

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

May 4-5, 2014

Washington, DC

Meeting Summary

Attending:

Guideline Development Panel (GDP) members: Christine Courtois (Chair), Joan Cook, John Fairbank, Joseph Gone, Russell Jones, Annette La Greca, John Roberts, Priscilla Schulz, Jeffrey Sonis, and Sharon Wise

Not attending: Laura Brown, Matthew Friedman, and Devon Hinton

Advisory Steering Committee (ASC) Liaisons: Daniel Kivlahan and Jeffrey Magnavita

APA staff: Shannon Beattie, Lynn Bufka, Marianne Ernesto, Raquel Halfond, and Howard Kurtzman

Guests: Gerald Gartlehner and Daniel Jonas, methodologists from RTI International

Welcome and Introductions

Members were welcomed and all present introduced themselves and reviewed the agenda.

RTI Presentation and Discussions

Dr. Gartlehner provided an overview of the framework known as Grading of Recommendations Assessment, Development and Evaluation (GRADE); the methodology of guideline development; the structure of evidence profiles; and the purpose and structure of decision tables.

Panel members engaged in discussion about making a strong vs. a conditional guideline recommendation. Concern was expressed that GRADE appears to indicate that a strong recommendation implies patients should virtually always receive the treatment while a conditional recommendation implies that patients should be helped to make a decision about receiving the treatment. Panel members raised concern about whether a strong recommendation would still incorporate patient preferences. Dr. Gartlehner explained that the GRADE language aimed to give the panel a general sense of the meaning of strong vs. conditional, not hard and fast criteria. The panel will be able to tailor its recommendations as it determines is best, including incorporating roles for patient values and preferences in all recommendations.

One panel member asked if there is a specific approach the panel will use for voting and making decisions. APA staff informed the panel that for situations in which consensus is not achieved by the

panel; the Advisory Steering Committee (ASC) has developed rules concerning what percentage of participating panel members need to endorse a decision in order for it to be accepted.

Some concern was expressed that including a serious dissenting view in the guideline document might weaken the impact of the recommendations supported by the majority. Dr. Gartlehner stated that he did not think that including dissenting viewpoints would negatively affect the quality of the guideline, and said that documenting such viewpoints enhances transparency. Several panel members agreed, saying points of disagreement could serve as a starting point for future guideline development panels. Also in the interest of transparency, the panel proposed documenting the number of any dissenting individuals for a particular issue and the rationales for their dissent. It was noted that the Institute of Medicine (IOM) encourages including a description and explanation for any differences of opinion regarding recommendations.

A panel member asked Dr. Gartlehner how the panel should balance benefits and harms when the evidence profiles do not contain much evidence on harms (especially for psychological treatments). How has RTI guided other guideline development panels in similar situations? Dr. Gartlehner provided two options:

- 1) The panel can search for such evidence systematically, or
- 2) The panel can include what evidence on harms is available in the form of case reports and uncontrolled observational studies, despite such studies being rated as low/very low in quality. Dr. Gartlehner commented that these types of studies are worth bringing in, even if not done entirely systematically.

APA staff added that that IOM notes that expert opinion, clinical experience, and personal judgments can be used to estimate the potential harms in a qualitative fashion. Such an approach involves subjectivity however.

Panel members proposed relaxing the criteria on the types of studies that will be considered in order to obtain additional information about harms and benefits of treatments, even if the studies are lower quality. APA staff responded that collecting such studies was a possibility, but suggested proceeding with the review of decision tables and process of drafting recommendations before deciding what additional information is needed (see next section).

Dr. Gartlehner recommended that the panel consider both the general efficacy and comparative evidence of treatments in a linked fashion in order to avoid comparing interventions that are not efficacious and inferring that they are equally efficacious, when they are actually equally inefficacious.

Decision Tables

Dr. Halfond walked the panel through the APA decision table template (developed by staff with ASC input) and instructed the panel members on how they will use the worksheets within the table. The panel also began to draft a recommendation by working through one decision table. That experience informed their discussion of the points below.

The panel revisited its previously developed list of outcomes to re-assess whether the six they rated as “critical” should remain so. The panel members expressed concern that they rated the outcomes as either “critical” or “important” without knowing that the overall strength of evidence rating within the decision tables will be based on the lowest strength rating among the individual critical outcomes, regardless of the strength of evidence for important outcomes. This concern led a panel member to suggest that they should avoid having too many critical outcomes. Dr. Gartlehner stated that it is acceptable to reconsider the outcomes, but urged the panel not to exclude outcomes from consideration as critical just because they are often rated as having lower quality evidence.

The panel ultimately decided to combine the two adverse events outcomes (“adverse events leading to withdrawals” and “other serious adverse events”) into one outcome called “serious harms,” and then decided that the two critical outcomes would be “serious harms” and “PTSD symptom reduction.” All other outcomes were relabeled as important outcomes. The entire updated set of outcomes is:

Critical outcomes:

- PTSD symptom reduction
- Serious harms

Important outcomes:

- Remission (no longer having symptoms)
- Loss of diagnosis
- Prevention or reduction of comorbid depression
- Prevention or reduction of comorbid anxiety
- Prevention or reduction of comorbid substance use
- Prevention or reduction of comorbid pain
- Quality of life
- Disability or functional impairment

The panel discussed at length how to make a strong guideline with limited evidence on harms. For additional perspective, APA staff will contact staff involved in guideline development at the National Institute for Health and Care Excellence (NICE) in the United Kingdom, for their feedback on how best to approach this issue.

The panel decided that it will use the little information available in the evidence profiles on harms and supplement that with information on harms and burdens from lower-quality published studies and other sources. APA staff will gather and organize information on harms and burdens (but not benefits) from published studies.

Regarding patient values and preferences, the panel members discussed the possibility of creating a web-based survey to collect data that would augment what they already have if, after they begin writing recommendations, they feel they are missing important information. APA staff reminded the panel that the public comment process would be another opportunity to solicit feedback from a variety of stakeholders (including patients) on the recommendations.

Evidence Profiles

Dr. Gartlehner provided an overview of the evidence profiles provided by RTI. This was supplemented with information from Dr. Jonas.

The panel discussed how best to proceed with examining the large number of evidence profiles received from RTI. The panel agreed to start by examining which individual treatments are efficacious and then next look at comparative effectiveness of treatments.

Staff will work on filling out the decision tables in advance with information from the evidence profiles, in order to reduce the burden on panel members and expedite their work. This will enable the panel members to concentrate on those elements of the decision tables that call upon their expertise and judgment.

For consistency, the panel will eventually choose what terms it wants to use when addressing strength of evidence/quality of evidence and insufficient/very low evidence. The AHRQ report and the evidence profiles use different wording, despite sharing the same meaning. A footnote clarifying this will be included in the guideline document.

Next Steps

Conference calls:

- The panel will move the regular monthly one hour long calls to Wednesday evenings at 8:00pm ET – 9:00pm ET.

In-person meeting:

- The panel will have an in-person meeting on July 13-14, 2014 in Washington, D.C.
- The panel also identified Sept. 12-13 as the dates of another in-person meeting in Washington, D.C., if that meeting is needed.

Copy of RTI's presentation slides:

- APA staff will obtain a copy of the slides that Dr. Gartlehner presented and post these on APA Communities for panel members.