

FINDING THE FORGOTTEN. MOTIVATING MILITARY VETERANS' TO REGISTER WITH A PRIMARY HEALTHCARE PRACTICE

INTRODUCTION

Before leaving the United Kingdom (UK) Armed Forces, service leavers receive a final medical examination. They then receive a written summary containing limited information regarding their medical and mental health (MH) history, and are directed to deliver this document to staff when they register with a civilian Primary Healthcare (PHC) general practice. The UK Ministry of Defence (MoD) does not monitor if service leavers actually register.

Since 1985, the UK has utilised Read Codes that are applied to a patient's PHC medical record to annotate characteristics such as diagnosis, ethnicity, and therapeutic interventions.¹ The UK's Department of Health directs that a Read Code should be applied to medical documentation indicating a "*history relating to military service*".² However, there are multiple military Read Codes available for distinctions such as service, i.e. Royal Navy, Army, Royal Air Force or Royal Marine. Whilst Health Education England (HEE) advocate the use of a single Read Code, there is no national agreement on which to apply.³ In addition, the utilisation of different databases systems, including those that are not synched, does not facilitate the compatible exporting of data.² Even in the UK, where all patients have a unique NHS identification number, there are still differences in the veteran numbering systems used in Scotland and Northern Ireland from that used in England, Wales and the Isle of Man. These factors contribute to an estimation that only 7.9% of PHC practices applied the Read Code correctly.⁴ This low figure is despite a National Health Service (NHS) website⁵ informing veterans of the healthcare benefits and there are no perceived barriers that specifically prevent veterans from registering. This study was funded by the UK NHS and assesses a strategy aimed at motivating veterans to register or notify their veteran status with their PHC General Practice, whilst improving PHC staff's awareness and knowledge of veteran related issues.

BACKGROUND

Armed Forces Community

The inclusion criteria for classification as a UK military veteran is 1 day of service in either the Regular Armed Forces or Reserves.⁵ The veteran population is estimated at approximately 2.6 million,⁶ embedded within the UK armed forces community (AFC) of 10M that includes veterans' families, and personnel still serving.⁵ This AFC is a diverse heterogeneous group differing by factors such as age, gender, and length of service. Veterans experience the same social and environmental stressors faced by the UK population,⁶ but are perceived as being more susceptible to MH issues due to previous "contact" situations (engagement with the enemy), particularly when colleagues were injured. As such, there is a public perception that Veterans are inevitably scarred by their military experiences,⁷ although a significant majority are physically and mentally well,⁸ and there is a need to redress this balance.⁹

Demographics

The veteran population is 89.5% (N=2,348,000) male and 10.5% (N=276,000) female.⁶ A Royal British Legion study¹⁰ indicated that of those aged 16-44 year olds, one in ten reports problems assimilating into society, and that they are more likely than the general population of the same age to report certain long-term illness such as depression. Veterans have entered the criminal judicial system in large numbers for violent crimes,¹¹ whilst Australian research indicates that there is an increase in alcohol intake after leaving the Armed Forces.¹² 52% of the veteran population is estimated at being 75 years old or older,^{6,10} and 70% are 60 years and over.⁶ They contribute to an estimated 190,000-290,000 of the 'hidden' ex-Service community e.g. those dwelling in communal institutions such as residential nursing homes.¹⁰ This study was completed in North West (NW) England, where Veterans form 5.1% (N=291,000) of the regional population. Many face social deprivation challenges,¹³ although the local civilian population are generally keen to help, which makes this a particularly apt setting for this study.¹⁴

National Health Service (NHS) & Help Seeking Behaviour

Military veterans are entitled to priority NHS treatment for operationally related physical and MH conditions.¹⁵ For enduring psychological problems there are bespoke Military Veteran Improved Access to Psychological Therapies Services. This model has benefits over statutory

NHS services, ¹⁶ including a better understanding of service culture, and is most effective for early services leavers. ^{17, 18} A Transition, Intervention and Liaison service offers another treatment option with multiple points of access including self-referral. ¹⁹

Veterans often “bottle up” their feelings; fearing the impact of sharing personal burdens with their family or appearing weak. ^{20, 21} Veterans may believe that civilian health professionals will not understand their past military experiences and not register with a PHC practice, ¹⁶ or not disclose their Veteran status. ²² Poor help seeking leads to excessive delays in addressing operationally attributable MH issues; often left until they are in crisis and social isolation. ²³ Innovations including social prescribing have emerged to positively and successfully promote help-seeking. EUROFIT ²⁴ is exploring the use of iconic football clubs to reach-out to men, ^{25, 26} whilst utilising creative motivators promoted by mobile applications. ²⁷

PHC have a clear role in improving and promoting the physical and mental wellbeing of the AFC and PHC Doctors can positively change behaviour patterns. ²⁸ NHS staff require an understanding and awareness of the health and social issues associated with the AFC and the treatment / referral pathways. To achieve this, HEE have provided a free online veterans education module ²⁹ and are supporting undergraduate AFC training sessions that will provide a common foundation for all clinical staff. ³⁰

AIM

To motivate veterans to notify PHC staff of the armed forces status or register with a GP.

The objectives were to:

- a. Identify whether an advertising campaign would motivate veterans to notify PHC staff of their armed forces status or register with a GP.
- b. Identify trends regarding age, gender, and marital status.
- c. Evaluate PHC staff assessment of the intervention, including the effectiveness, benefits, problems, and means for improvement.
- d. Determine PHC clinical personnel’s views regarding an online HEE educational module.

- e. Distinguish the potential for transferability to a larger national initiative.

THEORY & METHODOLOGY

This initiative intended to indicate how many veterans were registered with a PHC practice and the influence of an advertising campaign in improving this number. This information would help highlight if the health and social care services being provided for military veterans were being utilised. Data was drawn from a cluster of four PHC Practices containing 40,470 patients in Lancashire, England.

A mixed methods approach was adopted. Quantitative data was collected from patient medical records. PHC personnel completed pre and post Read Code searches either side of a 6-week intervention based around an advertising campaign that commenced in May 2017. This aim being to assess pre and post intervention the number of ex-military personnel with the correct veteran specific code annotated onto their medical records. Data collection captured demographic detail including age, gender, marital status, and any MH clinical diagnoses. A single Veterans Read Code was used (13Ji), thereby facilitating a robust, consistent, valid and reliable measurement. This strategy ensured conformity from different data collectors across the 4 practices. This search format was familiar to staff who routinely completed this task as a mandated quality return to their Clinical Commissioning Group. The data was anonymous and confidential, with the completed databases encrypted and sent directly to the first author before exporting to a SPSS database for analysis. When a suspected error was identified in the data, then the governance mechanism was to return to the PHC with the observation. This helped validate and confirm anomalies, although no other audit mechanism was in place to ensure compliance.

Qualitative data was obtained from interviews conducted in each Practice with the intent of capturing a balanced view. This provided an opportunity to gauge their observations of the intervention and to determine their views of what was appropriate and what could be made better. Finally, questions regarding benefits, shortfalls, and recommendations for improvements and their views on the HEE online module. These responses were subjected to content analysis³¹ incorporating modified grounded theory methodology³² that included: constructing analytical codes and categories from the data and not from preconceived assumptions; using the constant comparative method to construct comparisons during each stage of the analysis, and memo-writing to elaborate between categories, specify their

properties, define correlations and identify gaps. The evaluation was designed as a manageable pilot study that could be developed into a larger study if the results indicated the potential for wider transferability. Therefore, it did not matter if this initiative worked; the intent was to assert if it could be offer a cost effective method to meet the aim and objectives of the study.

METHOD

The first author visited each of the four PHC practices on three occasions. The first to meet staff and discuss their views on the initiative. This provided an opportunity to critically appraise the study and augment additional means for improving data capture. The lead author designed a Zap / display stand, and information for the PHC Practice's website and TV screens. External avenues of advertising included local professional sports clubs match day programmes, stadium announcements, social media including Facebook and local health networks. Author 2 circulated a press release (See Table 1). The common message conveyed was that veterans may be entitled to priority treatment including psychological therapies and to make their veteran status known. Alternatively, to stimulate family members to encourage their veteran relative to inform the PHC practice.

Table 1 here.

A pilot study was completed by veterans, lay people and academics. This determined that the advertising information conveyed the key messages, and in a format where the content was easily and consistently understood. For additional governance, the University of Chester's Westminster Veteran's Centre steering committee ³³ provided constructive comment.

The second occasion the author visited the practices was to deliver advertising materials, and information for uploading onto the practice TV screens. This also provided an opportunity to address any outstanding concerns. The PHC's practice manager was the nominated lead with responsibility for ensuring that the Read Code searches were completed in a timely fashion and for coordinating feedback. Each practice also nominated a lead General Practitioner, and each received a small financial remuneration. Certain PHC staff also completed an HEE e-learning package ²⁹ and received educational advice.

The third occasion the author visited the practices was following the advertising period to complete 8 post intervention interviews with the nominated lead and PHC staff. All interviews were recorded onto a digital audio recorder.

SPSS Version 24 was used for the management and analysis of quantitative information with the data exposed to descriptive statistical examination, predominately with frequency distributions and percentages. A one-sample test of binomial proportions was used to test whether rates of veteran registration differed per practice before and after the intervention was conducted. The authors acknowledge that each practice developed and introduced their own initiatives, and it is clear that there was no standardised start point, as certain practices were already more actively engaged with the veteran community due to factors such as a staff member having a relative who was a veteran.

The study was approved by the University of Chester's Research Ethics Committee and is in line with NHS Health Research Authority Guidelines. ³⁴

RESULTS

Pre and Post Testing The NW England veteran population is estimated at 291,000 veterans, this being 5.1% of the Great Britain Population.⁶ The sample group was 40,470; equating to an estimated 2,064 veterans registered within all 4 GP practices. The study's initial Read Code search indicated that 8.7% (N=180) of veterans had registered and had the correct Read Code applied to their medical record. Following the advertising intervention this increased by nearly 200% to N=537. This number equated to 26% of the estimated number of veterans. In comparing rates of veteran registration before and after the intervention (See Table 2), all practices experienced significantly higher rates post-intervention (z range from 6.46 to 43.69, $p < 0.0001$ for all practices).

Table 2 here.

Demographics. In this study, 87% (N=465) were men and 13% (N=72) women. The mean age was 63 years old although there were notable differences between each practice (See Figure 1).

Figure 1 here.

The median age was 64 years old with a mode of 79 years old. The standard deviation was 8 and the range 81 (16 years to 97 years). 44% (N=234) were aged 68 years old or over; 60% (N=324) were 58 years or over and 80% (N=429) 48 years or older. 10% (N=53) were 37

years or younger and 1.5% (N=8) were 27 years or younger (See Figure 2). 81% (N=439) of the relationship status detail was not available. From the remaining 19% (N=98); those potentially living with a partner was estimated at 68% (N=67) and 32% (N=31) living alone. (See Table 3). MH disorders were present in 28% (N=152) of veterans, including 15% (N=78) with depression.

Figure 2 here.

Table 3 here.

Staff Interviews: Interviews were conducted with 8 members of staff (individually or groups) from all 4 practices; lasting for a total of 109 minutes; with a mean of 27 minutes and they ranged from 12 to 45 minutes. Interviews revealed the PHC staff's opinions of how they can improve veterans' registration: characteristics of the veterans' population that influence their engagement; the impact of the advertising campaign and the role of education and further research. These are presented diagrammatically in Figure 3. The interviews also provided feedback regarding the value of the HEE education module.

Presentation of the findings is intended to protect the anonymity of the respondents, and no published material will contain references or specific attributable reference to the study participants or patient group. To help maintain the flow of the narrative, examples of the participant's commentary is embedded in the following discussion section.

Figure 3 here.

DISCUSSION

In 2015, Simpson and Leach reported that only 8% of UK veterans were registered at a PHC practice with the appropriate Read Code attached to their medical record. Two years later, and despite significant investment in veterans' health and social care, the pre intervention Read Code search in this study identified only 8.7% with the correct code. In this study's 6-week intervention period, there was an increase to 26%; with a one practice rising from 3% to 38%.

An important factor in this improvement was motivating all PHC staff to be involved. They accepted ownership and responsibility for making this initiative work. The PHC staff were creative in introducing original ways of enhancing recruitment, with some practices developed additional display materials. The study raised awareness, including reception staff who viewed the campaign as a worthy cause and enjoyed contributing to the campaign.

“It has raised awareness with the staff; whereas before nobody saw the relevance of it so it has been good to inform our staff what was going on because they didn’t know.”

This commitment was confirmed in that each PHC wanted to continue the recruitment drive. Indeed, three PHC practices kept their advertising Zap Stands on display after the closing date of the advertising campaign and one had the TV screen display still reaching out with information for the veteran community. They were actively recording veteran’s status, and all the PHCs added the Read Coding criteria for a military veteran to new patient registration forms.

“If we leave it up longer (*Display Stand*) then we’ll get more. Many won’t go online unless they need an appointment. I think it would be interesting to see what happens when we do the flu clinics in October. Because we get a lot of the older age people coming in.”

In one practice, all the staff approved and engaged in a new patient booking triage system. Thereby, booking a patient consultation activated a message prompting the question “*Has the patient been in military service?*” This added the veterans Read Code when the answer was yes. The same structure was applied to telephone requests for an appointment, and staff asked this question of every patient during the 6-week intervention period. One practice placed an alert on family members. The rationale being that whilst the Read Code is for veterans, referrals for MH services or bereavement counselling impacts on the whole family.

“We have also labelled their families as well. At the minute, there is only a military veterans code. So we now put an alert on so that their families can access support as well. Alert comes up on the first screen – Military Veteran Family. “

Staff were pleased to see an increase in the number of veterans correctly registered and to receive positive feedback for their efforts. They were interested in empirical evidence regarding veterans' health and social needs, and how these correlated with the veterans past military service. They wanted to know what services were available including the role of charities, and they wanted an information / resource pack that could give to their patients to take home with them.

“They might be telling you they are going to get kicked out of the house. If they take the pack home, they would read and then ask for help. They don't tell you the social things that cause the stressors. It's paying bills, relationship problems. At Christmas these (the nurses) are like financial advisors directing people to someone who can help.”

Respondents perceived veterans as a proud patient group, and reported men and women veterans of all ages welcomed this initiative. Some veterans visited PHC surgeries with the sole intent of highlighting their status, whilst others informed their GP. This formed part of multiple access points including informing nursing and reception staff. Some wanted to share their stories, in particular older patients wanted to discuss their military service with reception staff.

Veterans reported visiting GP Practices regularly over many years without knowledge that they may be entitled to priority care, and therefore had never mentioned their service history. Others simply did not class themselves as veterans, for example post World War 2 conscripts who completed UK National Service. A significant factor for non-declaration of veteran status was the inclusion criteria of serving one day in the Armed Forces. This was a surprise to staff, veterans and other patients. Many of whom disagreed with this position, expressing difficulty in correlating 1 day's service into a lifetime military status and entitlement to benefits.

“Everyone surprised about one day. Priority for mental health services and being in the Forces; if you have only been there one day then you are highly unlikely to be affected.”

Others veterans were interested in what priority treatment was available, the referral pathways, and their GP's specialist scope of practice. One patient wanted his priority

treatment immediately, and there was a raising of expectations. However, choice and communication is important as some did not want their veteran status recorded. They did not offer a reason, and staff felt it best not to press them.

“even when told that we weren’t after any further questions or it was purely to collate numbers; they didn’t like it at all. They said *“I’m a veteran, but I don’t want anything recorded or anything. I don’t want my name put down for that”*. But provided no reason. You don’t want to push them, they close the door and don’t look back, it’s not their life anymore.”

The advertising campaign at multiple levels was successful, and a three-fold increase of veterans registered with the correct coding clearly indicates that they responded positively to this campaign. However, even in the short intervention period there were nevertheless challenges with the advertising campaign effected by unpredictable events. These included a NHS cyber-attack³⁵ and a flash general election leading to a period of purdah.³⁶

It is difficult to create a hierarchy of what was most successful. Inside the GP practice, the Zap Stand was a focal point, and staff, patients and veterans were impressed with the message and impact.

“The girls said a “lot of the patients you didn’t have to ask them. They were sat in the waiting area and then saw it on the screen or come to pick their prescription up and saw the stand.”

The intervention was designed to reach out to younger veterans and those that rarely visit a GP practice and the support of the local professional sports clubs is likely to have influenced their registration. For all patients, the campaign included utilising information technology and social media such as Facebook and Twitter. One Facebook message received 920 likes (a best positive response) and a number of shares, and did not generate any negative comments. Not least, in close communities, word of mouth communication was viewed as particularly relevant, and there appeared to be an especially good uptake over the 2 weeks either side of an Armed Forces weekend in June 2017.

“In TOWN, good news goes fast; bad news very quickly. People talk to each other, and if positive it helps.”

Whilst healthcare systems differ between the UK and the USA, there are similarities and overlap between this initiative and the American Academy of Nursing “Have You Ever Served in the Military?” advertising campaign ³⁷ that suggest that elements are transferable. These include reaching out to relatives and the positive engagement and education of all frontline healthcare staff across all available treatment systems. This may lead to more veterans accessing the Veterans Association.

The HEE online module aimed at helping clinical staff understand the unique needs of the veteran community was viewed as being informative, although there were reports of it being repetitive, and time consuming.

CONCLUSION

The positive outcomes of this study in a very short time period are extremely encouraging, and it is highly likely that the number of veterans declaring their veteran status or registering with a GP for the first time is likely to increase. However, only a small number of younger veterans had registered, and there remains a need to catch those who never access a PHC practice. Research should explore the role of strong cultural links such as professional sports clubs (present in every UK city) and their role in promoting help seeking and mental / public health awareness. This should include if these mediums are: attractive option for women; impacting on the family; influencing minority groups living in regions of health inequality including socially deprived areas. These important differences will add to an emerging coherent body of knowledge. This will present a better means for diversity and equability and produce a clear pathway to better PH and wellbeing models. In addition, there remains a requirement to reach family members who may act as a conduit to reach the elderly isolated veteran community living in care homes.

There is an ongoing requirement to inform ex-service personnel of the 1day inclusion criteria for veteran status, and the service provision available. The introduction of a one stop “Veteran’s Gateway” ³⁸ may achieve this, although how veterans will become aware of this service is untested.

A better understanding of the Read Coding is required, reinforced by a re-invigoration of the campaign to routinely ask patients; “*Have you or your family served?*” The HEE ²⁹ online module advocates the use of a single veteran specific Read Code and there is a compelling case to confirm this position in policy. This would be assisted by developing health record systems that were synched to each other.

Educational packages should prepare staff for the typical case presentations; reinforce person-centered and individualised care packages whilst encouraging staff to remain cognisant of the complexity behind those indicators. The developments in online educational programme should be underpinned by common undergraduate syllabi.

There is clear area for further development and evaluation, and to forge a relationship with a funder to support the initiative and research. All staff stated that they would agree to future studies if the human resource implications were addressed. There remains a need to encourage and help veterans to either self-support or seek help as early as possible. The reason for the improved numbers are multi factorial, and it is clear that the advertising campaign was a motivator. What is less clear is the impact that the researcher’s personal advocacy and intervention with staff had on motivating them to reach out to veterans within their PHC practice.

The paper adds to the limited empirical research undertaken to explore help seeking behaviour in the armed forces community. It provides pointers to help isolated veterans to engage. The positive increase may result in those patients accessing care from specialist MH services. The striking aspect of this study is the simplicity of the intervention that can be replicated virtually anywhere. Therefore, the positive outcomes of increased awareness and staff commitment provides a template for sustainability that could be replicated nationally.

STUDY LIMITATIONS

The number of the veteran population is estimated on sampling, with the potential that the appraisal is artificially high. No data was collected regarding the Veteran’s military background such as length of service, service background, number and frequency of operational tours. The sample size for female veterans was small. The data did not define the impact that the author’s personal intervention and advocacy had on motivating staff to engage

with veterans, and this has implications for wider transferability. It was recognised that the advertising strategy was unlikely to access every veteran, but the intent was to determine if this cost effective strategy could be successful. Read coding was from patient declaration, and no checks were in place to determine that they served in the Armed Forces.

Table 4 Here.

This paper has been presented at the VA hospital in Pennsylvania, USA on 6 September 2017 and at the University of Chester, England Veterans Symposium on 5 October 2017.

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