Written evidence submitted by The RAF Association

1. Introduction

1.1. The RAF Association (the Association) is the charity that actively supports the RAF family, both serving and former RAF personnel and their families, looking after their welfare and helping them in times of need.

1.2. The foundations of the charity's present structure were laid during the last years of WWII supporting returning RAF personnel. The Association has continued this work giving assistance to vast numbers of RAF personnel including veterans of recent conflicts.

1.3. The Association's mission is to ensure that the sacrifices made by those who serve their country does not result in poverty, suffering, loneliness or isolation. Last year, their network of over 700 volunteer welfare officers made 115,000 welfare visits and calls offering personal support to meet the individual's and family's needs. Last year they provided over £1.9m in individual welfare grants to serving and ex-serving personnel. The charity is seeing welfare cases become increasingly more complex with the demand for welfare support raising by 47% since 2014. In particular, it has responded to the changing welfare needs and the increasing number of individuals experiencing mental health issues. The Association has, with other organisations, developed services focusing on the RAF Family's mental health and wellbeing.

2. Supporting statement

2.1. Mental health care for Armed Forces personnel in the UK while they are still in service is provided by the Defence Medical Services (DMS). For veterans, responsibility for payment and provision of services normally transfers to the National Health Service (NHS) or accessed through the Third Sector.

2.2. A significant minority of UK veterans experience complex, comorbid mental health and well-being difficulties including depression, anxiety, anger, alcohol addiction, homelessness, unemployment, relationship breakdown, criminal offending and social exclusion (Fear et al., 2010; Klein & Alexander, 2012; Murphy et al., 2008; Murrison, 2010). These issues can be exacerbated where care is transferred between providers and there is a lack of continuity of care.

2.3. It is worthy of note that although there are mental health services provided by the NHS and by a number of mental health charities the majority of these services will only focus interventions on the individuals mental health conditions. It appears that in terms of treating mental health conditions in this population, the physical, mental and social difficulties experiences by the individual must be taken into account, rather than a focus on just treating the mental health condition. However, a stronger evidence base is required to understand how to implement these changes in practice.

2.4. A systematic review of the needs of UK veterans established that while early service leavers (ESLs) were the most vulnerable there were also aspects within service that had an impact on future life events such as the type of leadership experienced, unit

cohesion and facing combat situations. The use of alcohol as a coping mechanism is also considered prevalent with adverse effects as is the worry of family situations at home (Hynes et al., 2016). Buckman et al., (2013) found that ESL were more likely to self-report symptoms of common mental disorders, probable Posttraumatic Stress Disorder (PTSD), fatigue and multiple physical symptoms, compared with non-ESLs.

2.5. In contrast, whilst young men who leave the UK Armed Forces are at increased risk of suicide, this may reflect preservice vulnerabilities, rather than factors related to service experiences or discharge (Kapur et al., 2009).

2.6. Pre service experience and childhood adversity are considered important risk factors in veterans mental health (Goodwin, 2013). Family relationships will also have an impact on mental health (Blosnich et al. 2016). Another issue that compounds mental health problems in veterans, is the culture of heavy alcohol consumption (Burdett et al., 2016).

2.7. Whilst addressing clinical needs is important, the therapies offered may not always address the other social issues that may be contributing factors to a mental health episode, for example, housing problems, relationships, isolation, loneliness and employment. When dealing with mental health conditions, the pathway to recovery may be catalysed by additional support to the clinical intervention.

2.8. There are a number of Casework Organisations that aim to support serving personnel, veterans, and their families. For example, The RAF Association casework can complement the clinical intervention that an individual receives as it exercises a person-centred, holistic approach to improving wellbeing. It can serve to address the issues that might be a cause or a consequence of a mental health condition, such as providing or signposting to organisations that can provide financial support and education, relationship support and bereavement support, for example. The RAF Association would also work in parallel with mental health specialist organisations and in addition continue to work with individuals after their clinical needs have been addressed.

2.9. A recent case involved the RAF Association Welfare staff providing support for a homeless veteran who, as result of mental health condition, had previously been evicted from their rental property. This individual had also had a long term relationship breakdown and was experiencing loneliness and isolation. The welfare team developed a package of support which not only including signposting to a Mental Health Specialist but also involved a referral to the Association Befriending service and a financial grant for a deposit and the purchase of white goods.

2.10. In summary, a range of unique factors may contribute to poor mental health in UK military veterans, suggesting a personalised approach to interventions may be appropriate.

2.11. We believe that there are a wide range of mental health services that are available to veterans compared to the general population. Armed Forces charities such as Combat Stress are well placed to deliver specialist mental health services to veterans. Their clinicians have well developed skills and are adept at supporting mental health conditions. Specifically there is an understanding of military life and some of the factors that may lead to mental health conditions. Moreover, the treatments are

founded in evidence-based research and are suitable to meet the clinical needs of this population. These organisations are not providing a service that is different to that provided by the NHS or competing with the NHS, but is increasing capacity, enabling timely intervention. However, charities like Combat Stress may not provide interventions for those veterans with common mental health conditions.

2.12. Research indicates that part of the problem is that many UK military veterans experiencing mental health and wellbeing problems have difficulties engaging with mental health treatment programmes to get the help they need (Iversen et al., 2005a; Kitchiner et al., 2012), as evidenced by them not seeking help or attending mental health appointments (Owen et al., 2016).

2.13. Veterans do not engage for a number of reasons including mental health stigma (Klein & Alexander, 2012), not feeling understood (Murrison, 2010), poor recognition of treatment need (Iversen et al., 2010), feeling alien and disconnected from civilian support services (Ahern et al., 2015) and only accepting the need for help when a crisis point is reached (Murphy et al., 2013).

2.14. In 2011, it was reported that only 23% of UK veterans suffering symptoms of PTSD went on to access support services. More recently, reports suggest that half of Armed Forces veterans with PTSD now seek help from NHS services but referral to the correct specialist care is rare.

2.15. In the UK, The Royal College of General Practitioners has embedded veterans' health as a mandated core curriculum in GP training. This is being extended (in collaboration with the National Health Service (NHS)) with nursing support to produce a standardised and manualised Primary Healthcare training programme that can be delivered in local health care practices. Despite this, there remains no universal, structured and systematic approach to educating health or social care personnel to deliver this care (Finnegan et al., 2017).

2.16. To address some of these issues, a number of treatment pathways are available for UK veterans.

2.17. Dalton et al. (2018) recently undertook a literature review to understand more about the provision of services for veterans with PTSD. They examined information on current UK service activity from 17 organisations, including eight specialist mental health service providers in England, one organisation each in Scotland, Wales and Northern Ireland, four from the third sector and two other providers. The responses showed a range of services being delivered to veterans, often via partnerships between the NHS and third sector, facilitated by various models of care. Collaborative arrangements are common, as are partnerships and networks. Pockets of integrated care were evident (e.g. general mental health services with embedded specialist care), and community outreach and peer support were also included.

2.18. As part of data collection, services were asked to share what they perceived to be some of the factors that influence implementation of mental health services for veterans.

2.19. Inadequate funding to meet current demand was frequently cited, as was the availability of appropriate clinicians and venues. A lack of resources was reported to result in lengthy waiting lists for services and treatment in some areas.

2.20. Perhaps as a consequence of inadequate funding and resources, further challenges to implementation included the negotiation of longer-term treatments within the NHS. It was mentioned that NHS Improving Access to Psychological Therapies (IAPT) can be slow to provide treatment. As already highlighted, veterans often present to mental health services at crisis and a delay in providing treatment can be detrimental to a population who require prompt attention.

2.21. Continuity and coordination of care between agencies was also cited as an obstruction to successful implementation of services and treatment. For example, if an individual with substance misuse problems attempted to access mental health services, there may be a requirement that the substance misuse must be addressed first. This raises an issue around inequality as it means that potentially some individuals are being excluded from any help for their mental health altogether. In addition, if there is a requirement that the crisis must be serious before help is available, there is no opportunity for prevention of escalation of crisis, only a response when the crisis has occurred.

2.22. Research by Murphy et al. (2017) has highlighted that PTSD and mental health conditions are not suffered in isolation, but in combination with a number of clinical comorbidities, increased physical and social challenges and high rates of childhood adversity.

2.23. The impact of veteran mental health on spouses and partners is now yielding research in this area, specifically around the mental health of spouses and partners. Dominic et al. (2016) found that in a sample of partners of UK veterans with PTSD 45% met criteria for alcohol problems 29% for depression, 37% for generalised anxiety disorder and 17% for symptoms of PTSD. This evidence suggested a considerable burden of mental illness that may be placed on these individuals.

2.24. A recent review article examining the development of an Optimal Integrated Care Pathway for military veterans, suggested UK veterans found peer mentoring beneficial (Kitchiner & Bisson, 2015). This is unsurprising as the comradeship and shared experiences are likely to be beneficial. However, there is currently limited research on Peer Support in relation to engaging the UK veteran population with mental health and wellbeing services. More recently, Weir et al. (2017) found that Peer Support Workers were perceived as an understanding, professional friend and a helpful and supportive connector. Of particular value was their role in enabling the veterans to re-engage with services.

2.25. It appears that to ensure that clinical needs are addressed, individuals must meet a certain threshold to be eligible for cognitive-behavioural therapies. This poses an issue as it seems that individuals who do not meet the criteria for these treatments are at risk of not receiving the most effective clinical intervention available, or may slip through the net entirely.

2.26. With regards to the knowledge around needs and entitlements of veterans and their families, there is a feeling that more could be done to educate NHS staff. For

example, GP surgeries could implement a similar model to the Carer Champion. This would involve a member of a medical practice staff team who supports with the identification of veterans. They would act as a voice for veterans within the practice and be a key point of contact for veteran information within the general practice which they work. We also believe that veterans and their families should be empowered to share experiences and develop learning at a policy level, for example, contributing to the review and development of relevant NICE guidelines and feeding into professional conferences.

3 September 2018

References

Ahern J, Worthen M, Masters J, et al. (2015). The challenges of Afghanistan and Iraq veterans' transition from military to civilian life and approaches to reconnection. *PLoS One, 10*, e0128599.

Blosnich, J. R., Dichter, M. E., Cerulli, C., Batten, S. V., & Bossarte, R. M. (2014). Disparities in adverse childhood experiences among individuals with a history of military service. *JAMA psychiatry*, *71*(9), 1041-1048.

Buckman, J. E., Forbes, H. J., Clayton, T., Jones, M., Jones, N., Greenberg, N., ... & Fear, N. T. (2012). Early Service leavers: a study of the factors associated with premature separation from the UK Armed Forces and the mental health of those that leave early. *The European Journal of Public Health*, *23*(3), 410-415.

Burdett, H., Fear, N. T., Jones, N., Greenberg, N., Wessely, S., & Rona, R. J. (2016). Use of a two-phase process to identify possible cases of mental ill health in the UK military. *International journal of methods in psychiatric research*, *25*(3), 168-177.

Dalton, J. E., Thomas, E. W. S., Melton, H. A., Eastwood, A. J., & Harden, M. (2018). The provision of services in the UK for UK armed forces veterans with PTSD: a rapid evidence synthesis. *Health Services and Delivery Research*.

Fear, N. T., Van Staden, L., Iversen, A., Hall, J., & Wessely, S. (2010). 50 ways to trace your veteran: Increasing response rates can be cheap and effective. *European Journal of Psychotraumatology, 1,* 5516. doi:10.3402/ejpt.v1i0.5516

Finnegan, A. P., McGhee, S., & Leach, J. (2017). Educating nurses to provide better care for the military veteran and their families. *Nurse education today*, *54*, 62-63.

Goodwin, L., Wessely, S., Hotopf, M., Jones, M., Greenberg, N., Rona, R. J., ... & Fear, N. T. (2015). Are common mental disorders more prevalent in the UK serving military compared to the general working population?. *Psychological medicine*, *45*(9), 1881-1891.

Hynes, C., & Thomas, M. (2016). What does the literature say about the needs of veterans in the areas of health?. *Nurse education today*, *47*, 81-88.

Iversen A, Dyson C, Smith N, et al. (2005a). 'Goodbye and good luck': The mental health needs and treatment experiences of British ex-service personnel. *Br J Psychiatry, 186,* 480–6.

Iversen AC, van Staden L, Hughes JH, et al. (2010). Help-seeking and receipt of treatment among UK service personnel. *Br J Psychiatry, 197,* 149–55.

Kapur, N., While, D., Blatchley, N., Bray, I., & Harrison, K. (2009). Suicide after leaving the UK Armed Forces—A cohort study. *PLoS medicine*, *6*(3), e1000026.

Kitchiner N, Roberts N, Wilcox D, Bisson J. (2012). Systematic review and meta-analyses of psychosocial interventions for veterans of the military. *Eur J Psychotraumatol, 3,* 19267.

Kitchiner, N. J., & Bisson, J. I. (2015). Phase I development of an optimal integrated care pathway for veterans discharged from the armed forces. *Military medicine*, *180*(7), 766-773.

Klein, S., Alexander, D. A., & Busuttil, W. (2012). Scoping review: A needs-based assessment and epidemiological community-based survey of ex-service personnel and their families in Scotland. *Final Report*.

Murphy D, Iversen A, Greenberg N. (2008). The mental health of veterans. *J Roy Army Med Corps, 154*, 136–9.

Murphy D, Hunt E, Luzon O, Greenberg N. (2013). Exploring positive pathways to care for members of the UK armed forces receiving treatment for PTSD: A qualitative study. Eur J
Psychotraumatology, 5, 21759.

Murphy, D., Ashwick, R., Palmer, E., & Busuttil, W. (2017). Describing the profile of a population of UK veterans seeking support for mental health difficulties. *Journal of Mental Health*, 1-8.

Murrison A. (2010). Fighting fit: *A mental health plan for servicemen and veterans.* London: Department of Health.

Owen R, Pyne J, Seal K, Cucciare M. (2016). US Department of Veteran Affairs. CREATE: Improving rural veterans' access/engagement in evidence-based mental healthcare. Available from http://www.hsrd.research.va.gov/centers/create/ruralmh.cfm [last accessed 5 Mar 2016].