Written evidence submitted by Veterans First Point Scotland

Executive Summary

• This submission will concentrate on Veterans First Point (V1P) a specialist service provider to the Veteran Community in Scotland. Its geographical focus will therefore be the Scottish community, it will address the needs of veterans rather than serving personnel and concentrate on those that have been able to access assistance and are already known to services.
• Little is known about the true extent and nature of mental health problems in the veteran community because it is believed only a small proportion seeks help.
• This report focuses on what we know about help-seeking veterans in Scotland and provides recommendations from our learning to date in relation to overcoming barriers to help seeking.

1. Background to Organisation:

Veterans First Point Scotland is a network of six regional teams across Scotland providing a health and well-being service for Veterans and their families. There are currently services in Ayrshire and Arran, Borders, Fife, Lanarkshire, Lothian and Tayside. V1P Lothian was established in 2009 as the first “one stop shop” of its kind and set out a model for replication. The expansion of this network was funded by The Armed Forces Covenant grant scheme. Since 2017 the six Centres receive 50% matched funding from the Scottish Government with the respective local Health and Social Care Partnerships contributing the other half. A national network is co-ordinated by V1P Scotland (Hosted by NHS Lothian and funded by Scottish Government).

The service provides support and services in four main areas:

• Co-ordination of care and welfare support
• Comradeship, reducing isolation and increasing social inclusion
• In-house evidence based psychological and pharmacological treatment
• Supported onward referral

The service is underpinned by an ethos of accessibility, credibility and co-ordination. The employment of Veteran Peer Support workers (VPSW) is key to achieving this ethos.
2. **Scope of Evidence Submitted**

V1P is a specialist service provider to the Veteran Community in Scotland. Our focus will be on those that attend V1P and our data on this cohort.

V1P data is gathered from Clinical leads of the V1P Services around Scotland and initial data from an evaluation commissioned from Queen Margret University. The data is not yet published but would likely be available to the Committee later this year (Prior, 2017, Pers. Comm)

3. **To what extent do current statistics accurately reflect the level of mental health issues in veterans, including PTSD?**

**Statistics**: Empirical studies suggest that veterans of the Iraq and Afghanistan conflicts are up to five times more likely to experience common mental illness, alcohol misuse disorders and increased rates of PTSD in combatants and reservists than ex-service personnel from other conflicts, demonstrating the increasing prevalence of mental health issues in the armed forces (Fear, 2010).

**Barriers to understanding the extent of the issues**: Across military, veteran and civilian populations there is ongoing stigma and reluctance to declare difficulties. Evidence shows that military personnel and males are significantly less likely to declare having a mental health problem due to concerns around being viewed as weak by their peers and treated differently by their next in command. Whilst this continues, it will be extremely difficult to gather accurate data on those that don’t approach services for help.

The Scottish Mental Health Strategy (2017-2027) outlines that even in the general population there is a need for increased parity of esteem between mental and physical conditions. In Scotland currently it is estimated that only 1 in 3 people who would benefit from treatment for a mental illness currently receive it.

**Those that do approach services**: Since opening our doors V1P Lothian has received over 1,500 new referrals. Referral rate in Lothian alone is approximately 50 new referrals a quarter. The other services are newer in establishment but are following a similar pattern. Approximately half of all new referrals are self referrals which we believe is testament to the credibility of the service. The service provision at V1P is designed for
veterans “whatever their needs may be.” This means that people may be referred for social and welfare concerns either in isolation or in conjunction with mental or physical health concerns. The majority, 70-90%, across different regions, will have difficulties in all areas and these issues are often interconnected.

The service treats all diagnoses and presentations. The most common diagnosis is depressive illness (35%), followed closely by PTSD (30%).

Veterans are asked about their self-identified difficulties when they first attend V1P. The service was designed in a manner that would help overcome the stigma previously mentioned. The model allows people to attend for a range of issues and to develop a relationship with a VPSW. When it is appropriate and they are ready to engage they are then referred internally for mental health support in the team. Comparing figures between 2009 and 2017 there has been a significant shift in that most individuals now readily declare mental health difficulties at registration. This may indicate a gradual shift from the traditional stigma of mental health support. It is now more likely than not, that veterans will report a difficulty in the following areas; low mood, sleep difficulties, distressing or recurring memories and anxiety and/or panic.

4. **What are the challenges to accurately assessing the extent of mental health issues in veterans and how could government improve its understanding of those issues?**

**Challenges:** Designing services that engage Veterans in the first instance is the most significant challenge to assessing the extent of mental health issues in any population. This is a particular challenge in the veteran community as most are males whom are less likely to approach services for help. A survey commissioned by the Mental Health Foundation (2016) found that men far less likely than women to seek professional support.

The majority of veterans at V1P are SIMD 1 (the most deprived) who are usually less likely to access services. Within serving personnel it is estimated that approximately 60% do not access help for current mental health issues they are experiencing (Fear, *et al.* 2010). This is largely interpreted as being related to stigma and negative beliefs about those with mental health problems. This cultural thinking naturally will continue and remains a barrier post discharge. Whilst post discharge some barriers are maintained, they often change in their nature. Whilst an individual may no longer be concerned about the impact of a mental health diagnosis on their career, they often have new concerns around the ability of a civilian service to understand.
In a recent study the role of VPSW was found to be key to enhance veteran engagement. Veterans valued the VPSW’s military connection, the social and well-being support and the role of providing veterans with a consistent support figure (Weir, et al. 2017) Yet this role or equivalent is not a common feature in most mainstream services.

Another significant problem is knowing whether those that engage in mental health service are veterans. Mental health teams do not routinely enquire about military experience. As standard, GPs in Scotland now ask the question on their registration forms about “whether you have served in the armed forces?” Unfortunately, this information is not collated and many GPs do not know what to do with that information. It would be beneficial to provide a short crib sheet on their system to give options for onward referral and analyse that information. This is something that has been established for spousal assault and abuse victims with positive results.

Consideration should be given to who provides diagnosis. Veterans often approach our services in the belief that they have been provided with a formal diagnosis. There is a lack of understanding of who is appropriately trained to provide diagnosis. For the purpose of war pensions applications any diagnosis must be given by a consultant Psychiatrist or Consultant Clinical Psychologist. During their initial registration approximately half the veterans at V1P, self report a prior mental health diagnosis. Of these, 20% report a previous diagnosis of PTSD and 47% report depressive diagnoses. These diagnoses are usually given by their General practitioners (40%). In a recent telephone enquiry to the Royal College of General Practitioners they were unclear and had no policy relating to whether GPs could provide formal mental health diagnoses without specialist onward referral. There is a need for more clarity in this area.

Of the veterans registered at V1P, 15% regard their living situation as unstable or no fixed abode and 2% are roofless homeless (compared to 0.6% national average). This makes it difficult for them to register with GPs and therefore have poorer access to health care. If they do not approach the services then they will not be included in current statistics. Promoting a range of referral routes including self-referral, opportunities for unscheduled open access appointments and peer support and befriending can help with engagement.
Consideration should also be given to the financial implications of diagnosis for this client group. At least one third of veterans with mental health problems will return to full health following appropriate treatment and yet war pensions compensation specifies a need to evidence enduring disablement. There are therefore fears for some individuals regarding the financial implications of their recovery which has challenges for the treating clinician.

**Developing an improved understanding** of the extent of mental health issues UK government may wish to consider:

- action based research to compliment epidemiological studies
- support the development of services that offer a range of referral routes:
  - self-referral
  - unscheduled open access appointments
- Veteran peer support and befriending to assist with engagement in this sector.
- co-ordinate and collate information held by GPs on veterans registered in their practice and perform an analysis of the pathways of care.
- develop a crib sheet/ on screen pop up to GPs which offers guidance on support available to veterans.

5. **How does the level of mental health issues, services and outcomes in veterans:**

   a. **compare both to the actual level in the general population and to public perceptions of mental health issues in veterans?**

**Mental Health Issues:** epidemiological studies at Kings College London suggests that military personnel are twice more likely to suffer from a common mental disorder (Goodwin, Wessley, Hotopf *et al.*, 2010). Public perception is that mental ill health was highest in serving personnel (59%) than former members of the armed forces (51%) when compared to civilian counterparts. Former members are thought to be most likely to have suicidal tendencies (57%) followed closely by serving military personnel (46%) when compared to civilians (Gribble *et al.* 2014).

**Services:** “At least 70% of the British public supported access to priority health services for ex-Service personnel with physical or mental health injuries, evidence of public support for care beyond the “equal outcomes” policy of the Armed Forces Covenant.” Veterans in Scotland have access to over five hundred support agencies to support their welfare needs and for some, the social and welfare support they receive far exceeds that of civilian counterparts.
In terms of physical health the community covenant pledge appears to be working well and in exceptional cases where it has not been adhered to this is generally responded to promptly within the community. The area in which there is not such parity is mental health services. In 2014 we conducted focus groups in eight health board area and themes highlighted veterans did not feel understood by mainstream services, found the systems difficult to navigate and services were not co-ordinated well. These themes were consistent with the original rationale for establishing the VIP model in Lothian:

- An open door drop-in policy and self referral, addresses accessibility issues.
- Employment of veteran peer support workers whom are integrated into the team addresses the credibility issue
- Offering clinic space to a range of partners under one roof offers co-ordination.

In terms of comparison between veterans services and civilian services: Key components of the VIP model (open access; employment of peer workers and partners sharing premises) are now being introduced in some mainstream services with good results and is seen as good practice in line with the current mental health strategy. For example, the Rivers Trauma service in Edinburgh now offers drop in, on site Citizen Advice Bureau services and peer support workers. Veteran mental health is still an emerging field in its infancy and yet good practice is now being replicated in other established specialisms.

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

Empirical evidence suggests those with multiple or extended deployments to combat zones, increases the risk of exposure and therefore increases risk of developing a mental health problem (Buckman et al, 2010). The reservist group are believed to be more at risk because they don’t necessarily have the same support from their unit on return (Harvey et al. 2011).

The vast majority of our veterans have served in the regulars (96%) but this is probably due to reservists established connection to civilian organisations and most importantly they will have a civilian GP. Whilst they qualify for veteran services when non-deployed, most reservists will perceive themselves as a serving soldier/civilian rather than a veteran. The correlation between referral route and type of service supports this view - the majority of regulars are self referred into the services whereas the majority of reserves are referred by a
GP. This may also be a reflection of less stigma and barriers for a reservist disclosing mental health problems to a civilian GP compared to disclosing this within his unit.

Contrary to epidemiology evidence, Veterans approaching help at our services report more significant emotional concerns if they served in both the regular and reserve forces. Those with the least emotional difficulties are the reserve forces (Prior, 2017, Pers. Comm.). This may be the result of the social support network surrounding the reserve soldier. A reduced stigma for this cohort may also mean that they are more likely to seek help before their problems escalate.

The majority of our veterans are male (95%) and served in the army (85%) and reached the rank of private (54%) as is reflective of the wider military population in Scotland. The vast majority of our veterans served between five and twelve years (61%) and therefore do not meet the criteria for early service leaver. The majority were medically discharged (23%) or elected discharge (22%). The mean number of deployments is four (Prior, 2017, Pers. Comm.). All military details are confirmed with the veterans’ military documentation.

c. Vary regionally across the UK and across the devolved administrations?

All V1P services in Scotland are helping veterans with significant biopsychosocial needs. Evaluation indicates that 38% of veterans have been homeless at some point in their lives and most have not been educated past secondary school.

We have also seen some variation in the level of deprivation and social demographics across Scotland. The Scottish Index of Multiple Deprivation (SIMD) consistently identifies small area concentrations of multiple deprivation across all of Scotland. It allows effective targeting of policies and funding where the aim is to wholly or partly tackle or take account of area concentrations of multiple deprivation.’ (Scottish Government).

Breakdown of referrals in terms of the SIMD over the last 12 months shows that V1P continues to provide a service to those parts of the population with the greatest need, with majority of veterans in SIMD 1 (most deprived). Whilst all referrals are from the most deprived areas, there are however slight regional differences between SIMD 1-3 (Prior, 2017, Pers. Comm.). This means that there are also slight differences in the biopsychosocial needs of the veterans we see in these areas.
Prior to the establishment of additional VIP services the Lothian team were accepting 30% of referrals from out of area or clients from no fixed abode. We now have six services and approximately 15% of referrals to each of our VIP services continue to be from out of area, suggesting that there is an importance placed on accessing specialist veteran services.

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

Mental health diagnoses rarely have a single direct causation, but approximately half of the veterans currently on psychological therapies referral list at VIP have clearly identified service related trigger. The majority of Veterans referred have multiple diagnoses and have had a number of predisposing factors that have contributed to their current difficulties. Evidence from the Lothian team indicates Childhood abuse is in the low to moderate level. Even for those veterans that report early childhood trauma it should be remembered that they were suitably well to be selected for the military and pass the basic medical. Very few individuals report mental health difficulties to us that commenced prior to service. Military service for these more vulnerable individuals may therefore have served more to exacerbate their difficulties making them less likely to cope with any secondary military related trauma.

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

Individuals from neglectful and abusive early backgrounds may benefit from the structure, routine and comradeship of the military. This environment is unlikely to mitigate against mental health difficulties developing, but may contain their difficulties during their service. What military service does achieve is to improve the individuals financial, social and employment prospects taking them away (at least during service) from a demographic group that is at higher risk of developing mental health difficulties.

A recent doctoral thesis conducted at VIP found that the key to a good transition is in fact the emotion regulation strategy that the serving personnel utilise. There is a relationship between different emotion regulation strategies and type of mental health problem. Transitioning personnel are more likely to have difficulty adjusting to civilian life if they use ‘experiential avoidance or cognitive reappraisal strategies’. Whilst these strategies may have utility within a conflict zone they are not effective in civilian life. The ideal is to have a repertoire of emotional regulation strategies that the individual can adapt to depending on the situation.
(Gratz & Roemer, 2004). If however the individual is from a background in which these skills are not modelled by parents or loved one they are more likely to struggle emotionally later in life and particularly so if exposed to traumatic incidents. This study has several implications; Firstly it provides increased understanding of vulnerability factors for serving personnel; Secondly it provides suggestions for military training that may develop the individuals psychological resources and lastly it provides direction to clinicians in terms of choice of therapeutic techniques to employ.

Dr Lucy Abraham - Clinical Lead Veterans First Point Scotland

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References


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