

American Psychological Association (APA)
Clinical Practice Guideline Development Panel for PTSD

June 8-9, 2015

APA Headquarters
 Washington, DC

Meeting Summary

Guideline Development Panel members: Christine Courtois (Chair), Laura Brown, Joan Cook, John Fairbank, Joseph Gone, Russell Jones, John Roberts, Priscilla Schulz, and Jeffrey Sonis (Not attending: Matthew Friedman, Annette La Greca, and Thomas Mellman)

Advisory Steering Committee liaison: Steven Hollon

APA staff: Shannon Beattie, Lynn Bufka, Lauren Fowler (intern), Raquel Halfond, Howard Kurtzman, Reagan Miller (intern), and C. Vaile Wright

Day One (June 8)

Panel members were welcomed and APA staff provided an overview of the agenda. Panel members were invited to state their expectations for the meeting, ask outstanding questions or issues, and provide any updates on their possible conflicts of interest (COI).

The panel reviewed all nineteen recommendation statements. These statements will be the core of the guideline document, and the corresponding decision tables will be published as an appendix to the guideline document.

While reviewing the recommendation statements, the panel noted that the statements were not uniform in conveying the recommendation or the support for the recommendation. The panel agreed that the recommendations and rationale statements should have a similar structure to be consistent. Several changes were made: “among adult patients” was removed from all recommendation statements since the focus of the guideline is only adults; conditional recommendations will use the word “suggest” instead of “recommend.”

The panel next reviewed all the decision tables and documentation for consistent language and to ensure that the same criteria for assessing strength of evidence were used throughout their decision making. This review was strictly for the purpose of identifying and resolving discrepancies based upon the same evidence, and not to re-decide recommendations.

The panel talked about adding an explanation in the final guideline document of the process the panel used for working through the decision tables so users have a better understanding of the reasoning behind the recommendations (i.e., consider strength of the evidence; evaluate evidence of benefits for critical outcomes and then factor in non-critical outcomes and weigh the benefits versus the harms/burdens; incorporate patient preferences; applicability resulting in final recommendation). The panel also discussed noting that if, for example, two treatments have moderate strength of evidence and moderate benefit, but

there are numerous harms associated with one treatment as well as evidence that patients don't prefer it, then the treatments may have different recommendations.

The panel concluded that the following elements should be included in the rationale summary for each recommendation statement:

- 1) Magnitude of benefit and strength of evidence for critical outcomes
- 2) Magnitude for non-critical/important outcomes
- 3) Patient preferences
- 4) Harms
- 5) Applicability

The panel noted that the decision tables do not address all clinically relevant questions, such as decisions about whether psychological vs. pharmacological treatments should be recommended. Additionally, the comparative effectiveness data will only be useful if one treatment is favored and corresponding efficacy data for that treatment is available. If comparative effectiveness is simply "treatment x" compared to "treatment x" plus an additional component and no difference is found, then the latter won't be included in the recommendations. Recommendations will be grouped by psychotherapy or medication and ordered by "strong" and "conditional" strength of recommendation.

The panel discussed the format and style of the guideline document. It was recommended that each section be no longer than five pages, though it will vary by the needs of the particular section. A working draft of the guideline is expected by the week after Labor Day, but panel members were strongly encouraged to submit their written sections earlier if possible. The panel noted that no current section describes the recommended treatments and assigned this task to APA staff. The table of descriptions of psychotherapies and pharmacology from the AHRQ review can serve as the basis for the content. Staff shared samples of the desired writing style with panel members (on Dropbox and jump drives distributed at meeting). The writing should be in the third person and be textbook style with limited jargon.

The panel members discussed what other content to include in which sections. They agreed that the following topics should be addressed:

- Implementation challenges such as readiness to change at the agency level, barriers and facilitators to instituting new practices (Competency to practice section)
- Effects of context on treatment delivery (Implementation section)
- Plan for updating guideline, commitment to regular evaluation (section of its own)
- Generalizability of findings (Applicability and Future Research sections)
- Measurement-based approach/process-based evidence as a strategy to systematically demonstrate benefit of interventions in care settings
- Education and training (Competency to practice section)
- A glossary, including terms such as "efficacy" and "effectiveness."

Day Two (June 9)

The panel discussed implementation of guideline recommendations and how/whether that should be addressed in the guideline document or companion documents. The panel does not have evidence-based recommendations regarding implementation, unlike the specific treatment recommendations. The ASC liaison, Dr. Hollon, noted that some of the ASC members have extensive implementation expertise and will be helping guide the process. The ASC has an in-person meeting at the end of 2015 that will focus mainly on dissemination and implementation. The chairs of each guideline development panel will be invited to join the ASC meeting in order to bring implementation information back to their respective panels. Also, before the final guideline product is released to the public, a draft version will be released for public comment and the PTSD panel will have the opportunity to make any changes necessary after reviewing feedback.

Additional concerns about the impact and development of the guideline were discussed. The panel discussed the relative contributions of physicians to the panel given that the document does have recommendations regarding medications. The panel hopes there will not be a perception of imbalance or overreach and will work to address this issue by actively soliciting comments from psychiatrists and other physicians during the public comment stage. Another member noted that clinicians may feel there is nothing new in the APA guideline – that it contains similar information as seen in other guidelines. However, what sets this guideline apart from prior guidelines is the development process, as articulated by the Institute of Medicine's (IOM) development standards.

The panel members noted that it would be useful to explain in the guideline document why new and developing therapies are not included, as well as to include a section on evaluating emerging therapies through research and how to think critically about new therapies.

The panel discussed the distinction between generalizability/applicability and sub-group effects. Generalizability/applicability of findings from a systematic review means that the direction and magnitude of effect of an intervention, based on the samples from the trials included in the systematic review, are similar to the direction and magnitude of effect of that intervention in an external population. Sub-group effects means that the findings differed by treatment effects modifiers such as sex, ethnic/racial minority status, etc. Lack of generalizability implies that there is treatment effect heterogeneity (i.e., that the magnitude of the treatment effect varies across specific subgroups) *and* that there are differences in those subgroup characteristics between the samples in the trials or a systematic review of trials and the external population. The AHRQ review found insufficient evidence to know whether any of the psychological or pharmacological treatments have stronger or weaker effects across subgroups defined by any of the following: demographic characteristics (e.g., sex, ethnic/racial group, age, military veteran, refugee), type of trauma (e.g., sexual assault, combat, disaster), comorbidity (e.g., substance abuse, depression), duration of symptoms, age at time of trauma, repeat victimization, and level of severity at presentation. The panel needs to address these limitations on what is known. The panel asked staff to add any additional information relevant to applicability that can be derived from the AHRQ review specific to each decision table so that the panel can then draft an applicability section.

The panel discussed a range of possible products for this guideline including a technical report, executive summary, web applications, and documents geared to different audiences. Staff expect the finished guideline will become policy of the American Psychological Association, in which case, it will be published in the journal, *American Psychologist*. The panel would like products to be electronic so as to

be more accessible to consumers and easier to disseminate. The earliest the guideline will be reviewed by the APA Council of Representatives (CoR) is when it meets in February of 2016. However, the panel may not have a document ready until the CoR meets again in August of 2016. Between now and then, the panel will have had to complete the guideline document as well as the public comment period.

Next Steps

- APA staff will incorporate all of the edits the panel members made to the decision tables during the course of the meeting and send back to them for review. The critical outcomes will be bolded.
- APA staff will update the rationale summary statements.
- APA staff will insert the D-2 demographic information from the AHRQ review into the applicability section of the decision tables as relevant.
- APA staff will help the panel correct any inconsistencies found in the patient values and preferences sections across decision tables.
- A separate document with drop-out rates will be created.
- APA staff will send a Doodle Poll to the panel members to determine a new monthly call time.