Written evidence submitted by Mandy Bostwick

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

The evidence from previous government reports listed below demonstrates the lack of comprehensive statistical data.

Stephen Phillips Report (2014) - Veterans in the Criminal Justice System

A report commissioned by government in 2014 considered Veterans in the Criminal Justice System (Stephen Phillips, QC, MP 2014) found that “7% of those identified in custody had previously served in the Armed Forces, with the highest proportion (13%) found in high security prisons: Category A and B including Training Prisons” (p:17). The report made 15 recommendations, to support Veterans in the Criminal Justice System given the, “lack of national guidance and piecemeal provision across the Criminal Justice Pathways in England and Wales”, (p: 1).

Recommendation (4) from this report – Data Collection:

(4) Data as to the numbers of those who have served in the Armed Forces and find themselves either in custody or subject to intervention by probation services should in future be routinely captured by the Ministry of Justice. Alongside such data, details of the offences committed, and the risk factors associated with, and characteristics of, offenders should be analysed.

To date none of the 15 recommendations from this report have been delivered and there remains no data capture by the Ministry of Justice for veterans in the Criminal Justice System, despite rising figures of armed forces personnel entering the Criminal Justice System which would inform on mental health issues.

Forces in Mind Report – Call to Mind (2015)


Data provided in this report was collected by means of a systematic review from poor data sources and recognised lack of data within local authorities, government agencies in that:

- Veterans status is not routinely recorded in primary and secondary care health statistics and rarely features in social care statistics.
- While the status of veteran may be recorded in a few primary care records those of family members and reservists are very seldom recorded.
- Veterans are dispersed across the country and while there is some intelligence and data about their residence this Is not uniform, robust, or sufficiently detailed at CCG or local authority level.

‘Incidence and Prevalence of Mental Health Problems’ requires further reading (p8).
NHS England – From Gate to Gate Report (2016)

The report found inter-relating issues both inside the military gate and through transition relating to mental health and the mis-diagnosis of PTSD and the inability to recognise C-PTSD that may lead to contact with the criminal justice system (p11).

‘Family Experiences and Perspective on Care’ (p20) identified key issues of serving and ex armed service personnel, families experience that requires further reading.

When considering points raised, within Stephen Phillips Review (2014) and the findings of the From Gate to Gate (2016), the need for data collection, accurate assessment, diagnosis, and treatment within DCMH Military Departments, NHS Psychological Trauma Departments was deficient and given the rising numbers of veterans entering the Criminal Justice System led to wider investigation in relation to mental health issues of serving and ex armed service personnel.

These reports also raised questions regarding figures published within MOD, military establishments given failings to accurately assess, diagnose and treat those with mental health issues including PTSD and C-PTSD.

An article dated: 30th January 2018, published in the Guardian Newspaper

“Armed Forces Mental Health Unit Unsafe and Wholly- Unsatisfactory”.

In an article published in the Guardian newspaper January 30th 2018, concerns were raised by a whistle-blower in relation to DCMH Tidworth stating, ‘despite 2015 concerns raised situation remained appalling and that soldiers had been dropped out of mental healthcare structures, being lost in the system’.

The MOD response was to reassure that concerns raised had been rectified however the Surgeon Commander Rick Coetzee, Head of Psychiatry for the Royal Navy made clear the serious ongoing problems with ‘several attempts of reform and amelioration met with limited success or outright failure’.

The full article can be read via the link below:

https://www.theguardian.com/uk-news/2018/jan/30/armed-forces-mental-health-unit-unsafe-and-wholly-unsatisfactory

NHS - National Minimum Data Set

In the case of ex-armed service personnel seeking help with mental health issues the direct referral pathway recently has been through NHS Psychological Trauma Departments (IAPT Model of treatment), located across NHS Mental Health Departments in England. Ex-armed services personnel can self-refer or primarily be referred through their GP into this service and depending on area, waiting times may vary.
Data relating to this service would normally be generated from the NHS Mental Health Minimum Data Set, which is a standard set of information taken from care records to capture ‘base data’ relating to client profile and efficacy of service being delivered. The National Minimum Data Set is important because it directs budgets, evaluates treatment, develops care pathways, and monitors standards of practice and outcome.

Despite the most recent conflicts, Iraq and Afghanistan spanning approximately 15 years no national figures for ex-armed forces personnel suffering the psychological injuries of war have been recorded on the NHS National Minimum Data Set. The reason being, that no indicator had been set to record data relating to ex-armed services personnel, despite a joint financial provision from MOD and NHS budgets allocated to this service. To date there is no available data that would provide a clear understanding as to the extent of those suffering the psychological injuries of war that have attended this service and whether NHS provision provides adequate treatment and care for this client group.

In April 2017, NHS England recognised this failing and set up an indicator within the NHS National Minimum Data Set to capture ex armed service personnel’s mental health. However, it is unclear what data is being collected and despite a request for this information, no information has been forthcoming. No doubt, it will inevitably be some time before data can be analysed on the effectiveness of these services and whether outcomes of treatment are being achieved.

**Transition Liaison and Diversion Service (TILS)**

Following the publication of From Gate to Gate Report (2016), the IAPT Treatment service was rebranded as the Transition Liaison and Diversion Service (TILS) to fill the gaps in service provision to support housing issues, welfare, employment with the collaboration of local charities in each commissioned area. However, in relation to mental health services the department still operates under the IAPT model of treatment which to date has provided no data outcome measure for this service. A report by the Centre of Social Policy, ‘Therapies’ (2012), highlighted that the NHS IAPT model has an 82 – 86% failure rate and is meant for low level mental health issues. NICE (2005) state that PTSD needs provision of a wider comprehensive assessment and manage risk.

**NICE (2005), ‘Assessment and Co-ordination of Care’ for PTSD recommend.**

1.4.2 Assessment of PTSD sufferers should be conducted by competent individuals and be comprehensive, including physical, psychological, social needs and a risk assessment.
1.4.3 Patient preference should be an important determinant of the choice among effective treatments. PTSD sufferers should be given sufficient information about the nature of those treatments to make an informed choice.

IAPT delivers CBT and EMDR and whilst there is a constant chant of professional to quote ‘NICE’ translation of such in doing so does not relate to the actual guidelines and remains misguided within the NHS. It is clear that not one size fits all and only competent individuals (qualified in trauma), are able to conduct a comprehensive assessment, with patient preference among effective treatments (ongoing review/adjustment of treatment plan).

**Veterans Mental Health Complex Treatment (CTS)**
In April 2018, NHS England launched a new service the Veterans Mental Health Complex Treatment Service for those with complex mental health. Clinicians working with clients at this level require training in both psychotherapy and trauma with the ability to work across a wider eclectic treatment regime including specialised techniques that commands a high level of knowledge and expertise which requires the ability to manage risk. Support for families is key.

The principle of this service is that clients are managed and treated in the community near their home with support for families. However, the geographical mapping of this service covers a wide area which questions the ability to manage risk and stabilise a client through treatment. Prior to this service the referral pathway was to Combat Stress with inclusion and exclusion criteria for a particular client type.

There is clear evidence that NHS IAPT services, third sector agencies, veteran charitable sector have not provided ‘treatment’ for those ex armed services personnel who are most vulnerable with Complex PTSD and, despite concerns being raised, for those with the signature injuries of war which also include: Mild Traumatic Brain Injury (please see below) and assessment for mefloquine. It remains a contentious issue in relation to the allocation of large amounts of monies to central services that are not able to treat and manage risk of such cases given the complexity of symptoms and the need to deliver a bio, psycho, social model of care. The result being many in crisis attend accident and emergency departments or are held in police custody.

‘Assessment of trauma related conditions’ Gate to Gate report (2016) page 37, provides further evidence 90 – 97 concerns regarding competency of conducting assessment for PTSD – CPTSD both inside and outside the military gate.

The Independent Medical Expert Group, IMEG (2017)

Refers to the ‘Signature Injury of War’ mild Traumatic Brain Injury (mTBI), a letter dated 5th December 2017, informs on a change of tariff and descriptor for compensation for those presenting with mTBI. The report also highlights that mTBI remains an unresolved diagnosis in particular, ‘there is yet no robust method of early identification or assessment of cases likely to develop persistent symptoms of mTBI. It also recognises a new tariff 4 for those suffering Complex – PTSD.

Research by Jones, Fear, Rona, Fertout, Thandi, Wessely and Greenberg (2011), conducted a study on the front line with operational personnel 5 – 6 months deployment in Afghanistan and collected data by using the General Health Questionnaire to detect mTBI. A total of 1332 ‘self-report questionnaires’ were analysed. Although the study recognised limitations of analysing questionnaires, in the absence of clinical examination, an important precursor in the diagnosis of mTBI. The study also recognised failure to consider those that had returned from the front line casi-vacced back to the UK with possible mTBI.

This is serious and raises further questions relating to attribution bias given consequences for disclosure and ethics in conducting a General Health Questionnaire for those operational on the front line deployed under extreme conditions. It is not surprising that data from this study concluded that probable mTBI symptoms amongst UK service personnel in Afghanistan were relatively uncommon, however at the same time it acknowledged US troops had facilities to detect mTBI on the front line.
When investigating further the referral pathway for currently serving personnel and ex armed service personnel with possible kinetic blast injury or head injury in service, it is alarming to discover that no referral pathway has ever been set up inside the military gate or outside the military to provide the correct scanning for mTBI, with MEG, T7 fMRI.

What is required is careful neurological assessment and detailed functional imaging assessment to move this issue forward by those who are qualified to do so.

The question has already been raised by the Defence Select Committee, session recorded on Tuesday 27th March 2018. This question can only be answered by experts in the field of Neurology and is concerning that the Defence Select Committee is reliant on those who are not. By the very nature of war, and terrorist acts, mTBI has become a common occurrence associated with such events. Indeed, mTBI in the recent wars in Iraq and Afghanistan has been labelled as the ‘signature injury’ of these conflicts (Hayward 2008). Modern conflicts not only involve the typical mechanism for head injury (e.g direct assault or blunt force trauma, MVA’s, falls, being struck by a projectile) but also blast injuries (Moore & Jaffee, 2010). I think we need to be clear it is not the length of time of deployment (response in Q20) that determines an mTBI it is the level of risk which given the environment of modern warfare, can happen at any time.

Within my own practice I am aware of many ex-armed serving personnel who have not been screened and show symptoms of the deadly signature injuries of war mTBI, C-PTSD and who were given the anti-malaria drug mefloquine living with the adverse effects. Due to the lack of timely diagnosis and treatment these men and women are now living with life limiting symptoms, not able to work or claim compensation for their injuries, with no support for treatment, medication, or continual assessment. Their families live with the difficulties of coping in isolation. I am also currently aware of several serving personnel soon to be discharged through DCMH. Evidence points to the shocking reality of this service and the lack of expertise to respond to diagnose, provide treatment and reports to support compensation upon release.

Therefore, services to detect mTBI in the UK have not been developed to any standard, evidence shows that referral inside the military gate and outside the military gate is for a MRI. It is widely researched that MRI will not detect a mTBI.

The matter has been raised with NHS England as a matter of serious concern. Within my own work in the UK a top team of leading UK Neurologists and Neuro Radiologists have come together linked to international partners to begin to address this issue.

What are the main 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 lack of ‘qualified’ individuals in specialist fields, clinical governance within practice and the continual attempt to translate NICE into a one model fits all to suit current NHS Mental Health and MOD mental health provision, provides the greatest challenge.

This level of mental dissonance continues to carry a level of arrogance by those who are in position to apply change, and continue to provide ill-informed practices even when outcomes
are poor and the writing is on the wall. This requires ‘independent’ investigation to move this agenda forward. The Defence Select Committee inquiry has the opportunity, to question current practice. However, it requires expert advice from those who understand the environment and clinical governance linked to the international platform within each specialist area, to question across organisations, government agencies which has been lacking so far.

Questions have been raised in relation to the NHS Clinical Reference Group, and its efficacy to deliver within a ‘specialist area’ that led to the development of TIL and the VTS (discussed above). A Freedom of Information Request in 2017 was submitted regarding membership of this group and denied stating membership is confidential. However, allocation of public spending is of public concern and those responsible should be accountable and transparent especially when justifying spending large amounts of public money and the way decisions are reached.

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, including reservists, those who have been deployed on operations and early leavers?
  Unfortunately, due to the lack of accurate data, and poor data sources as evidenced within this report, this question cannot be answered.

  The current train wreck of research of continually comparing serving and ex armed forces personnel with the general population does not provide a ‘like for like’ comparison. The military operate under a unique set of circumstances, comparisons drawn with the general population are therefore futile. Much of current research drawn within this field is through conducting continual ‘systematic reviews’ using primary studies replicating, analysing, and manipulating data which given government reports listed are unreliable due to the lack of accurate data sources. Monies for research allocated needs to be given to specialists within areas of expertise not solely within the field of psychiatry or social policy which continues to mask the reality of the landscape, to the point of being deliberate

- Vary regionally across the UK and across the developed administrations?
  Again, due to the lack of accurate data this question cannot be answered. However, I wish draw attention to Commonwealth troops, Evidence currently exists particularly for the Fijian Community who are not supported upon discharge leading to immigration and residency issues and the inability to access support and any form of health care which requires further investigation.

What proportion of mental health issues in veterans is attributed to service in the armed forces and how well is this measured and understood?

1. The Gate to Gate Report (2016), highlights the lack of assessment, diagnosis, and treatment inside and outside the military gate, which questions current statistics relating to mental health for both MOD and NHS.

2. NHS National Minimum Data had not collected any data for those returning from Iraq and Afghanistan or indeed previous theatres of war (discussed above).
3. Concerns have been raised in relation to the DCMH with people ‘slipping through the net’ on discharge (as above).

4. There has been no referral pathway developed for to provide the correct assessment, diagnosis, or treatment, pathway for those with a possible mTBI or those suffering the adverse effects of Mefloquine, no national figures exist for this client group.

5. No figures exist for veterans within the Criminal Justice System that might depict mental health issues within offending attributed to service despite the publication of Stephen Phillips Report (2014) and recommendation made.

This question cannot be answered.

To what extent does the military environment mitigate against the development of mental health issues?

It is clear within government reports listed above the extent to which the military environment mitigates against the development of mental health issues. Evidence points to archaic bureaucracy, out of date, ill-informed practices that are not fit for purpose, that have now fallen so far behind international counterparts it requires radical reform.

It is evident within the current landscape, the men and women that have given the very most have received the very least, with no compensation and the pathway made all the more difficult due to the lack of assessment, diagnosis and treatment.

We have a moral obligation to those that serve, those moral obligations are institutional both governmental and non-government. Serving and ex armed serving personnel are morally owed the best possible resources across the widest swath of medical, psychiatric, social, legal, and technical services.

Standards need to improve.

Mandy Bostwick MSc, MA, MBACP, ISSTD
Specialist Trauma Psychotherapist

6 June 2018