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Appendix 16c: Evidence statements for early interventions

Psychological interventions - Treatment for all

Description	Statement	Statements and Statistics
Education vs control		
Severity of PTSD symptoms mean scores at 6 month follow up	s3	There is evidence suggesting there is unlikely to be a clinically important difference between education and control on reducing the severity of PTSD symptoms (IES - self-report measure) at 6 month follow up (N = 1; n = 91; SMD = -0.18; 95% CI, -0.59 to 0.24). I
Depression symptoms mean scores at 6 month follow up	s3	There is evidence suggesting there is unlikely to be a clinically important difference between education and control on reducing depression symptoms (BDI – self-report) at 6 month follow up (N = 1; n = 91; SMD = -0.36; 95% CI, -0.77 to 0.06). I
Likelihood of leaving treatment early at 6 month follow up	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between education and control on reducing the likelihood of leaving treatment early at 6 month follow up (N = 1; n = 103; RR = 1.37; 95% CI, 0.47 to 4.05). I
Likelihood of having a PTSD diagnosis at 6 month follow up	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between education and control on reducing the likelihood of having a PTSD diagnosis at 6 month follow up (N = 1; n = 103; RR = 0.69; 95% CI, 0.37 to 1.3). I
Collaborative care vs control		
Severity of PTSD symptoms mean scores at 1 month	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between collaborative care and control on reducing the severity of PTSD symptoms (Posttraumatic Stress Disorder Checklist - self-report measure) at 1 month (N = 1; n = 29; SMD = -0.5; 95% CI, -1.24 to 0.24). I
Severity of PTSD symptoms mean scores at follow-up (4 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between collaborative care and control on reducing the severity of PTSD symptoms (Posttraumatic Stress Disorder Checklist - self-report measure) at follow-up (4 months) (N = 1; n = 26; SMD = 0.4; 95% CI, -0.38 to 1.18). I
Depression symptoms mean scores at follow-up (1 month)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between collaborative care and control on reducing depression symptoms (Center for Epidemiological Studies Depression Scale) at follow-up (1 month) (N = 1; n = 29; SMD = -0.26; 95% CI, -0.99 to 0.47). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Depression symptoms mean scores at follow-up (4 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between collaborative care and control on reducing depression symptoms (Center for Epidemiological Studies Depression Scale) at follow-up (4 months) (N = 1; n = 26; SMD = 0.68; 95% CI, -0.12 to 1.47). I
Likelihood of leaving treatment early	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between collaborative care and control on reducing the likelihood of leaving treatment early (N = 1; n = 34; RR = 1.13; 95% CI, 0.34 to 3.78). I

Trauma focused counselling vs control		
Severity of PTSD symptoms mean scores at 6 month follow up	s3	There is evidence suggesting there is unlikely to be a clinically important difference between trauma-focused counselling and control on reducing the severity of PTSD symptoms (IES - self-report measure) at 6 month follow up (N = 1; n = 151; SMD = 0.17; 95% CI, -0.15 to 0.49). I
Likelihood of leaving treatment early at 6 month follow up	s2x	There is limited evidence favouring trauma-focused counselling over control on reducing the likelihood of leaving treatment early at 6 month follow up (N = 1; n = 151; RR = 0.67; 95% CI, 0.35 to 1.3). I

Debriefing vs control		
Severity of PTSD symptoms mean scores at 1-4 months	s3	There is evidence suggesting there is unlikely to be a clinically important difference between debriefing and control on reducing the severity of PTSD symptoms (self-report measure) at 1-4 months (N = 5; n = 356; SMD = 0.11; 95% CI, -0.1 to 0.32)(N = 5; n = 356; SMD = 0.11; 95% CI, -0.1 to 0.32)&AI17&AB17&"
Severity of PTSD symptoms mean scores at follow-up (6-13 months)	s3	There is evidence suggesting there is unlikely to be a clinically important difference between debriefing and control on reducing the severity of PTSD symptoms (self-report measure) at follow-up (6-13 months) (N = 3; n = 265; SMD = 0.26; 95% CI, 0.01 to 0.5). I
Severity of PTSD symptoms mean scores at follow-up (3 years)	s3	There is evidence suggesting there is unlikely to be a clinically important difference between debriefing and control on reducing the severity of PTSD symptoms (IES - self-report measure) at follow-up (3 years) (N = 1; n = 61; SMD = 0.17; 95% CI, -0.34 to 0.67). I
Depression symptoms mean scores at 1-4 months	s3	There is evidence suggesting there is unlikely to be a clinically important difference between debriefing and control on reducing depression symptoms at 1-4 months (N = 3; n = 225; SMD = 0; 95% CI, -0.27 to 0.26). I
Depression symptoms mean scores at follow-up (6-13 months)	s3	There is evidence suggesting there is unlikely to be a clinically important difference between debriefing and control on reducing depression symptoms at follow-up (6-13 months) (N = 3; n = 265; SMD = 0.33; 95% CI, 0.09 to 0.58). I
Anxiety symptoms mean scores at 1-4 months	s3	There is evidence suggesting there is unlikely to be a clinically important difference between debriefing and control on reducing anxiety symptoms at 1-4 months (N = 3; n = 225; SMD = 0.03; 95% CI, -0.23 to 0.29). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Anxiety symptoms mean scores at follow-up (6-13 months)	s3	There is evidence suggesting there is unlikely to be a clinically important difference between debriefing and control on reducing anxiety symptoms at follow-up (6-13 months) (N = 2; n = 172; SMD = 0.25; 95% CI, -0.05 to 0.55). I
Severity of PTSD symptoms mean scores at follow-up (3 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between debriefing and control on reducing the severity of PTSD symptoms (CAPS2 - clinician-rated measure) at follow-up (3 months) (N = 1; n = 40; SMD = -0.38; 95% CI, -1.01 to 0.25). I
Likelihood of having a PTSD diagnosis at follow-up (3 to 6 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between debriefing and control on reducing the likelihood of having a PTSD diagnosis at follow-up (3 to 6 months) (N = 2; n = 238; RR = 1.2; 95% CI, 0.84 to 1.71). I
Likelihood of having a PTSD diagnosis at follow-up (13 months)	s2y	There is limited evidence favouring control over debriefing on reducing the likelihood of having a PTSD diagnosis at follow-up (13 months) (N = 1; n = 133; RR = 1.87; 95% CI, 1.12 to 3.12). I
Quality of Life symptoms at follow-up (3 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between debriefing and control on improving functioning & quality of Life symptoms (Bisson's visual analogue scales) at follow-up (3 months) (N = 1; n = 103; SMD = 1.41; 95% CI, 0.65 to 3.07). I
Likelihood of leaving treatment early	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between debriefing and control on reducing the likelihood of leaving treatment early (N = 5; n = 550; RR = 1.33; 95% CI, 1.03 to 1.72). I

Immediate debriefing vs delayed debriefing

Severity of PTSD symptoms mean scores at 2 weeks	s1x	There is evidence favouring immediate debriefing over delayed debriefing on reducing the severity of PTSD symptoms (Posttraumatic Stress Diagnostic Scale - self-report measure) at 2 weeks (N = 1; n = 77; SMD = -2.56; 95% CI, -3.17 to -1.95). I

Debriefing vs education only

Severity of PTSD symptoms mean end point scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between debriefing and education on reducing the severity of PTSD symptoms (IES - self-report measure) (N = 1; n = 106; SMD = 0.23; 95% CI, -0.15 to 0.62). I
Severity of PTSD symptoms mean scores at 6 month follow up	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between debriefing and education on reducing the severity of PTSD symptoms (IES - self-report measure) at 6 month follow up (N = 1; n = 92; SMD = 0.23; 95% CI, -0.18 to 0.64). I
Depression symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between debriefing and education on reducing depression symptoms (BDI – self-report) (N = 1; n = 106; SMD = 0.2; 95% CI, -0.18 to 0.58). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Depression symptoms mean scores at 6 month follow up	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between debriefing and education on reducing depression symptoms (BDI – self-report) at 6 month follow up (N = 1; n = 92; SMD = 0.23; 95% CI, -0.18 to 0.64). I
Likelihood of leaving treatment early	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between debriefing and education on reducing the likelihood of leaving treatment early (N = 1; n = 106; RR = 0.96; 95% CI, 0.36 to 2.56). I
Likelihood of having a PTSD diagnosis	s2y	There is limited evidence favouring education over debriefing on reducing the likelihood of having a PTSD diagnosis (N = 1; n = 106; RR = 1.44; 95% CI, 0.77 to 2.69). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Early psychological treatments for acute PTSD and acute stress disorder

Description	Statement	Statements and Statistics
Trauma-focused CBT vs control		
Severity of PTSD symptoms mean scores at follow-up (9-13 months)	s3	There is evidence suggesting there is unlikely to be a clinically important difference between trauma-focused CBT and waitlist (fixed effects) on reducing the severity of PTSD symptoms (clinician) at follow-up (9-13 months) (k = 2; n = 171; SMD = -0.45; 95% CI, -0.75 to -0.14). I
Depression symptoms mean scores at follow-up (9-13 months)	s3	There is evidence suggesting there is unlikely to be a clinically important difference between trauma-focused CBT and waitlist (fixed effects) on reducing depression symptoms (self-report) at follow-up (9-13 months) (k = 2; n = 171; SMD = -0.26; 95% CI, -0.56 to 0.04). I
Quality of life mean endpoint scores	s2x	There is limited evidence favouring trauma-focused CBT over waitlist (fixed effects) on improving quality of life (Sheehan Disability Scale – self-report) (k = 2; n = 96; SMD = -1.01; 95% CI, -1.44 to -0.58). I
Quality of life mean scores at follow-up (9 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and waitlist (fixed effects) on improving quality of life (Sheehan Disability Scale – self-report) at follow-up (9 months) (k = 1; n = 55; SMD = -0.53; 95% CI, -1.07 to 0.01). I
Likelihood of leaving treatment early	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and waitlist (fixed effects) on reducing the likelihood of leaving treatment early (k = 3; n = 252; RR = 0.66; 95% CI, 0.33 to 1.31). I
Likelihood of leaving treatment early at follow-up (9-13 months)	s2x	There is limited evidence favouring trauma-focused CBT over waitlist (fixed effects) on reducing the likelihood of leaving treatment early at follow-up (9-13 months) (k = 2; n = 209; RR = 0.63; 95% CI, 0.36 to 1.12). I
Severity of PTSD symptoms mean endpoint scores	s2x	There is limited evidence favouring trauma-focused CBT over waitlist (random effects) on reducing the severity of PTSD symptoms (self-report) (k = 3; n = 224; SMD = -0.98; 95% CI, -1.81 to -0.14). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Severity of PTSD symptoms mean scores at follow-up (9-13 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and waitlist (random effects) on reducing the severity of PTSD symptoms (self-report) at follow-up (9-13 months) (k = 2; n = 171; SMD = -0.68; 95% CI, -1.23 to -0.12). I
Severity of PTSD symptoms mean endpoint scores	s2x	There is limited evidence favouring trauma-focused CBT over waitlist (random effects) on reducing the severity of PTSD symptoms (clinician) (k = 3; n = 224; SMD = -0.88; 95% CI, -1.72 to -0.04). I
Depression symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and waitlist (random effects) on reducing depression symptoms (self-report) (k = 3; n = 224; SMD = -0.78; 95% CI, -1.63 to 0.07). I
Anxiety symptoms mean endpoint scores	s2x	There is limited evidence favouring trauma-focused CBT over waitlist (random effects) on reducing anxiety symptoms (self-report) (k = 3; n = 224; SMD = -0.82; 95% CI, -1.69 to 0.05). I
Anxiety symptoms mean scores at follow-up (9-13 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and waitlist (random effects) on reducing anxiety symptoms (self report) at follow-up (9-13 months) (k = 2; n = 171; SMD = -0.5; 95% CI, -1.35 to 0.35). I
Likelihood of having a PTSD diagnosis at follow-up (9-13 months)	s1x	There is evidence favouring trauma-focused CBT over waitlist (random effects) on reducing the likelihood of having a PTSD diagnosis at follow-up (9-13 months) (k = 2; n = 209; RR = 0.41; 95% CI, 0.11 to 1.45). I
Likelihood of having a PTSD diagnosis	s1x	There is evidence favouring trauma-focused CBT over waitlist (random effects) on reducing the likelihood of having a PTSD (k = 3; n = 252; RR = 0.4; 95% CI, 0.16 to 1.02). I

Prolonged exposure vs prolonged exposure & anxiety management

Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between prolonged exposure and prolonged exposure & anxiety management on reducing the severity of PTSD symptoms (IES - self-report) (k = 1; n = 29; SMD = -0.31; 95% CI, -1.04 to 0.43). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Severity of PTSD symptoms mean scores at follow-up (6 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between prolonged exposure and prolonged exposure & anxiety management on reducing the severity of PTSD symptoms (IES - self-report) at follow-up (6 months) (k = 1; n = 26; SMD = 0.03; 95% CI, -0.74 to 0.8). I
Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between prolonged exposure and prolonged exposure & anxiety management on reducing the severity of PTSD symptoms (CAPS2 - clinician) (k = 1; n = 29; SMD = -0.21; 95% CI, -0.94 to 0.52). I
Severity of PTSD symptoms mean scores at follow-up (6 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between prolonged exposure and prolonged exposure & anxiety management on reducing the severity of PTSD symptoms (CAPS2 - clinician) at follow-up (6 months) (k = 1; n = 26; SMD = -0.17; 95% CI, -0.95 to 0.6). I
Depression symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between prolonged exposure and prolonged exposure & anxiety management on reducing depression symptoms (BDI –self-report) (k = 1; n = 29; SMD = -0.13; 95% CI, -0.86 to 0.6). I
Depression symptoms mean scores at follow-up (6 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between prolonged exposure and prolonged exposure & anxiety management on reducing depression symptoms (BDI – self-report) at follow-up (6 months) (k = 1; n = 26; SMD = -0.11; 95% CI, -0.88 to 0.66). I
Anxiety symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between prolonged exposure and prolonged exposure & anxiety management on reducing anxiety symptoms (STAI self-report) (k = 1; n = 29; SMD = 0.11; 95% CI, -0.62 to 0.84). I
Anxiety symptoms mean endpoint scores at follow-up (6 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between prolonged exposure and prolonged exposure & anxiety management on reducing anxiety symptoms (STAI – self-report) at follow-up (6 months) (k = 1; n = 26; SMD = 0.12; 95% CI, -0.65 to 0.89). I
Likelihood of leaving treatment early	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between prolonged exposure and prolonged exposure & anxiety management on reducing the likelihood of leaving treatment early (k = 1; n = 37; RR = 0.95; 95% CI, 0.28 to 3.23). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Likelihood of leaving treatment early at follow-up (6 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between prolonged exposure and prolonged exposure & anxiety management on reducing the likelihood of leaving treatment early at follow-up (6 months) (k = 1; n = 37; RR = 1.14; 95% CI, 0.42 to 3.08). I
Likelihood of having a PTSD diagnosis	s2x	There is limited evidence favouring prolonged exposure over prolonged exposure & anxiety management on reducing the likelihood of having a PTSD diagnosis (k = 1; n = 38; RR = 0.58; 95% CI, 0.3 to 1.15). I
Likelihood of having a PTSD diagnosis at follow-up (6 months)	s2x	There is limited evidence favouring prolonged exposure over prolonged exposure & anxiety management on reducing the likelihood of having a PTSD diagnosis at follow-up (6 months) (k = 1; n = 38; RR = 0.64; 95% CI, 0.37 to 1.11). I

trauma-focused CBT vs trauma-focused CBT & hypnosis		
Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and trauma-focused CBT & hypnosis on reducing the severity of PTSD symptoms (IES - self-report) (k = 1; n = 47; SMD = 0.13; 95% CI, -0.45 to 0.7). I
Severity of PTSD symptoms mean scores at follow-up (6 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and trauma-focused CBT & hypnosis on reducing the severity of PTSD symptoms (IES - self-report) at follow-up (6 months) (k = 1; n = 47; SMD = 0.07; 95% CI, -0.5 to 0.64). I
Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and trauma-focused CBT & hypnosis on reducing the severity of PTSD symptoms (CAPS2 - clinician) (k = 1; n = 47; SMD = -0.01; 95% CI, -0.58 to 0.56). I
Severity of PTSD symptoms mean scores at follow-up (6 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and trauma-focused CBT & hypnosis on reducing the severity of PTSD symptoms (CAPS2 - clinician) at follow-up (6 months) (k = 1; n = 47; SMD = -0.02; 95% CI, -0.59 to 0.56). I
Depression symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and trauma-focused CBT & hypnosis on reducing depression symptoms (BDI2 – self-report) (k = 1; n = 47; SMD = -0.2; 95% CI, -0.77 to 0.37). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Depression symptoms mean scores at follow-up (6 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and trauma-focused CBT & hypnosis on reducing depression symptoms (BDI2 – self-report) at follow-up (6 months) (k = 1; n = 47; SMD = -0.26; 95% CI, -0.83 to 0.32). I
Anxiety symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and trauma-focused CBT & hypnosis on reducing anxiety symptoms (BAI – self-report) (k = 1; n = 47; SMD = -0.04; 95% CI, -0.62 to 0.53). I
Anxiety symptoms mean scores at follow-up (6 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and trauma-focused CBT & hypnosis on reducing anxiety symptoms (BAI – self-report) at follow-up (6 months) (k = 1; n = 47; SMD = -0.15; 95% CI, -0.72 to 0.43). I
Likelihood of leaving treatment early	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and trauma-focused CBT & hypnosis on reducing the likelihood of leaving treatment early (k = 1; n = 63; RR = 1.17; 95% CI, 0.5 to 2.75). I
Likelihood of leaving treatment early at follow-up (6 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and trauma-focused CBT & hypnosis on reducing the likelihood of leaving treatment early at follow-up (6 months) (k = 1; n = 63; RR = 1.17; 95% CI, 0.5 to 2.75). I
Likelihood of having a PTSD diagnosis	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and trauma-focused CBT & hypnosis on reducing the likelihood of having a PTSD diagnosis (k = 1; n = 63; RR = 1.21; 95% CI, 0.6 to 2.46). I
Likelihood of having a PTSD diagnosis at follow-up (6 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and trauma-focused CBT & hypnosis on reducing the likelihood of having a PTSD diagnosis at follow-up (6 months) (k = 1; n = 63; RR = 1.06; 95% CI, 0.59 to 1.92). I

trauma-focused CBT & hypnosis vs supportive psychotherapy		
Severity of PTSD symptoms mean endpoint scores	s2x	There is limited evidence favouring trauma-focused CBT & hypnosis over supportive psychotherapy on reducing the severity of PTSD symptoms (IES - self-report) (k = 1; n = 45; SMD = -1.07; 95% CI, -1.7 to -0.44). I

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Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Severity of PTSD symptoms mean scores at follow-up (6 months)	s2x	There is limited evidence favouring trauma-focused CBT & hypnosis over supportive psychotherapy on reducing the severity of PTSD symptoms (IES - self-report) at follow-up (6 months) (k = 1; n = 45; SMD = -0.73; 95% CI, -1.33 to -0.12). I
Severity of PTSD symptoms mean endpoint scores	s2x	There is limited evidence favouring trauma-focused CBT & hypnosis over supportive psychotherapy on reducing the severity of PTSD symptoms (CAPS2 - clinician) (k = 1; n = 45; SMD = -0.92; 95% CI, -1.54 to -0.3). I
Severity of PTSD symptoms mean scores at follow-up (6 months)	s2x	There is limited evidence favouring trauma-focused CBT & hypnosis over supportive psychotherapy on reducing the severity of PTSD symptoms (CAPS2 - clinician) at follow-up (6 months) (k = 1; n = 45; SMD = -0.59; 95% CI, -1.19 to 0). I
Depression symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT & hypnosis and supportive psychotherapy on reducing depression symptoms (BDI2 – self-report) (k = 1; n = 45; SMD = -0.45; 95% CI, -1.04 to 0.15). I
Depression symptoms mean scores at follow-up (6 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT & hypnosis and supportive psychotherapy on reducing depression symptoms (BDI – self-report) at follow-up (6 months) (k = 1; n = 45; SMD = -0.27; 95% CI, -0.85 to 0.32). I
Anxiety symptoms mean endpoint scores	s2x	There is limited evidence favouring trauma-focused CBT & hypnosis over supportive psychotherapy on reducing anxiety symptoms (BAI – self-report) (k = 1; n = 45; SMD = -0.62; 95% CI, -1.22 to -0.02). I
Anxiety symptoms mean scores at follow-up (6 months)	s2x	There is limited evidence favouring trauma-focused CBT & hypnosis over supportive psychotherapy on reducing anxiety symptoms (BAI – self-report) at follow-up (6 months) (k = 1; n = 45; SMD = -0.62; 95% CI, -1.22 to -0.02). I
Likelihood of leaving treatment early	s2y	There is limited evidence favouring supportive psychotherapy over trauma-focused CBT & hypnosis on reducing the likelihood of leaving treatment early (k = 1; n = 54; RR = 2.8; 95% CI, 0.64 to 12.26). I
Likelihood of leaving treatment early at follow-up (6 months)	s2y	There is limited evidence favouring supportive psychotherapy over trauma-focused CBT & hypnosis on reducing the likelihood of leaving treatment early at follow-up (6 months) (k = 1; n = 54; RR = 2.8; 95% CI, 0.64 to 12.26). I
Likelihood of having a PTSD diagnosis	s1x	There is evidence favouring trauma-focused CBT & hypnosis over supportive psychotherapy on reducing the likelihood of having a PTSD diagnosis (k = 1; n = 54; RR = 0.6; 95% CI, 0.3 to 1.18). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Appendix 16c: Evidence statements for early interventions

Likelihood of having a PTSD diagnosis at follow-up (6 months)	s1x	There is evidence favouring trauma-focused CBT & hypnosis over supportive psychotherapy on reducing the likelihood of having a PTSD diagnosis at follow-up (6 months) (k = 1; n = 54; RR = 0.69; 95% CI, 0.39 to 1.19). I

Trauma-focused CBT vs progressive muscular relaxation training		
Severity of PTSD symptoms mean endpoint scores	s2x	There is limited evidence favouring trauma-focused CBT over progressive muscular relaxation training on reducing the severity of PTSD symptoms (CAPS - clinician) (k = 1; n = 20; SMD = -0.79; 95% CI, -1.71 to 0.13). I
Severity of PTSD symptoms mean scores at follow-up (12 months)	s2x	There is limited evidence favouring trauma-focused CBT over progressive muscular relaxation training on reducing the severity of PTSD symptoms (CAPS - clinician) at follow-up (12 months) (k = 1; n = 20; SMD = -0.98; 95% CI, -1.92 to -0.04). I
Depression symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and progressive muscular relaxation training on reducing depression symptoms (BDI – self-report) (k = 1; n = 20; SMD = 0.1; 95% CI, -0.78 to 0.98). I
Depression symptoms mean scores at follow-up (12 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and progressive muscular relaxation training on reducing depression symptoms (BDI – self-report) at follow-up (12 months) (k = 1; n = 20; SMD = -0.13; 95% CI, -1.01 to 0.74). I
Anxiety symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and progressive muscular relaxation training on reducing anxiety symptoms (BAI – self-report) (k = 1; n = 20; SMD = -0.16; 95% CI, -1.04 to 0.72). I
Anxiety symptoms mean scores at follow-up (12 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and progressive muscular relaxation training on reducing anxiety symptoms (BAI – self-report) at follow-up (12 months) (k = 1; n = 20; SMD = -0.32; 95% CI, -1.2 to 0.57). I
Likelihood of having a PTSD diagnosis	s2x	There is limited evidence favouring trauma-focused CBT over progressive muscular relaxation training on reducing the likelihood of having a PTSD diagnosis (k = 1; n = 20; RR = 0.4; 95% CI, 0.1 to 1.6). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Likelihood of having a PTSD diagnosis at follow-up (12 months)	s2x	There is limited evidence favouring trauma-focused CBT over progressive muscular relaxation training on reducing the likelihood of having a PTSD diagnosis at follow-up (12 months) (k = 1; n = 20; RR = 0.2; 95% CI, 0.01 to 3.7). I
Likelihood of leaving treatment early	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and progressive muscular relaxation training on reducing the likelihood of leaving treatment early (k = 1; n = 22; RR = 1; 95% CI, 0.07 to 14.05). I
Likelihood of leaving treatment early at follow-up (12 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and progressive muscular relaxation training on reducing the likelihood of leaving treatment early at follow-up (12 months) (k = 1; n = 22; RR = 1; 95% CI, 0.07 to 14.05). I

trauma-focused CBT vs supportive psychotherapy		
Severity of PTSD symptoms mean endpoint scores	s1x	There is evidence favouring trauma-focused CBT over supportive psychotherapy on reducing the severity of PTSD symptoms (IES - self-report) (k = 3; n = 94; SMD = -1.11; 95% CI, -1.55 to -0.67). I
Severity of PTSD symptoms mean scores at follow-up (6 months)	s2x	There is limited evidence favouring trauma-focused CBT over supportive psychotherapy on reducing the severity of PTSD symptoms (IES - self-report) at follow-up (6 months) (k = 3; n = 94; SMD = -0.8; 95% CI, -1.22 to -0.37). I
Severity of PTSD symptoms mean endpoint scores	s2x	There is limited evidence favouring trauma-focused CBT over supportive psychotherapy on reducing the severity of PTSD symptoms (CAPS2 - clinician) (k = 2; n = 70; SMD = -0.94; 95% CI, -1.43 to -0.44). I
Severity of PTSD symptoms mean scores at follow-up (6 months)	s2x	There is limited evidence favouring trauma-focused CBT over supportive psychotherapy on reducing the severity of PTSD symptoms (CAPS2 - clinician) at follow-up (6 months) (k = 2; n = 70; SMD = -0.63; 95% CI, -1.12 to -0.15). I
Depression symptoms mean endpoint scores	s2x	There is limited evidence favouring trauma-focused CBT over supportive psychotherapy on reducing depression symptoms (BDI – self-report) (k = 3; n = 94; SMD = -0.56; 95% CI, -0.97 to -0.14). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Depression symptoms mean scores at follow-up (6 months)	s2x	There is limited evidence favouring trauma-focused CBT over supportive psychotherapy on reducing depression symptoms (BDI – self-report) at follow-up (6 months) (k = 3; n = 94; SMD = -0.57; 95% CI, -0.98 to -0.15). I
Anxiety symptoms mean endpoint scores	s2x	There is limited evidence favouring trauma-focused CBT over supportive psychotherapy on reducing anxiety symptoms (STAI – self-report) (k = 3; n = 94; SMD = -0.62; 95% CI, -1.04 to -0.21). I
Anxiety symptoms mean scores at follow-up (6 months)	s2x	There is limited evidence favouring trauma-focused CBT over supportive psychotherapy on reducing anxiety symptoms (STAI – self-report) at follow-up (6 months) (k = 3; n = 94; SMD = -0.64; 95% CI, -1.06 to -0.23). I
Likelihood of leaving treatment early	s2y	There is limited evidence favouring supportive psychotherapy over trauma-focused CBT on reducing the likelihood of leaving treatment early (k = 3; n = 105; RR = 2.22; 95% CI, 0.74 to 6.7). I
Likelihood of leaving treatment early at follow-up (6 months)	s2y	There is limited evidence favouring supportive psychotherapy over trauma-focused CBT on reducing the likelihood of leaving treatment early at follow-up (6 months) (k = 3; n = 105; RR = 2.22; 95% CI, 0.74 to 6.7). I
Likelihood of leaving treatment early at follow-up (4 year)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between TF-CBT and supportive psychotherapy on reducing the likelihood of leaving treatment early at follow-up (4 year) (k = 1; n = 80; RR = 1.07; 95% CI, 0.67 to 1.72). I
Likelihood of having a PTSD diagnosis at follow-up (6 months)	s1x	There is evidence favouring trauma-focused CBT over supportive psychotherapy on reducing the likelihood of having a PTSD diagnosis at follow-up (6 months) (k = 3; n = 105; RR = 0.51; 95% CI, 0.32 to 0.8). I
Likelihood of having a PTSD diagnosis at follow-up (4 year)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between trauma-focused CBT and supportive psychotherapy on reducing the likelihood of having a PTSD diagnosis at follow-up (4 year) (k = 1; n = 80; RR = 0.9; 95% CI, 0.61 to 1.33). I
Likelihood of having a PTSD diagnosis	s1x	There is evidence favouring trauma-focused CBT over supportive psychotherapy (random effects) on reducing the likelihood of having a PTSD diagnosis (k = 3; n = 105; RR = 0.39; 95% CI, 0.23 to 0.68). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

trauma-focused CBT & exposure therapies vs supportive psychotherapy		
Severity of PTSD symptoms mean scores at follow-up (4 years)	s2x	There is limited evidence favouring trauma-focused CBT & exposure therapies over supportive psychotherapy on reducing the severity of PTSD symptoms (CAPS2 - clinician) at follow-up (4 years) (k = 1; n = 41; SMD = -0.7; 95% CI, -1.35 to -0.05). I

Prolonged exposure vs supportive psychotherapy		
Severity of PTSD symptoms mean endpoint scores (self report)	s1x	There is evidence favouring prolonged exposure over supportive psychotherapy on reducing the severity of post-treatment PTSD symptoms (IES - self-report) (k=1; n=30; SMD = -1.67; 95% CI, -2.52 to –0.82). I
Severity of PTSD symptoms mean scores at follow-up (6 months)	s2x	There is limited evidence favouring prolonged exposure over supportive psychotherapy on reducing the severity of PTSD symptoms (IES - self-report) at follow-up (6 months) (k = 1; n = 28; SMD = -1.04; 95% CI, -1.83 to -0.24). I
Severity of PTSD symptoms mean endpoint scores (clinician)	s2x	There is limited evidence favouring prolonged exposure over supportive psychotherapy on reducing the severity of PTSD symptoms (CAPS2 - clinician) (k = 1; n = 30; SMD = -1.02; 95% CI, -1.78 to -0.25). I
Severity of PTSD symptoms mean scores at follow-up (6 months)	s1x	There is evidence favouring prolonged exposure over supportive psychotherapy on reducing the severity of PTSD symptoms (CAPS2 - clinician) at follow-up (6 months) (k = 1; n = 28; SMD = -1.36; 95% CI, -2.2 to -0.52). I
Depression symptoms mean endpoint scores	s2x	There is limited evidence favouring prolonged exposure over supportive psychotherapy on reducing depression symptoms (BDI – self-report) (k = 1; n = 30; SMD = -0.78; 95% CI, -1.53 to -0.03). I
Depression symptoms mean scores at follow-up (6 months)	s2x	There is limited evidence favouring prolonged exposure over supportive psychotherapy on reducing depression symptoms (BDI – self-report) at follow-up (6 months) (k = 1; n = 28; SMD = -0.77; 95% CI, -1.55 to 0). I
Anxiety symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between prolonged exposure and supportive psychotherapy on reducing anxiety symptoms (STAI – self-report) (k = 1; n = 30; SMD = -0.46; 95% CI, -1.19 to 0.27). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Anxiety symptoms mean scores at follow-up (6 months)	s2x	There is limited evidence favouring prolonged exposure over supportive psychotherapy on reducing anxiety symptoms (STAI – self-report) at follow-up (6 months) (k = 1; n = 28; SMD = -0.77; 95% CI, -1.55 to 0). I
Likelihood of leaving treatment early	s2y	There is limited evidence favouring supportive psychotherapy over prolonged exposure on reducing the likelihood of leaving treatment early (k = 1; n = 37; RR = 1.41; 95% CI, 0.36 to 5.43). I
Likelihood of leaving treatment early at follow-up (6 months)	s2y	There is limited evidence favouring supportive psychotherapy over prolonged exposure on reducing the likelihood of leaving treatment early at follow-up (6 months) (k = 1; n = 37; RR = 1.32; 95% CI, 0.42 to 4.15). I
Likelihood of having a PTSD diagnosis	s2x	There is limited evidence favouring prolonged exposure over supportive psychotherapy on reducing the likelihood of having a PTSD diagnosis (k = 1; n = 37; RR = 0.53; 95% CI, 0.25 to 1.1). I
Likelihood of having a PTSD diagnosis at follow-up (6 months)	s2x	There is limited evidence favouring prolonged exposure over supportive psychotherapy on reducing the likelihood of having a PTSD diagnosis at follow-up (6 months) (k = 1; n = 37; RR = 0.53; 95% CI, 0.28 to 1). I

Prolonged exposure & anxiety management vs supportive psychotherapy		
Severity of PTSD symptoms mean endpoint	s2x	There is limited evidence favouring prolonged exposure & anxiety management over supportive psychotherapy on reducing the severity of PTSD symptoms (IES - self-report) (k = 1; n = 31; SMD = -0.94; 95% CI, -1.69 to -0.19). I
Severity of PTSD symptoms mean scores at follow-up (6 months)	s2x	There is limited evidence favouring prolonged exposure & anxiety management over supportive psychotherapy on reducing the severity of PTSD symptoms (IES - self-report) at follow-up (6 months) (k = 1; n = 28; SMD = -1.03; 95% CI, -1.83 to -0.24). I
Severity of PTSD symptoms mean endpoint scores	s2x	There is limited evidence favouring prolonged exposure & anxiety management over supportive psychotherapy on reducing the severity of PTSD symptoms (CAPS2 - clinician) (k = 1; n = 31; SMD = -0.79; 95% CI, -1.52 to -0.05). I
Severity of PTSD symptoms mean scores at follow-up (6 months)	s2x	There is limited evidence favouring prolonged exposure & anxiety management over supportive psychotherapy on reducing the severity of PTSD symptoms (CAPS2 - clinician) at follow-up (6 months) (k = 1; n = 28; SMD = -1.09; 95% CI, -1.9 to -0.29). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Depression symptoms mean endpoint scores	s2x	There is limited evidence favouring prolonged exposure & anxiety management over supportive psychotherapy on reducing depression symptoms (BDI – self-report) (k = 1; n = 31; SMD = -0.58; 95% CI, -1.3 to 0.14). I
Depression symptoms mean scores at follow-up (6 months)	s2x	There is limited evidence favouring prolonged exposure & anxiety management over supportive psychotherapy on reducing depression symptoms (BDI – self-report) at follow-up (6 months) (k = 1; n = 28; SMD = -0.58; 95% CI, -1.34 to 0.18). I
Anxiety symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between prolonged exposure & anxiety management and supportive psychotherapy on reducing anxiety symptoms (STAI – self-report) (k = 1; n = 31; SMD = -0.47; 95% CI, -1.18 to 0.25). I
Anxiety symptoms mean scores at follow-up (6 months)	s2x	There is limited evidence favouring prolonged exposure & anxiety management over supportive psychotherapy on reducing anxiety symptoms (STAI – self-report) at follow-up (6 months) (k = 1; n = 28; SMD = -0.92; 95% CI, -1.7 to -0.13). I
Likelihood of leaving treatment early	s2y	There is limited evidence favouring supportive psychotherapy over prolonged exposure & anxiety management on reducing the likelihood of leaving treatment early (k = 1; n = 38; RR = 1.33; 95% CI, 0.34 to 5.17). I
Likelihood of leaving treatment early at follow-up (6 months)	s2y	There is limited evidence favouring prolonged exposure & anxiety management over supportive psychotherapy on reducing the likelihood of leaving treatment early at follow-up (6 months) (k = 1; n = 38; RR = 1.50; 95% CI, 0.50 to 4.48). I
Likelihood of having a PTSD diagnosis	s2x	There is limited evidence favouring prolonged exposure & anxiety management over supportive psychotherapy on reducing the likelihood of having a PTSD diagnosis (k = 1; n = 38; RR = 0.58; 95% CI, 0.30 to 1.15
Likelihood of having a PTSD diagnosis at follow-up (6 months)	s2x	There is limited evidence favouring supportive psychotherapy over prolonged exposure & anxiety management on reducing the likelihood of having a PTSD diagnosis at follow-up (6 months) (k = 1; n = 38; RR = 0.64; 95% CI, 0.37 to 1.11). I

Self-help booklet vs waitlist		
Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between self-help booklet and waitlist on reducing the severity of PTSD symptoms (Posttraumatic Stress Diagnostic Scale - self-report) (k = 1; n = 52; SMD = -0.27; 95% CI, -0.81 to 0.28). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Severity of PTSD symptoms mean scores at follow-up (9 months)	s3	There is evidence suggesting there is unlikely to be a clinically important difference between self-help booklet and waitlist on reducing the severity of PTSD symptoms (Posttraumatic Stress Diagnostic Scale - self-report) at follow-up (9 months) (k = 1; n = 52; SMD = 0.06; 95% CI, -0.49 to 0.6). I
Severity of PTSD symptoms mean endpoint scores	s3	There is evidence suggesting there is unlikely to be a clinically important difference between self-help booklet and waitlist on reducing the severity of PTSD symptoms (CAPS - clinician) (k = 1; n = 52; SMD = -0.23; 95% CI, -0.78 to 0.32). I
Severity of PTSD symptoms mean scores at follow-up (9 months)	s3	There is evidence suggesting there is unlikely to be a clinically important difference between self-help booklet and waitlist on reducing the severity of PTSD symptoms (CAPS - clinician) at follow-up (9 months) (k = 1; n = 52; SMD = 0.07; 95% CI, -0.47 to 0.62). I
Depression symptoms mean endpoint scores	s3	There is evidence suggesting there is unlikely to be a clinically important difference between self-help booklet and waitlist on reducing depression symptoms (BDI - self-report) (k = 1; n = 52; SMD = -0.12; 95% CI, -0.66 to 0.43). I
Depression symptoms mean scores at follow-up (9 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between self-help booklet and waitlist on reducing depression symptoms (BDI - self-report) at follow-up (9 months) (k = 1; n = 52; SMD = 0.36; 95% CI, -0.18 to 0.91). I
Anxiety symptoms mean endpoint scores	s3	There is evidence suggesting there is unlikely to be a clinically important difference between self-help booklet and waitlist on reducing anxiety symptoms (BAI - self-report) (k = 1; n = 52; SMD = -0.15; 95% CI, -0.7 to 0.39). I
Anxiety symptoms mean scores at follow-up (9 months)	s3	There is evidence suggesting there is unlikely to be a clinically important difference between self-help booklet and waitlist on reducing anxiety symptoms (BAI - self-report) at follow-up (9 months) (k = 1; n = 52; SMD = 0.16; 95% CI, -0.38 to 0.71). I
Quality of life mean endpoint scores	s3	There is evidence suggesting there is unlikely to be a clinically important difference between self-help booklet and waitlist on improving quality of life (Sheehan Disability Scale – self-report) (k = 1; n = 52; SMD = 0.04; 95% CI, -0.5 to 0.59). I
Quality of life mean scores at follow-up (9 months)	s2y	There is limited evidence favouring waitlist over self-help booklet on improving quality of life (Sheehan Disability Scale – self-report) at follow-up (9 months) (k = 1; n = 52; SMD = 1.31; 95% CI, 0.7 to 1.91). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Likelihood of leaving treatment early	s2y	There is limited evidence favouring waitlist over self-help booklet on reducing the likelihood of leaving treatment early (k = 1; n = 57; RR = 1.55; 95% CI, 0.28 to 8.61). I
Likelihood of leaving treatment early at follow-up (9 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between self-help booklet and waitlist on reducing the likelihood of leaving treatment early at follow-up (9 months) (k = 1; n = 57; RR = 1.04; 95% CI, 0.23 to 4.71). I
Likelihood of having a PTSD diagnosis	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between self-help booklet and waitlist on reducing the likelihood of having a PTSD diagnosis (k = 1; n = 57; RR = 1.09; 95% CI, 0.81 to 1.46). I
Likelihood of having a PTSD diagnosis at follow-up (9 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between self-help booklet and waitlist on reducing the likelihood of having a PTSD diagnosis at follow-up (9 months) (k = 1; n = 57; RR = 1.1; 95% CI, 0.71 to 1.71). I

Trauma-focused CBT vs self-help booklet

Severity of PTSD symptoms mean endpoint (clinician)	s2x	There is limited evidence favouring trauma-focused CBT over self-help booklet on reducing the severity of post-treatment PTSD symptoms (CAPS - clinician) (k = 1; n = 53; SMD =- 1; 95% CI, -1.58 to –0.43).
Severity of PTSD symptoms at 9 months follow up (clinician)	s2x	There is limited evidence favouring trauma-focused CBT over self-help booklet on reducing the severity of PTSD symptoms at 9 month follow up (CAPS - clinician) (k = 1; n = 53; SMD =--0.97; 95% CI, -1.54 to –0.40).
Severity of PTSD symptoms mean endpoint (self report)	s1x	There is evidence favouring trauma-focused CBT over self-help booklet on reducing the severity of post-treatment PTSD symptoms (Posttraumatic Stress Diagnostic Scale - self-report) (k = 1; n = 53; SMD =-1.28; 95% CI, -1.88 to -0.69).
Severity of PTSD symptoms at 6-9 months follow up (self-report)	s1x	There is evidence favouring trauma-focused CBT over self-help booklet on reducing the severity of PTSD symptoms at follow up (Posttraumatic Stress Diagnostic Scale - self-report) (k = 1; n = 53; SMD =-1.40; 95% CI, -2.00 to –0.79).
Anxiety symptoms at endpoint	s1x	There is evidence favouring trauma-focused CBT over self-help booklet on reducing post treatment anxiety symptoms (BAI - self-report) (k = 1; n = 53; SMD =-1.09; 95% CI, -1.67 to –0.51).

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Anxiety symptoms at 9 month follow up	s1x	There is evidence favouring trauma-focused CBT over self-help booklet on reducing anxiety symptoms (BAI - self-report) at follow-up (9 months) (k = 1; n = 53; SMD =-1.17; 95% CI, -1.76 to –0.58).
Depression symptoms mean endpoint scores	s1x	There is evidence favouring trauma-focused CBT over self-help booklet on reducing post-treatment depression symptoms (BDI-self report) (k = 1, n = 53; SMD = -1.35 –1.95 to –0.74). I
Depression symptoms mean scores at follow-up (9 months)	s1x	There is evidence favouring trauma-focused CBT over self-help booklet on reducing depression symptoms (BDI – self-report) at follow-up (9 months) (k = 1; n = 53; SMD = -1.23; 95% CI, -1.82 to -0.64). I
Quality of life mean endpoint scores	s2x	There is limited evidence favouring trauma-focused CBT over self-help booklet on improving quality of life (Sheehan Disability Scale – self-report) (k = 1; n = 53; SMD = -0.74; 95% CI, -1.3 to -0.18). I
Quality of life mean scores at follow-up (9 months)	s2x	There is limited evidence favouring trauma-focused CBT over self-help booklet on improving quality of life (Sheehan Disability Scale – self-report) at follow-up (9 months) (k = 1; n = 53; SMD = -0.79; 95% CI, -1.35 to -0.23). I
Likelihood of having a PTSD diagnosis	s1x	There is evidence favouring trauma-focused CBT over self-help booklet on reducing the likelihood of having a PTSD diagnosis (k = 1; n = 56; RR = 0.24; 95% CI, 0.12 to 0.49). I
Likelihood of leaving treatment early	s2x	There is limited evidence favouring trauma-focused CBT over self-help booklet on reducing the likelihood of leaving treatment early (k = 1; n = 56; RR = 0.14; 95% CI, 0.01 to 2.64). I
Likelihood of leaving treatment early at follow-up (9 months)	s2x	There is limited evidence favouring trauma-focused CBT over self-help booklet on reducing the likelihood of leaving treatment early at follow-up (9 months) (k = 1; n = 56; RR = 0.14; 95% CI, 0.01 to 2.64). I
Likelihood of having a PTSD diagnosis at follow-up (9 months)	s1x	There is evidence favouring trauma-focused CBT over self-help booklet on reducing the likelihood of having a PTSD diagnosis at follow-up (9 months) (k = 1; n = 56; RR = 0.18; 95% CI, 0.06 to 0.54). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.

Early Intervention drug treatments

Description	Statement	Statements and Statistics
B-adrenergic blocker propranolol vs placebo		
Severity of PTSD symptoms mean scores at 1-month	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between b-adrenergic blocker propranolol and placebo on reducing the severity of PTSD symptoms (CAPS - clinician rated) at 1-month (k = 1; n = 31; SMD = -0.39; 95% CI, -1.13 to 0.35). I
Severity of PTSD symptoms mean scores at follow-up (3 months)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between b-adrenergic blocker propranolol and placebo on reducing the severity of PTSD symptoms (CAPS - clinician rated) at follow-up (3 months) (k = 1; n = 24; SMD = 0.03; 95% CI, -0.8 to 0.86). I
Likelihood of leaving the study early	s2y	There is limited evidence favouring placebo over b-adrenergic blocker propranolol on reducing the likelihood of leaving the study early (k = 1; n = 41; RR = 1.44; 95% CI, 0.7 to 2.97). I
Likelihood of having a PTSD diagnosis at 1-month	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between b-adrenergic blocker propranolol and placebo on reducing the likelihood of having a PTSD diagnosis at 1-month (k = 1; n = 41; RR = 1.14; 95% CI, 0.55 to 2.35). I
Likelihood of having a PTSD diagnosis mean scores at follow-up (3 month)	s2y	There is limited evidence favouring placebo over b-adrenergic blocker propranolol on reducing the likelihood of having a PTSD diagnosis at follow-up (3 month) (k = 1; n = 41; RR = 1.28; 95% CI, 0.69 to 2.38). I
Hydrocortisone vs placebo		
Likelihood of having a PTSD diagnosis	s2x	There is limited evidence favouring hydrocortisone over placebo on reducing the likelihood of having a PTSD diagnosis (k = 1; n = 20; RR = 0.17; 95% CI, 0.03 to 1.17). I

TF- CBT= trauma focused CBT. (See early interventions chpt 8 for descriptions of interventions).

Note on order of presentation Outcomes are ordered accordingly: continuous/completer data outcomes reported first followed by intention to treat (ITT)/dichotomous outcomes. Within each of these categories, those estimated by fixed effects algorithm within Revman appear first, followed by those estimated by random effects.