SERVICE EVALUATION
SOUTH WEST OF ENGLAND
VETERANS' HIGH INTENSITY SERVICE

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NHS
Dorset HealthCare University
NHS Foundation Trust

COMBAT STRESS
FOR VETERANS' MENTAL HEALTH

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About Combat Stress

Combat Stress is the UK's leading charity for veterans' mental health. Operating for over a century, today Combat Stress provides specialist treatment and support for former servicemen and women from every military branch and conflict, focusing on those with complex mental health issues. Combat Stress operates all over the UK, on the phone, online, in the community, and at our specialist centres.

Founded in 2014, the Combat Stress Research Department is academically independent and committed to producing high-quality and robust research of direct relevance to the veteran community. The Department publishes in peer-reviewed journals and works closely with leading international academic, governmental and defence organisations to contribute to the advancement of the veteran mental health field. Further information on research at Combat Stress can be found at combatstress.org.uk/research.

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Declaration

Combat Stress is contracted to provide clinical services and a Clinician Advice Line to the High Intensity Service. The authors are not involved in the provision of either service, nor are any individuals in the provision of these services featured or covered in this report. This report does not constitute endorsement or otherwise of the High Intensity Service.

1. EXECUTIVE SUMMARY

The Veterans' Mental Health High Intensity Service provides urgent mental health care for veterans who are in mental health crisis or are inpatients on a mental health ward or unit. It comprises the third and newest arm of Op COURAGE: The Veterans Mental Health and Wellbeing Service.

Dorset HealthCare University NHS Foundation Trust is the Lead Provider of the High Intensity Service in the South West of England.

The High Intensity Service provides veteran-specific, add-on, time-limited, wraparound care, often alongside established local care services, to aid recovery. This includes ensuring veterans are referred onward to and accepted by healthcare services where appropriate.

This report on the South West High Intensity Service draws on interviews with four clinicians working across the footprint of the Service, to describe the patient population and Service provision during the first six months of operation.

KEY FINDINGS

- **Anger**, **depression** and **anxiety** are the most commonly reported presenting clinical factors.
- **Social isolation**, **relationship stress and breakdown**, and **financial difficulties** are frequently encountered in the patient population.
- The majority of post-traumatic problems in the patient population stem from **non-military related traumas**.
- **Psychosocial support and advocacy** are more frequently provided than short-term therapeutic clinical interventions.
- **Significant variation across the South West region** in local service provision was reported, which in turn impacts referral pathways and onward discharge options.

2. INTRODUCTION

2.1 Veteran Mental Health

There are currently an estimated 2.4 million military veterans in the UK.[1] Whilst the majority transition to a civilian life voluntarily[2] and without any significant health concerns,[3] there are those for whom life after military service will feature significant ill health.

The current understanding of veteran mental illness, comorbidity and the possible influencing factors, is both complex and nuanced.[4-7] Compared to civilian populations, both serving personnel and veterans show a higher prevalence of common mental health disorders (such as anxiety and depression), posttraumatic stress disorder (PTSD), and alcohol misuse.[8-11] Mental and behavioural disorders currently exceed musculoskeletal disorders and injury as the primary or contributory factors for discharge on medical grounds in the British Army and RAF.[12] Furthermore, the act of transition from military to civilian world in and of itself can be psychologically and socially challenging for any serviceman or woman, and their families.[13,14]

The veteran community are as varied as the wider population in their occupational and broader life experiences. Not all mental illness in veterans can or should be attributed to events in past military service. Nor do such difficulties always arise during or immediately post-service, with some veterans waiting many years to seek mental health treatment.[15] Nevertheless, once beyond the gates of the military environment, the responsibility for treatment and support of veterans rests with the civilian healthcare system and charitable sector.

It is significant that military veterans in general appear to display a reluctance to engage with mental health services.[16,17] Lack of awareness of services, stigma around help-seeking and a perception of weakness, and a lack of trust that civilian health professionals will fully understand and appreciate a military context or mindset, have all been cited as potential barriers to engagement.[14,18,19] Although not unique to veterans,[20] qualities such as mental toughness, self-sufficiency and pushing through adversity are highly regarded and encouraged during military service. However, these qualities can also negatively influence help-seeking, such that veterans might only seek help once a crisis point is reached.[21,22]

There are currently no accurate assessments of the number of veterans living in the UK. The 21 March 2021 Census in England and Wales for the first time asked whether respondents had previously served in the UK Armed Forces, with a further distinction made between Regular or Reserve service. Results are expected to be released in stages from early Summer 2022.[23] Current estimates state the veteran population, whilst projected to fall in number over the next decade, is also expected to proportionally become younger.[24] A Government consultation reported a demand for broader recognition, appreciation and accommodation of veterans' needs in both healthcare and in wider society.[25] Accordingly, the requirement for civilian healthcare systems to respond to an ongoing and potentially increasing lifetime demand for military-informed and sensitive mental health provision is clear.

2.2 South West Veterans' High Intensity Service

In March 2012, the NHS and the Office for Veterans' Affairs announced[26] the launch of Op COURAGE: The Veterans Mental Health and Wellbeing Service in order to provide a unified strategy for veterans to access specialist mental health care. Two arms of the strategy

were established previously – the Veterans' Mental Health Transition, Intervention and Liaison Service (TILS), and the Veterans' Mental Health Complex Treatment Service (CTS). The Veterans' Mental Health High Intensity Service comprises the third arm and provides urgent and emergency care and treatment for veterans who are in mental health crisis.

A number of pathfinder High Intensity Service programmes across England were commissioned. Whilst all had the same core aim, the service model and working partnerships differed between each region. The High Intensity Service for the South West of England (the region) covers the counties of Cornwall, Devon, Somerset, Bristol, North Somerset, South Gloucestershire, Bath and North East Somerset, Gloucestershire, Wiltshire and Dorset.

Dorset HealthCare University NHS Foundation Trust (DHC) was commissioned as Lead Provider for the South West of England High Intensity Service (SWHIS; the Service).

In the South West of England, the Service has a 'value-add[ed] liaison, advice and support model, supporting local Mental Health services and their respective support network by enhancing the recovery process of Veterans who present with an acute [mental health] crisis and providing a coherent support pathway in order to gain stability in their lives'.[27]

As such, SWHIS is designed to ensure that veterans in the geographic region have their needs met by NHS and third-sector organisations working in tandem or consort, by challenging known barriers to treatment access, increasing veteran engagement, and providing training and increasing awareness of veteran-specific needs within existing clinical services.

At time of study, SWHIS employ six NHS Band 6/7 clinical staff, each with responsibility for patient caseloads across individual counties and geographic areas, with the Service nominally split across two hubs: Wiltshire, Dorset and Somerset; and Cornwall, Devon and Gloucester. An Operations Manager, Business Manager, Administrator, Consultant Psychiatrist and Consultant Psychologist provide pan-Service input.

Acceptance to SWHIS is contingent on UK Armed Forces veteran status being confirmed. Self-referrals are not permitted; rather referrals must come from an existing NHS, private or third-sector service. Veterans are required to be in 'acute mental health crisis', which may also be co-occurring with substance or alcohol misuse. However, it is acknowledged that individuals may be judged suitable for SWHIS treatment, despite falling outside these core criteria. Complex mental health needs need not be directly attributable to military service.[27] Referred veterans may also be receiving psychiatric inpatient care.

SWHIS involvement is designed to last between 6 and 13 weeks, with flexibility to extend treatment as required. Of centrality, is the completion of a thorough needs assessment, encompassing mental and physical health, social needs and familial needs, conducted from a veteran-aware standpoint. This assessment informs both SWHIS interventions and transfer of care to other services on discharge.

SWHIS may provide a number of short-term therapeutic interventions including grounding techniques, brief psychoeducation, behavioural activation, distress tolerance, and harm reduction. In addition, broader psychosocial support includes facilitating access and involvement with other health services, housing and financial advice, and engagement with veteran communities and resources. In the case of mental health inpatients, SWHIS support may also include input in discharge planning and transition to the community on discharge.

Additional support for partners and families can also be facilitated, ranging from advice and psychoeducation, through to service engagement.

On completion of treatment, the veteran is discharged to their GP, returned to the original referring service, or referred onward to secondary or tertiary services in the public, private and third sectors as appropriate.

Each clinician is responsible for delivering the range of possible therapeutic and psychosocial support to their patients. Delivery is primarily conducted remotely, although a limited number of in-person appointments are provided by some clinicians.

The Service accepted its first referral in October 2021

2.3 Study Methods

Interviews were conducted with Band 6/7 SWHIS clinicians involved in direct patient care during the first six months of Service operation. Interviews took place in March and April 2022. In total, four out of the six eligible staff took part.

Topics covered included the Service model in operation, referral and discharge pathways, examples of patient mental health and psychosocial presentations, and the links between the Service and local care services.

The study team were unable to speak directly to veterans on the SWHIS caseload. Instead, data from the interviews were used to generate amalgamated archetypal patient histories that are included in this report. These provide an illustration of the range of patient experiences reported by the interviewed clinicians, whilst maintaining patient confidentiality. All names used are fictitious.

3. FINDINGS

3.1 Referrals: Pathways & Overview

Emergency Department Psychiatric Liaison services, psychiatric inpatient wards, third sector organisations, Crisis Teams, and TILS were all cited as frequent referral sources. Interviewees detailed **a wide range of referral sources and pathways, with notable variation across the region**.

For example, in one county a high proportion of referrals were made by Home Based Treatment Teams after initial veteran presentation to Emergency Departments, whilst another county predominantly received referrals from third sector organisations or existing veteran care networks.

Two over-arching influences were acknowledged by interviewees. Firstly, **referrals to SWHIS were impacted by the level of local service provision**. In areas where primary mental health services had comparatively diminished coverage, it is unlikely such services would serve as a major referrer as they were not in contact with the veteran population in significant numbers. Instead, it was reported that third sector organisations providing targeted support were more likely to refer to SWHIS, typically when a veteran had reached the limits of care provision and required more complex, broad and integrated care.

Secondly, interviewees indicated that **SWHIS relied on existing professional networks to generate referrals**. In recruiting clinicians with lived or prior professional experience in veteran-centric care, the Service is able to draw on an invaluable range of specialist expertise. Such knowledge, much of which was developed in prior, area-specific veteran care networks or clusters, is central to SWHIS being able to offer bespoke care and coordinated referrals to veteran community programmes and/or third-sector organisations.

Interviewees suggested that SWHIS had come to rely on pre-existing knowledge of the *clinicians* and not the *Service itself* as a means of ensuring referrals were made. Whilst clinicians' professional reputations and relationships have allowed a degree of continuity for referrers despite SWHIS being a new service, it may also have the effect of creating an uneven pattern of referrals across the whole of the South West region (see 4.3.4).

Estimates of the number of referrals made to SWHIS varied, with between two and four per week cited as a regional average. At time of interviews taking place, it was reported that no referrals had been recorded in the Wiltshire area. Several interviewees stated their active caseloads varied between five and ten patients, with a **pan-regional total of active cases estimated at around twenty-five**.

To the interviewees' knowledge, no veteran had been re-referred to SWHIS during the first six months of full operation. Data on the exact number of referrals, veterans entering and discharged from treatment, and wait times were not made available.

CASE STUDY: ALEX*

I'd been going to [a local alcohol service] and it was going well, but I had more things to sort out than they could help me with. They called SWHIS to help me with some ways of coping a bit better, stay calm and get back on an even keel. I'm back getting help with my drinking now.

3.2 Patient Demographics

Demographic data were not available to include. Anecdotally, patients covered a wide age range, with **the majority aged in their 30s to 50s** at time of referral. This indicates that the referred population skewed slightly younger than the current demographic estimates of the general UK veteran population, of whom two-thirds are thought to be over retirement age.[1,24] The majority were male.

Military service data, such as service branch, length of military service, and time elapsed since leaving military service, were not available for analysis. Clinicians reported that the more challenging and complex cases tended to be those who were classed as early leavers – those who left military service within four years of enlistment. Interviewees suggested that this may have been indicative of a subgroup of veterans with longstanding or latent health needs, which may also have contributed to leaving military service early.

One clinician reported that they had received four referrals of individuals who were making false claims of veteran status in order to gain access the perceived benefits of the Service. These false claims were confirmed through of Proof of Service checks.

CASE STUDY: SAM*

I'd been struggling for a while, but I'd become really good at hiding it from my wife and my friends. Everything was just piling up in my head. People knew I wasn't that happy in general, and I'd tried to tell them but they just didn't get that when I said 'I'm struggling a bit', what I really meant was 'I'm at the tipping point'. I've always downplayed stuff like that.

One night, I tried to end it all, but my wife interrupted me. I don't think she knew what I was trying to do to be fair - just that I was acting a bit off. She ended up making me go and see the GP.

My GP told me about SWHIS and how it was a service for veterans. SWHIS just 'got it'. I felt I could talk to them and open up. I couldn't open up at home about how I was feeling as I felt I had to be the strong one. I couldn't open up to my Army mates because some of them are in a far worse place than me. What have I got to complain about in comparison? I could talk openly to SWHIS; they didn't judge and they spoke the same language as me. They made me feel like they totally understood where I was coming from.

They did stuff with me like stabilisation, grounding to calm me, and working on all these negative thoughts I had in my head that just kept piling up, but also checked in with me loads. They helped me realise I wasn't weird or weak for feeling like I couldn't cope. They also helped me be open with my wife which was hard, but it actually made our relationship stronger I think.

Loads of difficult stuff has happened to me over the years, and one day I might speak to someone for longer about it all. But SWHIS helped me to get back to where I felt in control and able to cope day-to-day.

I'm back to work and feel much more like myself. I've even started working on a support network at work for my colleagues, encouraging them to reach out and talk before things get too much.

3.3 Patient Presentation: Psychosocial Stressors

A wide selection of stressors potentially underpinning, driving or resulting from current mental health difficulties in veterans referred to SWHIS were described. Although the causal relationship between referral to SWHIS and these stressors cannot be stated, they are representative of what is most salient to the veteran group when interventions and needs assessments are formulated.

Variation dependent on geographic location was again commented upon. However, these inter-county differences should not be taken as necessarily indicative of differences in the veteran population, rather as a result of the variation in typical referral routes seen between the counties (see 3.1).

Being at or near point of crisis is stated as being a core inclusion criterion for treatment for veterans referred to SWHIS. Clinicians reported that many referrals were made to the Service pre- or immediately post-crisis, with some veterans considered to be actively suicidal. It was not possible to establish absolute numbers or proportions.

However, not all referrals accepted for treatment were considered to fulfil this criterion, for which clinicians cited a number of potential factors.

Firstly, the Service operates an **acceptance-first policy for referrals** with a high threshold for refusing care. One clinician characterised this by stating *'the Service is built on saying yes, not no… which is refreshing'*. As a result, many veterans in need who may otherwise *'fall through the gaps'* between existing services are accepted for treatment. To this end, it is highly noteworthy how diligent and **highly committed clinicians appear to be in ensuring patients referred to SWHIS receive the support they need** and are not left in clinical limbo.

Secondly, as has been stated, the Service can only reflect the clinical populations and pathways referred to them. As a result, should local crisis services be overwhelmed or under-resourced, they will be unable to engage those veterans in crisis who are then suitable for onward referral to SWHIS.

Finally, several interviewees also stated that **indicators of a crisis point may differ in a veteran population** compared to a civilian cohort, due to veterans not actively seeking help, and a military culture of downplaying or minimising difficulties. For this reason, veterans may not be considered to reach the (comparatively high) threshold for crisis intervention by mainstream health services and consequently go undetected. Similarly, existing crisis services may also have strict exclusion criteria such as the use of controlled substances (see 3.4) of which some veterans may fall foul.

Social isolation was reported as being extremely common, and *'almost a given'* according to one clinician. This was regarded as being exacerbated by, but not exclusively the result of, COVID mitigation measures. Accordingly, an inference of a baseline need for increased social connectedness can be made amongst the patient group as a whole.

In addition, significant **relationship stress or breakdown** was cited not only as a consequence, but also a trigger for worsening mental health. Ancillary safeguarding considerations, access to children during estrangement, and wider criminal justice involvement were also mentioned as salient stressors, both with respect to the patient themselves and the support provided to spouses or wider family. **Financial stress**, particularly concerning claiming or adjusting benefits, **employment problems** and **housing issues** were also widely reported. Veterans typically reported multiple stressors.

Clinicians commented that in counties with fewer local services and resources, SWHIS saw a higher proportion of employment and social stressors, reflective of the general levels of economic and social need in the area.

More individual stressors such as a physical health were also mentioned. Due to the nascent status of the Service, it is not possible to say what impact national anniversaries such as Remembrance Day, or Bonfire Night acting as crisis triggers may have on the volume of referrals.

CASE STUDY: PAUL*

Everything went wrong at once. My mental health got out of hand, things with my partner went from bad to worse and we split up, everything with the kids was a mess. I completely lost touch with what was real, became convinced everything was a threat and was really erratic.

I ended up on a psychiatric ward for a while and although I felt better, what was waiting once I left absolutely terrified me. I no longer had a home, or family I could turn to. My care coordinator spoke to SWHIS and they got involved to see what they could add.

They totally got my sense of humour, which was great as not everyone gets me all the time.

SWHIS helped sort me some housing so I had somewhere to go to when I left the ward. I really didn't want to go back to the area where I had been before. The place they got for me was much nearer my old stomping ground, which is where I wanted to be for a fresh start. They made sure that I had support from the community teams in my new place as well, even though I'd never worked with them before.

They also helped sort out my benefits and hooked me up with other folk that had served in the area – turns out we've got a few friends in common. It all helped me get back on my feet. I'm still working with the community teams in my area, but I don't see them that often.

SWHIS also helped my ex-partner and made sure they were ok. They let them know what was happening, pointed them to places for help themselves, and with the kids too as what happened to me impacted everyone.

3.4 Patient Presentations: Clinical Factors

Clinical presentations of veterans on referral to SWHIS were discussed. The clinical factors described were considered to be both predisposing and perpetuating in nature. As such, they were discussed only as an indicators of what were the most salient factors in the needs and treatment of referred veterans. The factors discussed were informed by the existing research corpus on veteran mental and physical health.

Anger and **emotional dysregulation** were cited by all interviewees as the most frequently encountered amongst the veteran population, with poor distress tolerance seen as a widespread presentation. It is noteworthy that some interviewees also cited emotional dysregulation amongst veterans as a reason why mainstream services were apparently reluctant to engage with the population.

Anxiety, **depression**, and **paranoia** were considered widespread and often linked by clinicians to social isolation.

PTSD symptomology and **disturbed sleep** were reported, as were a high proportion of reported childhood adversities, in line with the existing academic and clinical findings.[28,29] However, care should be taken not to overinterpret the causal relationship between early life adversity and trauma, military service, and presentation to health services as a veteran.

Although trauma-related disorders were reported to be common, almost all those interviewed reported that the **majority of traumas disclosed as relevant were not related to military service**. As one clinician stated *'trauma is trauma…[our approach] is to find secondary services that will deal with the person'*. However, SWHIS is perhaps unique in that whilst it is a veteran-specific service, it is also trauma agnostic in comparison to many of the veteran-specific services to which onward referrals can be made such as CTS.

Levels of **alcohol** (including dependency) and **substance misuse** were reported to be high, with cannabis and cocaine use most often disclosed. It was commented that a lack of in-person appointments can make ascertaining the presence and levels of such behaviour difficult. Anecdotally, several clinicians commented that those with complex substance misuse histories, particularly of intravenous drugs, were more likely to be early military service leavers (before four years) and disengage from treatment or make initially false claims of veteran status (see 3.2). However, we were unable to explore this further due to a lack of available data.

Older veterans were considered to have more salient and **comorbid physical health concerns** that could also require addressing.

Several clinicians discussed a notable volume of veterans presenting with **personality disorder or personality disorder traits**, with specific reference to emotional and impulsive cluster B disorders.[30] Whether such presentations were clinically distinct was open to debate, with some interviewees considering them a consequence of learned functioning within a military environment and integral feature of post-traumatic presentation.

3.5 Interventions and Treatment

Short-term therapeutic and psychosocial interventions provided by SWHIS have already been outlined (see 2.2). It was reported that SWHIS attempts to **work alongside local services where they exist and are engaged in a veteran's care**. In these cases, the Service is able to take over some aspects of ongoing care, for example preparing a veteran for longer-term therapy on discharge.

Through individual clinicians' knowledge of veteran-specific services in their county, SWHIS was also able **signpost and facilitate access and onward referral** to services that were not previously open to the patient and their mainstream health providers.

Clinicians described their role as *'problem solving'*, *'engaging…and getting [the veteran] to trust and open up'*, through *'building camaraderie'* (see 3.6). One clinician specified that a SWHIS practitioner was able to conduct an assessment all of a veteran's needs, prioritising which were of most pressing priority, and empowering the veteran to use their existing skillset to take positive action. This **assessment of needs** and the generation of a care plan was also described as central to the Service's stated goal of providing a 'fully integrated pathway for veterans'.[27]

Clinicians' professional and personal expertise was seen as central to building rapport, engaging veterans and *'bolstering'* veterans during treatment.

CASE STUDY: MIKE*

It was my existing mental health treatment team who made the referral. I'd been seeing them for a few months, and they got SWHIS involved because I had been in the Navy. I was on antidepressants and had started talking with them about the possibility of therapy to deal with some of the stuff I had gone through.

SWHIS took over bits of my therapy – helping me with my grounding work and coming to terms with the fact that I wasn't a failure for feeling the way I did. My treatment team stayed involved, carried on helping me with meds and taking the lead.

SWHIS opened up doors though – they found some specialist therapy services that weren't put off by some of the military stuff I talked about. They helped me get ready for that, and stayed around in the background as I moved from my treatment team to my new therapist and a new phase. I've still got some way to go, but it's a start to hopefully getting some of my old self back again.

3.6 Engaging, Translating & Facilitating

All interviewees **emphasised the psychosocial and care enhancement function** of SWHIS, rather than more clinical interventions such as psychoeducation, stabilisation and nomalisation.

The central role of SWHIS as a *'translator service…with a foot in both camps'* and that *'nursing is advocacy'* was commented on by all interviewees; acting as both advocate and advisor to patients and professional partner services.

The ability to *'speak veteran and NHS'* was highlighted as crucially important by clinicians as a way of fostering a therapeutic relationship, building engagement and mitigating or combating any existing suspicions or grievances veterans may have of health services and vice versa. This was particularly important where multi-service involvement was necessary.

An intricate understanding of NHS and wider care services' operational requirements, referral pathways and procedures were said to positively facilitate the SWHIS **care advisory and advice role**.

However, it was commented that *'often [SWHIS is] working with veterans with no support'*. It was implied that ensuring a veteran's holistic needs were adequately assessed, and that the correct services are engaged on discharge, was frequently only as the result of considerable persuasion by the SWHIS team. Several interviewees cited having to contend with professional scepticism, ignorance or concern around veterans and veteran health presentations amongst partner health services. For example, a higher than typical instance of anger and personality disorder-type traits (see 3.4) were offered as being two of the most common presenting factors which contributed to mainstream health services demonstrating a reluctance to take on or engage with veterans.

The clinicians in question viewed a significant part of their role as **educating and demystifying veteran needs and presentations to colleagues**, in order to develop a cohesive health pathway for patients.

CASE STUDY: GUS*

To be honest, it felt a bit strange accepting help from a service for veterans. Yes, I had served, but that was a long time ago. I've had a whole life and a whole career since then.

None of my problems had anything to do with my time in the military. I'd worked as a first responder for over twenty years and it was that which had taken its toll. SWHIS explained that this didn't matter; I was entitled to their help.

They let my CMHT take the lead and were there if I needed them. They checked in with me, made sure I understood everything that was going on, and made suggestions about what other help might be out there for me.

3.7 Discharge & Onward Referral

It was reported that on discharge from SWHIS, veterans are typically referred onward to the care of mainstream health services, to Community Mental Health Teams (CMHT) with discharge to their GP as the default baseline option. The suitability of specific onward referral destinations were influenced by a veteran's needs but also the **availability and capacity of local services**. All interviewees commented that local services across the region, and particularly CMHTs, have limited capacity. Consequently, securing treatment for veterans post-SWHIS treatment can be problematic. As a result, it was stated that it is not uncommon for veterans to remain on SWHIS caseload far in excess of the nominal 13-week upper limit to ensure patients are not left without care.

Data on the quantifiable impact of SWHIS were not available. **Clinicians reported veteran satisfaction with the Service**, with anecdotal reports of veterans stating that SWHIS helped them feel listened to, supported, and in some cases had saved their lives. One interviewee detailed how a veteran who had been helped, made contact after discharge from the Service to recount how their life had been turned around and had continued to improve.

4. OBSERVATIONS & CONSIDERATIONS

4.1: Study Limitations

This study was originally conceived as exploring the presenting health profiles and needs of veterans accessing the South West High Intensity Service during the first six months of operation. However, the quantitative data required were not available. Consequently, the research team relied interviews with SWHIS clinicians and developing archetypal case studies to illustrate the range of reported presentations, whilst maintaining patient confidentiality.

Interviews with clinicians necessarily took place within a limited timeframe, and totalled four out of a possible six. The four clinicians represented a good geographical spread and range of professional experience the authors take as broadly representative of SWHIS.

The findings in this report represent a snapshot in time and care has been taken to present the results in an objective manner, whilst acknowledging the subjective nature of data derived from clinician interviews. Therefore, caution should be exercised by the reader in interpreting the results beyond their descriptive use. In acknowledging the limitations of the data, the findings in this report are offered as suggestions and impressions only.

With these factors in mind, the authors respectfully make a number of observations and present some topics for further consideration.

4.2: Observations

Significant acknowledgement should be made of the **dedication and experience** provided by the SWHIS team, which consistently appears responsive and adaptive to the needs of their patients. The SWHIS model requires a highly bespoke approach to individual care, and it is evident from the interviews that the team consistently strives to find the best-fit model of care in each case. The Service appears to be run on an inclusion-first basis with staff often working to ensure referrals are accepted for treatment and patients were not left without appropriate care.

The clinicians interviewed clearly took **enormous pride** in their work, particularly when confronted with limited resources, with one expressing that *'we do an amazing job… [my colleagues] are doing a brilliant job'*. The use of **veteran-informed staff**, anecdotally appears to **positively foster therapeutic and trusting relationships** with the patient group. Furthermore, the veteran-informed expertise was viewed as being central to inter-disciplinary and team relationships, particularly where SWHIS appeared to take on an unofficial care coordination or advisory role in patient care.

The authors acknowledge that the topics offered for consideration are presented from a detached position of reviewing first-person accounts. Nonetheless it is hoped that they serve as a starting point for meaningful discussion that may be of utility in the continued development of the Service.

Consideration 4.3.1: Regional Variation and Local Services

The SWHIS regional footprint covers several county areas and multiple NHS Trusts. As a result, there is wide variation across the region in terms of local service provision, existing third sector and private veteran services, as well as in the presentation profile of veterans. This **significant variation may merit consideration in a number of ways**.

Firstly, all clinicians interviewed stated that local services in their area face

significant challenges in meeting demand. This reportedly impacts both the beginning and end of a veteran's SWHIS involvement: those local services who do come into contact with veterans are viewed as eager to refer patients to SWHIS once veteran status has been disclosed as a means of alleviating their large caseloads; and local services are subsequently reluctant to accept veterans on discharge from SWHIS due to their own continued lack of capacity. As a result, *'[SWHIS is] sometimes seen as almost a dumping ground for overstretched services'*.

Consequently, once referred to SWHIS, veterans potentially are left with **nowhere to go once their involvement with the Service ends**.

Secondly, it was stated that SWHIS is built in part on the foundations previously established by veteran health clusters and groups such as the Dorset Armed Forces Community Health and Wellbeing Team in DHC. Whilst some areas in the region are served well by previous and existing veteran services in addition to SWHIS, others are not. Therefore, **opportunities for onward referral outside public sector care may also be severely limited**. This has particular relevance in light of the widespread social isolation reported amongst patients.

Thirdly, it is clear that SWHIS staff use their extensive local and professional knowledge to ensure veterans are able to access as appropriate and wide a range of care available in their area. Consequently, several interviewees commented that in order to maintain this high level of care, **differences necessarily exist in the way SWHIS operates in each region**. For example, some clinicians may have a lower threshold for meeting referral criteria that is applicable to their region, whilst others may experience an unofficial merging of previous professional roles and responsibilities with their current SWHIS position.

Finally, due to a range of electronic patient record systems being used across the region, clinicians reported **disparities in their ability to access patient histories**. It is not known to what degree the veteran population in the South West region is peripatetic. Nonetheless, a potential benefit of having a regional approach is the ability to effectively meet veteran needs no matter their current and previous geographic location.

In the face of such wide variation, it may be of use to consider two questions. Firstly, whether the SWHIS service provision model is clear and unified across the region, with defined inclusion/exclusion criteria and intervention guidelines? Secondly, if a more homogenous approach across the entirety of the SWHIS region is not possible, whether the suitability and flexibility of a regional operational framework for the Service should be considered more broadly?

Consideration 4.3.2: Function of SWHIS

It was stated that in practice SWHIS was fundamentally there to *'link people in and divert them to [appropriate] services'*. With specialised knowledge, the Service is **uniquely placed to facilitate targeted onward referrals** to appropriate general services than can accurately meet the needs of veterans. However, if those general services do not exist or have treatment capacity, then veterans risk facing a therapeutic cliff-edge once they are discharged from the Service.

Problems with onward referral of patients was cited by all interviewees. In addition, all clinicians recounted that building trust and engagement can take considerable time. Considering these two factors, it was reported that it was not uncommon for veterans to remain on

the caseload considerably beyond the 13-week guide model. Given this, it is valid to ask how time under the care of SWHIS can be best used for patients.

In terms of the input to patient care, it was reported that psychosocial support took primacy over short-term therapeutic interventions, to the point where *'it's very easy to get caught up in those social issues, which could easily be done by a [welfare support] worker'*. Whilst the authors are acutely aware of budgetary considerations, it may be worth considering whether the **psychosocial support role could be managed by additional SWHIS ancillary support workers**. Accordingly, clinician time would be freed up to allow focus on thorough needs assessment and therapeutic intervention which are of particular benefit in preparation for discharge or onward referral.

This last point is particularly pertinent, as one clinician commented: *'it's about freeing us up to do that acute mental health stabilisation work. In an ideal world, I'd like to be able to do a bit more therapeutic intervention'*. It is understood by the authors that SWHIS is not designed to be a therapeutic service and that the short-term clinical interventions provided are often transdiagnostic in nature. Nonetheless, considering that SWHIS is: often tasked with engaging veterans in need who otherwise are not on the caseload of local services; may be the first and only veteran-aware and veteran-tailored service patients come into contact with; and the variation in – and at times lack of – local services into which patients are being referred by SWHIS, it may be useful to re-examine the depth and breadth of therapeutic involvement SWHIS is able to provide. Indeed, considering the common range of presentations as detailed in sections 3.3 and 3.4, there perhaps exists the possibility for systematised therapeutic intervention pathways to be implemented across the SWHIS region. Such common therapeutic foundations may also provide the basis for more effective and cohesive pan-Service staff clinical supervision, support and development.

Consideration 4.3.3: Geography, Patient Contact and Risk

It is stated that SWHIS 'provides a fully manned operation…7 days per week… between the hours of 0800 and 1800',[27] with a (non-public facing) Clinician Advice Line providing out-of-hours coverage. Individual SWHIS practitioners are required to cover large geographic areas and it was reported **that the majority of patient contact takes place remotely, via online or telephone platforms**. Therefore, it may be of consideration whether these operational realities are congruent with the description of SWHIS as 'a 24/7, 365 day service'.[27]

In addition, due to the limited existing provision of crisis and acute mental health services in several of the counties covered by SWHIS, it was stated that it was not uncommon for a veteran to have no existing or effective local service provision, thus SWHIS were the only service actively engaged in patient management. Considering the acute nature of some patient referrals, it may be additionally beneficial to examine whether the operational model is suitably equipped to manage the risk inherent in the patient population.

Consideration 4.3.4: Outreach & Education

Several interviewed clinicians expressed the view that veterans' presentations and needs were not fully understood by mainstream services. Consequently, the **education and outreach role of SWHIS** to help local services become veteran-informed (as opposed to veteran-specific) is worth highlighting and perhaps enhancing as the Service develops. Whilst this may reduce barriers to engagement and facilitate onward referral from SWHIS, professional-to-professional education

will not necessarily positively impact capacity challenges in local services.

However, this education function can only be fulfilled if there is suitable awareness of the existence of SWHIS amongst relevant professionals and services. Whilst knowledge of SWHIS currently appears to rely on the pre-existing professional networks of the Service clinicians, consideration could be given to a more **proactive outreach and publicity programme,** with a **standardised package of training delivered to local services around the Service and its role** . That said, it is unknown how a raised profile of SWHIS would positively bear on the issues discussed in 4.3.1.

It is abundantly clear to the authors that there is demonstrably a **great deal of professionalism, expertise, compassion and enthusiasm amongst the SWHIS clinicians** interviewed for this report. Clinicians appear to have their patients' interests at heart and SWHIS involvement in care is rooted in positive and practical change. The veteran population and their needs described in this report is diverse, with significant variation across the region. It is the authors' hope that this report can positively contribute to the continued development of a High Intensity Service, that can appropriately align with and enhance the most appropriate local care services available to address the unmet needs of veterans in crisis.

5. REFERENCES AND NOTES

1 Office for Veterans' Affairs. (2020). *Veterans Factsheet 2020*. https://www.gov.uk/government/publications/veterans-factsheet-2020

2 In 2020, 12 700 left regular service and 4 660 left reserve service. Ministry of Defence. (2021). *UK Armed Forces Quarterly Service Personnel Statistics 1 April 2021*. https://www.gov.uk/government/statistics/quarterly-service-personnel-statistics-2021

3 Iversen, A., Nikolaou, V., Greenberg, N., Unwin, C., Hull, L., Hotopf, M., Dandeker, C., Ross, J., & Wessely, S. (2005). What happens to British veterans when they leave the armed forces? *European Journal of Public Health*, *15*(2), 175–184. https://doi.org/10.1093/eurpub/cki128

4 Burdett, H., Greenberg, N., Fear, N. T., & Jones, N. (2014). The mental health of military veterans in the UK. *International Psychiatry*, *11*(4), 88–89. https://doi.org/10.1192/S1749367600004665

5 Diehle, J., Williamson, V., & Greenberg, N. (2019). Out of sight out of mind: an examination of mental health problems in UK military reservists and veterans. *Journal of Mental Health*, 1–6. https://doi.org/10.1080/09638237.2019.1581348

6 Sharp, M.-L., Busuttil, W., & Murphy, D. (2019). Examining physical health conditions and associations of pain, obesity, and function of UK Veterans diagnosed with PTSD and other mental health conditions. *Journal of Military, Veteran and Family Health*, *5*(2), 75–87. https://doi.org/10.3138/jmvfh.2018-0051

7 Burdett, H., Fear, N. T., Wessely, S., & Rona, R. J. (2021). Military and demographic predictors of mental ill-health and socioeconomic hardship among UK veterans. *BMC Psychiatry*, *21*(1). https://doi.org/10.1186/s12888-021-03296-x

8 Goodwin, L., Wessely, S., Hotopf, M., Jones, M., Greenberg, N., Rona, R. J., Hull, L., & 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. https://doi.org/10.1017/S0033291714002980

9 Rhead, R., Macmanus, D., Jones, M., Greenberg, N., Fear, N., & Goodwin, L. (2020). Mental health disorders and alcohol misuse among UK military veterans and the general population: a comparison study. *Psychological Medicine*, 1–11. https://doi.org/https://doi.org/10.1017/S0033291720001944

10 Stevelink, S. A. M., Jones, M., Hull, L., Pernet, D., Maccrimmon, S., Goodwin, L., Macmanus, D., Murphy, D., Jones, N., Greenberg, N., Rona, R. J., Fear, N. T., & Wessely, S. (2018). Mental health outcomes at the end of the British involvement in the Iraq and Afghanistan conflicts: A cohort study. *British Journal of Psychiatry*, *213*(6), 690–697. https://doi.org/10.1192/bjp.2018.175

11 Goodwin, L., Norton, S., Fear, N. T., Jones, M., Hull, L., Wessely, S., & Rona, R. J. (2017). Trajectories of alcohol use in the UK military and associations with mental health. *Addictive Behaviors*, *75*, 130–137. https://doi.org/10.1016/j.addbeh.2017.07.010

12 This may be attributed to a number of factors including variation in operational tempo or content, leading to fewer physical injuries, awareness and de-stigmatisation campaigns, as well as policy and clinical activity change due to COVID. In the Royal Navy, musculoskeletal disorders and injury are still the primary reasons for discharge, and this is particularly demonstrated when the Royal Marines are considered as a separate cohort. Ministry of Defence. (2021). *Annual Medical Discharges in the UK Regular Armed Forces*. https://www.gov.uk/government/collections/medical-discharges-among-uk-service-personnel-statistics-index

13 Binks, E., & Cambridge, S. (2018). The Transition Experiences of British Military Veterans. *Political Psychology*, *39*(1), 125–142. https://doi.org/10.1111/pops.12399

14 Gordon, K., Burnell, K., & Wilson, C. (2020). Outside the Military “Bubble”: Life After Service for UK Ex-armed Forces Personnel. *Frontiers in Public Health*, *8*. https://doi.org/10.3389/fpubh.2020.00050

15 Murphy D, Weijers B, Palmer E, & Busuttil W. (2015). Exploring Patterns in Referrals to Combat Stress for Uk Veterans with Mental Health Difficulties between 1994 and 2014. *International Journal of Emergency Mental Health and Human Resilience*, *17*(3). https://doi.org/10.4172/1522-4821.1000250

16 Iversen, A., Dyson, C., Smith, N., Greenberg, N., Walwyn, R., Unwin, C., Hull, L., Hotopf, M., Dandeker, C., Ross, J., & Wessely, S. (2005). ‘Goodbye and good luck’: the mental health needs and treatment experiences of British ex-service personnel. *British Journal of Psychiatry*, *186*(6), 480–486. https://doi.org/10.1192/bjp.186.6.480

17 Coleman, S. J., Stevelink, S. A. M., Hatch, S. L., Denny, J. A., & Greenberg, N. (2017). Stigma-related barriers and facilitators to help seeking for mental health issues in the armed forces: A systematic review and thematic synthesis of qualitative literature. *Psychological Medicine*, *47*(11), 1880–1892. https://doi.org/10.1017/S0033291717000356

18 Williamson, V., Greenberg, N., & Stevelink, S. A. M. (2019). Perceived stigma and barriers to care in UK Armed Forces personnel and veterans with and without probable mental disorders. *BMC Psychology*, *7*(1). https://doi.org/10.1186/s40359-019-0351-7

19 Mellotte, H., Murphy, D., Rafferty, L., & Greenberg, N. (2017). Pathways into mental health care for UK veterans: A qualitative study. *European Journal of Psychotraumatology*, *8*(1). https://doi.org/10.1080/20008198.2017.1389207

20 Mitchell, C., McMillan, B., & Hagan, T. (2017). Mental health help-seeking behaviours in young adults. *British Journal of General Practice 67*(654). https://doi.org/10.3399/bjgp17X688453

21 Murphy, D., Hunt, E., Luzon, O., & Greenberg, N. (2014). Exploring positive pathways to care for members of the UK Armed Forces receiving treatment for PTSD: a qualitative study. *European Journal of Psychotraumatology*, *5*(1), 21759. https://doi.org/10.3402/ejpt.v5.21759

22 Rafferty, L. A., Wessely, S., Stevelink, S. A. M., & Greenberg, N. (2019). The journey to professional mental health support: a qualitative exploration of the barriers and facilitators impacting military veterans’ engagement with mental health treatment. *European Journal of Psychotraumatology*, *10*(1). https://doi.org/10.1080/20008198.2019.1700613

23. The 2021 Census in Northern Ireland took place on the same date and did not include a question on previous UK Armed Forces service. The Census in Scotland in expected to take place in 2022.
Office for National Statistics. *Census 2021*. https://census.gov.uk/

24 Ministry of Defence. (2019). *Population Projections: UK Armed Forces Veterans residing in Great Britain, 2016 to 2028*. https://www.gov.uk/government/publications/population-projections-uk-armed-forces-veterans-residing-in-great-britain-2016-to-2028

25 HM Government. (2020). *Strategy for our Veterans – UK Government Consultation Response*. https://www.gov.uk/government/consultations/strategy-for-our-veterans-uk-government-consultation-paper

26 https://www.england.nhs.uk/2021/03/nhs-launches-op-courage-veterans-mental-health-service/

27. Dorset HealthCare University NHS Foundation Trust (2021). *Veterans High Intensity Mental Health Service South West Region, Ops Policy Document (Final) [Working Procedures], v1.8 01 August 2021.*

28 Iverson, A.C, Fear, N.T., Simonoff, E. et al. (2007). Influence of childhood adversity on health amongst male UK military personnel. *British Journal of Psychiatry*, 191. https://doi.org/10.1192/bjp.bp.107.039818

29 Ross, J., Armour, C., & Murphy, D. (2020). Childhood adversities in UK treatment-seeking military veterans. *Journal of the Royal Army Medical Corps*. https://doi.org/10.1136/jramc-2019-001297

30 American Psychiatric Association. (2013) *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. American Psychiatric Publishing.

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