EDITORIAL

Veteran mental health services in the UK: Are we headed in the right direction?

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Approximately 10% of the UK Armed Forces, equivalent to 20 000 service personnel, leave the military each year (DASA, 2007). For most individuals, service in the Armed Forces is beneficial but a minority have a bleaker outlook as a result of health, behaviour and social problems, some of which are related to their experiences in military service (Hatch et al., 2013; Iversen et al., 2009; MacManus et al., 2012a, 2013; Rowe et al., 2013). Specific health care for veterans is a relatively recent development in the UK, but it has been in place in other countries such as the USA for many years. The US systems developed after World War I and developed significantly in response to the needs of the veteran population in the aftermath of the Vietnam conflict. Indeed, that the current budget for the US Department of Veteran Affairs for an estimated population of 23 million veterans is roughly equivalent to that of the entire NHS emphasises the priority given to veteran health care in the US. Individuals who have served in the armed forces of the United States may be eligible for a broad range of mental health services provided by the US Department of Veterans Affairs (VA) (Kizer et al., 1997). However, despite the VA operating the nation’s largest integrated mental healthcare system, with more than 1400 sites of care, the majority of veterans still do not access these services (Goffman, 1963). The VA policy is to continue to increase its accessibility and address barriers to care (James & Woods, 2010), and in 2012 President Obama signed an Executive Order that pledged to improve access to mental health services for veterans, service members, and military families.

Such impetus for veteran care in the UK arrived much later than in the US. The much publicised physical and psychological burden placed on the UK Armed Forces by the conflicts in Iraq and Afghanistan (Caesar, 2010; King, 2009) has led to increased awareness of the problems faced by some veterans. International estimates of the prevalence of mental health problems among military personnel vary (Milliken et al., 2007; Sundin et al., 2010). Studies of UK military personnel have shown that depression, anxiety and alcohol misuse disorders are most prevalent (Iversen et al., 2009; Murphy et al., 2008),
but among UK clinical veteran samples Posttraumatic Stress Disorder (PTSD) is a more frequent presentation with estimated rates varying from 15% (Palmer, 2012) to 70% (van Hoorn et al., 2013). These high proportions are to be expected among those who are seeking help from services such as Combat Stress who specifically offer treatment for PTSD, and do not reflect the overall population prevalences. While these figures highlight the need for effective treatments for PTSD, they do not give us an indication of the prevalence of PTSD among veterans in the general population. It is increasingly recognised that veterans with mental health problems often present with significant clinical complexity due to a combination of early life difficulties (Iversen et al., 2007; MacManus et al., 2012b) and significant comorbidity such as substance misuse and anger problems. Substance misuse is of major concern among veteran populations (Fear et al., 2007; Graham & Livingston, 2011; Thomas et al., 2010), with its well-known links to numerous adverse outcomes (McFarlane, 1998; Graham & Livingston, 2011).

Once UK military personnel leave the Armed Forces, the responsibility for their care falls to the NHS. These problems have proved difficult to manage as veterans have been shown to be reticent to seek help for mental health problems (Iversen et al., 2011, Iversen et al., 2010), though whether this is worse than men in general or other occupational groups is unclear. This reticence to seek help is confounded by the fact that historically main stream NHS mental health services have often been ill-equipped to identify and respond to the needs of veterans. The problems of ex-serving personnel may fall between the cracks of existing services, too complex for primary care but not considered to cross the threshold for community mental health services, which are more focused on severe mental illness. There has been an explosion of new third sector providers in recent years, alongside more established brands such as the Royal British Legion and Combat Stress, which have endeavoured to fill in the cracks and deliver veteran-specific care and support to the UK veteran community for many years. This has resulted in a plethora of different approaches, interventions, philosophies and governance procedures. It is not surprising that many veterans report being rather confused. It is also unclear exactly which of these bodies should properly come under the official regulation of bodies such as the Care Quality Commission (CQC), and where the boundaries of treatment versus support lie.

Concerns about the ramifications of the prolonged military presence in Iraq and Afghanistan have led to new government motivation in recent years to support the development of veteran-specific mental health services in the UK as highlighted in the report in 2010 by Dr Andrew Murrison MP (Murrison, 2010). These government recommendations for an uplift in veteran mental health workers and the establishment of new community mental health services for veterans were followed by investment in regional NHS community veteran mental health services to work collaboratively with a main charitable organisation as their strategic partner (Combat Stress). There is significant variation in the choice of model of service delivery used by each regional NHS veteran service, ranging from the implementation of a veterans’ champion, who signposts into either NHS services or combat stress treatment pathway, to veteran-specific IAPT services. Combat Stress offers the main inpatient PTSD treatment programme in the UK with three main treatment centres. The model/effectiveness of collaborative working between Combat Stress and NHS services also varies across the UK. The newly structured NHS England has pledged to place an emphasis on the commissioning and development of services for prosthetics and mental health. With the rapid growth and development of NHS community mental health services and the establishment of a National Veterans’ Mental Health Network, the aim is to ensure that, with improved joined up working, gaps in service provision throughout the country will be filled. One thing that is clear is the motivation and energy behind these
teams to improve access to services and the quality of mental health care for a vulnerable group in society.

The new political support has been reinforced by the enshrinement in law of the Military Covenant, an important social pact predicated on society’s obligation to compensate for sacrifices made by serving personnel (Forster, 2012). The argument for the Military Covenant was that society has a duty to ensure that service personnel do not suffer disadvantage, health or otherwise, as a result of military service and that compensation is owed to those who have been prepared to (and sometimes do) sacrifice their lives in their country’s service. The nation’s duty of care to servicemen and women is considered to extend to payment towards health care, which can be for physical injuries or support for mental health problems after discharge, if incurred as a result of service. The enshrinement of the Covenant in law now places a formal obligation on the State. With this in mind, and in light of government money for Veteran Mental Healthcare that is ring-fenced from the rest of the NHS budget, are we set on a political pathway toward a system of separate veteran healthcare such as the US Department of Veteran Affairs? The fact that specific provision seems to be limited to prosthetics and mental health, means we are a long way from a specific veteran healthcare system as exists in the US, or even a specific mental healthcare system. The key argument against a system like that in the US must be first the size. There are 4.5 million veterans in the UK, and there would be serious objections to favouring, for example, only those who have been injured in the most recent wars over other older groups, and second, the issue that not all, or perhaps even most, mental health problems in veterans are directly attributable to service. For example, even considering PTSD alone, the quintessential disorder of combat trauma, only 50% of cases arising in currently serving personnel can be directly attributed to deployment (Jones et al., 2012).

It is important to emphasise that the USA and the UK each have different systems of health and social care. The need for separate health and social care provision for veterans in countries where health care is unequal is more easily justified. In the UK, the argument is less straightforward as the NHS has been freely available to anyone who wants to avail, including veterans. However, new veteran NHS services have developed as veterans were not accessing mainstream NHS services and anecdotally it is thought many prefer to see clinicians with an understanding of and sensitivity towards military life and culture (Ben-Zeev et al., 2012), at least at the assessment stage. One can sympathise with this, but, while we hear more from those who do want at least “veteran informed“ services if not “veteran specific” services, there are likely to be others who do not want either. Given the range of views expressed by those who are serving about preferred options for mental health care, we should remember that it is most unlikely there is a single “one size fits all” solution for veteran mental health (Greenberg et al., 2003).

In an age when the term “veteran” has become, in the eyes of many, synonymous with “hero”, and the military culture emphasises resilience and strength, it is worth considering how at odds this is with the traditional mental health discourse: a discourse that speaks of victims, sufferers and mental health problems. Is it any wonder ex-serving personnel find the transition into civilian health care difficult? On the other side, increasingly we read of veterans who have taken the other path and fallen foul of society, especially with regard to crime and violence (MacManus & Wessely, 2011). Usually neither heroes nor villains, this is a population which requires a balanced and sensitive approach to the development of mental health care suited to identifying, assessing and managing their needs (McCartney, 2011).

As we look towards 2015 when the government will decide whether or not to renew funding for veteran mental health services, we need to take stock of the direction in which
these services are heading. Further cuts in Ministry of Defence budget and increasing reliance on the Reserve forces, who we know to be more vulnerable to mental health problems (Harvey et al., 2012), come with renewed warnings of the potential rise in mental health needs among the future veteran population. In the UK, there is a considerable body of research which highlights that early service leavers are at greater risk of mental ill-health and social exclusion (Buckman et al., 2012; Woodhead et al., 2011a, 2011b) and carry a heavier burden of pre-military disadvantage (Buckman et al., 2012). Early intervention was a key recommendation of the Murrison report (Murrison, 2010), and veteran services in the UK are well placed to provide an outreach service to those in transition out of the Armed Forces. Whether the veteran population in an area warrants an independent veteran mental health service or just the training of NHS mental health workers in veteran-sensitive practice, the aim should be to have practitioners in each area with knowledge of working with veterans and their needs. The emphasis should be on ensuring there is no wrong door for veterans to access services (Kudler, 2007).

Declaration of Interest: Professor Wessely is a Trustee of Combat Stress, a charity providing mental health services to ex servicemen and women.

References


