Written evidence submitted by Walking With The Wounded

Introduction

Established in 2010, Walking With The Wounded (‘WWTW’) supports ex-servicemen and women who have struggled with their transition from the military to re-integrate back into society and sustain their independence.

The charity focusses on employability, mental health and early intervention services to ensure social inclusion and independence to those who have served. This includes supporting those who are homeless, in police custody, unemployed or suffering with mental health difficulties. Walking With The Wounded’s programmes all work in harmony to address persistent social problems and make lasting improvements lives to the men and women we support; breaking the cycle of poor outcomes by focusing on the causes of the problem rather than its symptoms.

This submission is written by three WWTW representatives: CEO Edward Parker, Klara Mack Head Start Programme Manager and Rodney Eldridge Clinical Lead, a former serving MoD Nurse Consultant (mental health) who welcome this opportunity assist with the inquiry.

Executive summary

The armed forces mental health arena is a complex one. Much has improved in the UKAF and veteran mental health provision along with recognition of the affected others. We must acknowledge that in the course of their duties it is inevitable that some personnel with be affected both physically and psychologically and in the case of mental ill health the origins are not always directly related to service. We need to promote the positive aspects of service and the protective, life enhancing experience it offers leading to positive personal growth. Whilst we accept a minority will be affected, we must endeavour to change the culture across the defence community to promote help seeking at an earlier stage and make services equal, accessible and responsive. The PTSD diagnostic label needs to be more carefully used and understood as this is a source of distortion of the true picture relating to mental ill health in the UK’s armed forces. The excessive drinking culture is well known but efforts should be made to educate and moderate excessive alcohol consumption whilst in service. The holistic model can be used in meeting the wider social, economic needs of the UKAF and veterans will have positive effect on their mental health. WWTW supports beneficiaries who find themselves caught up in the criminal justice system, encounter homelessness, experiencing mental health problems or struggle to find suitable and sustainable employment. It is this hard to reach group of veterans that WWTW seeks to support, as their complex issues can be difficult for some statutory services to understand or support. We believe partnership working with a truly collaborative approach from assured providers is vital in supporting those who deserve the best we can offer.

Qn 1. To what extent do current statistics accurately reflect the level of mental health issues in serving armed forces personnel and veterans, including PTSD?

Generally accepted as inaccurate due to variable data capture issues. Different diagnostic criteria are used DSM-5 or ICD-11 for PTSD. A distorted and negative perception surrounding UK Armed Forces (UKAF) and mental health exists based on the assumption
service is synonymous with suffering PTSD or psychological injury. There is a need to focus on protective factors of military service and where PTSD exists there is in fact potential for post-traumatic growth.

This perpetuates a myth that a tidal wave or tsunami of PTSD is on the horizon. We know CMD and Alcohol are more prevalent but the ubiquitous term PTSD has over shadowed other presentations, possibly leading to veterans feeling you have to have operationally related PTSD to be deserving of help. We must identify the myths and reveal the positive aspects of service, which outweigh the inevitable effects of service, which as we know form a small but significant minority.

Self-diagnosis (should be a Cons psych or clinical specialist) is rife as this label has a degree of kudos when seeking support for the numerous agencies involved in UKAF and veteran population. This underpins the earlier point regarding the ignorance and lack of mental health literacy not only amongst those affected but by the well-meaning agencies involved. There is the issue of the PTSD label being more acceptable to men, a badge of honour over other diagnosis like depression or anxiety for which a perception of weakness manifests.

Some veterans will live overseas permanently or for periods which will affect gaining accurate figures. I.e. foreign and commonwealth.

The use of defence statics, war pension armed forces compensation scheme statistics, RBL household survey and GP registrations statistical sources cannot accurately reveal the extent of mental ill health including PTSD in the UKAF and veterans.

Transparency and rigour is required in the methodology used in clinical statistical analysis/outcomes to ensure reliability.

Standardised, reliable and valid commonly used clinical measures for all clinicians working with veterans. An agreed minimum data set should be universally used by all agencies. Any findings need to be verified and scrutinised by an independent body before being released to stop misrepresentations.

Qn2. What are the challenges to accurately assessing the extent of mental health issues in serving armed forces personnel and veterans and how could government improve its understanding of those issues?

The electronic transfer of MoD health records to NHS systems on discharge from the services ensures registration and acknowledgement of veteran status should increase visibility of the veteran population. There is currently an MoD/DoH initiative addressing this called project Cortisone.

The Government has a role here to promote the need for people to be open and have a conversation around mental health early on as this is a taboo subject leaving people to seek help too late and suffering unnecessarily.

All GP practices at point of registration should ask the question “have you ever served in the UK UKAF.” If GP’s read code number of veterans on their e-health record systems, then Joint Strategic Needs Analysis would more accurately inform CCG’s about their local population at risk and would help in the procurement of bespoke services for UKAF and veteran population.
Barriers to early or timely help seeking be they self (stigma, shame) or organisationally
(access and effects on career) induced are an issue in what is arguably a hyper-masculine
setting believing most people try to cope, struggle on as there is culture of self-reliance or
sufficiency in the UKAF which carries on after leaving the services.

The MoD in-service provision is inflexible seeing the MO/CMP or Defence Mental Health
Services being 9-5, Mon to Fri, a more accessible (evening and weekends) and responsive
(self-referral or drop in) should be available including use of digital services offering remote
access and providing options and choice in how and when you receive support. This could be
anonymous and one that mitigates the barrack room perceptions of being weak, being
downgraded affecting their career prospects, being judged negatively by comrades or
believing they will be medically discharged on mental health grounds. Those who do present
often do so in crisis, having struggled or contemplated seeking help and for some time. This
situation can result in affecting those close to them particularly partners and family. It is only
when things have reached a crisis point, usually following an ultimatum from a partner,
employer or judge that help is sought which is not in therapeutic terms always the best time
to work on underlying issues as reparation or stabilisation is needed in the first instance.

All agencies must agree to work to agreed principles as in the Contact Guiding Principles;
this will foster true collaboration and assure the support pathway. All agencies must offer
something different therefore avoiding duplication and confusion across the landscape of
provision; this will offer choice and promote a front door to services. If all agencies used a
common, agreed and shared assessment this would improve communication and avoid users
complaining about being asked the same questions repeatedly.

Those who have a negative experience on their first contact with mental health services may
go to ground or give up. One often-mooted point is lack of cultural understanding or
sensitivity of those who are making assessments, providing treatment or support, leading to
disengagement and an unsatisfactory experience.

Some healthcare and support staff feel unable to help UKAF and veterans, as this is a
“specialist subject” beyond their experience, knowledge and scope of competence. There is a
need to up skill the health and social care workforce to feel competent in providing services
for UKAF and veterans and this should feature in curriculums, for all levels of staff where a
nationally recognised training award is given. GPs, psychiatrists, psychology, mental health
nursing, social work etc. A standalone nationally recognised course should be developed and
delivered at various taxonomies dependant on depth of training required for all others e.g.
charity sector. It is inevitable people will be changed as a result of service, some will be for
the good others for the detriment of their health and wellbeing. This is the cost of putting
our armed forces in harm’s way to execute the Government’s foreign and defence policies.

The Government should ask the users and more importantly the non-users of services for
their opinions, they should have a voice and influence the development and production of
services ensuring they accurately meet their needs and those affected others such as family.

An innovative through life approach to record an individual’s details or status is required to
optimise data capture, from service to the grave; this may require a bespoke IT programme
with periodic incentives for users to comply.

It is evident that some veterans have a high sense of entitlement because of their service,
which can lead to frustrations on their part if not getting the service they feel they deserve.
This has the potential to result in disengagement with services, especially if not culturally sensitive. For others, a sense of resentment or anger exists towards the services believing this is the cause of their issues, both of the aforementioned are challenges to the accurate visibility of UKAF and veterans.

Qn 3. How does the level of mental health issues, services and outcomes in serving armed forces personnel and veterans?

Compare both to the actual level in the general population and to public perceptions of mental health issues in armed forces personnel and veterans?

The majority of veteran help seekers will experience common mental health disorders that are amenable to standard NHS wellbeing treatment and therefore in the interests of aiding adjustment and not dependence from the services this approach should be maintained. Where service attribution can be determined then a specialist and culturally sensitive service seems appropriate, this need to properly resourced and funded.

Comparisons between the Adult Psychiatric Morbidity Survey – General Population and King’s College Military Mental Health Research cohort study would help.

The Public’s perception reveals a belief that the majority UKAF or veterans are likely to be or have been psychologically injured because of their service, this needs to be challenged for a balanced and true reflection of service.

Common Mental Disorders are higher in UKAF but PTSD lower less specific groups i.e. infantry and reserves.

Do veterans need a bespoke service, as many do not identify themselves as being a veteran when using mainstream NHS services and successfully complete treatment?

The issue of clinical competence over having military understanding is an often-debated point. Does the clinician with an understanding of military culture only serve to keep people in the military mindset perpetuating their dependence and over identification or is this really key to engagement with this hard to reach group. The latter has both the potential to foster dependence and or hinder transition?

Vary between different groups of serving and former personnel, including reservists, those who have been deployed on operations and early leavers?

Serving: less likely to report sick for mental health reasons and as result can present in crisis, barriers such as stigma and restricted access to mental health services. Prompt access to services if urgent in working hours or next day. Recruitment from regions with historical Lower Social Economic status e.g. NE, NW often join with pre-service vulnerabilities poor educational attainment, attachments/bonds and childhood adversity which are likely to manifest in emotional dysregulation, disaffection resulting in early discharge from the services or mental health difficulties. The Mental health questions at discharge from the services are perfunctory and few wish to have anything on record as this may jeopardise future employment opportunities.

Early Service Leavers struggle in transition and experience higher rate of CMD. Some UKAF personnel who do not deploy can often feel unfulfilled or not part of the unit’s recent history and feel disconnected, resulting in difficulties.
Reserves: More likely to suffer PTSD, they return to Civvy Street away from protective factors the unit in which they served and may not understand services available to them i.e. Reserves & Veteran Mental Health Programme etc.

Veterans: The Dr Murrison fighting Fit recommendations: six months follow up for those discharged on mental health grounds and one-year social worker support via a MoD DCMH. Access to R&VMHP, NHSE Veteran Mental Health, Transition Intervention Liaison service (TIL) and Complex Treatment Service (CTS) and devolved provision. There are many other agencies and charities, which can create a complicated system for the users or potential users to navigate especially when unwell. The RBL Veteran gateway and the Contact group helps streamline available services but the effectiveness or impact of such initiatives have yet known.

Families to be considered here, as treating or supporting the individual UKAF person or veteran in isolation can alienate their main source of support who are a powerful protective factor in aiding their resilience, recovery and mental wellbeing, but also may have needs themselves.

**Vary regionally across the UK and across the devolved administrations?**

The new NHSE VMH TILs and CTS services should mitigate the postcode lottery and it will be useful to know how well they are meeting the needs of veterans. There are gaps in services, veterans are often considered as too risky or complex due to the PTSD label so NHS IAPT for wellbeing services and do not accept them, if you approach the NHS secondary mental health services, they are considered not unwell enough, as they are not suffering from serious or enduring mental health conditions. Wales (Veterans Wales) and Scotland (Veterans First Point) have devolved arrangements using a different model of treatment and care funded by the devolved administrations. Northern Ireland has a limited service of after care for Home service or Irish Regiments.

Qn 4. **What proportion of mental health issues in veterans is attributable to service in the Armed Forces and how well is this measured and understood?**

This is not well or easily measured, due to issues pre, during, peri (when not on duty) and after service. Would you treat any differently irrespective of causation? Transition is tough for all, but if you leave suddenly on medical, administrative or disciplinary grounds with little preparation then this all the more difficult. Failure to successfully transition can lead to increased mental health difficulties. For some their service will define them and become an important part of their identity, often highly regarded strict rules in service carry on long after leaving, often-causing frictions with those around them. Hence, some feel they do not fit in or can’t seem to replicate the camaraderie, banter they enjoyed in service. Recognition that service isn’t always the direct cause of problems but can aggravate underlying conditions.

Qn 5. **To what extent does the military environment for serving armed forces personnel mitigate against the development of mental health issues?**

For some the sense of identity, belonging, purpose, bonds, camaraderie will be something they have not experienced before, this coupled with having a roof over your head, good food wage (pension) opportunities to travel, fitness and better yourself are all mitigating factors. You have chance to prove yourself, do your bit, take pride in yourself, unit and service resulting in increased self-esteem, confidence and personal growth the structure, discipline
learning to working in teams suborning your own needs for others or the collective is positive
growth personality changing, remembering that most join the services when their personality
is still malleable. This can work both ways as a small minority who cannot adjust to the
rigours of service and adjust to this environment quickly realise they have made the wrong
decision in joining the UKAF. This is worthy of a study.

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