

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

October 3-4, 2013

Washington, DC

Meeting Summary

Attending:

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

Devon Hinton sent regrets.

Advisory Steering Committee (ASC) Liaisons: Michelle Craske and Kermit Crawford

APA Staff: Shannon Beattie, Lynn Bufka, Raquel Halfond, and Howard Kurtzman,

Guests: Gerald Gartlehner (via phone), Bradley Gaynes (via phone) and Meera Viswanathan, all from RTI International

Welcome and Introductions

Members were welcomed and provided a brief overview of their charge by the GDP chair, APA staff, and the Advisory Steering Committee (ASC) liaisons. All present introduced themselves and reviewed the agenda.

Initial Panel Discussion

Panel members discussed any questions or concerns they would like acknowledged during the meeting and the overall guideline process. The issue of how co-morbidities will be addressed and how they might complicate implementation of the guideline was raised. The panel talked about the need to take into account the context in which people will be applying the guideline and how that's essential for what the final product looks like in order to have credibility for the larger membership. It was suggested that the guideline be not only evidence-based but also contextualized and responsive to context. Panel members noted that David Forbes (Australian Center for War-Related Illnesses), who was the lead author of, "A Guide to Guidelines", could provide further information on how to address context.

Four systematic reviews, produced by RTI through the comparative effectiveness initiative of the Agency for Healthcare Research and Quality (AHRQ), have been completed in the area of PTSD (see References). However, in many instances, the review concluded that evidence was

insufficient for specific questions. In order to handle the issue of lack of evidence, the panel considered requesting a potential update from RTI. In the meantime, the panel will focus on an area where it believes it can speak to some of the issues relatively easily based on the existing reviews.

The panel members discussed which evidence bases they'll be relying on as a group and posed the question of whether or not to start with just the AHRQ reviews. A panel member cautioned colleagues to systematically select any additional evidence bases, just as these systematic reviews were carefully completed with a rigorous methodology.

It was noted that some of the other needed information may not be clinical treatment studies like comparative effectiveness studies, but other kinds of research such as qualitative and context studies.

A panel member asserted that incorporating evidence-based practices about behaviors of therapists and the therapist-client relationship into the guidelines is relevant and important for treatment of trauma survivors.

One panel member expressed the desire for the panel to reach a consensus on what shape the guideline will take, with the goal of having the guideline reach clinicians and change behavior in a direct fashion. The guideline should be simple and accessible. One possible format would be a decision tree, which is used throughout medicine and, according to a panel member, has more clinical utility than other formats.

APA staff informed the panel members that, while they may produce a large primary document, the panel can advise APA staff on how to put together multiple additional products that can be disseminated to different audiences. Examples include: a decision tree for clinicians; a one-page paper that clinicians can quickly and easily refer to; and a document that is structured for the patient community. APA staff is looking to see what types of products, including electronic products, other organizations are producing, in order to find useful models and also recognizing that psychologists won't be the only audience for these guidelines.

Regarding dissemination and implementation, it was proposed that the panel members examine what was successful or unsuccessful in promoting previous APA guidelines (though these have not been clinical practice guidelines).

The possibility of offering web-based interactive training and continuing education (CE) credits or a workshop at APA's annual convention was mentioned.

The panel discussed reviewing evidence-based approaches from implementation science to plan the guidelines. However, it was also noted that implementation comes after the development of the guideline and is a separate process.

The three chairs of APA's guideline development panels (for PTSD, obesity, and depression) may choose to have a discussion regarding process and content overlap or topics that are common to all three panels. If panel chairs choose to do so, their discussion would occur after each panel has held its first meeting.

RTI Presentation and Discussions

The scientists from RTI oriented the panel to the systematic review process and how evidence is translated into guidelines. They also discussed common methodological issues and to what extent there are commonalities and differences amongst the full reports on PTSD that the panel has reviewed. There was a conversation on conflicts of interest (COI) as well.

Dr. Gaynes walked the panel members through methodology and PICOTS questions (which are framed in terms of population, intervention, comparison, outcome, time, setting) of each of the adult PTSD reviews. The adult prevention systematic review largely has findings of "insufficient evidence" and the panel discussed the possibility of not including it when writing guideline recommendations.

Panel members raised concern about how current the reviewed research is and potential gaps that may require additional analyses. Members of the panel will consider what statement to make in the guidelines about not having a recommendation for prevention of PTSD due to insufficient evidence.

Dr. Viswanathan talked about risk of bias and explained the methodology as well as the PICOTS of the child PTSD reviews to the panel.

Dr. Gartlehner informed the panel how evidence is translated into guidelines. He then provided a brief introduction to Grading of Recommendations Assessment, Development and Evaluation (GRADE); evidence profiles and a summary of the findings table; how to formulate key questions and prioritize outcomes. Dr. Gartlehner then showed an example of a decision table and led the panel through an interactive exercise.

The timetable for completing the guideline was discussed. The panel agreed to plan on having a solid product to take to APA's Board of Directors by January 2015. To reach that goal, a draft for public comment would be available by the fall of 2014.

Panel Discussion

Some panel members raised the issue of what would be the best available evidence on which the panel can base recommendations regarding treatments that are useful. The question of whether or not qualifiers undermine recommendations was raised. Some panel members expressed the view that it will be critical to have sufficient qualifiers and caveats related to applicability across various populations and contexts as well as a statement of need for more research.

Despite such limitations, the list of trials included in the systematic reviews was deemed impressive and panel members acknowledged the value of these summaries of the literature.

There was also substantial discussion about the value of evidence obtained from randomized controlled trials (RCTs). Some members emphasized the rigor and quality of such evidence, while others raised concerns that RCTs do not always include a sufficient range of populations to enable conclusions about the generalizability of the results.

Panel members recognized the need to use systematic reviews, which are largely based on RCTs, in the development of guidelines in order to be compatible with guideline development in other areas of health care. The panel also decided to examine the populations covered in the AHRQ systematic reviews more thoroughly in order to address generalizability in the guideline document it produces.

Final Guideline Development Panel Discussion

Dr. Visawanathan proposed that a “catch up” review to identify any emerging interventions that were not included in the current AHRQ reviews may be useful prior to completion of the APA guideline.

The panel would like its guideline to have a broad scope but agreed that beginning with the existing reviews from AHRQ is sensible. Based on the strength of evidence in the various AHRQ reviews, the panel decided to take a sequential approach to writing guideline documents. It will first consider the review on adult treatment. If there is sufficient time and resources, it will then move to the two reviews on child PTSD, and then to the review on adult prevention.

The panel members then engaged in an exercise to identify outcomes that they felt were important to consider when developing the guideline on adult treatment (i.e., their “dream list” of outcomes). The list generated by the panel will then be used after the meeting to form a survey in which panel members will rank their top outcomes. As part of this survey, the outcomes from the AHRQ review will also be ranked (separately from the “dream list”). Panel members will then have the opportunity to discuss the survey results and do an additional one to two rounds of ranking as needed. This exercise will help narrow the scope of the guideline development effort. APA will commission RTI International to complete evidence profiles for the top 7 or so outcomes for the panel to use in guideline development.

The “dream list” of outcomes identified by the panel at the meeting included:

- Reduction of PTSD symptoms, severity and diagnosis
- Improvement in quality of life; changing world view; self-efficacy; satisfaction
- Improvement in function and decreased impairment as they relate to work , relationships, educational attainment, etc.
- Reduction of co-morbid symptoms and diagnoses
- Reduction in risk-taking behavior

- Reduction in service utilization such as hospitalization
- Remission as it relates to a specified reduction of symptoms
- Decrease in suicidal, homicidal, and aggressive behavior
- Improved physical health and health behaviors
- Maintenance of treatment gains
- Complicated and traumatic grief
- Perceived justice
- Culturally specific outcomes
- Homeless to housed
- Resource loss

In order to address the generalizability of the conclusions from the AHRQ adult treatment review, the panel members also discussed what additional demographic and other information about the samples of the studies covered in the review they were interested in obtaining. They generated the following list of characteristics:

Patient/Consumer Characteristics:

- Gender and sexual orientation
- Type of exposure to child trauma
- Socioeconomic status
- Education
- Age range
- Nationalities and refugee status
- Immigrant status
- Idioms of distress by race

Other Topics:

- Allegiance/status as treatment developer of authors
- Settings

Next Steps

Conference calls:

- The panel will have regular monthly one hour long calls. The panel elected that the November call will be Friday, November 22nd at 1:00 EST until 2:00. APA staff will send further details for the call in as the date approaches.
- Panel will be on the lookout for a doodle poll from APA staff for scheduling a regular time and date for its monthly calls. Members voted that Fridays would work best.

Outcomes:

- APA staff will put together a document with two lists: one is the panel's "dream list" of outcomes from the AHRQ adult treatment report that it would like to have data on; the second is the list of outcomes that are specifically examined in the report. Panel members will review the "dream list" for clarity and completeness and send feedback to APA staff. APA staff will then develop a survey in which panel members can rank their top outcomes on each list. Once the panel has finalized (after 1-3 rounds of voting) its top outcomes, APA staff will commission evidence profiles based on those outcomes from RTI International.

Demographic and other characteristics:

- APA staff will prepare a list of the characteristics of study samples from the AHRQ adult treatment review that the panel members were interested in as well as a list of characteristics explicitly discussed in the AHRQ review. Panel members will review this list and provide feedback to APA staff.

Copies of articles reviewed by adult treatment report

- The panel was interested in having access to PDF copies of the articles that were included in the AHRQ adult treatment report (101 articles). APA staff will look into the possibility of obtaining these articles internally.

Copies of RTI's presentation slides:

- APA staff will obtain copies of all the slides and handouts that RTI speakers presented and post these on APA Communities for panel members.

Article describing Dr. Gartlehner's presentation on evidence profiles/decision tables:

- A panel member asked whether there was a particular article that would provide a summary of the content Dr. Gartlehner presented on evidence profiles and decision tables. APA staff will follow up on this request and post the article on APA Communities.

Common factors:

- The panel discussed the issue of the contribution of common (non-specific) factors to the effectiveness of treatments for PTSD. An article by John Norcross was recommended. APA staff will place this article on APA Communities.

References

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