Post-Traumatic Stress Disorder (PTSD)

What is it?

To some, Post-Traumatic Stress Disorder (PTSD) is something that disproportionately affects those who have seen combat situations, or experienced hostage situations; natural disasters and other rare but extreme events. Whilst these **are** examples of causes of PTSD, there are many other stress inducing events that can trigger this condition – for example car accidents, traumatic pregnancies and births[1], bereavement, or a significant change in health status (for example a cancer diagnosis)[2].

PTSD is an anxiety disorder caused by very stressful, frightening or distressing events, an individual can develop PTSD immediately after a traumatic event, however, it may not become apparent for months or even years after[3]. Although anyone can experience a traumatic event, the exposure to this will depend on a number of factors, for example, a person's upbringing, where they live and how they live[4]. There is still a lack of clarity in the definition of 'a traumatic event'[4]. It is this subjectivity that can make a diagnosis and subsequent treatment challenging.

Estimates for incidence and prevalence of PTSD vary, however for the UK the most accurate point adult prevalence estimate we have is 3% (based on findings from the Adult Psychiatric Morbidity Survey)[4],[5]. Lifetime prevalence is higher in women compared to men[6], figures tend to be in the region of 5% for men and 10–11% for women[4]. PTSD prevalence in certain at risk groups (such as vicitims of crime) could be up to 75%[6]. Current estimates suggest that 1 in 3 people that experience a traumatic event will be affected by PTSD, however there is no clear marked that explains why some people develop the condition and others do not[3].

Complex PTSD is a condition that can cause similar symptoms to PTSD with a similar delayed onset in some, it affects people who repeatedly experience traumatic situations such as severe neglect, abuse or violence, and is particularly detrimental when the trauma was experienced in early life, as it can adversely affect a child's development[3].

People affected by PTSD may experience a range of symptoms for example: flashbacks; a heightened state of alertness; being angry or upset easily; reckless behaviour[7]: For many, these symptoms may disappear in a relatively short period of time. However, if these problems last for longer than a month, or are very extreme, a diagnosis of PTSD may be made[7].

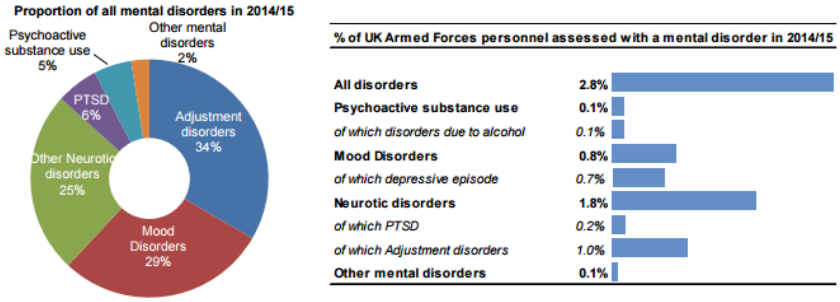
PTSD in armed forces populations

A recent report concluded the majority of serving and ex-service personnel have good mental health[8]. However, in those with mental health conditions the most common are depression or anxiety[9]. National data appears to support this, indicating that adjustment disorders were the most prevalent mental disorder among UK Armed Forces personnel in 2014/15, accounting for around 34% of all mental disorders in the Armed Forces, PTSD accounted for 6% (see Figure 1).

A report produced by the Royal British Legion (RBL)[10] notes that rates of mental health problems amongst service personnel and recent veterans appear to be generally similar to the UK population, however elevated levels of heavy drinking appear to be an issue[11], and depression was also

highlighted as being higher in the RBL survey findings. Conversely, Public Health England [12] note that the serving population is more likely to experience common mental health problems such as depression or anxiety than the general population.

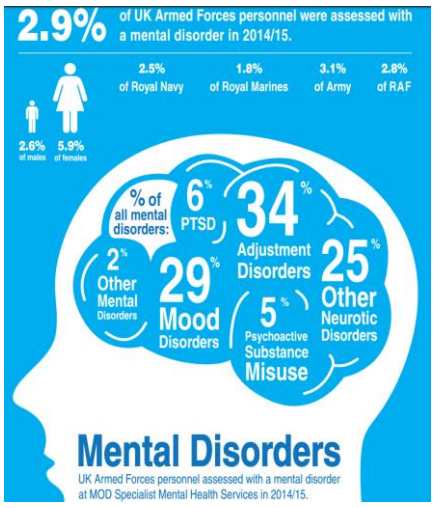
Figure 1: UK Armed Forces personnel mental disorders at initial assessment at MOD DCMH, 2014/15



Source : DS Database and DMICP
1. Percentages in doughnut may not sum 100% due to rounding.
2. Excludes personnel where Initial diagnosis was not supplied (See BQR)
3. Percentages are based on the calculation of the absolute number and are presented to 1dp (See paragraph 74)

Source: [13]

Figure 2: Mental health in the armed forces, 2014/15



Source: [13]

A recent study has found that ESLs were more likely to self-report symptoms of common mental disorders, probable PTSD, fatigue and multiple physical symptoms, compared with non-ESLs after having left Service [14]. ESL are an important group to explore in more detail as they fall in to a highly vulnerable group of service leavers that tend to struggle most, yet get the least help [15].

A report from the campaigning organisation Forces Watch concluded younger recruits are significantly more likely to suffer PTSD, to drink at levels harmful to health, and to behave violently on their return from war[9]. Other evidence also notes that those in the armed forces have a higher prevalence of depression, anxiety disorders, alcohol abuse and PTSD[6].

The mixed evidence for the increased prevalence of mental ill-health in armed forces personnel and veterans appears to persist. Issues are complex and difficult to untangle, as with the general population. However, there appears to be two specific cohorts that are more at risk of PTSD; ESL and younger recruits.

The NHS five year forward view for mental health (5YFVMH) [16] emphasises the need for timely continuity of care, noting that only half of veterans of the armed forces experiencing mental health problems like Post Traumatic Stress Disorder seek help from the NHS. Amongst those that do, they are rarely referred to the right specialist care. It is therefore imperative to work on joining up mental health services to create seamless, prompt and consistent care to those who need it, especially those who are most vulnerable.

Why is it important for Suffolk?

Based on 2014 population estimates[17] and a PTSD point prevalence estimate of 3%, would equate to 18,000 Suffolk residents aged 16+ with PTSD. Evidence suggests that around 70% of people with PTSD in the UK do not receive any professional help at all[2]. This means that there will be a significant number of people in Suffolk that are 'hidden' and not receiving any support or help with their illness, utilising the estimates above, approximately 13,000 Suffolk residents may have untreated PTSD. Pooled hospital admission data for 2013-2016 indicates there were 436 hospital admissions where a diagnosis of PTSD was mentioned, 59% of admissions were males.

Over the period 1 October 2014 - 1 October 2015 an estimated 300 veterans sought support for a range of mental health issues in Suffolk. Approximately 230 of these were accessed through local statutory services and some 70 sought support from military charity mental health providers[18].

It is important that the family, friends and carers of those with PTSD are not overlooked, as they will also be impacted when a loved one has PTSD.

PTSDUK notes that trauma may create a ripple effect through to loved ones. Listening to trauma stories or being exposed to symptoms like flashbacks may trigger secondary traumatisation in family, friends and carers, adequate support must also be given to affected family members/carers[19].

Current action/ What are we doing?

The question of whether PTSD is preventable is often raised, and it is a lack of robust evidence around specific preventative interventions. There is no way to ensure that exposure to trauma/stress does not occur, but there are ways the impact of the trauma can be mediated. Whilst there is a potential that some cases could be prevented it is vital to focus on effective identification of the first signs of PTSD, with timely intervention to minimise impact. A period of 'watchful waiting' may be observed, where symptoms are mild are and have been present for less than 4 weeks after

the trauma, a follow up appointment should be offered within one month[20]. There must also be access to continued support to promote recovery and prevent relapse.

The Royal College of Psychiatrists (RGP)[21] note that psychological (talking) therapies and antidepressants seem to be most helpful. There are only two antidepressants specifically licensed for the treatment of PTSD - paroxetine and sertraline (although others have been found to be effective), however other methods of treatment will be offered before medication. Both the RGP and The National Institute for Health Research (NIHR) note that there are two established and effective trauma-focused psychological therapies (Cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR)), these should be offered before medication[4].

The Suffolk Wellbeing Service (for those living in East and West Suffolk) and the Norfolk and Waveney Wellbeing Service (for those living in Waveney) offer a range of free support services to help people make changes in their life in order to improve mental health and wellbeing, and help people cope with stress, anxiety and depression. There is also good evidence that social support can be helpful in aiding post-incident recovery[4].

The Norfolk and Suffolk NHS Foundation Trust supports Veterans and links closely to the Suffolk Wellbeing Service - a community network. A range of services are available to support the Service community, for example PTSD Resolution is a national charity which delivers counselling and psychotherapy to Veterans, Reservists, and families, struggling with emotional and behavioural problems. For more information on other services available click here: http://www.suffolkmilitarycovenant.org.uk/health-and-wellbeing/

What else could we do?

Costings data for PTSD is patchy, even at a national level, even the King's Fund could not identify data sources that would enable them to estimate costs of treatment associated with PTSD[22]. 2010 data estimates the burden of anxiety disorders in the UK to be €11.7 million (purchasing power parity (PPP)) (PTSD is contained within this classification)[23]. The National Institute for Health and Care Excellence (NICE) did provide some cost estimation in their PTSD guidance document, however this guidance is over 10 years old and [CG26] is currently being updated[20], with the revised publication not expected until August 2018. It would be prudent to look at this as soon as it becomes available.

One study indicated that the use of a nurse composed Intensive Care Unit (ICU) diary for patients in ICUs in America (given to them post discharge), helped reduce PTSD related symptoms [24]. The incidence of new cases of PTSD was reduced in the intervention group compared to the control patients (5% versus 13%). The findings suggest that the use of this diary helped create a logical coherent narrative to fill in the gaps in patient's memories (that may otherwise have been filled in with inaccurate memories adding to the stress felt by patients). Research has indicated that hydrocortisone may also prevent PTSD or reduce the severity of symptoms[25].

NHS England is currently consulting on the future of mental health support for veterans and it is essential that more is done to ensure their needs are identified early and they are supported to access specialist care swiftly[16]. Again review of this information should occur when published.

Recent work by Healthwatch Norfolk indicated that those with combat related PTSD may be less likely to engage with civilian targeted services, as they felt that civilian services wouldn't understand them or respond to their needs[26]. This indicates the need for specialised support, whilst there some services are available, support is heavily reliant on third sector provision. It is also worth noting that NHS England currently provides 12 dedicated services for veterans in other areas of the country, but no dedicated service is provided for veterans in Norfolk and Suffolk[26]. GPs are key to accessing services, and yet often aren't aware of veteran's needs. Replicating the Healthwatch Norfolk work in creating a protocol to enable GPs to better identify and treat veterans would be advantageous in relation to early help in Suffolk.

What not to do?

NIHR note that psychological debriefing or counselling interventions, shortly after trauma exposure may cause more harm than good, and were found to be ineffective. Both the NIHR and the Royal College of Psychiatrists note that medication as a treatment method should not be offered in the first instance[21],[4].

There is also little evidence to support the use of debriefing interventions for the prevention of psychological trauma in women following childbirth[28], more research is needed to this area, to support women who have traumatic pregnancy/births.

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Acronyms

CBT	Cognitive Behavioural Therapy
EMDR	Eye Movement Desensitisation and Reprocessing
ESL	Early Service Leaver
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NHS	National Health Service
PTSD	Post-traumatic stress disorder

Glossary

Cognitive behavioural therapy (CBT): helps people to think differently about their memories, so that they become less distressing and more manageable. It usually involves relaxation to help tolerate the discomfort of recalling the traumatic events.

Early Service Leaver: A member of the armed forces who has completed less than 4 years' service when they leave, or has been compulsorily discharged.

Eye movement desensitisation and reprocessing (EMDR): uses eye movements to help the brain to process flashbacks and to make sense of the traumatic experience.

Point Prevalence: Number of current cases (new and pre-existing) at a specified point in time.

Post-traumatic stress disorder (PTSD): PTSD is an anxiety disorder caused by very stressful, frightening or distressing events.

NHS 5 Year Forward View for Mental Health: This is an independent report of the Mental Health Taskforce which sets out the start of a ten year journey for transformation of mental health services and care, commissioned by Simon Stevens on behalf of the NHS