



March 2018

Evidence *summaries*

The provision of services in the UK for armed forces veterans with PTSD

- About half of armed forces veterans with PTSD (post traumatic stress disorder) now seek help from NHS services
- Research suggests referral to the correct specialist care is rare
- Requirements for specialist support may grow following armed forces restructuring and more complex needs arising from recent conflicts
- Evidence found potentially promising models of care for armed forces veterans with PTSD were:
 - Collaborative arrangements and community outreach for improving intervention access and uptake
 - Integrated mental health services and behavioural intervention for increased smoking abstinence, but with no effect on PTSD symptoms
 - Peer support as an acceptable complement to PTSD treatment

This evidence summary has been produced as part of independent research funded by the NIHR Health Services and Delivery Research programme (Project ref: 13/05/11).

The views expressed in this publication are those of the authors and do not necessarily reflect those of the NIHR or the Department of Health.

Why is this evidence needed now?

The transition of ex-service personnel (or veterans) from Defence Medical Services (DMS) to the National Health Service (NHS) can add to poor mental health and there appears to be a reticence for veterans to present for help. Reports suggest that half of armed forces veterans with post-traumatic stress disorder (PTSD) now seek help from NHS services, but referral to the correct specialist care is rare.¹

The background to the research arises from current thinking about anticipated increases in demand for psychological trauma services in the UK, with particular reference to armed forces veterans with PTSD. In 2014, there were 2.8 million ex-service personnel in the UK and it was envisaged that requirements for specialist support would grow following armed forces restructuring and more complex needs arising from recent conflicts.²

A recent NHS England strategic review of commissioning intentions for armed forces and their families for 2016-17 reported priorities to improve care for veterans with mental health issues.³ The review was specifically in relation to people with complex PTSD including co-morbidities linked to substance misuse, and also where stigma is a barrier to accessing care. NHS England have also published findings from an engagement exercise presenting stakeholder views and experiences on the 12 specialist mental health services provided for veterans in England which included NHS England pilots for enhanced models of care in 2015-2016.⁴⁻⁶

Detailed mental and related health needs assessment in veterans and their families were reported in England in 2015,⁷ and in Scotland⁸ and Wales⁹ in 2016. Issues for veterans in Wales and Scotland resonate with three suggested building blocks for future service planning in England:

1. targeted and intelligent use of data and information;
2. implementation of appropriate and sensitive evidence-based services; and
3. involvement of veterans and family members.

Given the transitional arrangement from DMS to NHS services, and the anticipated rise in demand for services, there is a need to explore the adequacy and suitability of current and planned mental health services to treat PTSD (and complex presentations of PTSD) to meet the specific requirements of armed forces veterans.

Summary of evidence

This summary comes from the findings of a rapid evidence synthesis on the provision of services in the UK for armed forces veterans with PTSD following repeated exposure to traumatic events.

Information on UK service provision was requested and evidence was sought to establish potentially effective models of care for armed forces veterans with PTSD. The views of veterans were drawn from a number of needs assessments and stakeholder engagement surveys conducted in England,^{6,7} Scotland and Wales.^{8,9} (An assessment of needs among veterans and their families in Northern Ireland was published in May 2017 but was not available for inclusion in this analysis.¹⁰) We also drew additional insights from an individual veteran service user.

The evidence for the most promising models of care had some limitations in the quality of the evidence. A trial evaluating collaborative care¹¹ and a qualitative study evaluating peer support¹² were well conducted and had minimal risks of bias. However the remaining two trials evaluating community outreach¹³ and integrated care^{14, 15} had potential biases in their conduct which may limit the reliability of their findings. The three trials reported clinical outcomes including PTSD-related and smoking abstinence and were measured using various scales and checklists. Other outcomes included intervention access and service-uptake. The qualitative study, using interviews, sought veterans' views on the benefits, drawbacks and programme characteristics. Where reported, most studies measured follow-up at 3-6 months. All studies were

conducted in the USA in the context of the Veterans Health Administration (US Department of Veterans Affairs) which may limit the generalisability of some findings to the UK setting.

Not all models of care in UK practice appeared in the literature that was subsequently included in the review, suggesting a poor fit between the research literature and UK service provision. However there is tentative support for the effectiveness of some models of care currently delivered in UK practice. The findings are timely for commissioners and service providers when developing present activity in veterans' healthcare.

What are the most promising models of care?

The evidence identified was limited, but the most promising evidence suggests the potential effectiveness of:

- Collaborative care arrangements, where education and support for primary care clinicians and staff across multiple sites resulted in veterans having higher numbers of mental health visits, antidepressant prescriptions, refills and costs relating to outpatient pharmacy. However, there was no difference compared to usual care for PTSD symptoms, depression or functioning. The intervention was associated with lower perceived quality of PTSD care.¹¹
- Community outreach (a pro-active mailed intervention to patients with telephone follow up) for improving intervention access and uptake of treatment. Barriers to accessing care included personal obligations, inconvenient appointment times, and receipt of treatment from elsewhere.¹³
- Integrated care (including smoking cessation treatment for veterans within general mental health services) for increased smoking abstinence, but with no effect on PTSD symptoms.^{14, 15}

Sources of evidence

- Seventeen organisations provided information on current UK service activity. These included providers from England, Scotland, Wales, Northern Ireland, and the third sector.
- Review based on 24 studies of system-based models of care (eg case management, community outreach):
 - The “best evidence” focused on three randomised controlled trials and one qualitative study;
 - Twenty other studies contributed to the analysis.
- Thirty two studies reported on treatment delivery mechanisms (eg telehealth, assessment or triage) but were not included in the analysis.

Details of the project are presented in the full report available online: <https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr06110/#/abstract>¹⁶

- Peer support (where patients ‘in recovery’ from an illness provide support to patients with the same disorder) as an acceptable complement to other PTSD treatments. Perceived benefits included improved social support and understanding, purpose and meaning (for peer supporters); normalisation of PTSD symptoms; and feelings of hope and therapeutic benefit as a result of talking to others. Peer support also helped to initiate professional treatment. Reported drawbacks were largely related to uneasiness about group dynamics and trusting others.¹²

These broad types of delivery were also seen to some degree in the overview of current UK practice which also formed part of the project.¹⁶

What is most important for future healthcare commissioning & research?

Future practical arrangements to improve veterans' mental health might helpfully focus on:

- Early intervention to improve transition from military to civilian life.
- Improving knowledge and awareness of specialist services available to veterans across primary care (especially GPs) and general mental health services.
- Understanding more clearly the complex needs of veterans and account for these in future service design.
- Addressing challenges for veterans presented by the wider system of care.
- The provision of adequate funding and resources to deliver future services.

A number of implications for research include:

- More research relevant to the UK setting.
- Routine and continuous evaluation of how interventions work in practice.
- More robust research on models of care, with longer follow-up.
- Explore a wider range of outcomes, including process outcomes (intervention uptake), clinical, patient satisfaction, social functioning, quality of life, disparities in age-related treatment effectiveness; improving access to services by minority populations; and cost-effectiveness.
- More research on the format and structure of group peer support.
- More research on peer support using telephone outreach.

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