s43	(mh "crossover design") or (mh "placebos") or (mh "random assignment") or (mh "random sample")
s42	mw double blind* or single blind* or triple blind*
s41	(mh "clinical trials+")
s40	s7 or s8 or s9 or s10 or s11 or s12 or s13 or s14 or s15 or s16 or s17 or s18 or s19 or s20 or s21 or s22 or s23 or s29 or s30 or s31 or s34 or s35 or s36 or s37 or s38 or s39
s39	ti (analy* n5 review* or evidence* n5 review* or methodol* n5 review* or quantativ* n5 review* or systematic* n5 review*) or ab (analy* n5 review* or assessment* n5 review* or evidence* n5 review* or methodol* n5 review* or qualitativ* n5 review* or quantativ* n5 review* or systematic* n5 review*)
s38	ti (pool* n2 results or combined n2 results or combining n2 results) or ab (pool* n2 results or combined n2 results or combining n2 results)
s37	ti (pool* n2 studies or combined n2 studies or combining n2 studies) or ab (pool* n2 studies or combined n2 studies or combining n2 studies)
s36	ti (pool* n2 trials or combined n2 trials or combining n2 trials) or ab (pool* n2 trials or combined n2 trials or combining n2 trials)
s35	ti (pool* n2 data or combined n2 data or combining n2 data) or ab (pool* n2 data or combined n2 data or combining n2 data)
s34	s32 and s33
s33	ti review* or pt review*
s32	ti analy* or assessment* or evidence* or methodol* or quantativ* or qualitativ* or systematic*
s31	ti “systematic* n5 search*” or ab “systematic* n5 search*”
s30	ti “systematic* n5 review*” or ab “systematic* n5 review*”

#	Searches
s29	(s24 or s25 or s26) and (s27 or s28)
s28	ti systematic* or ab systematic*
s27	tx review* or mw review* or pt review*
s26	(mh "cochrane library")
s25	ti (bids or cochrane or embase or “index medicus” or “isi citation” or medline or psyclit or psychlit or scisearch or “science citation” or web n2 science) or ab (bids or cochrane or “index medicus” or “isi citation” or psyclit or psychlit or scisearch or “science citation” or web n2 science)
s24	ti (“electronic database*” or “bibliographic database*” or “computeri?ed database*” or “online database*”) or ab (“electronic database*” or “bibliographic database*” or “computeri?ed database*” or “online database*”)
s23	(mh "literature review")
s22	pt systematic* or pt meta*
s21	ti (“fixed effect*” or “random effect*”) or ab (“fixed effect*” or “random effect*”)
s20	ti (“mantel haenszel” or peto or dersimonian or “der simonian”) or ab (“mantel haenszel” or peto or dersimonian or “der simonian”)
s19	ti (handsearch* or "hand search*" or "manual search*") or ab (handsearch* or "hand search*" or "manual search*")
s18	ab "data extraction" or "data synthesis"
s17	ab "selection criteria"
s16	ab "relevant journals"
s15	ab "published studies"
s14	ab bibliograph*
s13	ti "reference list*"
s12	ab "reference list*"
s11	ti (“research review*” or “research integration”) or ab (“research review*” or “research integration”)
s10	ti (metaanal* or “meta anal*” or metasynthes* or “meta synethes*”) or ab (metaanal* or “meta anal*” or metasynthes* or “meta synethes*”)
s9	(mh "meta analysis")
s8	(mh "systematic review")
s7	(mh "literature searching+")
s6	s1 or s2 or s3 or s4 or s5
s5	ti ((posttraumatic* or "post traumatic*" or "stress disorder*" or "acute stress" or ptsd or asd or desnos or ("combat neuros*" or "combat syndrome" or "concentration camp syndrome" or "extreme stress" or flashback* or "flash back*" or hypervigilan* or hypervigilen* or "psych* stress" or "psych* trauma*" or psychotrauma* or psychotrauma*) or (posttrauma* or traumagenic* or "traumatic stress*"))) or ab ((posttraumatic* or "post traumatic*" or "stress disorder*" or "acute stress" or ptsd or asd or desnos or ("combat neuros*" or "combat syndrome" or "concentration camp syndrome" or "extreme stress" or flashback* or "flash back*" or hypervigilan* or hypervigilen* or "psych* stress" or "psych* trauma*" or psychotrauma* or psychotrauma*) or (posttrauma* or traumagenic* or "traumatic stress*")))
s4	ti ((trauma* and (avoidance or grief or horror or death* or nightmare* or "night mare*" or emotion*))) or ab ((trauma* and (avoidance or grief or horror or death* or nightmare* or "night mare*" or emotion*)))

#	Searches
s3	ti (("railway spine" or (rape near/2 trauma*) or reexperienc* or "re experienc*" or "torture syndrome" or "traumatic neuros*" or "traumatic stress")) or ab (("railway spine" or (rape near/2 trauma*) or reexperienc* or "re experienc*" or "torture syndrome" or "traumatic neuros*" or "traumatic stress"))
s2	(mh "stress, psychological")
s1	(mh "stress disorders, post-traumatic")

Health economic evidence

Note: evidence resulting from the health economic search update was screened to reflect the final dates of the searches that were undertaken for the clinical reviews (see review protocols).

Database: Medline

Last searched on:**Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R), Embase, PsycINFO**

Date of last search: 1 March 2018

#	Searches
1	*acute stress/ or *behavioural stress/ or *emotional stress/ or *critical incident stress/ or *mental stress/ or *posttraumatic stress disorder/ or *psychotrauma/
1	*acute stress/ or *behavioural stress/ or *emotional stress/ or *critical incident stress/ or *mental stress/ or *posttraumatic stress disorder/ or *psychotrauma/
2	1 use emez
3	stress disorders, traumatic/ or combat disorders/ or psychological trauma/ or stress disorders, post-traumatic/ or stress disorders, traumatic, acute/ or stress, psychological/
4	3 use mesz, prem
5	exp posttraumatic stress disorder/ or acute stress disorder/ or combat experience/ or "debriefing (psychological)"/ or emotional trauma/ or post-traumatic stress/ or traumatic neurosis/ or "trauma"/ or stress reactions/ or psychological stress/ or chronic stress/
6	5 use psyh
7	(railway spine or (rape adj2 trauma*) or reexperienc* or re experienc* or torture syndrome or traumatic neuros* or traumatic stress).ti,ab.
8	(trauma* and (avoidance or grief or horror or death* or nightmare* or night mare* or emotion*)).ti,ab.
9	(posttraumatic* or post traumatic* or stress disorder* or acute stress or ptsd or asd or desnos or (combat neuros* or combat syndrome or concentration camp syndrome or extreme stress or flashback* or flash back* or hypervigilan* or hypervigilen* or psych* stress or psych* trauma* or psycho?trauma* or psychotrauma*)).ti,ab.
10	or/2,4,6-9
11	budget/ or exp economic evaluation/ or exp fee/ or funding/ or exp health care cost/ or health economics/ or exp pharmacoeconomics/ or resource allocation/
12	151 use emez
13	exp budgets/ or exp "costs and cost analysis"/ or economics/ or exp economics, hospital/ or exp economics, medical/ or economics, nursing/ or economics, pharmaceutical/ or exp "fees and charges"/ or value of life/

#	Searches
14	153 use mesz, prem
15	exp "costs and cost analysis"/ or cost containment/ or economics/ or finance/ or funding/ or "health care economics"/ or pharmacoeconomics/ or exp professional fees/ or resource allocation/
16	155 use psyh
17	(cost* or economic* or pharmacoeconomic* or pharmaco economic*).ti. or (cost* adj2 (effective* or utilit* or benefit* or minimi*)).ab. or (budget* or fee or fees or financ* or price or prices or pricing or resource* allocat* or (value adj2 (monetary or money))).ti,ab.
18	or/12,14,16-17
19	decision theory/ or decision tree/ or monte carlo method/ or nonbiological model/ or (statistical model/ and exp economic aspect/) or stochastic model/ or theoretical model/
20	159 use emez
21	exp decision theory/ or markov chains/ or exp models, economic/ or models, organizational/ or models, theoretical/ or monte carlo method/
22	161 use mesz, prem
23	exp decision theory/ or exp stochastic modeling/
24	163 use psyh
25	((decision adj (analy* or model* or tree*)) or economic model* or markov).ti,ab.
26	or/20,22,24-25
27	quality adjusted life year/ or "quality of life index"/ or short form 12/ or short form 20/ or short form 36/ or short form 8/ or sickness impact profile/
28	167 use emez
29	quality-adjusted life years/ or sickness impact profile/
30	169 use mesz, prem
31	(((disability or quality) adj adjusted) or (adjusted adj2 life)).ti,ab.
32	(disutili* or dis utili* or (utilit* adj1 (health or score* or value* or weigh*))).ti,ab.
33	(health year equivalent* or hye or hyes).ti,ab.
34	(daly or qal or qald or qale or qaly or qtime* or qwb*).ti,ab.
35	discrete choice.ti,ab.
36	(euroqol* or euro qol* or eq5d* or eq 5d*).ti,ab.
37	(hui or hui1 or hui2 or hui3).ti,ab.
38	(((general or quality) adj2 (wellbeing or well being)) or quality adjusted life or qwb or (value adj2 (money or monetary))).ti,ab.
39	(qol or hql* or hqol* or hrqol or hr ql or hrql).ti,ab.
40	rosser.ti,ab.
41	sickness impact profile.ti,ab.
42	(standard gamble or time trade* or tto or willingness to pay or wtp).ti,ab.
43	(sf36 or sf 36 or short form 36 or shortform 36 or shortform36).ti,ab.
44	(sf6 or sf 6 or short form 6 or shortform 6 or shortform6).ti,ab.
45	(sf12 or sf 12 or short form 12 or shortform 12 or shortform12).ti,ab.
46	(sf16 or sf 16 or short form 16 or shortform 16 or shortform16).ti,ab.
47	(sf20 or sf 20 or short form 20 or shortform 20 or shortform20).ti,ab.
48	(sf8 or sf 8 or short form 8 or shortform 8 or shortform8).ti,ab.

#	Searches
49	or/28,30-48
50	or/18,26,49

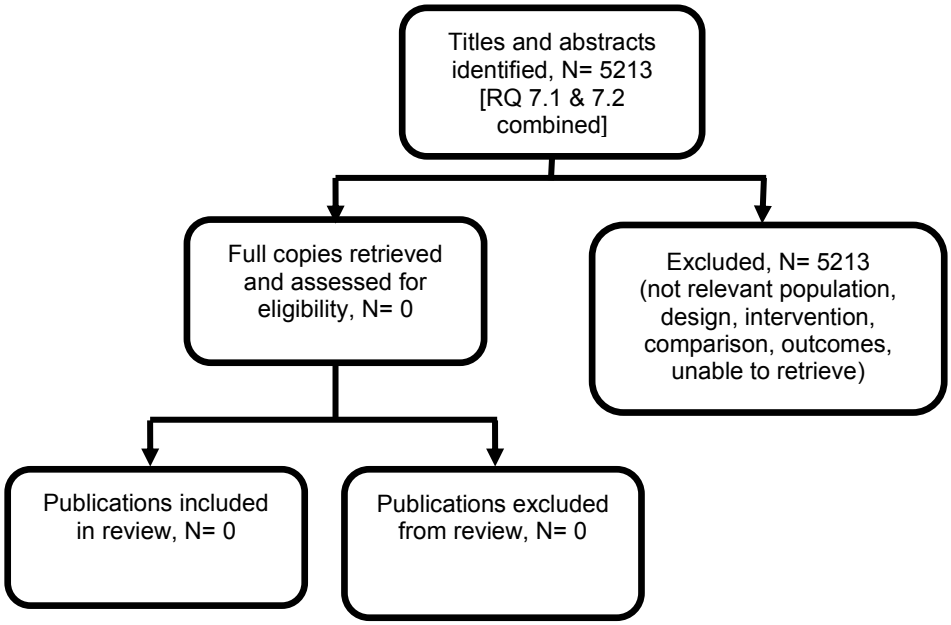
Database: HTA, NHS EED

Date of last search: 1 March 2018

#	Searches
#1	MeSH descriptor: Stress Disorders, Traumatic this term only
#2	MeSH descriptor: Combat Disorders this term only
#3	MeSH descriptor: Psychological Trauma this term only
#4	MeSH descriptor: Stress Disorders, Post-Traumatic this term only
#5	MeSH descriptor: Stress Disorders, Traumatic, Acute this term only
#6	MeSH descriptor: Stress, Psychological this term only
#7	("railway spine" or (rape near/2 trauma*) or reexperienc* or "re experienc*" or "torture syndrome" or "traumatic neuros*" or "traumatic stress"):ti (Word variations have been searched)
#8	("railway spine" or (rape near/2 trauma*) or reexperienc* or "re experienc*" or "torture syndrome" or "traumatic neuros*" or "traumatic stress"):ab (Word variations have been searched)
#9	(trauma* and (avoidance or grief or horror or death* or nightmare* or "night mare*" or emotion*)):ti (Word variations have been searched)
#10	(trauma* and (avoidance or grief or horror or death* or nightmare* or "night mare*" or emotion*)):ab (Word variations have been searched)
#11	(posttraumatic* or "post traumatic*" or "stress disorder*" or "acute stress" or ptsd or asd or desnos or ("combat neuros*" or "combat syndrome" or "concentration camp syndrome" or "extreme stress" or flashback* or "flash back*" or hypervigilan* or hypervigilen* or "psych* stress" or "psych* trauma*" or psychotrauma* or psychotrauma*) or (posttrauma* or traumagenic* or "traumatic stress*")):ti (Word variations have been searched)
#12	(posttraumatic* or "post traumatic*" or "stress disorder*" or "acute stress" or ptsd or asd or desnos or ("combat neuros*" or "combat syndrome" or "concentration camp syndrome" or "extreme stress" or flashback* or "flash back*" or hypervigilan* or hypervigilen* or "psych* stress" or "psych* trauma*" or psychotrauma* or psychotrauma*) or (posttrauma* or traumagenic* or "traumatic stress*")):ab (Word variations have been searched)
#13	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12

Appendix C – Clinical evidence study selection

Figure 1: Flow diagram of clinical article selection for review on "For adults, children and young people with clinically important post-traumatic stress symptoms, what are the aspects of a clinical care pathway that are associated with better outcomes?"



Appendix D – Clinical evidence tables

No clinical evidence was identified for this review.

Appendix E – Forest plots

No clinical evidence was identified for this review.

Appendix F – GRADE Tables

No clinical evidence was identified for this review.

Appendix G – Economic evidence study selection

A global health economics search was undertaken for all areas covered in the guideline. The flow diagram of economic article selection across all reviews is provided in Appendix A of Supplementary Material – Methods Chapter'.

Appendix H – Economic evidence tables

No health economic evidence was identified for this review.

Appendix I – Health economic evidence profiles

No health economic evidence was identified for this review and no economic modelling was undertaken.

Appendix J – Health economic analysis

No health economic analysis was conducted for this review

Appendix K – Excluded studies

Clinical studies

No clinical studies were reviewed at full text and excluded from this review.

Economic studies

No economic studies were reviewed at full text and excluded from this review.

Appendix L – Research Recommendations

No research recommendations were made for this review question.

Appendix M – Formal consensus questionnaire

Round 1 questionnaire

PTSD: consensus questionnaire for statements regarding clinical care pathway

Name:

Access										
	Strongly disagree								Strongly agree	Insufficient knowledge
1. Treatment for PTSD should not be delayed or withheld because of court proceedings or applications for compensation	1	2	3	4	5	6	7	8	9	☐
Comments:										
2. Information should be provided about the services and interventions that constitute the care pathway, including the range and nature of interventions	1	2	3	4	5	6	7	8	9	☐
Comments:										
3. Information should be provided about the services and interventions that constitute the care pathway, including settings in which services are delivered	1	2	3	4	5	6	7	8	9	☐
Comments:										

4. Information should be provided about the services and interventions that constitute the care pathway, including processes by which a person moves through the pathway and means by which progress and outcomes are assessed	1	2	3	4	5	6	7	8	9	☐
Comments:										
5. Information about services should be provided in a range of languages and formats (visual, verbal and aural) and be available from a range of settings	1	2	3	4	5	6	7	8	9	☐
Comments:										
6. Care pathways should promote access to services for people with PTSD by supporting the integrated delivery of services across primary and secondary care	1	2	3	4	5	6	7	8	9	☐
Comments:										
7. Care pathways should promote access to services for people with PTSD by minimising the need for transition between different services or providers	1	2	3	4	5	6	7	8	9	☐
Comments:										
8. Care pathways should promote access to services for people with PTSD by having clear and explicit criteria for entry to the service, and focusing on entry and not exclusion criteria	1	2	3	4	5	6	7	8	9	☐
Comments:										
9. Care pathways should promote access to services for people with PTSD by having multiple means (including self-referral) to access the service and providing multiple points of access	1	2	3	4	5	6	7	8	9	☐

Comments:										
10. Care pathways should promote access to services for people with PTSD by establishing clear links (including access and entry points) to other care pathways (including those for physical healthcare needs)	1	2	3	4	5	6	7	8	9	☐
Comments:										
11. Services for people with PTSD should be delivered flexibly, taking into account the person's needs (including financial considerations, mobility needs or any anxieties about travel)	1	2	3	4	5	6	7	8	9	☐
Comments:										
12. For people with PTSD service-user preference for a worker of a particular gender, or ethnic or cultural background, should be accommodated where possible	1	2	3	4	5	6	7	8	9	☐
Comments:										
13. For people with PTSD who may find it difficult to, or choose not to, attend a specific service, modifications to the method and mode of delivery of treatment interventions should be considered including technology (for example, text messages, email, telephone and computers)	1	2	3	4	5	6	7	8	9	☐
Comments:										
Engagement and uptake										

	Strongly								Strongly	Insufficient knowledge
14. People with PTSD may be anxious about and avoid engaging in treatment, and engagement strategies may include following up people who miss scheduled appointments	1	2	3	4	5	6	7	8	9	☐
Comments:										
15. Uptake of interventions should be supported by offering interventions outside normal working hours	1	2	3	4	5	6	7	8	9	☐
Comments:										
16. Uptake of interventions should be supported by offering interventions in different settings (for instance, in the person's home, other residential settings or community centres)	1	2	3	4	5	6	7	8	9	☐
Comments:										
17. Uptake of interventions should be supported through the provision of both generalist and specialist intervention services in primary care settings	1	2	3	4	5	6	7	8	9	☐
Comments:										

18. Families and carers should be engaged in treatment, where appropriate, to inform and improve the care of the person with PTSD and meet the identified needs of the families and carers	1	2	3	4	5	6	7	8	9	☐
Comments:										
19. Family members or carers of people with PTSD should be provided with information about support and interventions in an appropriate language and format	1	2	3	4	5	6	7	8	9	☐
Comments:										
Treatment and referral for treatment										
	Strongly								**Strongly**	**Insufficient**
20. Patient preference should be an important determinant of the choice among effective treatments	1	2	3	4	5	6	7	8	9	☐
Comments:										
21. Treatment should be delivered by competent individuals who have received appropriate training and are appropriately supervised	1	2	3	4	5	6	7	8	9	☐
Comments:										
22. When discussing treatment options with a person with PTSD, an important consideration includes past experience of the disorder (including severity and duration)	1	2	3	4	5	6	7	8	9	☐

Comments:										
23. When discussing treatment options with a person with PTSD, an important consideration includes previous treatment history	1	2	3	4	5	6	7	8	9	☐
Comments:										
24. When discussing treatment options with a person with PTSD, an important consideration includes the trajectory of symptoms	1	2	3	4	5	6	7	8	9	☐
Comments:										
25. When discussing treatment options with a person with PTSD, an important consideration includes any associated functional impairment	1	2	3	4	5	6	7	8	9	☐
Comments:										
26. When discussing treatment options with a person with PTSD, an important consideration includes any social or personal factors that may have a role in the development or maintenance of the disorder	1	2	3	4	5	6	7	8	9	☐
Comments:										
27. When discussing treatment options with a person with PTSD, an important consideration includes the presence of any coexisting conditions	1	2	3	4	5	6	7	8	9	☐
Comments:										

28. When discussing treatment options with a person with PTSD, information should be provided about the nature, content and duration of any proposed intervention, including acceptability and tolerability and possible interactions with any current interventions	1	2	3	4	5	6	7	8	9	☐
Comments:										
29. When developing and agreeing a treatment plan, a person with PTSD should receive information about common reactions to traumatic events, including the symptoms of PTSD and its course and treatment	1	2	3	4	5	6	7	8	9	☐
Comments:										
Coexisting conditions										
	Strongly								**Strongly**	**Insufficient**
30. When a person presents with PTSD and depression, the PTSD should usually be treated first, as the depression will often improve with successful treatment of the PTSD	1	2	3	4	5	6	7	8	9	☐
Comments:										
31. For people with PTSD who are so severely depressed that initial psychological treatment of PTSD is very difficult, the depression should be treated first	1	2	3	4	5	6	7	8	9	☐

Comments:										
32. For people with PTSD with drug or alcohol dependence or in whom alcohol or drug use may significantly interfere with effective treatment, the drug or alcohol problem should usually be treated first	1	2	3	4	5	6	7	8	9	☐
Comments:										
33. For people with PTSD whose assessment identifies a high risk of suicide or harm to others, the management of this risk should be concentrated on first	1	2	3	4	5	6	7	8	9	☐
Comments:										
Care coordination and transitions										
	Strongly								**Strongly**	**Insufficient**
34. Systems should be in place to provide for the overall coordination and continuity of care of people with PTSD, designating a key individual to oversee the whole period of care (usually a GP in primary care settings)	1	2	3	4	5	6	7	8	9	☐
Comments:										
35. Transitions for people with PTSD should be planned in advance	1	2	3	4	5	6	7	8	9	☐

Comments:										
36. The person with PTSD and their families and carers should be involved in the planning of transitions	1	2	3	4	5	6	7	8	9	☐
Comments:										
37. All effort should be made to ensure the person with PTSD feels adequately supported during transitions	1	2	3	4	5	6	7	8	9	☐
Comments:										
38. For people with PTSD consideration should be given to any special requirements that may assist with a smooth transition between services (such as difficulties with changes to routine or anxiety about meeting new people)	1	2	3	4	5	6	7	8	9	☐
Comments:										
39. A joint meeting should be held during the transition period with the person with PTSD, their families and carers and staff from both the outgoing and incoming services	1	2	3	4	5	6	7	8	9	☐
Comments:										
40. Children and young people with PTSD who are within the care system should receive additional support when transitioning between settings	1	2	3	4	5	6	7	8	9	☐
Comments:										

41. People with PTSD who are admitted to hospital because of neurological or physical health problems should receive additional support during admission or discharge	1	2	3	4	5	6	7	8	9	☐
Comments:										
42. All involved agencies should ensure that they communicate information clearly, both between services and with the person with PTSD and any key people involved (such as family members or carers)	1	2	3	4	5	6	7	8	9	☐
Comments:										
43. It is important for each key person and service to clarify their role and responsibility regarding the care of the person with PTSD	1	2	3	4	5	6	7	8	9	☐
Comments:										
44. For people with PTSD who need ongoing care, the referring organisation should ensure that they do not discharge the person before another organisation has accepted the referral	1	2	3	4	5	6	7	8	9	☐
Comments:										

Round 2 questionnaire

PTSD: consensus questionnaire for revised statements regarding clinical care pathway

Name:

Access										
	Strongly disagree								Strongly agree	Insufficient knowledge
1. Information should be provided about the services and interventions that constitute the care pathway, including how progress and outcomes are assessed	1	2	3	4	5	6	7	8	9	☐
Comments:										
2. Care pathways should promote access to services for people with PTSD by having clear and explicit criteria for entry to the service, and focusing on entry and not exclusion criteria unless the exclusion criteria are evidence based and promote an alternative more effective/safe pathway	1	2	3	4	5	6	7	8	9	☐
Comments:										
3. For people with PTSD service-user preference for characteristics of worker such as particular gender, ethnicity or cultural background, should be accommodated where possible	1	2	3	4	5	6	7	8	9	☐
Comments:										
Engagement and uptake										

	Strongly disagree								Strongly agree	Insufficient knowledge
4. Uptake of interventions should be supported by offering interventions outside normal working hours if this supports effective use of resources	1	2	3	4	5	6	7	8	9	☐
Comments:										
5. Uptake of interventions should be supported by offering interventions in different settings (for instance, in the person's home, other residential settings or community centres) if this supports effective use of resources	1	2	3	4	5	6	7	8	9	☐
Comments:										
Treatment and referral for treatment										
	Strongly disagree								Strongly agree	Insufficient knowledge
6. When discussing treatment options with a person with PTSD, an important consideration includes the trajectory of symptoms, that is whether symptom severity is increasing or decreasing.	1	2	3	4	5	6	7	8	9	☐
Comments:										
Coexisting conditions										

	Strongly disagree								Strongly agree	Insufficient knowledge
7. When a person presents with PTSD and depression, the PTSD should usually be treated first, as the depression will often improve with successful treatment of the PTSD except where depression poses risks or likely to interfere with engagement in treatment	1	2	3	4	5	6	7	8	9	☐
Comments:										

Care coordination and transitions										
	Strongly disagree								Strongly agree	Insufficient knowledge
8. Systems should be in place to provide for the overall coordination and continuity of care of people with PTSD, designating a key individual to oversee the whole period of care	1	2	3	4	5	6	7	8	9	☐
Comments:										

Appendix N – Formal consensus questionnaire: Statements, ratings and recommendations

Topic	Statement	Agreement rating (%)	Decision	New statement ID	Resulting recommendation number (from short guideline)
Access	Treatment for PTSD should not be delayed or withheld because of court proceedings or applications for compensation	87.5	Use	NA	1.3.2
Access	Information should be provided about the services and interventions that constitute the care pathway, including the range and nature of interventions	87.5	Use	NA	1.4.2
Access	Information should be provided about the services and interventions that constitute the care pathway, including settings in which services are delivered	87.5	Use	NA	1.4.2
Access	Information should be provided about the services and interventions that constitute the care pathway, including processes by which a person moves through the pathway and means by which progress and outcomes are assessed	75	Re-rate	1	1.4.2
Access	Information about services should be provided in a range of languages and formats (visual, verbal and aural) and be available from a range of settings	100	Use	NA	1.4.1
Access	Care pathways should promote access to services for people with PTSD by supporting the integrated delivery of services across primary and secondary care	87.5	Already captured by existing recommendation	NA	1.2.3
Access	Care pathways should promote access to services for people with PTSD by minimising the need for transition between different services or providers	50	Use (obvious and addressable issues identified from the comments)	NA	1.3.1
Access	Care pathways should promote access to services for people with PTSD by having clear and explicit criteria for entry to the service, and focusing on entry and not exclusion criteria	62.5	Re-rate	2	1.3.1

Topic	Statement	Agreement rating (%)	Decision	New statement ID	Resulting recommendation number (from short guideline)
Access	Care pathways should promote access to services for people with PTSD by having multiple means (including self-referral) to access the service and providing multiple points of access	100	Use	NA	1.3.1
Access	Care pathways should promote access to services for people with PTSD by establishing clear links (including access and entry points) to other care pathways (including those for physical healthcare needs)	87.5	Use	NA	1.3.1
Access	Services for people with PTSD should be delivered flexibly, taking into account the person's needs (including financial considerations, mobility needs or any anxieties about travel)	87.5	Use	NA	1.3.1
Access	For people with PTSD service-user preference for a worker of a particular gender, or ethnic or cultural background, should be accommodated where possible	75	Re-rate	3	1.3.1
Access	For people with PTSD who may find it difficult to, or choose not to, attend a specific service, modifications to the method and mode of delivery of treatment interventions should be considered including technology (for example, text messages, email, telephone and computers)	100	Use	NA	1.3.1
Engagement and uptake	People with PTSD may be anxious about and avoid engaging in treatment, and engagement strategies may include following up people who miss scheduled appointments	100	Use	NA	1.6.2
Engagement and uptake	Uptake of interventions should be supported by offering interventions outside normal working hours	62.5	Re-rate	4	1.3.1
Engagement and uptake	Uptake of interventions should be supported by offering interventions in different settings (for instance, in the	75	Re-rate	5	1.3.1

Topic	Statement	Agreement rating (%)	Decision	New statement ID	Resulting recommendation number (from short guideline)
	person's home, other residential settings or community centres)				
Engagement and uptake	Uptake of interventions should be supported through the provision of both generalist and specialist intervention services in primary care settings	37.5	Discard	NA	NA
Engagement and uptake	Families and carers should be engaged in treatment, where appropriate, to inform and improve the care of the person with PTSD and meet the identified needs of the families and carers	100	Use	NA	1.4.6
Engagement and uptake	Family members or carers of people with PTSD should be provided with information about support and interventions in an appropriate language and format	100	Use	NA	1.4.1
Treatment and referral for treatment	Patient preference should be an important determinant of the choice among effective treatments	100	Already captured by existing recommendations	NA	1.6.8, 1.6.13, 1.6.15, 1.6.16, 1.6.19
Treatment and referral for treatment	Treatment should be delivered by competent individuals who have received appropriate training and are appropriately supervised	100	Already captured by existing recommendation	NA	1.4.3
Treatment and referral for treatment	When discussing treatment options with a person with PTSD, an important consideration includes past experience of the disorder (including severity and duration)	28.57	Discard	NA	NA
Treatment and referral for treatment	When discussing treatment options with a person with PTSD, an important consideration includes previous treatment history	87.5	Use	NA	1.6.1
Treatment and referral for treatment	When discussing treatment options with a person with PTSD, an important consideration includes the trajectory of symptoms	66.67	Re-rate	6	NA

Topic	Statement	Agreement rating (%)	Decision	New statement ID	Resulting recommendation number (from short guideline)
Treatment and referral for treatment	When discussing treatment options with a person with PTSD, an important consideration includes any associated functional impairment	85.71	Use	NA	1.6.1
Treatment and referral for treatment	When discussing treatment options with a person with PTSD, an important consideration includes any social or personal factors that may have a role in the development or maintenance of the disorder	100	Use	NA	1.6.1
Treatment and referral for treatment	When discussing treatment options with a person with PTSD, an important consideration includes the presence of any coexisting conditions	100	Use	NA	1.6.1
Treatment and referral for treatment	When discussing treatment options with a person with PTSD, information should be provided about the nature, content and duration of any proposed intervention, including acceptability and tolerability and possible interactions with any current interventions	100	Use	NA	1.6.1
Treatment and referral for treatment	When developing and agreeing a treatment plan, a person with PTSD should receive information about common reactions to traumatic events, including the symptoms of PTSD and its course and treatment	87.5	Use	NA	1.4.2
Coexisting conditions	When a person presents with PTSD and depression, the PTSD should usually be treated first, as the depression will often improve with successful treatment of the PTSD	71.43	Re-rate	7	1.7.1
Coexisting conditions	For people with PTSD who are so severely depressed that initial psychological treatment of PTSD is very difficult, the depression should be treated first	87.5	Use	NA	1.7.1
Coexisting conditions	For people with PTSD with drug or alcohol dependence or in whom alcohol or drug use may significantly interfere with effective treatment, the drug or alcohol problem should usually be treated first	16.67	Discard	NA	NA

Topic	Statement	Agreement rating (%)	Decision	New statement ID	Resulting recommendation number (from short guideline)
Coexisting conditions	For people with PTSD whose assessment identifies a high risk of suicide or harm to others, the management of this risk should be concentrated on first	87.5	Use	NA	1.7.3
Care coordination and transitions	Systems should be in place to provide for the overall coordination and continuity of care of people with PTSD, designating a key individual to oversee the whole period of care (usually a GP in primary care settings)	71.43	Re-rate	8	NA
Care coordination and transitions	Transitions for people with PTSD should be planned in advance	87.5	Use	NA	1.2.4
Care coordination and transitions	The person with PTSD and their families and carers should be involved in the planning of transitions	87.5	Use	NA	1.2.4
Care coordination and transitions	All effort should be made to ensure the person with PTSD feels adequately supported during transitions	87.5	Use	NA	1.2.4
Care coordination and transitions	For people with PTSD consideration should be given to any special requirements that may assist with a smooth transition between services (such as difficulties with changes to routine or anxiety about meeting new people)	85.71	Use	NA	1.2.4
Care coordination and transitions	A joint meeting should be held during the transition period with the person with PTSD, their families and carers and staff from both the outgoing and incoming services	57.14	Discard	NA	NA
Care coordination and transitions	Children and young people with PTSD who are within the care system should receive additional support when transitioning between settings	100	Use	NA	1.2.5
Care coordination and transitions	People with PTSD who are admitted to hospital because of neurological or physical health problems should receive additional support during admission or discharge	83.33	Use	NA	1.2.5
Care coordination and transitions	All involved agencies should ensure that they communicate information clearly, both between services	100	Use	NA	1.2.4

Topic	Statement	Agreement rating (%)	Decision	New statement ID	Resulting recommendation number (from short guideline)
	and with the person with PTSD and any key people involved (such as family members or carers)				
Care coordination and transitions	It is important for each key person and service to clarify their role and responsibility regarding the care of the person with PTSD	85.71	Use	NA	1.2.4
Care coordination and transitions	For people with PTSD who need ongoing care, the referring organisation should ensure that they do not discharge the person before another organisation has accepted the referral	87.5	Use	NA	1.2.6