



# 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.

## FUTURE HEALTHCARE PRACTICE & RESEARCH PRIORITIES

In November 2018 NHS leaders confirmed that specialist health support for veterans will be available in every part of the health service across the country.

Not all models of care in UK practice were represented in the literature we identified which limits the generalisability of our findings. It also highlights a need for better research to inform evidence based commissioning.

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.
- Provision of adequate funding and resources to deliver future services.

Future research priorities arising from our rapid evidence synthesis include a need for more robust research on models of care with longer follow-up exploring a wider range of outcomes and relevant to the UK setting.

## 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 <sup>a</sup>	2010 <sup>a</sup>	2013 <sup>b</sup>	2015 <sup>b</sup>
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  
\*These categories were derived from an information gathering exercise to describe UK service provision.

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).