Supplementary evidence submitted by Walking with the Wounded

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Mark Francois as a Member of the Defence Select Committee asked the following question “One of things the Committee really wants to understand is how what the NHS does could be better focused for these people. At the risk of tasking you, perhaps afterwards you could all drop us a brief note with your key suggestions on how the NHS could do this better”

Introduction

1. Whilst I welcome the opportunity to answer this question, it only confirms what George Wilhelm Friedrich Hegel states, “What we learn from history is that we learn nothing from history”. After every conflict, there is a ground swell of interest and services are hastily developed to meet the needs of those affected. This is certainly true of the world wars and subsequent conflicts. This interest is partly generated by political and public anxiety surrounding the welfare of our Armed Forces. As the media interest in Iraq and Afghanistan wanes so does the drive to provide quality and effective services for those who have served their country. The fragmented and patchy development of services to meet this need has led to a confusing array of services for veterans, who struggle to navigate the system. The NHS as a statutory provider should have a comprehensive established veteran specific mental health service or pathway, which evolves in the light of user involvement and evidence to meet the needs of this deserving population. A swathe of service charities have grown partly with objects that supplement the NHS provision in meeting service and veterans wider social healthcare needs e.g. Housing, employment etc. Whilst charities have a valued place the lack of a properly funded and bespoke NHS services, has led to some charities exploiting this situation and in some cases offering healthcare support that is not evidence based. This can therefore potentially do more harm as such therapeutic approaches are not scientifically tested; this is unethical and is not acceptable.

Summary

2. The NHS and devolved administrations do great work in these difficult times with competing demands on funding. In our experience, WWTW has identified areas of improvement that could benefit and improve the current NHS provision of care /support from the NHS:

a. Obtain accurate data on the prevalence of mental health disorders in veteran population.

b. Promote GP registration and read coding.
c. Invest in comprehensive and adequately resourced veteran mental services not limited to NHSE TILs a one off appointment varying types of assessment and extended complex treatment beyond 32 weeks closer to the veterans home.

d. Quick access to a culturally sensitive service, for a thorough veteran specific assessment, offering case management and peer mentor if appropriate thorough the whole care pathway.

e. Education whilst serving to increase mental health literacy also a national training programme for provider agencies to better understanding veteran’s backgrounds and needs to equip and empower them to work effectively with this population.

f. Service users should have greater representation in the services designed for them, using co production and evaluation.

g. The value of veteran services in the criminal justice system, homeless residences needs to be recognised and invested in as many veterans who struggle find themselves in such situations.

h. The social aspects of holistic provision need to be considered in terms of suitable homes and work for veterans, as there are key building blocks to recovery and sustained wellbeing.

3. It is recognised that the mental health literacy of veterans is poor which affects help seeking. This lack of knowledge compounds the problems certainly, as veterans often wait until they are broken or present to services in crisis. Navigating the complex landscape of services when in crisis is difficult and there needs to be in-service and post service education offered up stream on mental health literacy and resilience to promote recognition of symptoms and early intervention.

4. The postcode lottery of and design of NHS veteran services are largely produced based on the motivation of individual clinicians, cheapest and convenient options with such services currently and historically being underfunded. A UK wide strategic health needs analysis is required which must include the voice of those who use or more importantly do not use services to ensure they are activity involved in the production of services, “no decision about me without me”. We simply do not have any reliable way of counting the historical cost of sending our Armed Forces on operations in the prosecution of the government’s Defence and Foreign policy. The MOD and NHS need to improve veteran GP registration, health system read coding as serving personnel or veterans and transfer service medical records. The delayed Project Cortisone aims to improve record transfer. The Health Education England GP training initiative is recommending that the question: have you served in the armed forces is included on initial registration with your local medical practice. A system extolling the merits of GP registration should be introduced long before a service persons discharge date.
5. Once we have an accurate picture of the extent of the problems or not as the case, maybe the developers, funders and providers of services could make informed decisions about what is required in providing comprehensive and accessible services across the UK.

6. Organisational barriers still exist within the NHS with many only offering a 9 to 5 service with no evening or weekend service, this inflexibility does not reflect modern life. The NHSE VMH TILs service offers only an assessment, not always face to face, as the geographical coverage is challenging so some telephone assessments are conducted. The quality of these vary across the four regions and then if indicated the individual is sign posted to additional services. This is a concern as those expecting treatment are made to wait and are referred to yet another agency. Veterans as we know are reluctant to come forward, so when they do they do not want to repeat their story over and over to yet another person. The NHSE VMH CTS once operational may mitigate this; this however has some restrictive criteria; firstly any mental health condition must be caused or aggravated by service to be entitled to treatment. We know this to be difficult in many cases to say what is caused or aggravated by service if the person has had an adverse childhood, which is not uncommon in our established recruiting heartlands e.g. North East and North West. Secondly if you are entitled to support it is limited to 32 weeks, which for many serious, complex and enduring problems will not be sufficient. For veterans expecting help may be told they have to be treated by NHS mainstream services may result in lack of engagement. I am also concerned about the distances veterans are expected to travel to appointments will be a further barrier to engagement. An independent review of the NHSE VMH TILs and CTS is required to ensure it is delivering contract specification.

7. Peer mentoring has been introduced in many settings and is a proven way of working alongside veterans to guide and support them on their journey of recovery. Complex and chronic cases would be better supported this way in fostering independence and focussing on recovery and wellbeing and not just cure. The use of social prescribing leading to more activity and local community engagement is an additional proven adjunct to support. Walking With The Wounded are training and building a network of Individual Placement and Support staff within NHS Veteran services to facilitate securing suitable and sustainable employment viewing this as key to holistic support, wellbeing and longer term recovery. In addition to this Walking With The Wounded Project NOVA programme are working with the NHS and Police services in getting the question asked in police in custody suites: are you or have you served in the Armed Forces? If appropriate under liaison and diversion Walking With the Wounded support staff work in a client focussed way problem solving to break the cycle of offending using a raft of agencies.

8. As mentioned in the hearing the speed and quality of response is a key determinant of engagement, culturally service and ex service personnel are used to responsive medical services that understand them. So waiting for an initial assessment for weeks or months, which can be in the form of a telephone triage, face to face assessment or a suggestion they join a taster session or group is generally unacceptable, remembering this is prior to being offered treatment which can be a further 6-8 months. Walking With The Wound Head Start programme mitigates this waiting for mild to moderate
presentations and is in contracted with NHSE to do so in one region, but also supports the other three NHSE TILs regions for which it receives no funding. The NHS should provide a universal and standardised core assessment recording key service information that can be used with permission across the spectrum of providers; this mitigates repetition and ensures consistency and continuity of care. Currently the depth and quality of assessments varies and is not readily available. Trusted organisations should work together to communicate and work to agreed standards as in the COBSEO CONTACT group using agreed principles to assure quality of services. The veteran’s passport concept may have a role in addressing this issue. Furthermore the NHS should case manage each referral from beginning to end of the care pathway, so the individual has a shared care plan and has a single point of contact whilst being supported.

9. The NHS should review its current inclusion and exclusion criteria to bridge the gap between primary and secondary Mental Health care. We often hear veterans are too risky or complex because of co-morbid illnesses or due to the use of alcohol for NHS wellbeing services but not unwell enough for NHS secondary mental health services, I am not confident the NHSE TILs or CTS will adequately address this issue. Routine treatment should be community based not in residential or hospital settings, and hospitalisation in crisis should be the last resort.

10. The NHS should invest in veteran specific digital platforms to improve access, waiting times and capacity. E.g. The Big White wall.

11. There is a need to improve the education of those agencies that meet veterans in terms of needs and increasing cultural sensitivity including the military covenant. This includes Clinical specialists, Nurses, NHS L&D teams and their respective custody Police staff, local authority housing teams and most crucially GP’s. One of main barriers to help seeking is support staff not having some cultural understanding of the Armed Forces. Veterans often cite this as the reason they disengage following initial contact or do not access services. The NHS is not sufficiently resourced to do this on the kind of scale required to meet the need. Thought should be put into including veterans’ health in nationally recognised, medical, nursing, and social work etc. curriculums. NHS GPs and Psychiatrists have access to two training MRCGP/MRCPsych modules on service and ex-service health and Health Education England is delivering a rolling programme of service and veteran healthcare to GP Trainees. The NHS need to expand and extend this training across the UK with evidenced based core messages that educates and empowers staff who often feel they do not know anything about the military or more worryingly have adopted attitudes and belief, which are based on popular myths etc.

12. The NHS and academic institutions need to work closely with the media to report accurate and credible information to challenge the distorted image of military service being synonymous with physical or psychological injury notably PTSD. Help seeking is affected by such perceptions as those suffering with common mental disorders may believe if they don’t have service attributable PTSD they are therefore not entitled or
deserving of help. We seem to forget pre-service adversity and that life events surrounding service impact on our mental health e.g. only 50% of reported PTSD is directly attributable to service. The opportunities for posttraumatic growth and the protective factors for good mental health and wellbeing as a military service should be a positive story that is rarely mentioned. The catastrophised PTSD label has become a catchall term and has clouded the multitude of other presenting mental health conditions; furthermore the concept of moral injury is only now becoming recognised as a key aspect, service and veterans ill health.

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