Fighting Fit

A mental health plan for servicemen and veterans

"We will work to rebuild the Military Covenant by ..... providing extra support for veterans' mental health needs."

The Coalition: our programme for government. HM Government, May 2010.

Recommendations

Thirteen action points are identified in bold script throughout the text of which four are principal recommendations;

- Incorporation of a structured mental health systems enquiry into existing medical examinations performed whilst serving.
- An uplift in the number of mental health professionals conducting veterans outreach work from Mental Health Trusts in partnership with a leading mental health charity.
- A Veterans Information Service (VIS) to be deployed 12 months after a person leaves the Armed Forces.
- Trial of an online early intervention service for serving personnel and veterans.

Introduction

Service in HM Forces is generally associated with good mental and physical health. However, cases like that of Corporal Johnson Beharry VC have drawn attention to Post Traumatic Stress Disorder (PTSD) and, more generally, to service-related mental disorder including mild traumatic brain injury (mTBI)[1]. The linked issue of alcohol abuse is significantly associated with service in the Armed Forces and there is evidence that it is more common among combat veterans[2]. Mental illness is a root cause of both homelessness and involvement in the criminal justice system. It is probable that veterans are either over-represented or more likely to have mental health problems in the two groups[3][4].

The veterans' mental health charity Combat Stress received 1,257 new referrals in 2009, an increase of two-thirds since 2005. However, veterans with mental illness characteristically seek help late and may not do so at all. Their reticence is largely the result of stigma surrounding mental health issues. The title of this plan - Fighting Fit - recognises the importance of stigma and of making interventions acceptable to a population accustomed to viewing itself as mentally and physically robust. This philosophy has underpinned the Trauma Risk Management (TRiM) peer-group risk

[1] Mild traumatic brain injury project team final report. DMSD/16/1/03. MOD, 25 March 2008.
[2] Fear NT et al. Mental health of the UK Armed Forces: what are the consequences of deployment to Iraq and Afghnaistan? A cohort study. Lancet, 13 May 2010.
[3] National Association of Probation Officers briefing paper. September 2009.
[4] The experience of homeless ex-service personnel in London. York University June 2008.

assessment tool pioneered by the Royal Marines and now in general use among combat troops.

A society that wishes to discharge its responsibilities under the military covenant must do all it can to minimise casualties and maximise access to assessment and treatment where necessary. The previous government's strategy document *New Horizons*[5] bound the NHS and the MOD to improving access and support for early treatment and prevention of mental illness among servicemen and veterans. Although the strategy is under review, the coalition government is unlikely to depart from its philosophy.

In March 2008 David Cameron set up the Military Covenant Commission under the chairmanship of Frederick Forsyth CBE (www.militarycovenantcommission.com) and in government he has asked Professor Hew Strachan to lead a working party on the covenant. Frederick Forsyth's report was followed by the Leader of the Opposition's Combat Stress Summit at Westminster in June 2009. The Prime Minister's enduring interest in veterans' mental health and that of the Defence Secretary, Dr Liam Fox, is clear from the speed with which this review has been ordered.

Work is in hand to improve the mental health of servicemen. The development for the first time of an Armed Forces Mental Health Plan[6] recognises the need to pass personnel back to civilian life in the best possible health. The 2009 Defence Mental Health Services Review recommended changes in professional structuring that are being worked through the Strategic Defence and Security Review.

FF goes further. It recognises our obligations under the military covenant and reflects the high importance placed on the welfare of the Service community by the coalition government. The proposals are rooted in material gathered from a wide range of authorities and are the result of close cooperation between the MOD and DH. Good practice in Scotland, Wales and Northern Ireland has been noted. The recommendations are UK-wide for those currently serving and England-specific in relation to devolved matters.

General principles

The recommendations are based on the following propositions;

- Established models of care should be used in designing the programme.
- Any provider that can deliver against National Institute for Health and Clinical Excellence (NICE) guidelines and Care Quality Commission (CQC) standards should be considered in accordance with the precepts of The Big Society[7].
- Follow-up and management should be as close to home as possible.
- Stigma deters Servicemen from engaging with conventional mental health provision.

[5] New Horizons – a shared vision for mental health. Department of Health. December 2009.
[6] Draft Armed Forces Mental Health Plan. Ministry of Defence.
[7] Building the Big Society. Cabinet Office. May 2010.

Three groups were identified;

- Regulars and reserves currently serving.
- Personnel transitioning to civilian life.
- Existing veterans.

Regulars and reserves currently serving

Current provision

The in-service mental health strategy for mental illness attributable to operational exposure rightly concentrates on prevention, emphasising the importance of good leadership, structural issues such as length of tour and programmes like TRiM. Personnel are given every opportunity to consult a healthcare professional but the UK has avoided screening or formalised health surveillance of deployment returnees in contrast to the US, Canada, Australia and New Zealand[8]. Britain's Anglophone partners typically deploy a variety of standard self-administered questionnaires at various stages designed to inform face-to-face clinical assessment and referral as appropriate.

Recommendations

The King's Centre for Military Health Research (KCMHR) has secured US funding to determine the efficacy of PTSD screening tools in a randomised controlled trial using a naïve UK Service population. **The MOD should encourage research to develop a PTSD screening tool, ensuring that the work is capable of generating data that will be of benefit in a UK context.** Any tool would need to be capable of being validated for use with UK personnel.

The consistency and quality of periodic, discharge and invaliding medical examinations carried out in the Armed Forces are unclear. There is scope for improving their focus on service-related ill health, particularly mental health. **It is recommended that a mental health systems enquiry is built into routine Service medical examinations, discharge medicals and the medical examinations conducted prior to invaliding from the Service on the grounds of physical or mental incapacity.** This will employ a series of structured questions designed to highlight common mental health problems such as depression and anxiety together with alcohol misuse and PTSD.

The examination will be followed by reassurance or appropriate health advice. If necessary, the examining doctor will seek an opinion from a military Department of Community Mental Health (DCMH). Patients will be advised of the procedure before the examination and will be reassured that the outcome will not delay their departure from the Service even if a referral is necessary. However, we should go further to reassure leavers that discovery of mental health problems will not hold up their discharge and to ensure that they are returned to civilian life in good mental health. **It**

[8] Post deployment mental health screening, surveillance and research in TTCP countries. The Technical Cooperation Programme. October 2008.

is recommended that a serviceman whose requirement for a specialist opinion is identified at the time of his discharge should be able to obtain it and any follow-on treatment from a military DCMH for the next six months.

In the event that a person leaving the Service declines to be referred to a DCMH, the medical officer will simply write to the receiving civilian GP with his findings and advise of the arrangements for people transiting to civilian life set out below.

Appropriate guidance to medical officers will be promulgated by the Surgeon General in a policy document.

FF must cast its nets more widely than conventional Service health surveillance. To achieve this it should consider interventions that appeal to the target population. An anonymously administered online early intervention services has been pioneered by the award winning social enterprise company Big White Wall (BWW) in partnership with the Tavistock and Portman NHS Foundation Trust (www.bigwhitewall.com). Its potential to engage people who will not access traditional clinical services because of stigma attached to mental illness is apparent from the servicemen and veterans who pay to use BWW.

The case for trialling an online tool-kit and facilitated support network of this sort for serving personnel is compelling. **It is recommended that the Big White Wall or similar is invited to design, in consultation with DMS mental health professionals, a customised mental wellbeing website and to trial an online support network.** It is suggested that this should focus on troops returning from Afghanistan and that the service is evaluated after twelve months.

Costs

The cost of the website, its maintenance and promotion together with the offer of membership of an online support network to 10,000 returning troops with a take-up of 10% is estimated at £150,000.

Costs for the rest of this element of FF are assessed as modest. They would lie where they fall within the MOD and be incorporated within the Strategic Defence and Security Review.

Personnel transitioning to civilian life

Current provision

Each year 24,000 servicemen leave the Armed Forces. Of these, 10,000 have served in recent operations. This means that the 32,738 GPs in England and 58 English Mental Health Trusts will receive on average one veteran every 16 months and 413 a year respectively. Whilst most achieve a seamless transfer to civilian life, for a minority the experience is traumatic.

In April 2010 the outgoing government announced a £2 million package to improve veterans' mental health services. The initiative proposed employing 15 mental health nurses, establishing a 24 hour helpline and improving the knowledge base of GPs and

veterans[9]. It is a DH work in progress involving partners Combat Stress and the Royal British Legion.

Elements of the DMS-Connecting for Health Connectivity Programme to improve support for veterans in the NHS in England are currently being piloted. Connectivity will ensure that those leaving are much more likely to be registered with a civilian GP, that their status is flagged and that in the future their medical records are transferred reliably from the DMS to the NHS.

Recommendations

The following models have been noted in designing FF for veterans transitioning to civilian life and existing veterans;

- The Northern Ireland Aftercare Service operated for veterans of the Ulster Defence Regiment and the Royal Irish Regiment (Home Service) in recognition of the special nature of their service.
- The insertion of third sector employed professionals into the NHS including those working for Combat Stress.
- Early lessons from the different approaches taken by the existing six mental health pilots.
- The Cancer Patient Experience Survey used by the NHS to trace, contact, survey and advise cancer patients.
- The Big White Wall online mental wellbeing service.

Those carrying a latent burden of mental illness may decompensate in the months following release as Service support structures are no longer available. If health surveillance is considered appropriate during a person's Service life, it is appropriate to ensure that it is available when he is at risk after discharge. **It is recommended that regulars and reserves are followed-up approximately twelve months after they leave.**

Personnel transiting to civilian life and reserves being demobilised will be advised at discharge medical to expect a postal follow-up after approximately twelve months. They will be asked to consent to their details being passed to a specialist provider for this purpose. This element of FF will be known as the Veterans' Information Service (VIS).

The specialist provider appointed to conduct VIS will use the NHS Personal Demographics Service to trace veterans at the twelve month point. The NHS Cancer Patient Experience Survey suggests that a high success rate for tracking veterans can be anticipated if a suitable patient survey organisation is used (www.quality-health.co.uk).

The VIS follow-up will contain a questionnaire in which the veteran is asked if he has any concerns about his health, including but not exclusively his mental health and alcohol use. It will also explain the range of services available locally as part of his

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9 http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/MediaCentre/Pressreleasesarchive/DH_115239

entitlement under the military covenant, including his right to priority treatment. It will remind reservists of the special provision made for them under the Reserves Mental Health Programme.

The veteran will be asked to consent to relevant details being passed to the local MHT embedded mental health professional and his GP. He will be able to request a call from the mental health professional or ask for further information on specific health and welfare issues.

VIS will offer an opportunity to promote the BWW type online early intervention service. It will direct veterans to the wellbeing website element of the service and, with the agreement of local healthcare commissioners, offer membership of the online support network.

It is recommended that the cadre of 15 new mental health professionals announced in April 2010 is doubled. This will mean that one Mental Health Trust (MHT) embedded professional would be appointed to cover on average two MHTs throughout England. The appointees will be employed by a CQC and NICE compliant service provider such as Combat Stress.

MHTs will be required to formulate a plan for managing cases referred by embedded mental health professionals, GPs or other agencies.

The Medical Assessment Programme at St Thomas' Hospital and the Reserves Mental Health Programme will continue in their assessment role accepting referrals and self-referrals. The impact of FF on the workload of both will be assessed when these proposals are evaluated after twelve months.

Costs

The cost of VIS can be calculated from the Cancer Patient Experience Survey. There will be a start up cost of £75,000 and an annual running cost of £150,000. The cost of 15 extra MHT embedded mental health professionals would be £750,000 per annum. The cost of membership of the online support network is £70 per person per year.

Existing veterans

Current provision

This third group presents the greatest challenge. The KCHMR experience suggests that tracing veterans is difficult. Furthermore, service delivery will have to be through a complex network of government and non-governmental organisations.

Since 2007 six mental health pilots have been rolled out by MHTs to address the needs of veterans with the financial support of the MOD. Although formal evaluation (by Sheffield University) will not be available until October 2010, initial reports indicate that the pilots have seen relatively small numbers of patients, particularly self referrals. This supports the case for a more pro-active approach to case discovery.

DH is working with the Royal College of General Practitioners to produce a veterans' health e-learning package for GPs.

Recommendations

The MHT embedded mental health professionals established under FF will undertake community outreach work in order to discover cases and refer appropriately to other professionals and ex-Services organisations. They will use the experience of the Northern Ireland Aftercare Service and existing Combat Stress outreach teams. Appointees will take particular care to engage with prison and probation services, homelessness organisations and housing officers in their areas.

The e-learning veterans' health package being designed for GPs should introduce FF and highlight the availability of MHT embedded outreach professionals and the BWW type service.

The Big White Wall type online mental wellbeing website will be available to existing veterans together with, subject to the agreement of local healthcare commissioners, membership of the online support network.

Costs

The bulk of the cost of outreach work needed to find existing veterans with mental health problems would be largely included within the £750,000 cited in the previous section. There would be an additional requirement for administrative costs and expenses in the region of £250,000 annually. Consequential costs arising from case discovery and subscriptions to the online mental wellbeing service would lie where they fall within the NHS.

Evaluation

FF will be evaluated twelve months after full roll-out with an anticipated report date in October 2012. The programme will be designed so that, subject to ethical approval, KCMHR is able to extract maximum research benefit.

Implementation

The start-up plus first year cost of the programme to the MOD and DH is £150,000 and £1,225,000 respectively in the absence of third sector co-payment. Though modest, the costs are subject to the SDSR and the Government Spending Review.

Delivering FF will require coordination between the charitable sector, government departments and the devolved administrations. **It is proposed that the partnership agreement with Combat Stress, announced in a written ministerial statement in January 2010,[10] is extended to ensue that resources and activity are deployed in a cohesive way.**

[10] Medical Care for Veterans. Written ministerial statement. 11 January 2010

The MOD is responsible for the healthcare of those currently serving. In addition the MOD currently makes payments to Combat Stress for the treatment of war pensioners and has provided funding to help set up and evaluate the community mental health pilots. Although *New Horizons* is under review, this paper anticipates the January 2010 WMS intention to make 'special provision for veterans' in 'all mental health services.'

The Big Lottery has responded to the concerns of the Mental Health Foundation and others[11] with the launch of *Forces in MIND* 'to support the psychological wellbeing and successful and sustainable transition of veterans and their families into civilian life.' It intends to distribute £35 million through a Trust to appropriate charities from summer 2011[12] and has explicitly mandated partnership between Service, ex-Service and other organisations so that veterans and their families receive an integrated service from providers. Combat Stress launched a £30 million appeal *The Enemy Within* in March.

It is clear that considerable funds exist for improving the mental health of veterans. **It is recommended that government takes a lead under FF in drawing together the principle partners to ensure that money is spent in a coordinated and effective manner.**

Acknowledgement

Fighting Fit has drawn from a wide range of authorities. In particular, the Surgeon General, Surgeon Vice Admiral Philip Raffaelli, and Mr Mark Davies of the Department of Health have been heavily involved throughout.

Andrew Murrison MD MP
31 August 2010

[11] The Mental Health of Veterans. 'Need2Know' briefing paper. Mental Health Foundation. January 2010
[12] Big Lottery Fund in letter to Secretary of State for Defence dated 14 May 2010