Written evidence submitted by Dr Walter Busuttil

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Regarding the question from *Mark Francois* Member of the Defence Select Committee regarding what the NHS needs to focus on:

**Summary:**

1. Access and engagement in clinical services for veterans with chronic long term complex presentations and co-morbidity
2. Education and CPD for NHSE clinical staff working with complicated veterans MH needs
3. Proper funding and consultation with the clinical evidence base and with all the experts to develop a national clinical strategy for treatment of the most seriously unwell veterans who require treatment.
4. Evaluation of treatment programme efficacy and practice led Service Design

1. **Help seeking and The NHS and Combat Stress**

At the Defence Select Committee hearing I stated that 80% of help seeking veterans who had accessed care at Combat Stress had tried to get help from their NHS GP; or Mental Health Services run by the NHS; or had consulted medical staff within the MoD before they left the military.

This figure was based on clinical audits performed on 609 veterans accessing help between 2007 and 2009. The most recent figures are from our Veteran Mental Health Needs Study which will be published in a series of papers shortly. (Some papers are already published but the following data has not been published as yet).

The Needs Study collected data from 667 veterans who were representative of 3500 veterans who accessed clinical services during 2017. These figures are consistent when compared to the 2007-2009 data and are as follows:

- Sought mental health help from the NHS previously = 82.1%
- Of these from General Practitioner = 69%
- NHS Mental health services =62.5%

These latest figures collected in 2017 are very similar those collected between 2007 and 2009. This is despite an increase in education in relation to military and veteran mental health issues within the NHS as well as the setting up of some veteran clinical services within the NHS including the Murrison related Mental Health Networks set up after 2010 and the more recent Transition and Liaison Services (TILS in 2016). The new Complex Treatment Services have only been operating since April 2018.

Many of our veterans tell us that the NHS clinicians did not understand them; that they could not connect or engage in treatment if this was available as their military background culture was not understood.

These figures indicate that there continues to be a lack of education amongst NHS clinical staff and that services generally for veterans are unfit for them and that bespoke services that the NHS has set up may also be inadequate.
Combat Stress welcomes Dr Jonathon Leach’s GP champion’s scheme and the new veteran friendly NHSE hospital trust network but it will take time to establish and its impact will be dependent on other larger pressures. It’s a good start. Our advice is that the route to improving practice is more partnering with the charities who already have trusted customer service relationship and deliver evidence based treatment and publish the outcomes. No outcome studies are available for English NHS England services bar one for Pennine Care.

I raised the option to upskill all medical staff by passing a law making it compulsory for all Royal Colleges to have a question about veterans’ mental health in their professional examinations – this could also be targeted at medical school and nursing and other professions’ examinations. This makes sense as military health – and especially for veterans has now largely been subsumed into the NHS which clearly does not cater for or understand the population well enough.

2. Treatment of the most seriously ill veterans.

I stated at the Defence Committee Hearing that there appear to be two groups of seriously ill veterans. These groups overlap and are based on the timing of their clinical presentation.

a. The first group are those who are acutely unwell who are a risk to themselves or others and who need urgent care. This group are usually treated by NHS statutory general mental health acute and Crisis response services with little expertise in military health. Veterans might be referred to these services via the TILs services or more usually their GP when they are assessed as being acutely unwell and many will not even be identified as veterans. These patients are eventually stabilised and are then treated within mainstream mental health services. Because of the lack of skilled knowledge within NHS services in psychiatry and other Mental Health Disciplines in relation to military mental health (and including post-traumatic stress disorders) the fact that someone is a veteran and has been exposed to combat or other military related trauma may not be appreciated as an important issue and the wrong diagnosis might be given as many mental health practitioners are not familiar with acute and severe presentations of PTSD.

Eventually some of these patients will be recognised as veterans and a more discerning assessment relating to the possibility that symptoms may be related to military service and psychological trauma might be made. Commonly Combat Stress is asked to reassess some of these veterans.

b. The second group who are very ill include these patients as well as many who present to Combat Stress without having been treated acutely by the NHS.

By definition this group comprises veterans who have chronic long term complex presentations and co-morbidity. Combat Stress sees many of these patients. Commonly they suffer from severe from a combination PTSD (82%), Anger (74%), Common mental disorders including depression and anxiety (72%) and alcohol misuse disorders (current =42%; past and current=69%; and increasingly illicit drug misuse disorders (current rates approximately 11% - self reported and thought to be an underestimate). These veterans usually have also suffered family, social and economic slide and most are unemployed. Many will have tried to get help from the NHS but they have not improved. These are the typical veterans who access care at
Combat Stress. Many will have been in military operations including Combat – 62% of all Combat Stress veterans.

Combat Stress clinical audits calculate that there are around 300 veterans annually who require more intensive treatment because of the complexity and chronicity of their presentation. Most of these have served in direct Combat – 77%.

The world literature points markedly to the fact that these most vulnerable of patients need a combination of residential and community / outpatient treatment. Treatment programmes for these veterans were first designed and trialled in Australia and continue to be run successfully there. They are benchmarked nationally in Australia by the Center for Post Traumatic Mental Health (also known as Phoenix Australia).

In 2008 Combat Stress applied for National Specialised Commissioning from NHS England to set up and run a residential programme for those most unwell from chronic PTSD, depression and alcohol disorder based in Australian lines. Combat Stress liaised directly with Phoenix Australia and sent staff to train in Australia. National Specialised Commissioning was granted on 13 March 2011. The programme was benchmarked by Phoenix Australia for the first four years of its delivery.

Over the course of the contract under National Specialist Commissioning (NHS England) arrangements; Combat Stress developed a 6 week residential Intensive Treatment Programme (ITP) whose results are rated as world beating in terms of impact and enduring effect. The outcomes followed up to one year were published in two papers by the British Medical Journal on 401 veterans. Data on a further 940 veterans who attended the programme confirm the findings of the original BMJ publications and has been accepted last week to be published in the prestigious International Journal of Traumatic Stress. The Programme has attracted international interest and has enabled us to develop some comprehensive and ground-breaking research into the treatment of complex trauma. The medical director has described the programme and its outcomes to the Ministers for Veterans of Australia and Canada.

**Funding for residential treatment going forward.**

The NHS England National Specialised Commissioned contract catered for 224 English post coded veterans to be treated on the ITP. (Please note that the National Specialised Commissioned funding changed hands in 2014 and was then managed by the Armed Forces Commissioning Team).

NHS Scotland has commissioned the ITP since 2012 (and still commissions this contract was extended for a further three years recently) 32 places.

Northern Ireland and Wales do not commission any treatment from Combat Stress and veterans assessed as requiring this intervention have historically been funded through charitable sources. Provision for approximately 32 veterans for each of Welsh and Northern Irish veterans annually was planned while Combat Stress was running the programme at three treatment centres until summer of 2017.

The NHS England contract with Combat Stress ends in April 2018 with transitional funding for 38 places finishes on 30 June 2018. NHS England decided not to fund any residential services. Instead it tendered to fund community based Complex Treatment Services. This decision was only based on an audit of preferences of veterans and service providers. This
decision did not appear to take account of any of the evidence base we have amassed and published and neither did it follow the evidence base from overseas.

This decision does not in my opinion take into account the needs of those who are especially unwell and who have been identified as needing a combination of residential and community care. NHS England decided to redistribute the money to a four region based community based Complex Treatment Service.

While the upscaling of community services by the NHS is welcome and desired, the lack of funding for those who are in need of a mix of residential and community services is very disappointing. Given our track record and expertise Combat Stress is also very disappointed not to have been selected as service providers for either or both of the two regions that we bid for in England. Whilst we understand why moving away from investing in residential PTSD treatment is considered necessary to treat more veteran numbers on an outpatient basis closer to where veterans live and work. There is a balance to be struck we believe between more distrusted outpatient support for the many and continuing residential treatment for the smaller numbers of those who are most unwell. The concern is that despite this move to the community that engagement and completion rates for those most unwell including cancellation and did not arrive rates will be a problem for these new services. The new complex treatment service needs to collect and publish outcomes, DNAs and programme completion rates. So that Parliament can be assumed that the investment made is working. NHSE VMH KPIs should be reported to parliament annual in both NHSE targets and Armed Forces Covenant reports.

3. Sustained Funding for the most unwell Veterans: Consequence for the Future

The drop of £3.2 million pounds to the Combat Stress annual revenue has meant that Combat Stress has stopped operating three residential treatment centres. The one based in the Midlands have now been mothballed and is operating as an outpatient/community hub.

This means that our available beds have been reduced from 87 to 57. The number of veterans we will look to treat on the ITP will be reduced from the targeted 300 annually to 160 annually. Our ITP places for each devolved United Kingdom nation are as follows: (see also Appendix 1)

- Scotland – commissioned and funds 32 places.
- Wales 20 – unfunded
- Northern Ireland 10– unfunded
- England up to 98 – unfunded

Starting this July 140 veterans who would otherwise have been treated within a residential setting will be participating in a trial using an outpatient and community modular programme. Our completion rates for the residential six week ITP were very high with 94% completing year on year; similarly our engagement rates were very high. We do not anticipate that such high rates with this new pilot to the community.

We expect that the Complex Treatment Services set up in England will lack the expertise and the ability to engage veterans properly. We hope this is not the case and we would be happy to collaborate as we always have to make these services a success.

4. National Service Design
My advice is that the NHS should focus on the evidence base from the world literature regarding those who are most unwell and also from our evidence base which reported and published and which is available on the Kings Centre for Military Health Research with which we have a formal connection. We have a senior researcher embedded with KCMH who authors joint papers with them.

There needs to be a UK wide national clinical strategy and a menu of appropriate clinical services to treat all veterans with mental health disorders; and especially those who are most seriously unwell. This is an important obligation covered by the Armed Forces Covenant. Decisions about clinical services should be coordinated between the NHS and the Third Sector and consultation should include the evidence base including advice from similar overseas veterans’ mental health services which are led by clinical experts. Experts who make decisions should be those who are clinical leaders who routinely manage mental health care of veterans (and not necessarily just those who are serving in the military who have not treated veterans – as veterans and serving personnel present with mental illness differently). Veterans are as this is indeed a unique population and their personal circumstances and health and social care needs are not the same as serving personnel.

There has been a lack of published evaluation of any NHS run services for veterans. The data released surrounds numbers attending – performance but there is no data on treatment efficacy

These evaluations of efficacy are badly needed and should be used to justify decisions made relating to service design.

The opportunity to learn lessons from the 10-pilot veteran mental health services run between 2010 and 2017 have not been objectively captured as no or little meaningful data was captured.

References – all available on Combat Stress Website or the Kings Centre for Military Health Research

https://www.combatstress.org.uk/about-us/research

https://www1.kcl.ac.uk/kcmhr/pubdb/


Appendix 1

1. **Number of veterans:**

   Combat Stress budget and work plans call for total residential ITP of 160
   Of these, Scotland pay for -32
   Help for Heroes have been asked to fund:
   - Welsh Veterans -10
   - Northern Irish Veterans -20
   The veterans not covered above are 98

2. **Cost per veteran.**

   We have more than one figure for costs.

   1. The NHS used to pay us £14,400 for each veteran on ITP. This covers just the residential part – not triage, assessments, appraisals or follow-ups. And this was a cut price deal based on the original NHS agreement.
   2. We did a “proper” costing for the external ITP that we did – for the fire service. That rate – including the items excluded above – was £19,000.

3. **Total cost**

   So, the 98 places at NHS rates would be £1.41m

   The 98 places at full cost would be £1.86m

3 May 2018