

Guideline Development Group response to public consultation submissions

Public Consultation Submissions and Guideline Development Group Response

We received 7 submissions. They are presented as follows:

Table 1: Royal Australian and New Zealand College of Psychiatrists	2
Table 2: Australian Psychological Society	16
Table 3: Exercise and Sport Science Australia	31
Table 4: Australia and New Zealand Association of Contextual Behavioural Science	40
Table 5: Individual submission Michael Scheeringa MD	43
Table 6: Individual Submission Veteran with PTSD	49
Table 7: Individual submission	54

<p>treatment recommendations in the context of good clinical judgement, not as rigid rules. We recommend that Phoenix Australia places greater emphasis on this throughout the Guidelines.</p> <p>The RANZCP commends the acknowledgement in the plain language statement that each person’s unique circumstances and overall mental healthcare needs must be considered. We recommend the Guidelines should go further to highlight the effect of intersectional identities on people’s experiences of trauma and be attentive to guidance about cultural safety as well as practicing with people with disabilities and people who identify as lesbian, gay, bisexual, trans, intersex and queer/questioning (LGBTIQ+).</p> <p>An additional minor item to note is the repetition of “there is” on page 1, paragraph 1, line 6 of this section.</p>	<p>introduction to MagicApp and the first paragraph of the Treatment Recommendations chapter.</p> <p>We agree that this is important.</p> <p>Thanks for picking this up.</p>	<p>The Introduction to MagicApp and the first paragraph of the Treatment Recommendations chapter has been amended to include the following sentences:</p> <p>“The Guidelines do not substitute for the knowledge and skill of competent individual practitioners and are designed to guide appropriate interventions in the context of each person’s unique circumstances and their overall mental health care needs. Practitioners should be enabled to interpret and implement treatment recommendations in the context of good clinical judgement, not as rigid rules.”</p> <p>The following sentence has been added to the subheading “Demographics” under Intervention Planning (p. 27) in Chapter 2:</p> <p>“Particular attention should be paid to the potential impact of intersectional identities on people’s experience of trauma. Practitioners should be attentive to guidance about cultural safety as well as practicing with people with disabilities and people who identify as lesbian, gay, bisexual, trans, intersex and queer/questioning (LGBTIQ+).”</p> <p>The repetition of “there is” on page 1, paragraph 1, line 6 of this section has been removed.</p>
---	--	---

<p>Chapter 1 Introduction</p> <p>The RANZCP appreciates that the Guidelines are a “living” document and that there is the opportunity to include additional evidence as it is developed, noting the ever-evolving evidence in relation to the treatment of trauma.</p> <p>The RANZCP suggests amending the statement: “the Guidelines are intended to influence the care of all Australian men, women and children, across the full range of populations, who develop, or are at risk of developing, these forms of distress following traumatic events” to read “the Guidelines are intended to influence the care of all people living in Australia, across the full range of populations, who develop, or are at risk of developing, these forms of distress following traumatic events” so that it is more inclusive.</p>	<p>Thank you for this suggestion. The GDG agreed to amend this statement.</p>	<p>The last paragraph in Chapter 1 page 2 was amended to read</p> <p>“the Guidelines are intended to influence the care of all people living in Australia, across the full range of populations, who develop, or are at risk of developing, these forms of distress following traumatic events” so that it is more inclusive.</p>
<p>Chapter 2 Trauma and Trauma Reactions</p> <p>The RANZCP commends the Guidelines use of clear definitions for trauma, potentially traumatic events, acute stress disorder, PTSD and CPTSD.</p> <p>The RANZCP suggests that the ‘screening, assessment and diagnosis’ section within this chapter should highlight that people with intellectual disabilities and autism are subject to high levels of abuse and trauma and, consequently, are at high risk of developing</p>	<p>Thank you for this suggestion. The GDG agreed to this addition.</p>	<p>The first paragraph under “Screening and assessment” on page 12 of Chapter 2 was amended to include the following statement:</p> <p>“Practitioners should consider modifying assessment and treatment approaches when supporting people with intellectual disabilities and autism who may be experiencing acute stress disorder, PTSD and CPTSD. People with intellectual disabilities and autism can be subject to high levels of abuse and trauma and, consequently, are at high risk of developing stress related disorders. However, their</p>

<p>stress related disorders. However, these may not be easily recognised because of communication and cognitive impairments. Practitioners must therefore consider modifying treatment approaches when supporting people with intellectual disabilities and autism who may be experiencing acute stress disorder, PTSD and CPTSD.</p>		<p>symptoms may not be easily recognised because of communication and cognitive impairments.”</p>
<p>Chapter 3 Children and Adolescents The RANZCP identifies that there is an opportunity to provide additional clinical-based advice, including information around holistic and systemic approaches, clinical values, patient preferences, alongside the evidence base for treating children and adolescents who experience or are at risk of experiencing trauma.</p>	<p>The GDG agreed and added additional clinical-based advice. Also please note that patients’ preferences are considered in the EtD framework, details of which can be found for each recommendation in MAGICapp under the ‘Key info’ tab and ‘Preferences and values’.</p>	<p>On pages 1- 2 of Chapter 3 Children and Adolescents the following was added (in italics):</p> <p><i>Parents and caregivers are central to trauma-informed care for a variety of reasons. Children and adolescents are typically dependent upon an adult to present them for treatment in the first instance and to ensure that they attend subsequent appointments. For many adults and children, it is not immediately obvious that psychological approaches that emphasise talking about the traumatic event would be helpful. This means that it is as important to engage with, and maintain, the relevant adult’s motivation to both support and pursue treatment, as it is to do these things with the child or adolescent client. It is also very well established that for some presentations, especially complex PTSD, a parent, member of the extended family or</i></p>

		<p><i>caregiver may be the perpetrator of sexual or physical abuse of the child or adolescent. Child protection issues are always an important consideration when working with children and adolescents. For adolescents these issues can also be complicated by issues of privacy and consent.</i></p> <p>Children and adolescents are part of a system (typically a family). Thus, their symptoms have the potential to both influence, and be influenced by, anything that is happening within the system in which they live. <i>Some family systems have high rates of domestic violence, verbal or physical abuse or family members with alcohol or drug addictions. Conflictual relationships can be longstanding and continue after family separation and divorce. Other events that children and adolescents find traumatic include the illness or death of grandparents. Systems issues outside the family include some young people residing in communities with high rates of violence, substance use and family breakdown. Thus, the clinician needs to be continually aware of what is happening within the child's system.</i></p>
--	--	--

		<p>In line with the first two considerations, the younger the child, the more critical it is <i>to involve parents/caregivers in the child's treatment. Infants and young children may present with trauma directly related to parenting and attachment related trauma which may require specialist infant-parent clinical intervention.</i> However, as will be discussed below, there are many reasons why caregivers may be unwilling or unable to participate in their child's treatment in a helpful manner. The clinician needs to be aware of this and to manage the relationships accordingly.</p> <p>However, the child has an important voice in decisions to take up any assessment or intervention. It cannot be assumed that a child does not have capacity to consent at any specific age; this must be judged on a case-by-case basis. In general though, if a child is unwilling to engage in treatment their wishes need to be accommodated, irrespective of the caregivers' views. <i>Complementary to this, child and adolescent practitioners need to be experts at communicating the benefits of treatment to children and motivating them to engage in therapy.</i></p>
--	--	---

		<p>The rate of agreement between parents/caregivers and children in relation to internalising symptoms (and especially posttraumatic mental health problems) is very low. <i>If possible</i> the clinician should seek to obtain both caregiver and child reports for assessment of a child’s internalising symptoms – even if the child is of preschool age. <i>When appropriately asked, which may include creative endeavours such as drawing or play, children have the ability to discuss thoughts, feelings and physiological symptoms of trauma, even when reluctant to discuss the actual traumatic event. Clinicians should also be aware that traumatic stress responses can include externalising behaviours and these may be the most obvious signs of traumatic stress. Unfortunately these behaviours can be misinterpreted by parents/caregivers as well as clinicians.</i></p> <p>On page 23 under “What’s different about working with children and adolescents”, the first point has been amended to:</p> <p><i>1 Parents/caregivers need to be involved as available to improve understanding of the child’s difficulties and experiences and to support recovery. Specifically:</i></p>
--	--	---

		<p><i>On page 24 an additional point has been added:</i></p> <p><i>4 In cases where family groups and communities have experienced trauma it is important to provide psychoeducation around the needs of children.</i></p> <p>On page 26 under ‘Guidance for clinicians’ an additional dot point was added:</p> <ul style="list-style-type: none"> • For some cases, child protection issues are key considerations, in terms of the nature of the traumatic event, as well as ensuring the ongoing safety of the child or adolescent.
<p>Chapter 4 Interventions</p> <p>As previously noted, the RANZCP has identified that the recommended interventions within the Guidelines have a strong psychological focus. We acknowledge that this is due to a gap in high-quality evidence in relation to effective biological interventions for people experiencing acute stress disorder, PTSD and CPTSD that meets the National</p>	<p>The GDG notes that in Chapter 6 Treatment Recommendations there is a section on the “Role of Medications” which acknowledges the important role of pharmacological therapies, particularly antidepressant medications, in the treatment of PTSD in clinical practice, and provides clinical guidance.</p>	<p>No change</p>

<p>Health and Medical Research Council (NHMRC) standards. While the Guidelines do state in the ‘Introduction’ section that the absence of evidence does not necessarily mean that these interventions are ineffective, the RANZCP suggests that there be greater clarification of the role of pharmacological interventions in the Guidelines.</p>		
<p>The RANZCP commends the well-described and clear methodology for developing the Guidelines. However, we do point out that the literature search seemed to come up with some anomalies in the Treatment Recommendations section. For example, there is no mention of the use of Stellate Ganglion Blocks (SGB) for PTSD, which has a small, but serious, evidence base including 2 RCTs, (Hanling et al 2016; Olmsted et al 2019), while an obscure Japanese herbal treatment called Saikokaishikankyoto is mentioned, as is ‘nature adventure therapy.’</p>	<p>The GDG opted to use an approach consistent with Cochrane methodology, in which randomised controlled trials (RCTs) are used to address questions about the effectiveness of interventions because they are the best design for providing an unbiased estimate of treatment effect (Reeves et al., 2019).</p> <p>While it was the intention of the GDG to consider all RCTs that included an intervention aimed at preventing or improving PTSD symptoms, the GDG acknowledges that some RCTs may have been missed during the systematic review process.</p> <p>In specific regard to SGB for PTSD, of the 2 available RCTs, Olmstead et al., 2019 was published outside of the cut-off date for the current guideline search and is therefore ineligible for inclusion. The second RCT Hanling et al., 2016 was not included in the search results provided by ISTSS but the GDG can see no clear rationale for the exclusion of this study</p>	<p>The Hanling study investigating Stellate Ganglion Blocks will be included in the systematic review but this will not result in a change to recommendations as the study did not show a clinically important benefit (SMD=0.04 CI -0.67, 0.59) and the GRADE was very low due to serious risk of bias and very serious imprecision (n=42).</p>

<p>The RANZCP acknowledges and appreciates the NHMRC’s standards for high-quality research to inform the Guidelines. However, as stated above, it is important to clearly highlight the messaging included in the ‘Introduction’, that guidance should not limit treatment innovation and development based upon scientific evidence, expert consensus, practitioner judgment, and the person’s preferences, throughout the Guidelines. This will ensure that practitioners are supported to continue exercising their clinical judgement in specific clinical situations to meet the needs of the individuals they are treating, including those who are experiencing comorbid issues, with both psychotherapeutic and pharmacological interventions.</p>	<p>Reeves BC, Deeks JJ, Higgins JPT, Shea B, Tugwell P, Wells GA. Chapter 24: Including non-randomized studies on intervention effects. In: Higgins JPT, Thomas J, Chandler J, Cumpston M, Li T, Page MJ, Welch VA (editors). <i>Cochrane Handbook for Systematic Reviews of Interventions</i> version 6.0 (updated July 2019). Cochrane, 2019. Available from www.training.cochrane.org/handbook.</p> <p>The GDG agreed and the comment highlights the potential value of gathering data to establish wider consensus for some recommendations (and details about the ‘conditions’ that influence whether to use particular therapies or not) for the next iteration of the guideline.</p>	<p>The first paragraph of the Interventions chapter has been amended to include the following sentences:</p> <p>“The Guidelines do not substitute for the knowledge and skill of competent individual practitioners and are designed to guide appropriate interventions in the context of each person’s unique circumstances and their overall mental health care needs. Practitioners should be enabled to interpret and implement treatment recommendations in the context of good clinical judgement.”</p>
<p>Chapter 6 Treatment recommendations</p> <p>The RANZCP commends the clear recommendations supported by high-quality</p>		<p>No change</p>

<p>evidence. As previously mentioned, the RANZCP notes that the treatment recommendations are psychologically dominated. The RANZCP highlights that it is particularly important for psychiatrists to be enabled to use their clinical experience to support individuals. The RANZCP urges Phoenix Australia to make it clearer within the Guidelines the importance of pharmacological therapies.</p> <p>Page 3, conditional recommendation for venlafaxine, paragraph b should read ‘where SNRIs are indicated.’</p> <p>Appendix to Chapter 6 – Medication prescribing algorithm</p> <p>The RANZCP suggests that the literature included to inform the Medication Prescribing Algorithm could be revised to reflect the most up-to-date evidence that is available in this area. An additional minor item to note is that the Appendix contains some typographical errors.</p> <p>Treatment recommendations for children and adolescents</p> <p>The RANZCP identifies that there is an opportunity to build on the evidence-base for treating children and adolescents with acute stress disorder, PTSD and CPTSD. We would</p>	<p>The GDG agrees but considers that this has been adequately addressed in the section on “Role of Medications”</p> <p>Thanks for picking this up.</p> <p>Medication prescribing algorithm The GDG has included this algorithm an example of an evidence-informed clinical tool for use in prescribing medications for PTSD, and has reproduced it in its original form without amendment. The GDG agrees that it could be revised, and will seek to address this in future revisions.</p> <p>The GDG agrees that there is an opportunity to build on the evidence-base for treating children and adolescents. A number of</p>	<p>Chapter 6, Treatment Recommendations has been amended Page 3, conditional recommendation for venlafaxine, paragraph b has been amended to read ‘where SNRIs are indicated.’</p> <p>No change at this stage</p> <p>No change</p>
---	---	--

<p>welcome additional high-quality research in this area to inform these Living Guidelines.</p>	<p>recommendations for further research have been made on page 7 in Chapter 6.</p>	
<p>Chapter 7 Complex PTSD</p> <p>The RANZCP commends the inclusion of the principles of "trauma-informed care", and the emphasis that this is an empowering, strengths-based approach. We suggest the discussion of specific trauma treatments for people with CPTSD could further highlight the importance of developing trust, establishing safety, working with emotions and building relationships alongside the implementation of trauma-focused treatments.</p> <p>The RANZCP also recommends that the Guidelines go further to highlight that systematic trauma-focused approaches may not be well tolerated in some people with CPTSD. In addition to "torture survivors", survivors of childhood sexual abuse and of repeated intimate partner violence must also be included as groups that are more likely to be unable to "tolerate" trauma-focused approaches.</p>	<p>The GDG notes that given that CPTSD is a relatively new diagnosis it will take more time before an evidence base emerges about how best to treat it in adults, children, and adolescents. A number of the treatment models discussed in this chapter would support developing trust, establishing safety, working with emotions and building relationships alongside the implementation of trauma-focused treatments, but there is not yet clear support in the literature for a particular model such as STAIR.</p> <p>The GDG considered the statement that these "groups are more likely to be unable to tolerate trauma-focused approaches" is too strong for a statement based on clinical experience rather than research evidence. The preferred language is that these approaches may not be well tolerated in some people with CPTSD. However the GDG agreed that this comment could also apply to the other groups mentioned.</p>	<p>No change</p> <p>In the third paragraph on page 6, the following amendment has been made: "However systematic trauma-focussed approaches may not be well tolerated in some CPTSD populations (<i>such as survivors of torture, childhood sexual abuse and repeated intimate partner violence</i>) for whom an integrated supportive framework may be more appropriate. <i>In the case of attachment related trauma with impacts on self-esteem, mood and interpersonal function, interventions that support gaining insight into relationships patterns and promoting self-development may be useful. Where there is overlap in symptoms of CPTSD and borderline personality disorder, the NHMRC Clinical Practice</i></p>

		<i>Guidelines for Borderline Personality Disorder that support the use of several structured interventions and longer term psychotherapy may be applicable.”</i>
<p>Chapter 9 Special Populations: Military and Ex-Military Personnel</p> <p>The RANZCP is encouraged by the inclusion of the importance of building a trusting therapeutic relationship particularly when supporting military and ex-military personnel with acute stress disorder, PTSD or CPTSD. Further, the RANZCP supports that managing military-related PTSD with more than one psychotherapy modality has better treatment outcomes.</p>	The GDG noted these comments.	No change
<p>Chapter 9 Special Populations: Intimate Partner Violence</p> <p>The RANZCP highlights the need to build on the evidence-base around effective therapeutic interventions to support women and children who are experiencing or at risk of experiencing acute stress disorder, PTSD and CPTSD in the context of intimate partner violence.</p>	The GDG noted these comments.	No change
<p>Comments on treatment recommendations and their evidence contained in MAGICApp</p> <p>The RANZCP supports the use of MAGICApp to enable the Guidelines to be a “living” document and to detail the considerations</p>	The GDG agrees. The MAGICApp online platform has great merit as an online platform for maintaining and publishing a living guideline. The GDG has anticipated some users may have difficulty navigating this new software and has fed back to the developers a number of suggested improvements to increase	Links to MAGICApp will be inserted in the Chapters once the final version of MAGICApp has been approved and can be published.

<p>behind each recommendation. However, we suggest that the MAGICApp may cause some confusion and difficulty for people seeking to access the treatment recommendations. The RANZCP recommends that instructions for navigating MAGICApp be included in the 'Introduction' section of the Guidelines and that measures be taken to ensure that it is accessible for people with disabilities and older adults.</p>	<p>the accessibility of the software. In addition, all of the treatment recommendations have been reproduced throughout the supporting Chapters so that the information is available without having to access MAGICApp for people who may be unable to access. A section titled, "Guidance on the use of MAGICApp" is included in the Introduction to the MAGICApp platform. Links to MAGICApp will also be inserted throughout the Guideline Chapters once the final version of MAGICApp is finalised.</p>	
<p>General comments</p> <p>The RANZCP would again like to commend Phoenix Australia for developing these comprehensive Guidelines and the multidisciplinary approach used in their development, including the involvement of a number of psychiatrists.</p> <p>The RANZCP feedback has been developed with input from a range of RANZCP Committees. We are also aware that a number of our members have provided their individual feedback directly to Phoenix Australia.</p> <p>One final general comment is that the use of the acronym ASD for Acute Stress Disorder may cause confusion in the mental health field, as it is most often used to abbreviate Autistic Spectrum Disorder.</p>	<p>The GDG noted these comments. Thank you.</p>	<p>No change</p>

Table 2: Australian Psychological Society

Submission Comments	Guideline Development Group response	Change to Guideline Yes/No Where new section inserted
<p>Chapter 1 – Introduction</p> <p>The GLs state, The Guideline developers recognise that there are a number of interventions that are widely used in clinical practice that have not been adequately tested, and it is important to acknowledge that the absence of evidence does not necessarily mean that these interventions are ineffective (p 3).</p> <p>This is a noble sentiment. The reality, however, is that those who are not interested in evidence based practice - it is important to keep the evidence around implementation of EBP practice generally (see McHugh & Barlow, 2010) and as it applies to specific interventions, like the gold standard psychological treatment of exposure (see Rosqvist, 2005) - can see such statement as an endorsement of non-EBP or treatments they personally perceive to be effective (e.g., neurofeedback) (when they do not understand the nature of the science of psychology or have a commitment to it). Just because a practitioner believes a treatment works does not constitute psychological science; such attitudes are widespread in the world of practice.</p> <p>The GLs briefly talk of remote delivery in a variety of places (see further comment under chapter 2) especially in rural and remote settings - and of appropriate education and training to support practitioners in the delivery of the recommended evidence-based interventions.</p>	<p>The GDG agrees that there should be a clear message that evidence-based treatments are first line.</p>	<p>In Chapter 1, page 3, paragraph 2 after “ineffective” insert:</p> <p><i>“However, interventions that have a proven evidence base should be considered as first line.”</i></p>

<p>In talking about such limitations, the GLs correctly briefly talk about the need for practitioners to use their experience and expertise in applying the Guidelines (p 3).</p> <p>This is a crucially important point. It, of course, assumes that practitioners understand how to implement and translate the EB interventions related to TRMHCs based on experience. Such a broad statement can give practitioners sufficient wriggle room to ignore the GLs.</p> <p>It is hence suggested that it is important for the GLs is re-emphasised at this point.</p> <p>The GLs quite rightly observe that its key recommendations need to be effectively disseminated to health practitioners, service planners, purchasers and people directly affected by trauma.</p> <p>This is, of course, correct. It is equally important to include all possible audiences in this; for example, families and friends of affected individuals. It is recognised that references are made to such parties in other chapters of the GLs, but to refer to the her would be important.</p> <p>Similarly, while it could be construed that observation also applies to third parties, it is important that they are be specifically identified. Must engage systems, be they third party compensable funders, organisations that deliver MH care (e.g., OAs or private hospitals that specialise in programmatic PTSD treatment and is comorbidities) or formal MH systems (e.g., public sector MH services). This is the time when all key stakeholders need to as strongly as possible promote the implementation and translation of psychological science.</p>	<p>The GDG agreed that it is important to emphasise that practitioners use their experience and expertise in applying the guidelines.</p> <p>The GDG agreed that key recommendations should be disseminated as broadly as possible, including to families and friends of affected individuals. The dissemination strategy will include families and friends in the target audience.</p> <p>The GDG agreed. The dissemination strategy will include in the target audience organisations responsible for the provision of trauma related mental health services and third party insurers</p>	<p>On page 3 under ‘Limitations of the Guidelines’ after “use their experience and expertise in applying the Guidelines.” Insert: <i>“Practitioners should always provide treatment within the limits of their expertise and seek further training and/or supervision as required.”</i></p> <p>No change</p> <p>No change</p>
<p>Chapter 2 – Trauma and trauma reactions</p> <p>The GLs correctly point out the tendency for practitioners and observers to indiscriminately use the word trauma. It is a subtle, but</p>	<p>The GDG noted that the term PTE, defined as potentially traumatic event, is the accepted term internationally.</p>	<p>No change</p>

<p>significant point and is very welcome. Then the GLs deploy the term Potentially Traumatic Event (PTE) to emphasise the conditional nature of traumatic experience and that not everyone exposed to a trauma develops a TRMHC. While this is an incredibly important point, that is itself a grammatical error (adjective versus adverb confusion) , and that the term PTE should be Potentially Traumatizing Event.</p> <p>In a similar vein, the GLs observe that recovery from PTSD related to compensable injuries appears to be less likely and associated with the compensation process. This observation is too narrow a description of the problem of compressible injuries and takes no account of the treatment by the type of trauma, individuals sense of having been subject to workplace injustice and the actions of the employer, which result in considerable anger, which in turn maintains the conditions concerned.</p> <p>The GLs also observe that around one-third of patients will make a good recovery following effective treatment, one-third will do moderately well, and one-third are unlikely to benefit. There is a logical error in this statement - how can treatment be effective and not render a benefit. It needs to be finessed. It should also again compare outcomes to non-EB treatment and not treatment.</p>	<p>The GDG agreed that anger is a potential contributing factors affecting recovery from PTSD. Clinically it seems likely that issues of workplace injustice may affect the recovery trajectory, but the GDG did not have research before it to support this.</p> <p>The GDG agreed and made a wording amendment.</p>	<p>Under ‘The course of PTSD’ add to the second last paragraph on page 11: <i>“Elevated levels of anger may also be a contributing factor to a poor recovery trajectory from PTSD.”</i></p> <p>Reference added: Lloyd D, Nixon R, Varker T, et al. Comorbidity in the prediction of Cognitive Processing Therapy treatment outcomes for combat-related posttraumatic stress disorder. J Anxiety Disord. 2014;28(2):237-240. </p> <p>On page 11, the references to ‘evidence-based’ in the following sentence changed from ‘effective’: “Importantly, PTSD is less likely to follow a chronic course with <i>evidence-based</i> treatment. Based on several studies it is reasonable to</p>
--	---	---

<p>Posttraumatic mental health disorders: Key differences between ASD and PTSD (p12)</p> <p>Various differences are drawn out under this subheading. It is not clear what the overall implications of these are - should they not be stated here (or referenced to other areas of the GLs and vice versa).</p> <p>Within the topic heading of Screening, assessment and diagnosis, there is an attempt to explain what deters affected individuals from presenting for treatment.</p> <p>Here, the GLs talk of stigma (as they should). This is a complex topic that needs to be thought about with subtlety. The adage in dealing with self-stigmatisation that “Maybe you’re not thinking what I think you’re thinking” illustrates this. Also, messages that external stigmatisation is now well recognised as inappropriate, but is still impactful and is the responsibility of employers and systems to eradicate would be well place.</p> <p>There are other possible deterrents about which the GLs make no mention. For example, the impact of the lack of awareness suffers of TRMHCs may have about what constitutes effective treatment or</p>	<p>The GDG agreed and added a comment about the implications.</p> <p>The GDG added a note that self-stigma is a more important barrier to help-seeking than public stigma</p>	<p>assume that around one-third of patients will make a good recovery following <i>evidence-based</i> treatment, one-third will do moderately well, and one-third are unlikely to benefit.”</p> <p>.....</p> <p>On page 12, after the last paragraph of ‘Key differences between ASD and PTSD’ insert:</p> <p><i>“Despite these differences in diagnostic criteria, there is no difference in recommended treatments for PTSD and ASD. PTSD treatments however have a stronger evidence-base.”</i></p> <p>.....</p> <p>On page 13, the section on stigma has been expanded to: “This problem is due, in part, to the avoidance that is characteristic of PTSD, which may prevent the person speaking about it or seeking assistance. <i>Importantly, self-stigma has been found to contribute more to a reluctance to seek help, than public stigma (Clement et al., 2015).</i>”</p>
--	---	--

<p>how to find it and the often poor confidence people have in MH practitioners psychologists based on their or associates prior experience of unhelpful practice(s).</p> <p>It is the mental sequelae of traumatisation that determine who presents for treatment. If one's symptoms do not upset there will be no presentation: if my anger is not apparent to me, then I will not seek assistance.</p> <p>For people presenting to primary care services with repeated non-specific physical health problems, it is recommended that the primary care practitioner consider screening for psychological causes, including asking whether the person has experienced a traumatic event and to describe some examples of such events.</p> <p>This is a significant message, but why only PC services and practitioners (i.e., medicos) - this should be the case for all MH practitioners who may have such presentations.</p> <p><i>Screening should be undertaken in the context of a service system that includes adequate provision of services for those who require care.</i></p> <p>It is not clear that what system that is. Is this a real world or aspirational statement (of ideal practice/best practice)? It's</p>	<p>The GDG agreed and expanded the examples of barriers to reporting symptoms. .</p> <p>The GDG noted that the suggestion is specific to primary care practitioners – mental health issues have already been recognised in those who seek or are referred to a mental health practitioner</p> <p>The GDG agreed and clarified this point.</p>	<p>On page 13 after “It also needs to be acknowledged that there remains a social stigma attached to mental health problems, and the fear of discrimination may be a barrier to some people reporting their symptoms.” Insert “<i>Other barriers to reporting symptoms may include a lack of insight into or awareness of the symptoms, or low confidence that the treatment or practitioner will be effective.</i>”</p> <p>.....</p> <p>No change</p>
--	---	--

<p>appropriate to have and state aspirations in GLs and set challenges; they simply need to be articulated for what they are.</p> <p>Comprehensive assessment of PTSD</p> <p>Where possible, and with the person’s permission, information from other sources should be incorporated into the assessment process. (p15)</p> <p>About here, the GLs declare Assessment should cover the broad range of potential posttraumatic mental health problems beyond PTSD, including other anxiety disorders, depression and substance abuse. Please add anger - it’s so important.</p> <p>With respect to permission, it is importantly noted that</p> <p>The Australian Psychological Society has developed ethical guidelines for clinicians working with clients who report previously unreported traumatic memories, and they advise against using interventions designed to ‘recover’ such memories. The relevant American and British professional bodies have also issued strong warnings against this therapy approach.</p> <p>These are really important statements - practitioners are ethically bound by them - the sources are not cited/referenced. It is best that they are.</p>	<p>The intent of this guidance is to highlight the importance of assessing for other mental health disorders in addition to PTSD. This has been clarified.</p> <p>The GDG agreed to add appropriate references where they are publicly available. The APS guidance, for instance, is only accessible to members.</p>	<p>On page 14 under ‘Guidance for clinicians’ insert the following (in italics) before the second last bullet point:</p> <p><i>“There is no value in screening for mental health problems if services are not available to refer those with a positive screen. As such, screening should only be undertaken in the context of a service system that includes adequate provision of services for those who require care.”</i></p> <p>Amend ‘Practice points’ on page 17 to: “Assessment should cover the broad range of potential posttraumatic mental health <i>disorders</i> beyond PTSD, including other anxiety disorders, depression and substance abuse.”</p> <p>References to be added where they are available in the public domain.</p>
--	--	---

<p>Next the GLs talk about Factors influencing treatment outcome. It is strongly suggested the GLs you add anger here. No mention of it here is derelict - it's so associated with symptom maintenance and condition chronicity.</p> <p>The GLs next talk about Therapeutic alliance and treatment expectations</p> <p>It is strongly suggested that caution be exercised about the former. There is a literature that challenges the long held 30% of outcome assumption that has historically applied (see Horvath). The emphasis given to</p> <p>It is the experience of members that when they appropriate relationships with clientele, what they (coppers, DVA bods, ambos and other FRs) express after they have successfully undertaken exposure, is what a difference it has made and their outrage at not having been provided with it by previous psychologists.</p> <p>The power of expectations remains true: if people develop expertise, and are thought to have it by acclaim, they will do better. The more pineapples on one's shoulders, the greater the potential influence.</p> <p>Under the heading Treatment goals, the GLs state that the first goal of treatment is likely to be a reduction in PTSD and related symptoms. It is important to emphasise this IS A NECESSARY FIRST STEP to the GLs following points/paras. The second step is emotional regulation and then the re-strengthening of personal coping resources.</p> <p>It is obvious to the APS that too many practitioners do not understand it. They are instead wandering around in a morass or relationship building with little by way of outcomes while trying to</p>	<p>The GDG noted that anger is included as a feature that may affect treatment outcome under 'comorbidity' (third line).</p> <p>The GDG considered that this section remains important.</p> <p>The main purpose of the Guideline is of course to provide treatment recommendations. However, the GDG considered that this section is appropriate as written.</p>	<p>No change</p> <p>No change</p> <p>No change</p>
--	--	--

<p>interpret and develop insight. Insight and the relationship are not enough and active treatment must be emphasised.</p> <p>The GLs talk about integrated and co-ordinated care under rpt heading of General professional issues. They take no account What about the role of government in supporting this by the introduction of incentives for case co-ordination etc. We should not rule out psychologists being the fulcrum in this (psychologists should not be handmaidens to psychiatrists and GPS, but active and expert partners and need to be endorsed as such based on client focused assertive practice same).</p> <p>In talking of the challenges of assessing and treating TRMHCs in R, R & R locations, the GLs observed that</p> <p>Wherever possible the person should be referred to an appropriately trained mental health practitioner who can provide time-limited specialist psychological treatment and ongoing consultation to the primary care practitioner. In some cases, it may be possible to achieve this through telehealth or even telephone consultations.</p> <p>As it stands, this is somewhat flimsy and needs to be bolstered by reference (as is made elsewhere in other chapters that talk to telepsych and how it might best work). Issues deserving comment include, can EBP (i.e., exposure-based treatments) be done by telepsych, what are the appropriate supervision arrangements and the</p>	<p>The GDG considers that GPs are best placed to assume the care coordination role.</p> <p>We did not undertake meta-analyses specifically looking at the effectiveness of telehealth as part of the systematic review. This is therefore not a formal recommendation. However reference will be made to a small number of studies that support the efficacy of telehealth.</p>	<p>On page 32 under “General professional issues after “Where a number of practitioners are involved in care, the general practitioner is well placed to assume overall management of care, making appropriate referrals and coordinating the contribution of other practitioners.” Insert:</p> <p><i>“The introduction of payment for case coordination would support this.”</i></p> <p>On page 32 after “In some cases, it may be possible to achieve this through telehealth or even telephone consultations.” The following references have been cited:</p>
---	---	---

<p>level and quality of mentoring required for QA-assured practice in this space.</p>		<p>Acierno, R., Knapp, R., Tuerk, P., Gilmore, A. K., Lejuez, C., Ruggiero, K., ... Foa, E. B. (2017). A non-inferiority trial of Prolonged Exposure for posttraumatic stress disorder: In person versus home-based telehealth. <i>Behaviour Research and Therapy</i>, 89, 57–65. doi:10.1016/j.brat.2016.11.009</p> <p>Morland, L. A., Mackintosh, M. A., Rosen, C. S., Willis, E., Resick, P., Chard, K., & Frueh, B. C. (2015). Telemedicine versus in-person delivery of cognitive processing therapy for women with posttraumatic stress disorder: A randomized noninferiority trial. <i>Depression and Anxiety</i>, 32, 811-820.</p> <p>Olden, M., Shingleton, R., Finkelstein-Fox, L. et al. Telemedicine Exposure Therapy and Assessment for PTSD: a Systematic Clinical Practice Narrative Review. <i>J. technol. behav. sci.</i> 1, 22–31 (2016). https://doi.org/10.1007/s41347-016-0004-0</p>
---	--	---

<p>Chapter 4 – Interventions</p> <p>The APS has little by way of comment about this chapter. One exception, relate to the way observations about interventions further research</p> <p>The APS is a concerned that by cursorily identifying intervention for research without any comment about their proposed merits or potential problems without any clarification of what needs to be researched can lead to difficulties. Perhaps an introductory statement or statements at various places specific comments the theoretical models that inform those about those forms of intervention would be wise. Where no such explanatory or declarative model do not exist, then it would appear unjustified to include them in these critically important GLs.</p> <p>The all-too-common experience of thought and field leaders is that the instant any GL refer to such concepts worthy of research, this confers licence to utilise them. This is potentially a risk for unintended harm.</p>	<p>The GDG noted that recommendations were made for further research where the GDG considered preliminary evidence to be promising. However it is important to note that interventions that have been recommended for further research are NOT currently recommended for the treatment of PTSD. Nor should it be inferred that evaluating these interventions should take priority over strengthening the evidence for some more routinely used interventions or among important populations who are under-represented in current research.</p>	<p>This will be stated explicitly on p.2 after the list of recommendation types.</p> <p>In Chapter 4 on page 2 after the list of recommendation categories, the following text has been added:</p> <p><i>It is important to note that interventions that have been recommended for further research are NOT currently recommended for the treatment of PTSD. Nor should it be inferred that evaluating these interventions should take priority over strengthening the evidence for some more routinely used interventions or among important populations who are under-represented in current research.</i></p> <p>In Chapter 6 under the heading “Research recommendations” the following text has been added:</p> <p>The guideline development group considered that the</p>
--	---	---

		<p><i>preliminary evidence for the following interventions was promising and warranted further research. However it is important to note that interventions that have been recommended for further research are NOT currently recommended for the treatment of PTSD. Nor should it be inferred that evaluating these interventions should take priority over strengthening the evidence for some more routinely used interventions or among important populations who are under-represented in current research.</i></p>
<p>Chapter 9 – Special Populations <i>Refugees and Asylum Seekers</i> Often involves type two traumata; anger among survivors needs to be commented upon.</p>	<p>The GDG noted that it has made a change to the section “common responses to potentially traumatic events” in Chapter 2 to emphasise anger as a common emotional response. However this was not added to each of the special population chapters as they were written by subject matter experts.</p>	<p>No change</p>

<p><i>Military and Ex-Military Personnel</i></p> <p>There appears to be no readily identifiable comment on anger in this population, when it is, and is well documented, as a such significant problem. See comments in next sub-section of this chapter. They are pertinent to the military and ex-military community.</p>	<p>The GDG agreed that anger problems in this population are well documented. Problematic anger is mentioned on page 7 as potentially contributing to a poor treatment response.</p>	<p>No change</p>
<p><i>Emergency Service Personnel</i></p> <p>In the subsection on ES personnel it is observed Anger is a significant issue in this population. Pre-existing anger may influence the development of PTSD following a critical incident, while PTSD in turn is associated with an increase in anger.</p> <p>There is room to conclude that anger is a problem for many traumatised sub-populations. It would be appropriate [aide to buttress references to anger in this chapter especially, and elsewhere across the document. It generally, appears insufficiently referred to across the GLs.</p> <p>PTSD is now considered a stress disorder in both the DSM and ICD classification systems. There is a small but significant literature that underscores the importance of anger in stress responses. It needs to be cited, reference and described more for its impact and recovery interfering properties.</p>	<p>The GDG noted that it has made a change to the section “common responses to potentially traumatic events” in Chapter 2 to emphasise anger as a common emotional response. However this was not added to each of the special population chapters as they were written by subject matter experts.</p>	<p>No change</p>
<p><i>Older Adults</i></p> <p>Exposure works for this group - they should not be denied. Any and all emphasis that can be given to this is highly be appropriate.</p>	<p>The GDG noted that standard PTSD treatment approaches are appropriate with older patients. The GDG did not consider that there was evidence warranting specific mention of exposure.</p>	<p>No change</p>

<p><i>Victims of Crime</i></p> <p>Most commonly involves type two traumata; anger among survivors needs to be commented upon.</p>	<p>The GDG noted that it has made a change to the section “common responses to potentially traumatic events” in Chapter 2 to emphasise anger as a common emotional response. However this was not added to each of the special population chapters as they were written by subject matter experts.</p>	<p>No change</p>
<p><i>Sexual Assault</i></p> <p>A type two trauma; anger among survivors needs to be commented upon.</p>	<p>The GDG noted that it has made a change to the section “common responses to potentially traumatic events” in Chapter 2 to emphasise anger as a common emotional response. However this was not added to each of the special population chapters as they were written by subject matter experts.</p>	<p>No change</p>
<p><i>Intimate Partner Violence</i></p> <p>A type two trauma; anger among survivors needs to be commented upon.</p>	<p>The GDG noted that it has made a change to the section “common responses to potentially traumatic events” in Chapter 2 to emphasise anger as a common emotional response. However this was not added to each of the special population chapters as they were written by subject matter experts.</p> <p>The GDG noted that it has made a change to the section “common responses to</p>	<p>No change</p>

<p><i>Terrorism</i></p> <p>A type two trauma; anger among survivors needs to be commented upon.</p>	<p>potentially traumatic events” in Chapter 2 to emphasise anger as a common emotional response. However this was not added to each of the special population chapters as they were written by subject matter experts.</p>	<p>No change</p>
<p>General Comments</p> <p>It is important that Phoenix consult with the treater community via professional bodies and third-party funders once these GLs are completed so that their implementation and translation can be optimised.</p> <p>Clients would not know how to find a competent treater. A shopper’s guide in what to look for in treaters (experience, can describe how recovery take place, the treatments that work and how they are supported in evidence and <u>whether they use them</u>).</p> <p>BTW, there is an inconsistency in the positioning of in text citations in relationship to punctuation. In the main they appear after full stops (BTW, is this correct? Under APS style it is not). In other places, citations appear before commas and full stops; for example, see recovery from PTSD related to compensable injuries appears to be less likely⁴¹ and associated with the compensation process⁴².</p> <p>There are also a small number of areas where there could be great clarity and hanging sentences reduced. The following are examples. Chapter 2, page 16</p>	<p>The GDG agreed. This forms part of the Guidelines implementation and dissemination strategy.</p> <p>The GDG agreed. The companion booklet on recovery after trauma which provides guidance to service users on how to select a therapist and what questions to ask, will be promoted.</p> <p>The GDG agreed. JAMA style is used in the citations and this will be reviewed for consistency when the Guidelines are presented in final form.</p> <p>Agreed, and amended to improve clarity.</p>	<p>No change</p> <p>No change</p> <p>To be reviewed and edited for consistency</p> <p>Change to: Consideration should also be given to the diagnosis of complicated grief (formerly known as traumatic</p>

<p>... Consideration should also be given to the diagnosis of complicated grief (formerly known as traumatic grief) following bereavement, with increasing demand for its inclusion as a separate diagnostic entity. It is not precisely clear what that last sentence means.</p> <p>[and]</p> <p>... There is currently no agreed gold standard with which to make a comprehensive diagnostic assessment for PTSD. This is not as clear as it might be clear and the table 2.2 refers to the CAPS as the GS (it is understood that the GLs are talking about more than a specific metric, but it's confusing)</p> <p>It's such a good document that it might as well be free of distracting grammatical inelegancies.</p> <p>It is also suggested that consideration be given to internal cross-referencing within the GLs. They are very well written, but dense and further guiding the reader would be helpful.</p>	<p>Agreed and amended to avoid confusion.</p> <p>The GDG agreed. The final Guideline will be presented online where there will be a focus on linkages between sections</p>	<p>grief) following bereavement, with increasing demand for <i>inclusion of traumatic grief</i> as a separate diagnostic entity.</p> <p>Change to: <i>“In undertaking a comprehensive diagnostic assessment for PTSD, clinicians should adopt a multifaceted approach incorporating information from a variety of sources.”</i></p> <p>No change to PDFs but will be addressed on the dedicated Guidelines website</p>
---	--	--

Table 3: Exercise and Sport Science Australia

Submission Comments	Guideline Development Group response	Change to Guideline Yes/No Where new section inserted
<p>Chapter 5 Methodology</p> <p>ESSA is concerned that whilst chapter 5 highlights a thorough and robust search criteria for inclusion and exclusion into the guidelines, the search terms do not include physical health and wellbeing nor interventions that might address these factors, such as physical activity or exercise.</p> <p>Poor physical health outcomes are widely reported across populations with a mental illness [1] and a recent Lancet Commission outlined that the physical health of people with mental disorders be emphasised [2]. Exercise & Sport Science Australia (ESSA) provide the following recommendations for consideration:</p> <p>Recommendations 1: Additional scoping questions are included in the literature review to encompass the physical health and wellbeing of people with PTSD. This can be achieved by the inclusion of the search terms “physical activity” and “exercise” to the existing terms utilised thus far.</p>	<p>The search criteria used were as broad as possible to ensure that any RCT testing an intervention aimed at or reducing PTSD diagnosis or symptom severity was captured.</p> <p>In regards to Recommendation 1: by utilising the broad search terms; “PTSD”, “posttrauma*”, “post-trauma*”, “post trauma*”, “combat disorder*”, “stress disorder*”, specific interventions were not targeted but any studies aimed at improving PTSD symptoms through any type of intervention were captured. The GDG acknowledge that inclusion of physical health and wellbeing are important outcomes and it would be valuable to include these, however, it was beyond the scope of the current iteration of the guidelines. The GDG value this suggestion and will consider inclusion of these outcomes in future updates of the guideline.</p> <p>In regards to Recommendation 2, the GDG opted to use an approach consistent with Cochrane methodology, in which randomised trials are used to address questions about the effectiveness of interventions because they are the best design for providing an unbiased estimate of treatment effect. We conducted new reviews, rather rely on existing reviews, to overcome well-recognised</p>	<p>No change</p>

<p>Recommendation 2: The following literature be considered for inclusion in the methodology and therefore subsequent documentation:</p> <p>[3, 4] (systematic reviews)</p> <p>[5, 6] (narrative reviews)</p> <p>[7, 8] (randomised controlled trials)</p>	<p>problems with dealing with review evidence McKenzie and Brennan 2017). Importantly, any RCT included in the systematic reviews by Rosenbaum et al., 2015 or van de Kamp et al., 2019 that met the inclusion criteria for this guideline's search will have been captured and included where the study met the inclusion criteria. In regards to the specific RCT's the submission recommends be added; a) the RCT by Hall et al 2019 was published after the search was conducted and therefore was not eligible for inclusion in the current guideline- it will be included for review in the next update, b) the RCT by Fetzner et al 2015 was ineligible for inclusion due to the absence of a comparator intervention within the inclusion criteria i.e. eligible comparator interventions were; waitlist, treatment as usual, symptom monitoring, repeated assessment, other minimal attention control group or an alternative psychological treatment.</p> <p>Reeves BC, Deeks JJ, Higgins JPT, Shea B, Tugwell P, Wells GA. Chapter 24: Including non-randomized studies on intervention effects. In: Higgins JPT, Thomas J, Chandler J, Cumpston M, Li T, Page MJ, Welch VA (editors). <i>Cochrane Handbook for Systematic Reviews of Interventions</i> version 6.0 (updated July 2019). Cochrane, 2019. Available from www.training.cochrane.org/handbook</p> <p>McKenzie, J. E. and S. E. Brennan (2017). "Overviews of systematic reviews: great promise, greater challenge." <i>Systematic Reviews</i> 6(1): 185.</p>	
<p>Chapter 6 Treatment recommendations</p>	<p>The treatment recommendations in the Guidelines are limited to the systematic review underpinning the</p>	<p>Chapter 6 page 5:</p>

<p>Treatment recommendations for adults</p> <p>Recommendation 1: Exercise & Sport Science Australia (ESSA) recommends the addition of exercise and physical activity as treatments for PTSD in adults.</p> <p>Recommendation 2: ESSA recommends exercise and physical activity be considered as an adjunct to other treatments, with the understanding that physical health problems begin early in the course of mental illness [9].</p> <p>Recommendation 3: ESSA recommends direct referrals between medical specialists and Accredited Exercise Physiologists (AEP) within their scope of practice to achieve cost savings for Medicare and consumers, to reduce the administrative burden on General Practitioners, and to ensure early access to appropriate health care.</p> <p>Recommendation 4: ESSA recommends increasing referrals from mental health treatment facilities and community based mental health services to AEP-led community exercise services to foster better health outcomes.</p>	<p>guidelines. However the GDG recognises the value of exercise to promote general wellbeing and this is noted on page 5 in Chapter 6.</p>	<p>In recent years there has been increasing interest in a range of non-psychological and non-pharmacological interventions for people with PTSD. These include interventions such as yoga, meditation and exercise. While none of these therapies have a sufficient evidence base to recommend them as a treatment for PTSD, we would support their use as adjunctive or supplementary interventions to promote general wellbeing.</p>
<p>General comments</p> <p>People with severe mental illness live between 10-32 years less than the general population [1]. A major contributing factor to the lower life expectancy experienced by people with severe mental illness is poor physical health, e.g., cardiometabolic disease [10]. People with severe mental illness are more likely to be overweight, to smoke and to have diabetes, hypertension and dyslipidaemia [10]. Low levels of physical activity are a key modifiable risk factor contributing to the</p>	<p>It is beyond the scope of the Guidelines to provide general information about the value of exercise for people with severe mental illness or to promote ESSA's offering to improve Australia's mental health system.</p>	<p>No change</p>

<p>increased burden of poor physical health in this population. As such, people experiencing mental health issues can benefit greatly from timely access to appropriate exercise interventions [11].</p> <p>As the peak professional body and accrediting authority for Accredited Exercise Scientists (AES) and Accredited Exercise Physiologists (AEP), ESSA can assist to improve Australia's mental health system by:</p> <ul style="list-style-type: none"> • preventing the development of some trauma and stress related mental health issues in healthy Australians • mitigating the increasing burden of healthcare expenditure invested in the prevention and treatment of mental health in Australia • reducing the administrative burden on the primary healthcare system through the provision of exercise to prevent and manage mental health issues in individuals and the community by tertiary qualified and accredited AESs and AEPs • educating the Australian community on the evidence-based benefits of physical activity in preventing and treating mental health issues <p>With the permission from the authors, the following information has been extracted from the ESSA consensus statement on the role of accredited exercise physiologists within the treatment of mental disorders [12]. The role of AEPs within the treatment of mental disorders includes:</p> <ul style="list-style-type: none"> • Design and implement evidence-based physical activity interventions to improve the physical health 		
--	--	--

<p>profile and prevent/manage the development of metabolic and cardiovascular disease</p> <ul style="list-style-type: none"> • Work as part of a multidisciplinary team to conduct and promote regular physical health screening and metabolic monitoring (body weight, body mass index (BMI), waist circumference, blood glucose levels and blood pressure) as part of standard care and in line with treatment guidelines • Provide individual and group education sessions, outlining the benefits of physical activity for people experiencing mental illness • Consider clinical outcomes, risk factors and comorbidities such as cardiometabolic health, aerobic fitness, strength, movement capacity, and other health parameters (e.g. medication side-effects, sleep, fatigue and/or pain) that will inform the appropriateness and specificity of exercise interventions • Play a key role in the prevention/management of psychotropic-induced weight gain by increasing physical activity levels, reducing sedentary behaviour [13] and providing basic healthy eating advice [11] • Contribute to the mental health team through a client-centred approach incorporating recovery and strength-based models to achieve client-specific health related goals. Incorporate health coaching techniques such as motivational interviewing, physical activity education sessions (individual or group-based) regarding the benefits of physical activity, and goal-setting strategies to encourage effective and sustainable behaviour change for people with mental illness [14]. Using such 		
--	--	--

<p>strategies will aid in empowering independent physical activity/ exercise participation.</p> <ul style="list-style-type: none"> • Promote ‘Healthy Active Lives’ for people experiencing mental illness, to achieve the physical activity targets outlined in the HeAL declaration [15], developed by an international working group comprising clinicians, researchers and consumers, which was endorsed in 2014 by Exercise & Sports Science Australia (more information at http://www.iphys.org.au/). • Work collaboratively with mental health clinicians and other health professionals involved in the multidisciplinary team to provide a holistic and integrated approach to care. This would meet the International Organization of Physical Therapy in Mental Health (IOPTMH) call for ‘shared responsibility’ of health care providers, general practitioners, psychiatrists, policy makers and society as a whole to promote healthy and active lifestyles [16]. • Facilitate linkages with general practitioners (GPs), other allied health professionals (e.g. dietitians, occupational therapists and social workers), community gyms and sports teams that can assist with a multidisciplinary approach to better health management. • Assist in reducing the stigma and minimizing barriers for community-based clients utilising mental health services. Exercise is a normalised activity, particularly for young people, and therefore can act as a facilitator ensuring greater engagement with mental health services [13, 17, 18]. 		
---	--	--

References

1. De Hert, M., et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World psychiatry*, 2011. 10(1): p. 52-77.
2. Patel, V., et al., The Lancet Commission on global mental health and sustainable development. *The Lancet*, 2018. 392(10157): p. 1553-1598.
3. Rosenbaum, S., et al., Physical activity in the treatment of Post-traumatic stress disorder: A systematic review and meta-analysis. *Psychiatry Res*, 2015. 230(2): p. 130-6.
4. van de Kamp, M.M., et al., Body- and Movement-Oriented Interventions for Posttraumatic Stress Disorder: A Systematic Review and Meta-Analysis. *J Trauma Stress*, 2019. 32(6): p. 967-976.
5. Keyan, D. and R.A. Bryant, The capacity for acute exercise to modulate emotional memories: a review of findings and mechanisms. *Neuroscience & Biobehavioral Reviews*, 2019.
6. Hegberg, N.J., J.P. Hayes, and S.M. Hayes, Exercise Intervention in PTSD: A Narrative Review and Rationale for Implementation. *Front Psychiatry*, 2019. 10: p. 133.
7. Hall, K.S., et al., Pilot randomized controlled trial of exercise training for older veterans with PTSD. *J Behav Med*, 2019.
8. Fetzner, M.G. and G.J. Asmundson, Aerobic Exercise Reduces Symptoms of Posttraumatic Stress Disorder: A

Randomized Controlled Trial. *Cogn Behav Ther*, 2015. 44(4): p. 301-13.

9. Michael, T., et al., Do adjuvant interventions improve treatment outcome in adult patients with posttraumatic stress disorder receiving trauma-focused psychotherapy?

A systematic review. *European journal of psychotraumatology*, 2019. 10(1): p. 1634938.

10. De Hert, M., et al., Cardiovascular disease and diabetes in people with severe mental illness position statement from the European Psychiatric Association (EPA), supported by the European Association for the Study of Diabetes (EASD) and the European Society of Cardiology (ESC). *European psychiatry*, 2009. 24(6): p. 412-424.

11. Lederman, O., et al., Embedding exercise interventions as routine mental health care: implementation strategies in residential, inpatient and community settings. *Australasian Psychiatry*, 2017. 25(5): p. 451-455.

12. Lederman, O., et al., Consensus statement on the role of Accredited Exercise Physiologists within the treatment of mental disorders: a guide for mental health professionals. *Australasian Psychiatry*, 2016. 24(4): p. 347-351.

13. Curtis, J., et al., Evaluating an individualized lifestyle and life skills intervention to prevent antipsychotic-induced weight gain in first-episode psychosis. *Early intervention in psychiatry*, 2016. 10(3): p. 267-276.

<p>14. Beebe, L.H., et al., Effect of a motivational group intervention upon exercise self efficacy and outcome expectations for exercise in Schizophrenia Spectrum Disorders (SSDs). <i>Journal of the American Psychiatric Nurses Association</i>, 2010. 16(2): p. 105-113.</p> <p>15. Shiers, D. and J. Curtis, Cardiometabolic health in young people with psychosis. <i>The Lancet Psychiatry</i>, 2014. 1(7): p. 492-494.</p> <p>16. Vancampfort, D., et al., International Organization of Physical Therapy in Mental Health consensus on physical activity within multidisciplinary rehabilitation programmes for minimising cardio-metabolic risk in patients with schizophrenia. <i>Disability and rehabilitation</i>, 2012. 34(1): p. 1-12.</p> <p>17. Vancampfort, D., et al., Promotion of cardiorespiratory fitness in schizophrenia: a clinical overview and meta-analysis. <i>Acta Psychiatrica Scandinavica</i>, 2015. 132(2): p. 131-143.</p> <p>18. Carless, D. and K. Douglas, Narrative, identity and mental health: How men with serious mental illness restore their lives through sport and exercise. <i>Psychology of sport and exercise</i>, 2008. 9(5): p. 576-594.</p>		
--	--	--

Table 4: Australia and New Zealand Association of Contextual Behavioural Science

Submission Comments	Guideline Development Group response	Change to Guideline Yes/No Where new section inserted
<p>Psychological treatments for adults with PTSD</p> <p>We note that Acceptance and Commitment Therapy (ACT) has an emerging evidence base supporting it as a psychological intervention for PTSD.</p> <p>The evidence includes two RCT's, listed as references 1 and 2 below. These RCT's have been cited in several meta-studies.</p> <p>Spidel et al. (2017, reference 3) have investigated ACT as an intervention for clients with psychosis who have also experienced childhood trauma.</p> <p>Bean et al. (2017, reference 4) conducted an empirical review and stated that ACT "has demonstrated effectiveness across a variety of presenting problems, including PTSD and trauma", but further research is required. They noted that ACT is a transdiagnostic approach that has shown efficacy across a range of conditions.</p> <p>In a recent review, Coe et al. (2020, reference 5) highlighted the strong evidence base for ACT in treating conditions that co-occur with PTSD, most notably substance use and depression. They stated that "The theoretical rationale for applying acceptance-based approaches to promoting recovery in people living with PTSD and commonly co-occurring mental and physical health challenges is strong, and preliminary empirical evidence suggests these approaches may foster clinically meaningful change. In two RCTs that examined ACT in the treatment of people with PTSD symptoms, ACT plus TAU was superior to TAU (Boals & Murrell, 1) and equivalent to Present Centered Therapy (Lang et al., 2)" Furthermore, Coe et al. believe it is likely</p>	<p>The GDG reviewed the two RCTs cited as evidence for ACT therapy as a psychological intervention for PTSD in the submission comment.</p> <p>The GDG agreed that the study from Boals and Murrell (2016) met the inclusion criteria and have therefore now included ACT as an intervention with an evidence profile in the psychological interventions for adults with PTSD section of the guideline.</p> <p>The GDG found that the study from Lang et al., (2016) had methodological limitations precluding it from inclusion in the guidelines evidence review.</p> <p>Specifically, PTSD diagnosis was not a selection criteria for participants in this RCT. Additionally, PTSD was not a primary outcome measure, rather, the study aimed to reduce general distress as measured by the Brief Symptom Inventory-18 Global Severity Index. Therefore, this study does not meet the selection criteria for the guidelines which require: (a) At least 70% of participants</p>	<p>No change</p>

<p>that acceptance based interventions such as ACT will benefit some people who decline or opt out of first-line treatments for PTSD. The authors identified several key questions that could be the subject of additional research. They concluded their paper by stating that “given the complexity of the mental and physical health challenges associated with trauma exposure, combined with limitations associated with even the most well-established, efficacious treatments for PTSD, having a broad range of treatment options appears to be important. Acceptance-based interventions, by virtue of their strong acceptability for many people and their transdiagnostic approach, represent an important set of options for promoting recovery in trauma survivors.”</p> <p>We also note the strong practical evidence supporting ACT as a treatment for PTSD, such as its application at the National Center for PTSD - U.S. Department of Veterans Affairs. Further anecdotal evidence is provided by Dr Kevin Polk who spent several decades working with veterans suffering from traumatic memories. Dr Polk discovered ACT in 2005 and found this to be a more effective than PE or CPT (both of which have been given strong recommendations for adults with PTSD)</p> <p>Considering all of the above comments, we question whether ACT should be included as a psychological intervention for adults with PTSD, or at the very least as a research recommendation within these guidelines.</p> <p>References:</p> <ol style="list-style-type: none"> 1. Boals, A. & Murrell, A. R. (2016). I am > trauma: Experimentally reducing event centrality and PTSD symptoms in a clinical trial. <i>Journal of Loss and Trauma</i>, 21(6), 471-483. http://dx.doi.org/10.1080/15325024.2015.1117930 2. Lang, A. J., Schnurr, P. P., Jain, S., He, F., Walser, R. D., Bolton, E., ... Chard, K. M. (2016). Randomized controlled trial of acceptance and 	<p>required to be diagnosed with PTSD according to DSM or ICD criteria by means of a structured interview or diagnosis by a clinician, or study participants have been exposed to a traumatic event as specified by PTSD diagnostic criteria for DSM-III, DSM-III-R, DSM-IV, DSM-5, ICD 9, ICD 10 or ICD 11, and (b) randomised controlled trial (including cluster and cross-over trials) evaluating the efficacy of psychological interventions aimed at reducing symptoms of PTSD</p> <p>The addition of the Boals and Murrell study provides low certainty evidence, and the effect size was not clinically important according to the thresholds applied in the evidence review in this guideline, and therefore the GDG have not made a recommendation for ACT in the current guideline, but have presented the evidence with a statement regarding the limited certainty of the evidence at this point. The GDG will review the evidence for ACT in the next update and will consider whether there is evidence of sufficient certainty to make a recommendation at that point.</p>	
---	--	--

<p>commitment therapy for distress and impairment in OEF/OIF/OND veterans. <i>Psychological Trauma: Theory, Research, Practice, and Policy</i>, 1–12. http://doi.org/10.1037/tra0000127</p> <p>3. Spidel, A., Lecomte, T., Kealy, D. and Daigneault, I. (2017) Acceptance and commitment therapy for psychosis and trauma: Improvement in psychiatric symptoms, emotion regulation, and treatment compliance following a brief group intervention</p> <p>4. Bean, R.C., Ong, C.W., Lee, J. and Twohig, M.P. (2017) Acceptance and Commitment Therapy for PTSD and Trauma: An Empirical Review. Utah State University</p> <p>5. Coe, E., Batten, S.V. and Meyer, E.C. (2020) Acceptance-Based Behavioral Therapy for PTSD. A chapter in <i>Emotion in PTSD</i> (Tull, Kibrel, Eds., Elsevier).</p>		
---	--	--

Table 5: Individual submission Michael Scheeringa MD

Submission Comments	Guideline Development Group response	Change to Guideline Yes/No Where new section inserted
<p>Chapter 3 Children and Adolescents</p> <p>Page 2. The Guidelines described Terr’s proposal of Type I and II traumas. Terr’s proposal was a qualitative theory published nearly 30 years ago. There has never been an empirical validation of these Types. In the only direct test of these types, there were no differences in symptomatology between Type I and II traumas in very young children (Scheeringa 2015). Reference to Terr’s unverified theory ought to be deleted.</p>	<p>The GDG reviewed this comment and decided that while there may not be empirical support for the distinction between the two types of trauma it is a useful distinction conceptually. Chapter 3 was amended to remove reference to Terr’s theory but retain the reference to the two broad categories of trauma.</p>	<p>Chapter 3 pages 2-3 amended to remove the reference to Terr’s theory but retain the categorisation of the two types of trauma.</p>
<p>Chapter 3 Children and Adolescents</p> <p>(2) Page 10. The Guidelines stated that “. . . PTSD in very young children is also associated with a range of poor developmental outcomes,(e.g., 54) which in turn negatively impact upon children’s developmental trajectories.” This statement about development ought to be deleted. Contrary to this statement, the single study that was cited, Yates et al., did not show such an impact. The only development index measured in that study was an abbreviated measurement of IQ with the WISC-R when children were in the third grade. PTSD was not assessed at any time in that study. The WISC-R means for IQ were average in the sample, and was not significantly correlated with any ratings of trauma exposure prior to third grade. Furthermore, there are no studies that have demonstrated a negative impact of either trauma exposure or PTSD on developmental domains (i.e., cognition, motor, or language).</p>	<p>The GDG considered the focus on the WISC-R as an indication of developmental effect across neurological and psychosocial domains is too narrow, noting potential disruption of core processes including affect regulation, stress regulation, interpersonal understanding and functioning and cognitive delay in severe traumatic neglect. That said, this is a complex area not just in terms of expressions of traumatic stress in younger</p>	<p>The statement, “PTSD in very young children is also associated with a range of poor developmental outcomes, which in turn negatively impact upon children’s developmental trajectories.” has been deleted.</p>

	children, but also because of the range of other methodological issues in the field. The sentence has been deleted.	
<p>Chapter 3 Children and Adolescents</p> <p>(3) Page 13. “In concluding their discussion of these relational patterns, Scheeringa and Zeanah⁶³ recommended that for young children experiencing posttraumatic stress, caregiver symptomatology must be attended to first. This recommendation will be further discussed below”</p> <p>I was the first author on the Scheeringa and Zeanah paper, and I agree we did make the recommendation at that time to attend to caregiver symptomatology first. This has now been shown to be an error and I have not continued to support that recommendation for many years. The Guidelines correctly noted on page 23 that treating the caregiver first is not needed based on my 2011 study, and I would suggest deleting the section on page 13 to avoid confusion.</p>	The GDG agreed and Chapter 3 was amended to delete the recommendation from Scheeringa’s earlier paper to attend to caregiver symptomatology first.	The last sentence under “Relational PTSD patterns: The importance of parents/caregivers” on page 12 of Chapter 3 was deleted.
<p>(4) Page 14. The following recommendation was confusing: ”The simple conclusion to be drawn from the above information is that, even in the case of preschool-aged children, it is not only important, but necessary, to seek information from the child as well as their caregiver(s).”</p> <p>It is not recommended to seek information about diagnostic symptoms from preschool-aged children. Very young children do not have the cognitive and abstract capacities yet to understand the concepts of behaviors that are outside the norm. Because of this, no diagnostic interviews have ever been recommended for self-report from children under seven years of age. We empirically documented this in a study (Scheeringa et al., 2001).</p>	The GDG agreed and Chapter 3 was amended so that the accuracy of the sentence in question was improved.	The last paragraph under “Who to talk to? The low rate of agreement between parents/caregivers and children” on page 15 of Chapter 3 was amended to exclude pre-school children from the group from whom to seek information about diagnostic symptoms.
<p>(5) For Table 3.1, I recently published psychometric data on a revised version of the DIPA that includes Likert ratings for every symptom (Scheeringa 2020).</p>	The GDG considered this comment and decided to include a reference to the Scheeringa (2020) paper in Table 3.1.	A reference to the paper and the revised instrument was included in Table 3.1. on page 16 of Chapter 3

<p>(6) For Table 3.1, I recently published psychometric data on a 6-item brief screen for PTSD in very young children (Scheeringa 2019).</p>	<p>The GDG considered this comment and decided to include a reference to the Scheeringa (2019) paper in Table 3.1.</p>	<p>A reference to the paper and the revised instrument was included in Table 3.1. on page 17 of Chapter 3</p>
<p>(7) Page 24. The Guideline is correct that uptake of treatment in Jaycox’s school-based study was greater with school-based CBITS compared to office-based TC-CBT. But what the original study did not report was that the effect size of CBITS was much smaller than the effect size of TF-CBT. Effect sizes can be calculated from Table 4. The ES for TF-CBT was 1.17 and the ES for CBITS was 0.72. Both are large but TF-CBT is larger. A conclusion of that study should have been there may be a tradeoff that better uptake comes with lower effectiveness.</p> <p>The Jaycox manuscript also noted on page 228 that 65% of CBITS children remained in the at risk range (>12 on CPSS) compared to only 43% in the TF-CBT group, but glossed over this as statistically non-significant, but that was only due to power.</p> <p>There are substantial issues with privacy, not to mention efficacy, which must be considered before recommending school-based before office-based treatment.</p>	<p>The GDG agreed with this analysis of the Jaycox manuscript and decided to express a more qualified conclusion about the appropriateness of school-based treatment for PTSD.</p>	<p>Under “Does it matter where treatment occurs?” page 25 of Chapter 3 the commentary was amended to qualify the conclusions of the Jaycox study and the circumstances in which school-based treatment should be considered.</p>
<p>Chapter 7 – Complex PTSD</p> <p>(8) It is unfortunate that complex PTSD was added to these otherwise excellent guidelines. I recommend that the entire section on complex PTSD be greatly shortened and re-written with much greater skepticism and transparency about the campaign that has been waged to gain acceptance for complex PTSD despite a complete lack of scientific data. I realize that both ISTSS and ICD-11 have decided to recognize complex PTSD but their recognition for complex PTSD is premature. I have given feedback in the past to both ISTSS and ICD-11 (which was obviously ignored) and the following summarizes the state of empirical research on this topic.</p> <p>There is no evidence that this proposed disorder, complex PTSD, meets the most basic criteria for diagnostic validity for any age group. General guidelines for</p>	<p>The GDG considered this feedback but decided to retain the chapter on complex PTSD. In the absence of a current evidence base for the treatment of complex PTSD (CPTSD), and therefore the absence of any treatment recommendations, the Guideline Development Group decided to include a chapter on CPTSD that considers conceptual, diagnostic, assessment, management and treatment issues, and present a</p>	<p>No change</p>

<p>diagnostic validation of psychiatric disorders have been in existence for decades and there are specific types of evidence that are needed before concluding that a new disorder exists. The first step toward establishing a new disorder is case reports. There is not a single case report of an individual with a convincing syndrome of complex PTSD. The discussion of whether complex PTSD exists ought to stop there.</p> <p>The primary thing that needs to be shown in case studies is that the additional symptoms that are not part of PTSD were NOT present prior to trauma exposure and developed only AFTER trauma exposure. There is not a single case study that has shown this time-dependent prospective development of symptoms, and certainly no group study, that has established this temporal sequence. It is entirely possible, and I think most probable, that the additional symptoms of complex PTSD were present prior to trauma exposure and have no causal relation as post-trauma symptoms. Treatment approaches that address these additional symptoms as being caused by trauma exposure are misguided and potentially harmful.</p> <p>Also, the proponents of complex PTSD need to demonstrate that this disorder is needed to complement PTSD by showing that individuals with complex PTSD cannot be diagnosed with PTSD. Prior to DSM-IV, the field trial for DESNOS demonstrated that 95% of individuals with so-called DESNOS could be diagnosed with PTSD, which was one of the reasons the developers of DSM-IV refused to include DESNOS in DSM-IV. The followers of complex PTSD, perhaps snake bitten by that experience, have never attempted to publish similar findings again. Instead, they have resorted to the pseudo-authenticity of factor analyses.</p> <p>The primary type of evidence that has been cited for the existence of complex PTSD has been factor analysis studies. Factor analysis studies have no place in</p>	<p>snapshot of the research currently underway. The GDG recognises that the evolution of diagnostic manuals is historically controversial, and that subsequent revisions may remove those diagnoses no longer considered to be mental disorders. It is however beyond the scope of these guidelines to interrogate those decisions. The aim of these Guidelines is to support high quality treatment for children, adolescents, and adults with ASD, PTSD and CPTSD (as currently recognised by the major diagnostic manuals) by providing a framework of best practice around which to structure treatment.</p>	
---	--	--

diagnostic validation. Factor analysis is a statistical method to discover an underlying latent construct. Disorders are not latent constructs. Disorders are manifest constructs that are explicitly and directly measured with observable symptoms.

The notion of complex PTSD implies that there is such a thing as simple PTSD. There is no such thing as simple PTSD. It is one of the most consistent findings in all of psychiatry that one or more disorders are comorbid with PTSD 80-90% of the time. There are more than 600,000 ways to manifest PTSD based on the PTSD criteria alone (Galatzer & Bryant, 2013), and when comorbid disorders are allowed there are more than one quintillion ways to manifest PTSD comorbidity (Young, Lareau, & Pierre, 2014). To claim that it would be meaningful to add a single new diagnosis of complex PTSD is missing the mark. It is counterproductive and patronizing towards individuals with “simple PTSD” to imply that their type of PTSD is somehow simpler and less severe than so-called complex PTSD.

The campaign that has been waged to gain acceptance for complex PTSD has been a propaganda campaign instead of a scientific process. A small group of researchers who have felt motivated to promote this disorder for their social policy agendas have decided to sidestep DSM when they could not gain acceptance through scientific data and have relentlessly promoted it.

Perhaps worse, the proponents of complex PTSD resort to scare tactics and demonizing colleagues who do not agree with their belief. Clinicians who fail to recognize complex PTSD are, in the words of proponents, harming their patients with misdiagnoses and wrong treatments. Judith Herman wrote in regards to adult patients, “Failure to recognize this syndrome as a predictable consequence of prolonged, repeated trauma contributes to the misunderstanding of survivors, a misunderstanding shared by the general society and the mental health professions alike. . . . Thus, patients who suffer from the complex sequelae of chronic trauma commonly risk being misdiagnosed as having personality disorders” (Herman, 1992, pp. 387-388). Bessel van der Kolk invoked the scare tactic of claiming that

the nonbelievers are giving their patients harmful treatment: “By relegating the full spectrum of trauma-related problems to seemingly unrelated ‘comorbid’ conditions, fundamental trauma-related disturbances may be lost to scientific investigation, and clinicians may run the risk of applying treatment approaches that are not helpful” (van der Kolk, 2005, p. 406).

The campaign to recognize complex PTSD is driven by an ideology. It is a dangerous ideology in part because it violates the public trust in researchers to speak honestly about what bits of truth we can learn about ourselves. If researchers do not adhere to scientific truth, they are little better than snake oil salesmen. The advocates of complex PTSD tried to get DESNOS into DSM-IV and failed for lack of evidence. They re-fashioned DESNOS for children and called it DTD. They tried to get DTD into DSM-5 and failed for lack of evidence. The parallel idea of complex PTSD has been gaining traction through their persistent campaign of propaganda. I have been embarrassed for our field the last several years as I have seen more presentations at ISTSS, more journals articles, and more books discussing this imaginary disorder.

It is noteworthy that this type of belief system does not exist for the other psychiatric disorders. There is no cadre of proponents advocating for complex depression disorder or complex anxiety disorder. One must be curious why the trauma field stands alone in this regard.

It has been said that science is a self-correcting process, and facts eventually prevail over ideology. In regards to complex PTSD, however ideology still seems to be on the upswing. It has been apparent that individual scientists who promote complex PTSD have opted to bypass the conventional steps of diagnostic validation. They have been neither willing nor able to self-correct as they have been more passionate about promoting their personal ideology than in conducting reliable science.

Table 6: Individual Submission Veteran with PTSD

Submission Comments	Guideline Development Group response	Change to Guideline Yes/No Where new section inserted
<p>1. Different treatment options between men and women- Due to different type of Hormones and the proportion of Dopaminergic Cells in the Mesocortical Pathways. **My personal experience of symptoms and treatments support this statement</p> <p>1a. Estrogen Shapes Dopamine-Dependent Cognitive Processes: Implications for Women's Health</p> <p>The Journal of Neuroscience – 6 April 2011 https://www.jneurosci.org/content/31/14/5286</p> <ul style="list-style-type: none"> Evidence for an estradiol–DA link exists in animals, yet no human study has examined whether DA mediates estradiol's effects on PFC function. <p>Given that estradiol levels may be higher in the PFC than any other cortical area (Bixo et al., 1995).</p> <ul style="list-style-type: none"> In a related pharmacogenomic study, Mattay et al. (2003) found that amphetamine administration improved WM performance and enhanced cortical efficiency for val/val subjects. Another important clue into estradiol's site of action comes from a series of immunocytochemistry experiments showing ERβ expression in midbrain dopaminergic neurons that project to PFC and constitute the mesocortical DA pathway (Creutz and Kritzer, 2002). 	<p>The GDG thanks the individual who made this submission for providing insight into the reality of the lived experience of PTSD and their insights into treatment which has assisted them.</p> <p>The aim of these Guidelines is to aim to support high quality treatment for children, adolescents, and adults with ASD, PTSD and CPTSD by providing a framework of best practice around which to structure treatment. The Guidelines developers recognise that there are a number of interventions that are widely used in clinical practice that have not been adequately tested, and it is important to acknowledge that the absence of evidence does not necessarily mean that these interventions are ineffective. The gap between evidence-based interventions and clinical practice should help define the research agenda into the future.</p>	<p>No change</p>

<ul style="list-style-type: none"> • Until recently it was thought that ~30% of cells within the rat mesocortical pathway were dopaminergic (TH-immunoreactive) (Swanson, 1982). However, the data came solely from males • a recent study discovered that females have a significantly greater proportion of dopaminergic cells, ~50%, within this pathway (Kritzer and Creutz, 2008). • Sex differences in mesocortical organization may carry functional consequences for cognitive processes that rely on PFC DA signalling. <p>I have been prescribed and managing my daytime symptoms of PTSD with Dexamphetamine since early 2017.</p> <p>Psychiatrists have stated I was different from others with PTSD, because I was “diagnosed” with ADHD to be prescribed this medication.</p> <p>(This undermined my inclusion whilst on a Veteran Trauma Recovery Program).</p> <p>1.b ACTION : REQUEST REFERENCE 1a above considered and PROPOSAL TO AMEND all state prescribing LAWS and TREATMENT – specific for women with ASD,PTSD & CPTSD,</p> <p>The option to be treated with amphetamines and to include the extended release Vyvanse</p> <ul style="list-style-type: none"> • this is a life changing medication to assist managing symptoms & in some states unable to be prescribed unless diagnosed with ADHD as a child. • Trying to remember to take a tablet 3-4 times a day when we already have problems remembering stuff is counter-productive. <p>It is ‘even more’ frustrating being a woman with PTSD as an invisible illness,</p>	<p>Equally, evidence-based interventions should be used in preference to non-evidence-based interventions, unless there is a strong reason not to do so.</p>	
---	--	--

<p>‘We are constantly undermined and persecuted by our family, friends, Govt & providers, peers and medicos, often under constant scrutiny and having to re-justify our ‘Trauma’ situations.</p> <p>2. Non-medical situations that are not discussed - ESSENTIAL in Treatment and Management.</p> <p>Acceptance and empowerment:</p> <ul style="list-style-type: none"> • I was alleviated whilst on the ‘Veteran trauma recovery program’ when the other male combatant vets stated, “you no longer need to justify to us, we know”. • On another peer lead non-clinical program, the true understanding between others experiencing similar provided relief and took the weight of shame and hidden embarrassment of this illness. • STAIR PROGRAM – Dr Jonathan Lane (Churchill Fellowship Program) <ul style="list-style-type: none"> - Empowered me with verbal cues to emotions that had been suppressed for many years, so many that I could not even name any! It was a VISUAL THAT HELPED>>>>and reopened memories.. BOTH GOOD AND BAD. - I BELIEVE UNLOCKED THE MEMORY FOR EMOTIONS – Particularly in ABUSE/OPPRESSION/MILITARY DEHUMANISATION... - Also this ALLOWED me to feel PHYSICAL PAIN. (I had been NUMBED mentally and physically for years!) hence many urgent surgeries since. <p>3. ‘Patient Treatment Options and Communications’</p> <ul style="list-style-type: none"> • Propose all sectors review how all information is presented to patients to include <ul style="list-style-type: none"> • SIMPLE * VISUAL* BASIC concepts <ul style="list-style-type: none"> - During Trauma times – We don’t read !!! - PICTURES Help ! 		
---	--	--

<p>- COLOURS and BLOCKS of INFORMATION – SIMPLE only 2 FONTS.</p> <p>–when to speak up, trying a new medication, Helpful tips from others....</p> <p>-All in VISUAL CUES so we can stick on the back of the loo door.</p> <ul style="list-style-type: none"> • WE ARE STRUGGLING IN COGNITION AND TAKE REPEATED TIMES TO UNDERSTAND and link THE information TO AN Action Task. <p>- Ie, the sky is dark grey... It’s about to rain.... Go Inside Now.</p> <p>- WE MISS VITAL IMPORTANT INFORMATION TOLD to Us OR WRITTEN.</p> <p>4. Mis-Diagnosis/Non-Diagnosis/Mis-Understood</p> <ul style="list-style-type: none"> - In a dark place and ready to end their life, abusing drugs/alcohol/people/power, these may be the only signs and often treated and managed for depression. - How long does this cycle have to go on before people are re-assessed for Trauma Symptoms? - ACTION ***: A FLAG NEEDS TO BE RAISED FOR ANY PATIENT PRESCRIBED ANY ANTI-DEPRESSANT at 6 MONTHS – to screen for Trauma illnesses. <p>It took 13 years for me on the wrong treatment plan! - HOW MANY MORE HAVE COMMITTED SUICIDE??</p> <p>In my situation I was never formally assessed for PTSD in Defence until a medical discharge “DVA -MLOCA” picked it up.</p> <p>(I didn’t know in 2006) and this wasn’t reflected in my ADF medical Documents and hence I was never treated correctly and wondered why ‘depression’ treatment wasn’t working.</p>		
--	--	--

<p>Reflecting hospitalisation suicide idealisation in 2003, was another PTSD relapse of symptoms, very different from ‘depression’.</p> <ul style="list-style-type: none"> - Symptoms are VERY overwhelming at the time, and for Doctors to do an accurate assessment would benefit if the patient had ‘Brain Respite’ – so they can verbalise better. - Propose short term – Overnight Respite Centres as a management option to provide ‘Treatment’ & switch off the sensory inputs, without the need to have full psychiatric hospital admission. - I always feel like I’ve gone on a holiday after surgery anaesthetic. It truly switches everything off and provides real ‘brain respite’. If I could do this once a fortnight, I could manage much better for longer. I am a mother and a carer of children, so I have no one to care for them, and I have not had in-patient treatment because of them. * This is often an area where we are disadvantaged, unable to access treatment due to no respite options. * How does the DV sector manage??? <p>5. Medical Health Tests and Supplements</p> <ul style="list-style-type: none"> - I was never tested for Vitamin D levels whilst in ADF- I worked and lived in submarines. “Sunshine” is the natural source. - PREVENTION and SUPPLEMENTS for those unable to access regular sunshine.. mines, secure access buildings, night shift workers etc. - 8 years later tested... Vitamin D is LOW. Vitamin D is a hormone that controls calcium levels in the blood. - Other Essential biochemistry tests essential for Mental Health... b6, b12. Still haven’t had mine tested. 		
---	--	--

Table 7: Individual submission

Submission Comments	Guideline Development Group response	Change to Guideline Yes/No Where new section inserted
<p>General comments</p> <p>You appear to have prematurely shut down your /my access, to your PTSD draft proposal. It is quite simply appalling/ professionally negligent, to put forward any draft proposal, that does not include increased access to a Medicare rebates. I have photographed this message.</p>	<p>The GDG notes that Medicare is considered in the Guideline (MagicApp) under ‘Resources and other considerations’.</p> <p>“For patients with work-related PTSD, treatment will be funded by third party insurers. For others with private health insurance, psychology sessions may be partially reimbursed. For patients relying on Medicare, the number of sessions on a mental health plan referral from a GP is limited to 10 per year. This can often be inadequate for comprehensive PTSD assessment and treatment. As such, patient’s access to psychological treatment varies according to funding sources including their capacity to pay for their own treatment.”</p> <p>Increasing access to Medicare rebates however is beyond the scope of this Guideline.</p> <p>Phoenix Australia had not closed the public consultation page at the date of this submission (17 March 2020). The public consultation page had all relevant documents accessible until 27 March 2020.</p>	<p>No change</p>