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

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BACKGROUND & OBJECTIVES

There is increasing demand for psychological trauma services in the UK, particularly for armed forces veterans with post-traumatic stress disorder (PTSD). We aimed to explore what is known about current UK service provision and establish potentially effective models of care and treatments for veterans with PTSD.

METHODS

A rapid synthesis of the research literature on models of care and treatments, guided by information from UK service providers. We focus here on models of care.

SERVICE USER INVOLVEMENT

We drew on both published public and patient involvement data, and experts with academic, military, and commissioning backgrounds.

One of the challenges of a rapid evidence synthesis, which is often completed within a few months, is being able to engage meaningfully with service users. This is particularly difficult in areas such as mental health. Through our experts we were able to make contact with an army veteran (Lieutenant Colonel (Retired)) with 35 years military service. He provided advice and input into the interpretation of our research findings, drawing on his deployments in worldwide conflicts and from reflections on his engagement with UK health services following a diagnosis of PTSD.

His input enriched researcher interpretations, including those around the influence of stigma, reticence to seek help, and associations with complex presentations of PTSD compounded by co-morbidities. He drew our attention to personal experience of time-lapse between trauma and presentation of PTSD, supporting the case for pre-emptive intervention early in the transition from military to civilian life.

WHAT ARE THE MOST PROMISING MODELS OF CARE?

We included 56 studies (61 articles). The "best evidence" focused on three randomised controlled trials (RCTs) and one qualitative study (see Table). 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.

Models of care	Best evidence, all conducted in USA (Veterans Health Administration)			
	RCTs			Qualitative
	2000[a]	2010[a]	2013[b]	2015[b]
Partnership, cross-sector, liaison work, co-location				
Co-ordinated, integrated, collaborative, networks, multidisciplinary care		●	●	
Inpatient				
Outpatient				
Day care				
Residential				
Primary care			●	
Peer support				●
Multicomponent treatment programmes				
Family systems model				
Community outreach	●			
Use of Improving Access to Psychological Therapies				
Prison in-reach				
Case management				
Stepped-care model				
Early intervention				
Crisis management				

a Some risks of bias which may impact on the reliability of their findings; b Low risk of bias

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 higher numbers of mental health visits, antidepressant prescriptions, refills and costs relating to outpatient pharmacy. However, there was no difference for PTSD symptoms, depression or functioning. The intervention was associated with lower perceived quality of PTSD care (1 RCT).
- Community outreach (a pro-active mailed intervention 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 (1 RCT).
- Integrated care (including smoking cessation treatment for veterans within general mental health services) for increased smoking abstinence, but with no effect on PTSD symptoms (1 RCT).
- Peer support 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; 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 (1 qualitative study).

The research reported here is the product of the **York HS&DR Evidence Synthesis Centre**, contracted to provide rapid evidence syntheses on issues of relevance to the health service, and to inform future HS&DR calls for new research (Project ref: 13/05/11)

Details are presented in the full report in **Health Services and Delivery Research 2018; 6 (11)** (https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr06110/#/abstract)

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