Dr. Neil Kitchiner

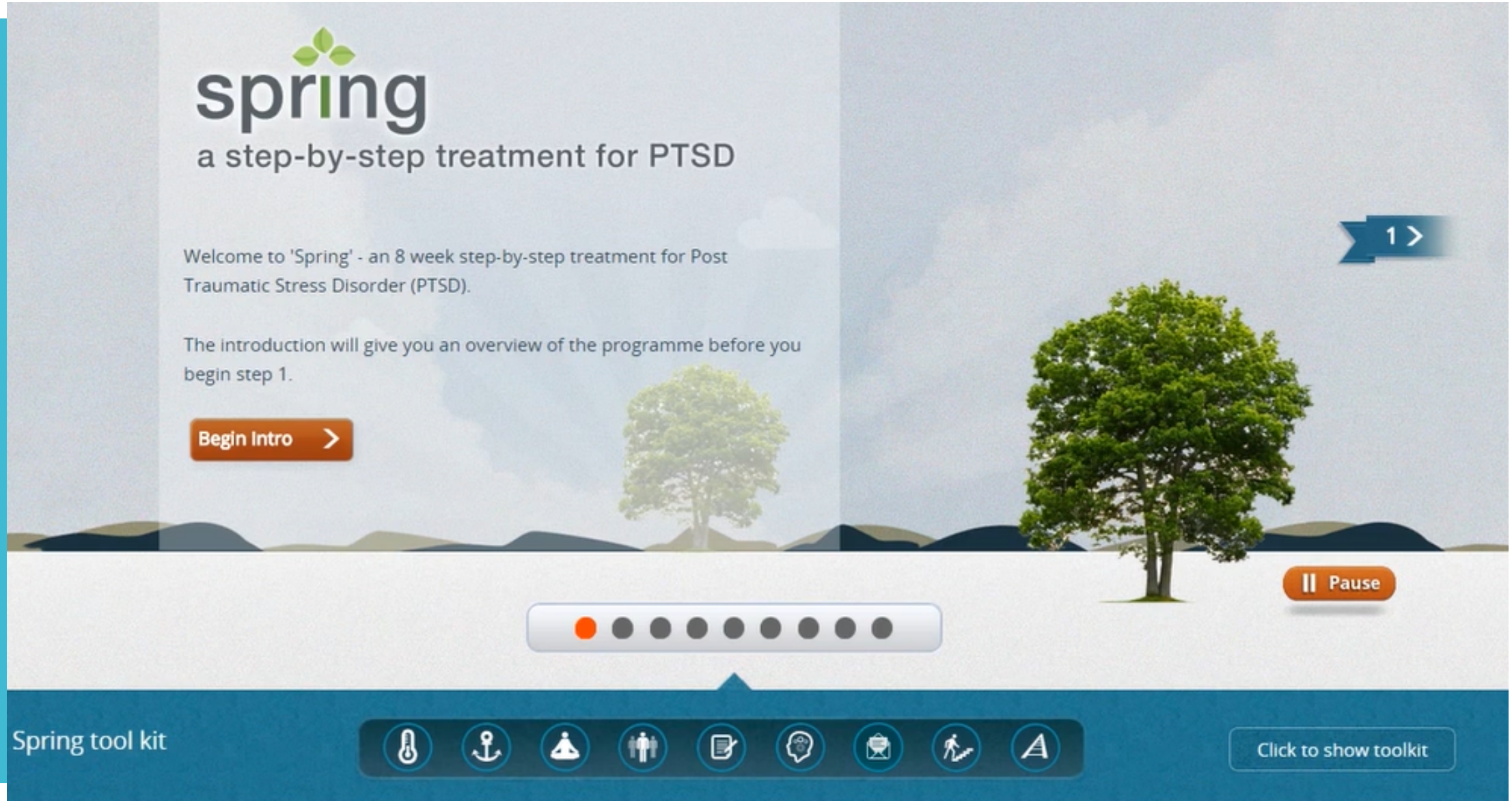
Veterans' NHS Wales ,

Honorary Senior Research Fellow, Cardiff University

Veterans' mental health research in Wales

How much do we spend on MH research?

- *For every **£1** the government spends, the public invests **£2.75** for cancer, **£1.35** for heart and circulatory problems, and only **0.3p** (or one third of a penny) for mental health (Mental Health Foundation, 2016)*


spring
a step-by-step treatment for PTSD
Welcome to 'Spring' - an 8 week step-by-step treatment for Post Traumatic Stress Disorder (PTSD).
The introduction will give you an overview of the programme before you begin step 1.
Begin Intro
1
Pause
Spring tool kit
Click to show toolkit

Phase I – Guided Self-Help for PTSD

NICE (2005) recommended a RCT on GSH for people with mild to moderate PTSD

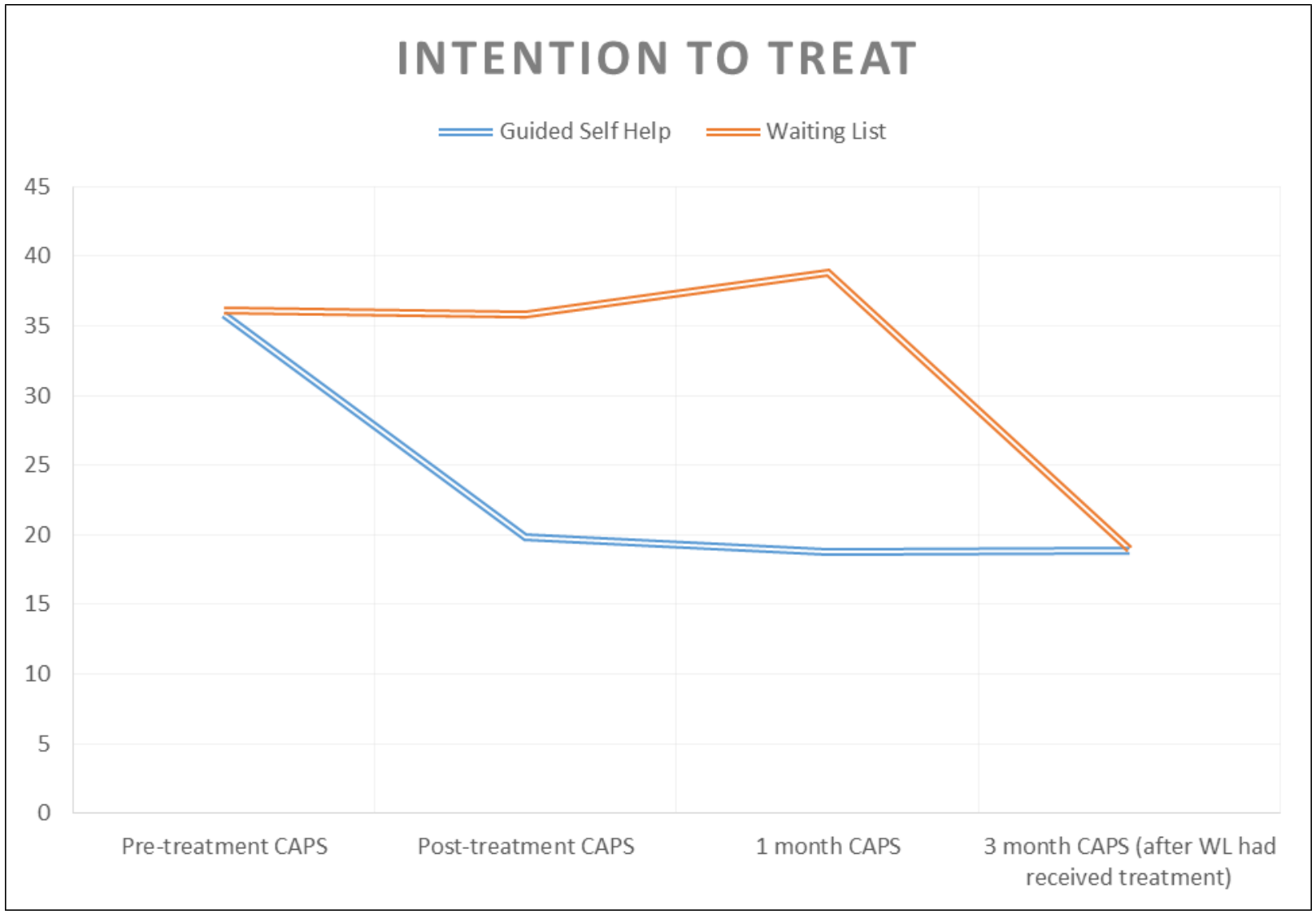
Catrin Lewis (PhD student, 2008-2011) develops & tests a GSH people with mild to moderate PTSD

Using MRC Phase I methodology for complex interventions

Interviews with people with PTSD & expert trauma clinicians

Prototype GSH website built & tested on two groups 10 & 9 people & evaluated on two occasions

CAPS-5 Results



Phase II RCT Spring – GSH for mild to moderate PTSD

Received: 2 September 2016 | Revised: 27 February 2017 | Accepted: 27 February 2017

DOI: 10.1002/da.22645

RESEARCH ARTICLE

WILEY ADAA

Internet-based guided self-help for posttraumatic stress disorder (PTSD): Randomized controlled trial

Catrin E. Lewis[1] | Daniel Farewell[1] | Vicky Groves[1] | Neil J. Kitchiner[2] | Neil P. Roberts[2] | Tracey Vick[2] | Jonathan I. Bisson[1]

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Work conducted at the Institute of Psychological Medicine and Clinical Neurosciences, Cardiff University School of Medicine, Hadyn Ellis Building, Maindy Road, Cardiff, CF24 4HQ

Grant sponsor: Knowledge Transfer Partnership. Contract grant number: KTP008512.

Background: There are numerous barriers that limit access to evidence-based treatment for posttraumatic stress disorder (PTSD). Internet-based guided self-help is a treatment option that may help widen access to effective intervention, but the approach has not been sufficiently explored for the treatment of PTSD.

Methods: Forty two adults with DSM-5 PTSD of mild to moderate severity were randomly allocated to internet-based self-help with up to 3 h of therapist assistance, or to a delayed treatment control group. The internet-based program included eight modules that focused on psychoeducation, grounding, relaxation, behavioural activation, real-life and imaginal exposure, cognitive therapy, and relapse prevention. The primary outcome measure was reduction in clinician-rated traumatic stress symptoms using the clinician administered PTSD scale for DSM-V (CAPS-5). Secondary outcomes were self-reported PTSD symptoms, depression, anxiety, alcohol use, perceived social support, and functional impairment.

Results: Posttreatment, the internet-based guided self-help group had significantly lower clinician assessed PTSD symptoms than the delayed treatment control group (between-group effect size Cohen's $d = 1.86$). The difference was maintained at 1-month follow-up and dissipated once both groups had received treatment. Similar patterns of difference between the two groups were found for depression, anxiety, and functional impairment. The average contact with treating clinicians was 2½ h.

Conclusions: Internet-based trauma-focused guided self-help for PTSD is a promising treatment option that requires far less therapist time than current first line face-to-face psychological therapy.

KEYWORDS
CBT, computer, internet technology, trauma, treatment

1 | INTRODUCTION

Posttraumatic stress disorder (PTSD) is a common psychological disorder with a lifetime prevalence of approximately 8% (Kessler, 2000). A substantial body of literature supports trauma-focused psychological therapies as effective treatments for PTSD (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013, Jonas et al., 2013), but numerous barriers limit access to these evidence-based interventions (Hoge et al., 2004, Koenen, Goodwin, Struening, Hellman, & Guardino, 2003). Trauma-focused psychological therapies require significant therapist input, and are time consuming and costly to deliver (NICE, 2005). This, combined with additional barriers to treatment including the perceived stigma associated with psychological therapy (Cuijpers, van Straten, & Andersson, 2008) and inadequate service provision in rural areas (Griffiths, & Christensen, 2007), has resulted in long waiting times (Hitt, Kitchiner, & Bisson, 2004) and low rates of treatment uptake (Hoge et al., 2004, Norris, Kaniasty, & Scheer, 1990). In response, there has been a growing interest in using the internet as a platform for the delivery of psychological therapy (Amstadter, Broman-Fulks, Zinzow, Ruggiero, & Cercone, 2009). Using the internet to deliver evidence-based treatment has the capacity to reduce the cost of effectively delivering evidence-based therapy (Hedman et al., 2011) and has the potential to overcome many other barriers that currently limit the availability and uptake of treatment (Griffiths, Lindenmeyer, Powell, Lowe, & Thorogood, 2006).

Abbreviations: PTSD, posttraumatic stress disorder; RCT, randomized controlled trial

RAPID- Phase III multi-center RCT of Spring (GSH) website vs TFCT

Nollett et al. BMC Psychiatry (2018) 18:77
https://doi.org/10.1186/s12888-018-1665-3

BMC Psychiatry

STUDY PROTOCOL Open Access

Pragmatic RAndomised controlled trial of a trauma-focused guided self-help Programme versus InDividual trauma-focused cognitive Behavioural therapy for post-traumatic stress disorder (RAPID): trial protocol

Claire Nollett[1*], Catrin Lewis[2], Neil Kitchiner[2,3], Neil Roberts[2,3], Katy Addison[1], Lucy Brookes-Howell[4], Sarah Cosgrove[5], Katherine Cullen[6], Anke Ehlers[7], Sarah Heke[8,9], Mark Kelson[10], Karina Lovell[11], Kim Madden[4], Kirsten McEwan[12], Rachel McNamara[1], Ceri Phillips[6], Timothy Pickles[1], Natalie Simon[2] and Jonathan Bisson[2*]

Abstract

Background: There is good evidence that trauma-focused therapies for Post-Traumatic Stress Disorder are effective. However, they are not always feasible to deliver due a shortage of trained therapists and demands on the patient. An online trauma-focused Guided Self-Help (GSH) programme which could overcome these barriers has shown promise in a pilot study. This study will be the first to evaluate GSH against standard face-to-face therapy to assess its suitability for use in the NHS.

Methods: The study is a large-scale multi-centre pragmatic randomised controlled non-inferiority trial, with assessors masked to treatment allocation. One hundred and ninety-two participants will be randomly allocated to receive either face-to-face trauma-focused cognitive behaviour therapy (TFCBT) or trauma-focused online guided self-help (GSH). The primary outcome will be the severity of symptoms of PTSD over the previous week as measured by the Clinician Administered PTSD Scale for DSM5 (CAPS-5) at 16 weeks post-randomisation. Secondary outcome measures include PTSD symptoms over the previous month as measured by the CAPS-5 at 52 weeks plus the Impact of Event Scale – revised (IES-R), Work and Social Adjustment Scale (WSAS), Patient Health Questionnaire-9 (PHQ-9), General Anxiety Disorder-7 (GAD-7), Alcohol Use Disorders Test (AUDIT-O), Multidimensional Scale for Perceived Social Support (MSPSS), short Post-Traumatic Cognitions Inventory (PTCI), Insomnia Severity Index (ISI) and General Self Efficacy Scale (GSES) measured at 16 and 52 weeks post-randomisation. Changes in health-related quality of life will be measured by the EQ-5D and the level of healthcare resource utilisation for health economic analysis will be determined by an amended version of the Client Socio-Demographic and Service Receipt Inventory European Version. The Client Satisfaction

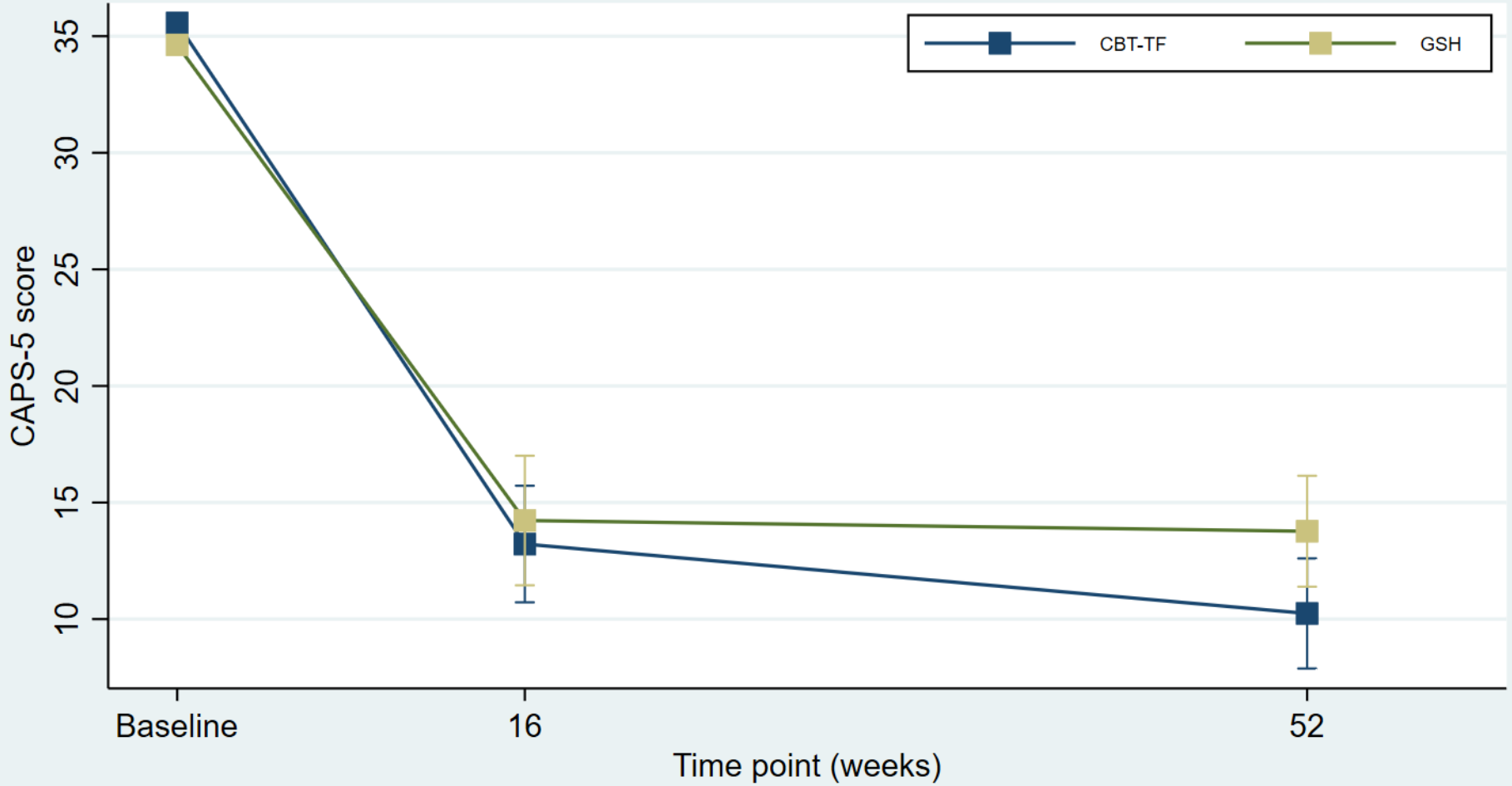
Phase III RCT

Treating people with mild to moderate PTSD (inc veterans) with Spring or TFCT (Ehlers & Clark)

Monthly clinical supervision to therapists by video across the UK

Post RCT Veterans' NHS Wales therapists trained in Spring

Adjusted Mean CAPS-5 Scores Over Time



Note: CI = confidence interval; CAPS-5 = Clinician-Administered PTSD Scale for DSM-5; GSH = Guided Self Help; CBT-TF = Cognitive Behavior Therapy - Trauma Focussed.

Means at 16 and 52 weeks adjusted for the following variables at baseline: CAPS-5 score, gender, research centre, co-morbid depression (baseline PHQ-9) and time since trauma (months).

RAPID

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Main results BMJ Jun 16 2022

Guided, internet based, cognitive behavioural therapy for post-traumatic stress disorder: pragmatic, multicentre, randomised controlled non-inferiority trial (RAPID)

Jonathan I Bisson,[1] Cono Ariti,[2] Katherine Cullen,[3] Neil Kitchiner,[1,4] Catrin Lewis,[1] Neil P Roberts,[1,4] Natalie Simon,[1] Kim Smallman,[2] Katy Addison[2] Vicky Bell,[5] Lucy Brookes-Howell,[2] Sarah Cosgrove,[1] Anke Ehlers,[6] Deborah Fitzsimmons,[3] Paula Foscarini-Craggs,[2] Shaun R S Harris,[3] Mark Kelson,[7] Karina Lovell,[5] Maureen McKenna,[8] Rachel McNamara,[2] Claire Nollett,[2] Tim Pickles,[2] Rhys Williams-Thomas[2]

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Additional material is published online only. To view please visit the journal online.

Cite this as: *BMJ* 2022;377:e069405 http://dx.doi.org/10.1136/bmj-2021-069405

Accepted: 04 May 2022

ABSTRACT

OBJECTIVE

To determine if guided internet based cognitive behavioural therapy with a trauma focus (CBT-TF) is non-inferior to individual face-to-face CBT-TF for mild to moderate post-traumatic stress disorder (PTSD) to one traumatic event.

DESIGN

Pragmatic, multicentre, randomised controlled non-inferiority trial (RAPID).

SETTING

Primary and secondary mental health settings across the UK's NHS.

PARTICIPANTS

196 adults with a primary diagnosis of mild to moderate PTSD were randomised in a 1:1 ratio to one of two interventions, with 82% retention at 16 weeks and 71% retention at 52 weeks. 19 participants and 10 therapists were purposively sampled and interviewed for evaluation of the process.

INTERVENTIONS

Up to 12 face-to-face, manual based, individual CBT-TF sessions, each lasting 60-90 minutes; or guided internet based CBT-TF with an eight step online programme, with up to three hours of contact with a therapist and four brief telephone calls or email contacts between sessions.

MAIN OUTCOME MEASURES

Primary outcome was the Clinician Administered PTSD Scale for DSM-5 (CAPS-5) at 16 weeks after randomisation (diagnosis of PTSD based on the criteria of the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, DSM-5). Secondary outcomes included severity of PTSD symptoms at 52 weeks, and functioning, symptoms of depression and anxiety, use of alcohol, and perceived social support at 16 and 52 weeks after randomisation.

RESULTS

Non-inferiority was found at the primary endpoint of 16 weeks on the CAPS-5 (mean difference 1.01, one sided 95% confidence interval −∞ to 3.90, non-inferiority P=0.012). Improvements in CAPS-5 score of more than 60% in the two groups were maintained at 52 weeks, but the non-inferiority results were inconclusive in favour of face-to-face CBT-TF at this time point (3.20, −∞ to 6.00, P=0.15). Guided internet based CBT-TF was significantly (P<0.001) cheaper than face-to-face CBT-TF and seemed to be acceptable and well tolerated by participants. The main themes of the qualitative analysis were facilitators and barriers to engagement with guided internet based CBT-TF, treatment outcomes, and considerations for its future implementation.

CONCLUSIONS

Guided internet based CBT-TF for mild to moderate PTSD to one traumatic event was non-inferior to individual face-to-face CBT-TF and should be considered a first line treatment for people with this condition.

TRIAL REGISTRATION

ISRCTN13697710.

WHAT IS ALREADY KNOWN ON THIS TOPIC

Face-to-face trauma focused psychological treatments are recommended as first line for post-traumatic stress disorder (PTSD)

Guided self-help with internet based programmes based on cognitive behavioural therapy with a trauma focus has been recommended as an alternative, but whether guided self-help is non-inferior to current first line treatments has not been established

WHAT THIS STUDY ADDS

Guided internet based cognitive behavioural therapy with a trauma focus was found to be non-inferior to and cheaper than face-to-face cognitive behavioural therapy with a trauma focus at 16 weeks

Guided internet based cognitive behavioural therapy with a trauma focus should be made available as a low intensity treatment option for people with mild to moderate PTSD to one traumatic event

Introduction

Post-traumatic stress disorder (PTSD) is a common mental health condition that can develop after experiencing traumatic events that involve threatened or actual death, serious injury, or sexual violence. Characteristic symptoms include re-experiencing, avoidance, and a current sense of threat.[1 2] About 4% of the adult population of the UK have PTSD[3] and symptoms can last for many years if not treated.[4] PTSD is strongly associated with substantial physical and mental health comorbidity,[5 6] and major economic burden.[7] People with PTSD often report marked negative effects on their functioning in occupational, home management, social, and private leisure situations. Individual face-to-face trauma focused psychological treatments, especially

Cardiff University, traumatic stress research group & VNHSW

CARDIFF UNIVERSITY

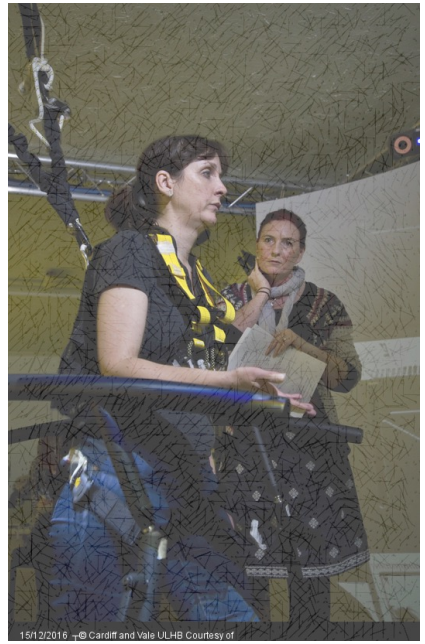
PRIFYSGOL CAERDYDD

FiMT

forces in mind trust

SUCCESSFUL SUSTAINABLE TRANSITION

3MDR



Multi-modular motion-assisted memory desensitization & reconsolidation (3MDR)

- Prof Eric Vermetten, Con Psych at Netherlands Military tests 3MDR on 2 military veterans
- Funding from FiMT to test 3MDR on 40 UK male veterans with treatment resistant PTSD x 6 sessions
- Veterans' NHS Wales therapists x 5 trained in 3MDR
- Veterans' NHS Wales assists with recruitment of participants
- Clinical supervision via team in the Netherlands

Acta Psychiatrica Scandinavica

Acta Psychiatr Scand 2020: 142: 141–151
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DOI: 10.1111/acps.13200

ACTA PSYCHIATRICA SCANDINAVICA

Randomized controlled trial of multi-modular motion-assisted memory desensitization and reconsolidation (3MDR) for male military veterans with treatment-resistant post-traumatic stress disorder

Bisson JI, van Deursen R, Hannigan B, Kitchiner N, Barawi K, Jones K, Pickles T, Skipper J, Young C, Abbott LR, van Gelderen M, Nijdam MJ, Vermetten E. Randomized controlled trial of multi-modular motion-assisted memory desensitization and reconsolidation (3MDR) for male military veterans with treatment-resistant post-traumatic stress disorder.

Objective: To explore the potential efficacy of multi-modular motion-assisted memory desensitization and reprocessing (3MDR) in British military veterans with treatment-resistant service-related PTSD.
Methods: Exploratory single-blind, randomized, parallel arm, cross-over controlled trial with nested process evaluation to assess fidelity, adherence and factors that influence outcome.
Results: A total of 42 participants (all male) were randomized with 83% retention at 12 weeks and 86% at 26 weeks. The difference in mean Clinician-Administered PTSD Scale for DSM-5 scores between the immediate and delayed 3MDR arms was −9.38 (95% CI −17.33 to −1.44, $P = 0.021$) at 12 weeks and −3.59 (−14.39 to 7.20, $P = 0.513$) at 26 weeks when both groups had received 3MDR. The likely effect size of 3MDR was found to be 0.65. Improvements were maintained at 26-week follow-up. 3MDR was found to be acceptable to most, but not all, participants. Several factors that may impact efficacy and acceptability of 3MDR were identified.
Conclusion: 3MDR is a promising new intervention for treatment-resistant PTSD with emerging evidence of effect.

J. I. Bisson[1], R. van Deursen[2], B. Hannigan[2], N. Kitchiner[3], K. Barawi[1], K. Jones[2], T. Pickles[4], J. Skipper[1], C. Young[5], L. R. Abbott[2], M. van Gelderen[6], M. J. Nijdam[7,8], E. Vermetten[6]

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EUROPEAN JOURNAL OF PSYCHO-TRAUMATOLOGY
THE OFFICIAL JOURNAL OF THE EUROPEAN SOCIETY FOR TRAUMATIC STRESS STUDIES

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CLINICAL RESEARCH ARTICLE

The psychophysiological response during post-traumatic stress disorder treatment with modular motion-assisted memory desensitisation and reconsolidation (3MDR)

Robert van Deursen[a], Kate Jones[a], Neil Kitchiner[b], Ben Hannigan[a], Kali Barawi[c] and Jonathan I. Bisson[d]

[a]School of Healthcare Sciences, Cardiff University, Cardiff, UK; [b]Veterans' NHS Wales, Cardiff and Vale University Health Board, Cardiff, UK; [c]School of Medicine, Cardiff University, Cardiff, UK; [d]Psychiatry, School of Medicine, Cardiff University, Cardiff, UK

ABSTRACT

Background: Psychophysiological changes are part of post-traumatic stress disorder (PTSD) symptomatology and can signal emotional engagement during psychological treatment.

Objectives: The aim of this study was to explore psychophysiological responses during multi-modular motion-assisted memory desensitization and reconsolidation (3MDR) therapy. Increased self-reported distress, substantially increased heart rate (HR) and breathing rate (BR) were expected at the start of therapy and predicted to improve over time. Since physical exercise demands during therapy were low, any large HR or BR responses were considered part of the psychophysiological response.

Methods: This study used pooled data collected during a randomized controlled trial of 3MDR, which demonstrated significant improvement as measured by the Clinician Administered PTSD Scale. Whilst attending therapy, HR and BR data, subjective units of distress (SUD) score and phrases to describe feelings whilst exposed to trauma-related images were collected continuously from 37 UK male military veterans with PTSD.

Results: HR and BR were significantly increased throughout all sessions ($p < .01$ for both). Whilst HR was raised slightly remaining on average below 100 beats/minute, BR was increased substantially with average values between 40 and 50 breaths/minute. SUD scores were very high during therapy which concurred with the many negative feelings experienced during therapy sessions. Across the course of the treatment, SUD scores ($p < .01$) and negative feelings were reduced ($p < .001$), and positive feelings have increased ($p < .01$) significantly, reflecting improvements in clinicians assessed PTSD symptoms. Across therapy sessions, HR ($p = .888$) and BR ($p = .466$) responses did not change.

Conclusions: The strong psychophysiological response alongside high levels of self-reported distress and negative feelings is interpreted as high emotional engagement during therapy. A novel finding was the very significant BR increase throughout recorded sessions. Future PTSD research should include BR response to therapy and explore breathing control as a treatment target.

ARTICLE HISTORY
Received 4 December 2020
Revised 21 April 2021
Accepted 22 April 2021

KEYWORDS
PTSD; psychophysiology; breathing; stress

PALABRAS CLAVES
TEPT; psicofisiología; respiración; estrés

关键词
PTSD; 心理生理; 呼吸; 应激

HIGHLIGHTS

- The psychophysiological response during post-traumatic stress disorder treatment with 3MDR in a virtual reality environment.

La respuesta psicofisiológica durante el tratamiento del trastorno de estrés postraumático con terapia modular de desensibilización y reconsolidación de la memoria asistida por movimiento (3MDR)

Future steps

- Several 3MDR RCTs ongoing in Netherlands, Canada, & US
- Plan to await data from International studies & apply for funding for multi-centre RCT in the UK

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CLINICAL RESEARCH ARTICLE

OPEN ACCESS Check for updates

Psychometric properties of the PTSD checklist for DSM-5 in a sample of trauma-exposed mental health service users

Neil P. Roberts [a,b], Neil J. Kitchiner [a,c], Catrin E. Lewis [b], Anthony J. Downes[b] and Jonathan I. Bisson [b]

[a]Psychology and Psychological Therapies Directorate, Cardiff & Vale University Health Board, Cardiff, UK; [b]Division of Psychological Medicine and Clinical Neurosciences, Cardiff University, Cardiff, UK; [c]Veterans' NHS Wales, Cardiff & Vale University Health Board, Cardiff, UK

ABSTRACT

Background: PTSD self-report measures are frequently used in mental health services but very few have been evaluated in clinical samples that include civilians. The PCL-5 was developed to assess for DSM-5 PTSD.

Objective: The aim of this study was to evaluate the psychometric properties of the PCL-5 in a sample of trauma-exposed mental health service users who were evidencing symptoms of PTSD.

Method: Reliability and validity of the PCL-5 were investigated in a sample of 273 participants who reported past diagnosis for PTSD or who had screened positively for traumatic stress symptoms. Diagnostic utility was evaluated in comparison to the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5).

Results: The PCL-5 demonstrated high internal consistency, good convergent and divergent validity, acceptable stability and good diagnostic utility. However, operating characteristics differed from those found in other samples. Scores of 43–44 provided optimal efficiency for diagnosing PTSD. A post hoc regression analysis showed that depression explained more of the variance in PCL-5 total score than the CAPS-5.

Conclusion: Whilst the PCL-5 is psychometrically sound it appears to have difficulty differentiating self-reported depression and anxiety symptoms from PTSD in trauma-exposed mental health service users and clinicians should take care to assess full symptomatology when individuals screen positively on the PCL-5. Clinicians and researchers should also take care not to assume that operating characteristics of self-report PTSD measures are valid for mental health service users, when these have been established in other populations.

ARTICLE HISTORY
Received 3 April 2020
Revised 6 November 2020
Accepted 9 November 2020

KEYWORDS
Post-traumatic stress disorder; psychometric assessment; PCL-5; psychiatric; self-report measures

PALABRAS CLAVE
Trastorno de estrés postraumático; evaluación psicométrica; PCL-5; psiquiátrico; mediciones auto reportadas

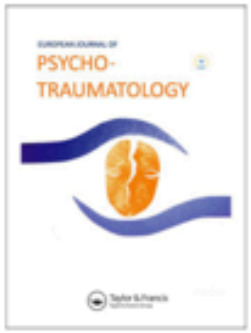
关键词
创伤后应激障碍,心理测评,PCL-5,精神病学,自我报告测量。

Rewind Technique (Muss, 1991)

- Return RCT

RETURN RCT

- Reconsolidation of traumatic memories for PTSD
- Prof Jonathan Bisson & Traumatic stress research group CU
- Unfunded RCT - 40 participants with mild to moderate PTSD (inc veterans)
- 3 sessions of the Rewind technique (David Muss, 1991)
- 40 participants randomised to Rewind or waiting list
- Completed Feb 2022
- The first RCT of Rewind technique
- Used extensively by 3rd sector charities i.e. PTSD Resolution



European Journal of Psychotraumatology

Taylor & Francis

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/zept20

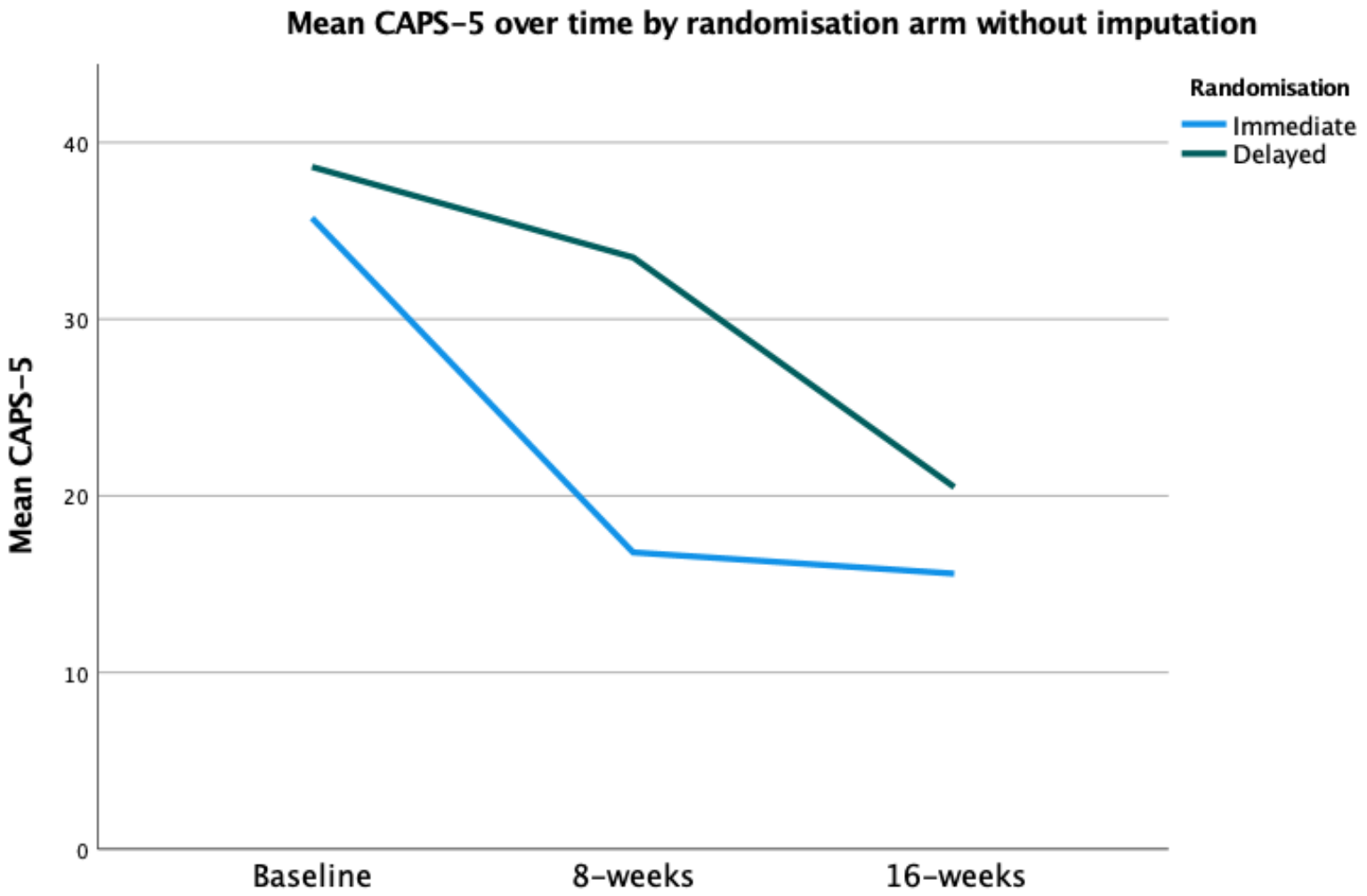
The reconsolidation using rewind study (RETURN): trial protocol

Laurence Astill Wright , Kali Barawi , Natalie Simon , Catrin Lewis , David Muss , Neil P. Roberts , Neil J Kitchiner & Jonathan I Bisson

To cite this article: Laurence Astill Wright , Kali Barawi , Natalie Simon , Catrin Lewis , David Muss , Neil P. Roberts , Neil J Kitchiner & Jonathan I Bisson (2021) The reconsolidation using rewind study (RETURN): trial protocol, European Journal of Psychotraumatology, 12:1, 1844439, DOI: 10.1080/20008198.2020.1844439

To link to this article: https://doi.org/10.1080/20008198.2020.1844439

Main results – using the CAPS-5



Prof. Simon Dymond, Swansea University

MILITARY BEHAVIORAL HEALTH
https://doi.org/10.1080/21635781.2019.1644263

Routledge
Taylor & Francis Group

Gambling Problems and Military- and Health-Related Behaviour in UK Armed Forces Veterans

Elystan Roberts[a], Glen Dighton[a], Matt Fossey[b], Lee Hogan[c], Neil Kitchiner[d], Robert D. Rogers[c], and Simon Dymond[a,e]

[a]Department of Psychology, Swansea University, Swansea, United Kingdom; [b]Veterans and Families Institute, Anglia Ruskin University, Chelmsford, United Kingdom; [c]School of Psychology, Bangor University, Bangor, United Kingdom; [d]Veterans NHS Wales, University Hospital of Wales, Cardiff, United Kingdom; [e]Department of Psychology, Reykjavík University, Reykjavík, Iceland

ABSTRACT

Internationally, problem gambling is elevated in Armed Forces veterans compared to the general population. Here, we re-examined the prevalence of problem gambling in veterans and non-veterans residing in England using an established large dataset and investigated whether gambling was associated with length of service, common mental health disorders, substance abuse, or financial management history. Using the 2007 Adult Psychiatric Morbidity Survey, 257 post-national service veterans and 514 age- and sex-matched controls were compared. Veterans had significantly higher rates of problem gambling than non-veterans. Male veterans were more likely than non-veterans to have experienced a traumatic event. The relationship between veteran status and problem gambling was not explained by differences in mental health conditions, substance abuse, or financial management. No differences were found for length of service. Further research is required with larger samples targeting problem gambling and Armed Forces experience in the United Kingdom population using contemporary diagnostic criteria.

KEYWORDS

Gambling; mental health; Armed Forces; post-national service; veteran

Gambling in UK military veterans (2021)

OPEN ACCESS

Social and economic costs of gambling problems and related harm among UK military veterans

Shaun Harris [1], R D Pockett,[1] G Dighton,[2] K Wood,[2] C Armour,[3] M Fossey,[4] L Hogan,[5] N Kitchiner,[6,7] J Larcombe,[8] R D Rogers,[5] S Dymond [2,9]

► Additional supplemental material is published online only. To view, please visit the journal online (http://dx.doi.org/10.1136/bmjmilitary-2021-001892).

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Correspondence to
Professor S Dymond, School of Psychology, Swansea University, Swansea, UK; s.o.dymond@swansea.ac.uk

ABSTRACT

Introduction Military veterans are at heightened risk of problem gambling. Little is known about the costs of problem gambling and related harm among United Kingdom (UK) Armed Forces (AF) veterans. We investigated the social and economic costs of gambling among a large sample of veterans through differences in healthcare and social service resource use compared with age-matched and gender-matched non-veterans from the UK AF Veterans' Health and Gambling Study.

Methods An online survey measured sociodemographic characteristics, gambling experience and problem severity, mental health and healthcare resource utilisation. Healthcare provider, personal social service and societal costs were estimated as total adjusted mean costs and utility, with cost-consequence analysis of a single timepoint.

Results Veterans in our sample had higher healthcare, social service and societal costs and lower utility. Veterans had greater contacts with the criminal justice system, received more social service benefits, had more lost work hours and greater accrued debt. A cost difference of £590 (95% CI −£1016 to −£163) was evident between veterans with scores indicating problem gambling and those reporting no problems. Costs varied by problem gambling status.

Conclusions Our sample of UK AF veterans has higher healthcare, social service and societal costs than non-veterans. Veterans experiencing problem gambling are more costly but have no reduction in quality of life.

Key messages

- Gambling is a growing public health issue, with military veterans at heightened risk of harm.
- Little is known about the costs of problem gambling and related harm among UK military veterans.
- We investigated the social and economic costs of gambling among a large sample of UK veterans through differences in healthcare and social service resource use.
- Veterans had higher healthcare, social service and societal costs and lower utility.
- Veterans had greater contacts with criminal justice services, received more benefits and had more lost work hours. Costs increased by gambling status.
- Overall, veterans experiencing problem gambling are more costly but experience no reduction in quality of life.

has long been adopted to calculating costs, the cost of gambling harms is estimated at AUSD$4.7 billion a year.[5]

Gambling harms and associated social-economic costs disproportionately impact vulnerable populations. Military veterans are at heightened risk of problematic gambling, with rates of lifetime problem gambling considerably higher than the

Main findings (2022)

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Gambling problems among United Kingdom armed forces veterans: Associations with gambling motivation and posttraumatic stress disorder

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ABSTRACT

Military service, mental health, and gambling activities and motivations as predictors of problem gambling in a sample of UK AF veterans. Age-and-gender matched veterans (n = 1,037) and non-veterans (n = 1,148) completed an online survey of problem gambling, gambling motivation, mental health (depression and anxiety), and posttraumatic stress disorder (PTSD). Past year problem gambling rates were higher in veterans compared to non-veterans. Veteran status predicted increased problem gambling risk. The relationship between problem gambling and gambling to cope with distress was significantly stronger among veterans. Veterans experiencing PTSD and complex PTSD (C-PTSD) were at increased risk of problem gambling. Overall, the present, findings contribute further international evidence that veterans are a population vulnerable to problem gambling. Veterans with PTSD or C-PTSD are most at-risk and may engage in problematic gambling to escape/avoid distress. Routine screening for gambling problems should be undertaken with current and former military personnel, and further research is needed on the interplay between gambling motivation and veterans' mental health.

ARTICLE HISTORY

Received 12 November 2021

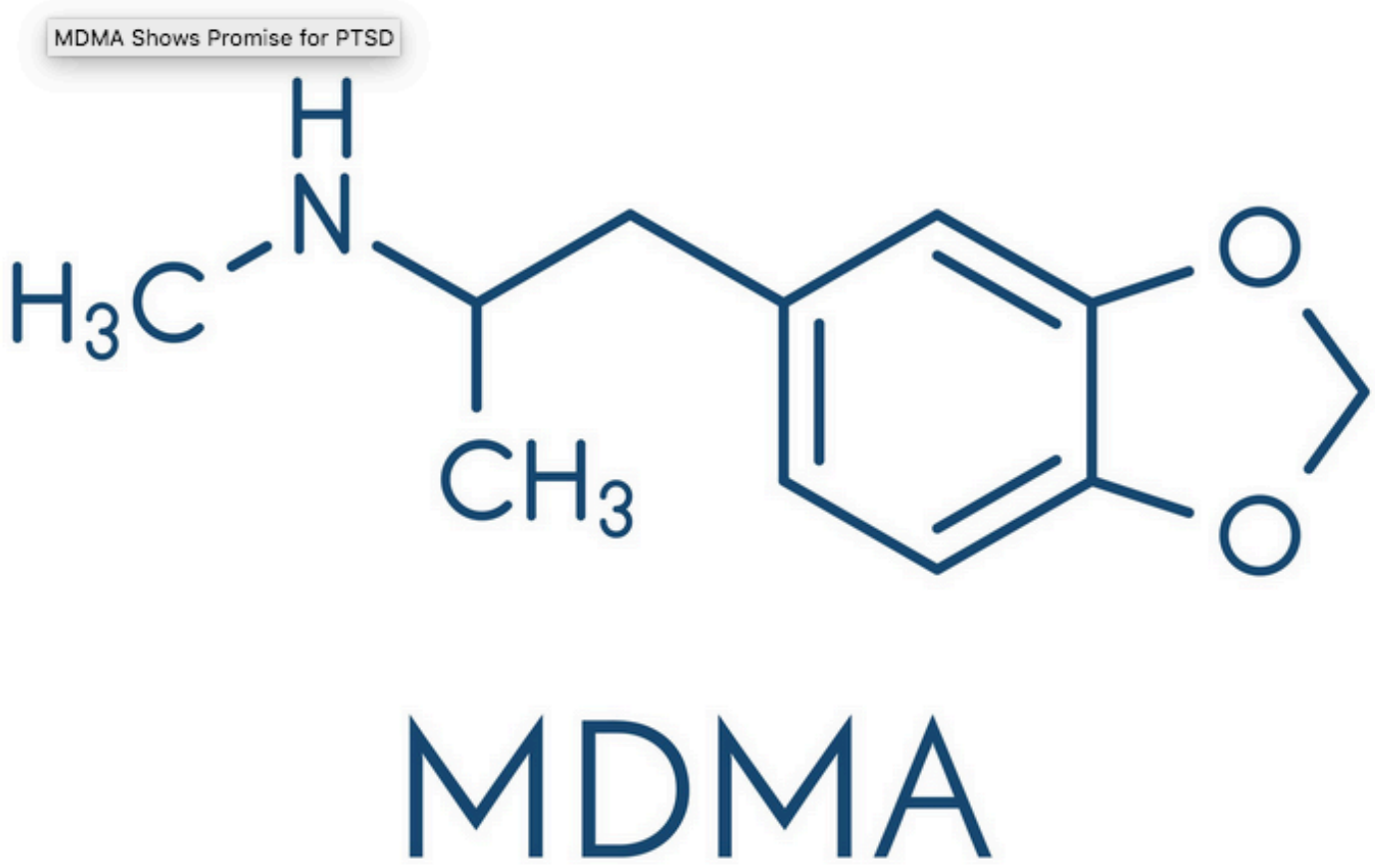
Veterans' family study – UK wide study funded by FiMT & Lottery

Prof Armour, Queen's University Belfast & Professor Fear, King's College London

Aims: to understand how social and psychological factors determine wellbeing and mental health of veteran families in the UK

- 10 spouses/significant others & 10 adult children of a veteran from each country in UK – semi structured interview
- Online survey

Assisted Psychotherapy with MDMA

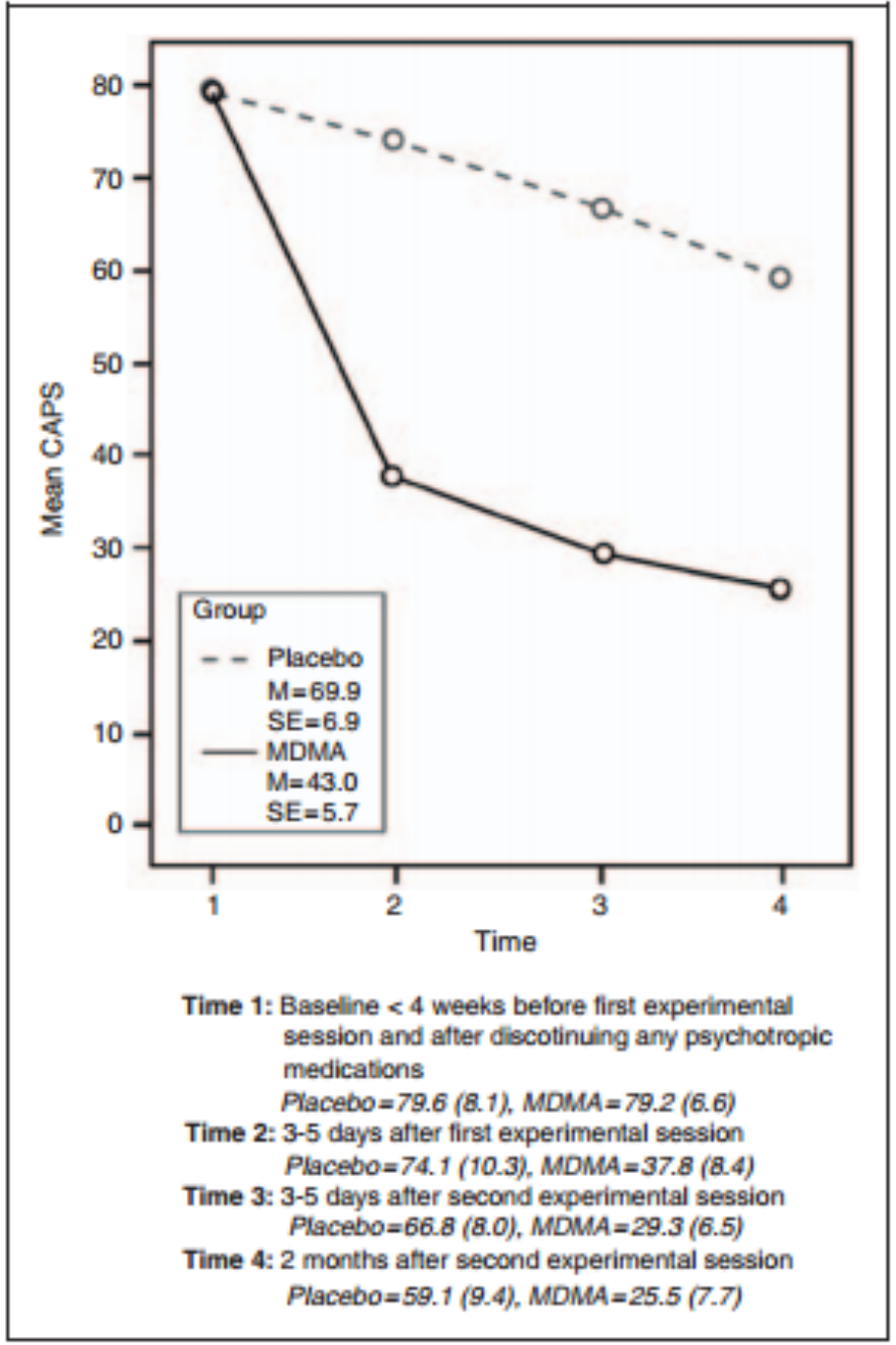


MDMA-assisted therapy: *are we there yet? Almost!*

Dr Mathew Hoskins MBBCh MSc MRCPsych

Consultant Psychiatrist, Clinical Teaching Fellow

Mithoefer et al 2010



Time 1: Baseline < 4 weeks before first experimental session and after discotinuing any psychotropic medications
Placebo=79.6 (8.1), MDMA=79.2 (6.6)
Time 2: 3-5 days after first experimental session
Placebo=74.1 (10.3), MDMA=37.8 (8.4)
Time 3: 3-5 days after second experimental session
Placebo=66.8 (8.0), MDMA=29.3 (6.5)
Time 4: 2 months after second experimental session
Placebo=59.1 (9.4), MDMA=25.5 (7.7)

Figure 3. CAPS Mean Scores by Group for Time 1-Time 4.

- Chronic, treatment resistant PTSD
- 16 weeks therapy
- 3 x 8hr drug-assisted sessions vs placebo
- Lying down, music, attention focussed inwards
- Male/female therapy team
- No serious adverse events

MP18

- Multicentre, Phase II open label lead in
- Sponsored by MAPS
  - UK, Netherlands, Prague
- N=40 across EU
- N=4 in Cardiff
  - Severe PTSD
  - fMRI scan pre-post

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CLINICAL RESEARCH ARTICLE

OPEN ACCESS Check for updates

Active duty and ex-serving military personnel with post-traumatic stress disorder treated with psychological therapies: systematic review and meta-analysis

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ABSTRACT

Background: Post-traumatic stress disorder (PTSD) is a major cause of morbidity amongst active duty and ex-serving military personnel. In recent years increasing efforts have been made to develop more effective treatments.

Objective: To determine which psychological therapies are efficacious in treating active duty and ex-serving military personnel with post-traumatic stress disorder (PTSD).

Method: A systematic review was undertaken according to Cochrane Collaboration Guidelines. The primary outcome measure was reduction in PTSD symptoms and the secondary outcome dropout.

Results: Twenty-four studies with 2386 participants were included. Evidence demonstrated that CBT with a trauma focus (CBT-TF) was associated with the largest evidence of effect when compared to waitlist/usual care in reducing PTSD symptoms post treatment (10 studies; n = 524; SMD −1.22, −1.78 to −0.66). Group CBT-TF was less effective when compared to individual CBT-TF at reducing PTSD symptoms post treatment (1 study; n = 268; SMD −0.35, −0.11 to −0.59). Eye Movement Desensitization and Reprocessing (EMDR) therapy was not effective when compared to waitlist/usual care at reducing PTSD

ARTICLE HISTORY
Received 25 May 2019
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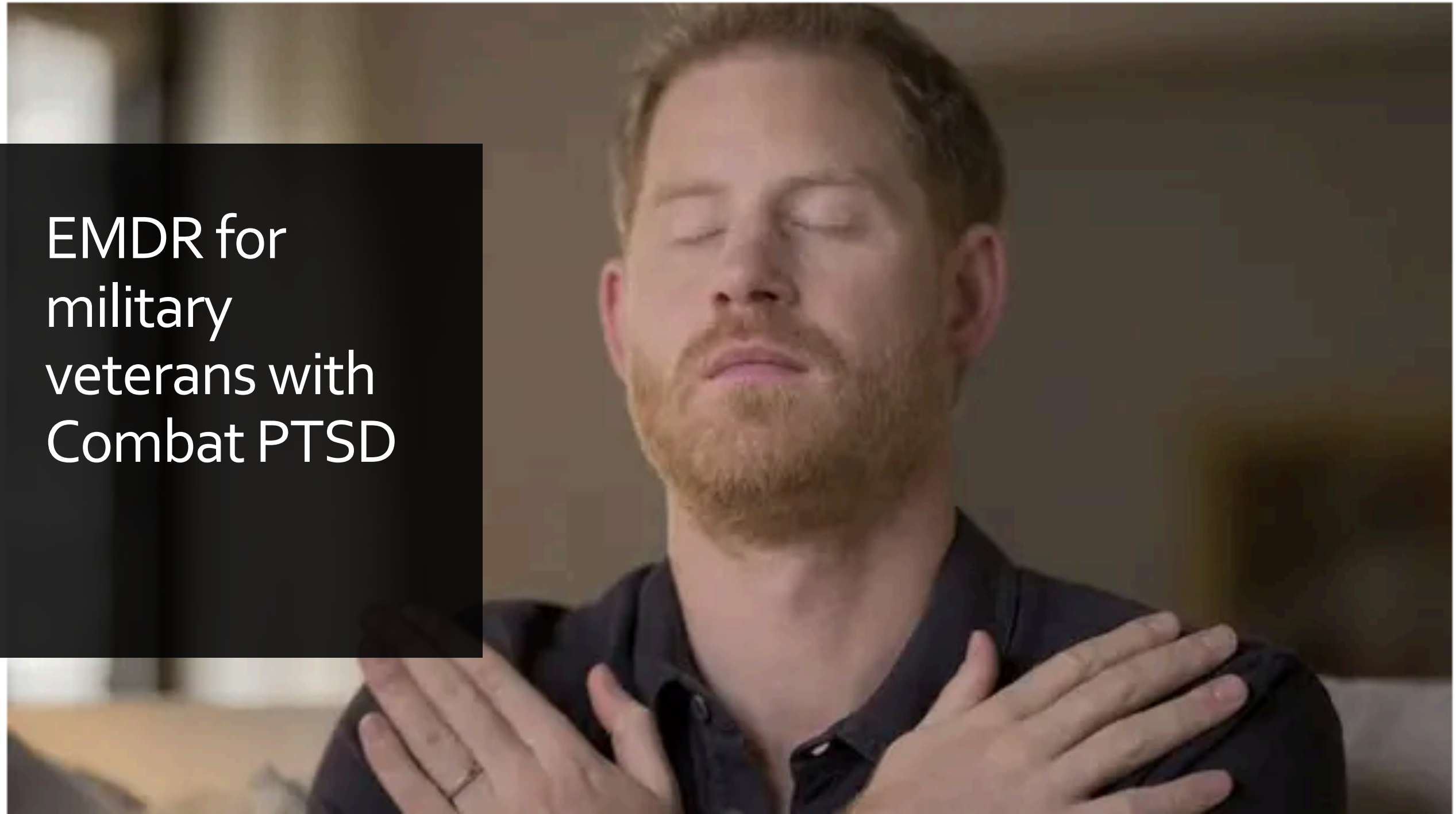
KEYWORDS
Military personnel; post-traumatic stress disorder; psychological therapies; systematic review and meta-analysis

PALABRAS CLAVE
personal militar; Trastorno de estrés postraumático; Terapias psicológicas; Revisión sistemática y metaanálisis

EMDR for military veterans with Combat PTSD



EMDR RCT

Aim: Is EMDR efficacious for UK military veterans with Combat PTSD? (NICE advise it should not be used for combat PTSD)!

- 60 UK veterans to be recruited from VNHSW WL from July 2022
- Randomised to 3 arms (in-person, online or waiting list)
- 12-16 EMDR therapy sessions
- Delivered by VNHSW therapists
- Supported by Tech Cymru and Cardiff University TSRG

Conclusions

- Only ***1-2%*** of MH pts are enrolled into research trials!
- Find your local Prof. Jonathan Bisson, academic research department & discuss collaboration ideas
- Encourage a research mindset in staff (Band 7 & above contracts)
- Invest in staff CPD (MSc/PhD) – promote a research culture
- Recruit veterans for local & national trials
- Staff interested in MH research should negotiate one/two sessions per week for research activities
- UK VMS in collaboration with academic university departments and funders can increase the evidence base in VMH and their families