Call to Mind: Wales

Findings from the Review of Veterans' and their Families' Mental and Related Health Needs in Wales

Final Report

May 2016

A report prepared by Community Innovations Enterprise on behalf of the Forces in Mind Trust

Preface

This report provides the findings from a review of the mental and related health needs of veterans and family members in Wales. A lot of good work has been developed in Wales in recent years to better meet the mental and related health needs of veterans and their family members. Some of the service models that have been established in Wales are unique in the UK and there is much that can be learnt from these by commissioners, policy makers and service providers in the rest of the UK.

There is good evidence in Wales of some effective multi-agency partnership working and a number of improvements have been made in data collection, support during transition to civilian life and work within the criminal justice system. There are also some examples of excellent and innovative work that involves the service community working together with a range of statutory and voluntary sector organisations.

The report highlights opportunities for further work and progress to be made and the identification of the need for even greater involvement, liaison and action at the point of serving and /or transition is particularly welcomed. As indeed is the proposal to ensure that veterans' and family members' mental and related health needs are considered in new legislation coming into force in Wales such as the Social Services and Wellbeing (Wales) and Wellbeing of Future Generations Acts, to be implemented by 2017.

The Forces in Mind Trust commissioned Community Innovations Enterprise to undertake this review in Wales following the successful completion of similar work in England. Reviews are also currently taking place in Scotland and Northern Ireland and the end result will be the first comprehensive review of meeting the mental and related health needs for veterans and family members for the whole of the UK. The Call to Mind: Wales report will contribute a great deal to this wider body of work while at the same time enabling policy makers, service planners and providers in Wales to continue to progress and build on their record of achievement in this area.

Professor The Lord Patel of Bradford OBE

Air Vice-Marshal Tony Stables CBE
Chairman, Forces in Mind Trust

Foreword

As Chair of the Cross Party Group on the Armed Forces and Cadets in the National Assembly for Wales (4th Assembly) I welcome the Call to Mind: Wales report on meeting the mental and related health needs of veterans and their family members. I have been calling for better treatment of our veterans for many years and this report is especially important as it focuses on an area where there continues to be a lot of stigma and so it is vital we understand the issues that people are facing.

We can be rightly proud in Wales of the work we have done to help veterans with mental health problems and the report recognises that we have some unique and innovative services, including the only national veterans' service in the UK. However, despite these achievements and in many ways being a leader in the UK there is still more that we can do. The Call to Mind: Wales report highlights that we need to be more strategic in how we focus and co-ordinate the planning and commissioning of services across sectors in relations to veterans' mental health. We need greater consistency in the implementation of services across Wales as a whole including our more rural areas. We also need to ensure the long term sustainability of our services in particular the excellent work provided by Veterans NHS Wales and Change Step. This will be particularly important for ensuring that we have effective multi-agency partnerships for meeting the needs of veterans with the most complex needs, especially those with a dual diagnosis involving both mental health problems and alcohol or drug problems and those involved with the criminal justice sector.

This is a very important time of change in Wales with the advent of the Social Services and Wellbeing (Wales) and Wellbeing of Future Generations Acts both of which have important implications for continuing to meet the needs of veterans and their families. The Call to Mind: Wales report is very timely in this respect and provides a sound assessment of the issues, our progress to date and where we need to be moving forward to ensure that any veteran and their family receives the best care at the earliest opportunity.

It is impossible to overstate the massive contribution that those serving in our armed forces make to keeping our nation safe, often at great personal risk, and for this they deserve the very best services and support. This report will help us to do that and I am very thankful to the Forces in Mind Trust and Community Innovations Enterprise for their valuable contribution in helping us achieve this.

Darren Millar AM
Chair of the Cross Party Group for the Armed Forces and Cadets (4th Assembly)
National Assembly for Wales

Forces in Mind Trust

The Forces in Mind Trust was founded in 2012 to improve the transition of military personnel, and their families, at the end of a period of service in the armed forces back into the civilian world. That world comprises many facets: employment; housing; health and wellbeing; social networks; and a sense of identity and worth each contribute to a 'successful' transition. Recognising early on that ex-Service personnel suffering mental health or wellbeing issues are particularly vulnerable to failed transition, the Forces in Mind Trust, established through an endowment from the Big Lottery Fund, committed itself to gaining a better understanding of the causes and effects of such issues on transition.

In addition to mental health, the Forces in Mind Trust has also commissioned research into supported housing, employment and the whole transition process itself. Grants have been awarded to programmes as diverse as mentoring ex-offenders through to challenge projects for wounded, injured and sick ex-Service personnel in partnership with the Royal Foundation. Full details can be found on our website www.fim-trust.org

Looking ahead, the Forces in Mind Trust will continue to initiate research and award grants to programmes that provide evidential output thus improving the transition process as well as directly supporting ex-Service personnel. Applications are welcome from any organisation engaged in such activity either through our website or by contacting enquiries@fim-trust.org.

Community Innovations Enterprise

Community Innovations Enterprise (CIE) was founded in March 2011 and provides a range of research, consultancy and project management programmes in the fields of mental health, drug and alcohol use, offender health and service user involvement.

CIE has significant experience in assessing needs for different population groups across the health, social care and criminal justice sectors. The key outcome of this work has been to help commissioners and service providers to better understand the full range of health and social care needs of the population groups they serve including assessing the impact of service re-design and identifying gaps in provision and areas of good practice.

CIE aims to go beyond traditional approaches to assessment and consultation services by placing the communities or client groups in question at the heart of the chosen development. We support organisations to reach the full diversity of their clients and communities while at the same time increasing their capacity and capability to achieve meaningful service user and public involvement and promote social inclusion.

Authors

Dr Clare Collins
Dr Jon Bashford
Sherife Hasan
Professor Lord Patel of Bradford OBE

Acknowledgments

The review team thanks all agencies and individuals across Wales who gave generously of their time, knowledge and experience to contribute to this report.

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Particular thanks are given to those who put us in touch with others who might be willing to participate in the review, shared data and reports or hosted discussions with veterans and families.

Executive Summary

Call to Mind: a Framework for Action. Findings from the review of veterans and family members mental and related health needs assessments (Forces in Mind Trust and CIE, June 2015) reviewed veterans and family members' mental and related health needs assessments in England. Forces in Mind Trust (FiMT) subsequently commissioned CIE to undertake reviews in the devolved nations of Northern Ireland, Scotland and Wales, with a view to producing a stand-alone report for each country and a UK wide report once all reviews are complete. Bespoke plans for each nation were developed through a scoping stage in autumn 2015 and the Wales review took place January-April 2016.

Chapter One of this report gives the background to and methods of the review, and sets out the Welsh context i.e. structure of the healthcare system, and key national strategies.

Chapter Two looks at the extent to which veterans' needs are covered in Local Health Board business plans; and sets out stakeholders' views on the need to engage veterans who are mental health users in the planning process. The need for Armed Forces Forums and Champions to work more effectively and consistently across the country is highlighted, and for further improvements to be made in terms of data to inform long-term local level planning/commissioning regarding veterans' mental health and related health needs. The need for a more strategic and co-ordinated approach to planning/commissioning across regions and sectors is identified. This is required if the improvements made by services and multi-agency partnerships are not to be placed at risk, and for the needs of all areas including urban and rural to be met on a long-term, sustainable basis. The importance of ensuring that the needs of veterans are taken into account in the new assessment and planning/commissioning processes being established over the next year under the Social Services and Wellbeing Act (Wales) 2014, and the Wellbeing of Future Generations (Wales) Act 2015, is highlighted.

Chapter Three sets out the further improvements stakeholders, veterans and families identified as needed relating to prevention and early identification, particularly within services and at the resettlement stage. While Veterans' NHS Wales was considered to provide a high quality service, unique to Wales within the UK, statutory sector stakeholders had strong concerns about its capacity and ability to meet demand robustly and sustainably across the whole of Wales. Voluntary and independent sector stakeholders and veterans and families attached stronger importance to making improvements in mainstream services, and particularly community services. These were seen as key to combatting isolation, early identification of problems and supporting and sustaining treatment.

Stakeholders also highlighted the need to address barriers to veterans and families accessing GPs and other services, such as reluctance to seek help and frustration at waiting times/waiting lists, and to support veterans and families to be more willing to access civilian services. They emphasised the importance of building the cultural competence of mainstream services to ensure veterans' needs are met on a long-term and sustainable basis, but the ability of Veterans' NHS Wales to help in this task could be limited by capacity problems.

Concerns were also expressed that common mental health needs may be overshadowed by over-emphasis on Post Traumatic Stress Disorder (PTSD); and about the diagnosis of and treatment response to PTSD within mainstream services. The importance of an appropriate and timely response to related health needs, such as physical health and dementia, was also raised.

Chapter Four sets out the need for multi-agency responses to complex psycho-social needs, particularly for high need groups such as Early Service Leavers, dual diagnosis patients and veterans with mental health problems involved in the criminal justice system (CJS). Stakeholders and veterans/families called for simpler, clearer, more efficient and better co-ordinated assessment and referral pathways across Wales as a whole. Some stakeholders expressed concern about the operation of the dual diagnosis pathway and how to meet the needs of veterans currently using drugs and alcohol and who are excluded from services. The importance of developing a strategic national approach and close working relationships at local levels to address the needs of veterans with mental health problems who become involved with the CJS was also highlighted.

Chapter Five sets out the practical, emotional, and support needs of families of veterans with mental health problems, currently seen as a gap both in terms of evidence and access to information and services. Some stakeholders and families reported safeguarding issues around domestic violence and the long-term effect on children's mental health and wellbeing, requiring a structured, holistic response. The important role families play in supporting and sustaining the recovery of the veterans, and identifying their problems and needs was emphasised; along with the need to capacity build families so they have the resilience and knowledge to play this role. This would also help prevent family breakdown, which can lead to the veteran becoming isolated.

Chapter Six sets out the top three priorities for change identified by all those who participated in the review, analysed together; and of each of the three sub-groups involved in the review i.e. statutory sector stakeholders, voluntary/independent sector stakeholders and veterans and families. While statutory sector stakeholders strongly prioritised increasing VNHSW's capacity and improving data to inform commissioning and service provision, the focus of voluntary and independent sector stakeholders and of veterans and families was on improving mainstream services, and on doing more to support families and carers.

Chapter Seven concludes that while much progress has been made in recent years in Wales with respect to meeting the mental and related health needs of veterans, there are a number of opportunities over the next year for further improvements including:

- the new commissioning and assessment mechanisms under the Social Services and Wellbeing (Wales) and Wellbeing of Future Generations Acts;

- the next round of Local Health Boards' annually refreshed business plans;

- the new Together for Mental Health delivery plan.

Key risks to progress are identified including:

- lack of strategic focus and co-ordination in terms of planning/commissioning of services for veterans - both generalist and specialist - across sectors and regions;

- inconsistent and variable implementation across Wales of the Armed Forces Forums and Champions;

- issues around long-term sustainability of/capacity within services identified as 'best in class' in Wales by stakeholders, which threaten the progress made in:

    - establishing effective local multi-agency partnerships to improve assessment and referral pathways; and
    - meeting the needs of veterans with highly complex needs particularly those with dual diagnosis and those involved in the CJS;

- unmet need among veterans and families, with more prevention, identification and early intervention needed within generalist/mainstream services to prevent pressure on crisis services.

It concludes that a more strategic, co-ordinated and effectively led approach across the whole of Wales to assessing and planning to meet veterans' and families' mental health and related health needs is needed to mitigate these risks.

The key issues identified throughout the report are listed at the end of Chapter Seven:

1: Ensure veterans' mental health and related health needs are factored into the development of Health Boards Integrated Intermediate Medium Term Plans, with broad engagement around veterans' issues including with mental health users and their families/carers.

2: Achieve more consistency and clarity around strategic structures such as Armed Forces Forums/Champions; and more integration between the work of Health Boards and Local Authorities, responsible for many of the key wider determinants of mental health and wellbeing such as housing and employment.

3: Continue to improve quantitative and qualitative data on veterans for local level needs assessment and planning/commissioning, including on specific sub-groups such as: female veterans; veterans with a dual diagnosis; veterans within the CJS; and veterans' families.

4: Strengthen leadership and accountability mechanisms at national level to:

- drive forward a co-ordinated, strategic and effectively implemented approach across Wales as a whole to assessing and planning to meet veterans' and families' mental health and related health needs;
- maximise the overall national spend on veterans' mental health across sectors, including ensuring high quality services are appropriately and sustainably funded;
- provide quality, effective services meeting the variety of needs of those living within both rural and urban areas sustainably and prudently.

5: Work with key partners to seek to improve quality assurance/governance and reduce confusion/duplication within the voluntary sector, particularly those offering treatment solutions to which individuals can self-refer.

6. Highlight in precise and sensitive terms the needs of veterans as a group and ensure they are factored into the new assessment and planning/commissioning mechanisms being implemented over the coming year under the Social Services and Wellbeing (Wales) and Wellbeing of Future Generations Acts.

7: Continue improvements at the point of serving and/or resettlement, particularly around: early identification and appropriate treatment of problems; and better liaison between military and civilian services to ensure continuity of care.

8: Ensure Veterans' NHS Wales has appropriate capacity on a sustainable basis across the whole of Wales.

9: Identify veterans as a population group with specific clinical risks, barriers to accessing services and cultural needs within services, and undertake:

- assertive outreach to veterans and families;
- capacity-building within mainstream services to meet their needs in a culturally competent manner;
- working with them around their expectations of civilian services and support them to be willing to access them;
- achieving an appropriate balance between specialist and generalist services across sectors.

10: Ensure the focus of planners and providers nationally, regionally and locally is on all types of conditions among veterans, physical and mental.

11: Address concerns about the diagnosis of and treatment response to PTSD within mainstream services.

12: Build, support and sustain Clinical Networks of agencies, including both mainstream and specialist services across sectors, to provide better co-ordinated and more effective and efficient assessment and referral processes across the whole of Wales.

13: Address concerns about how well the dual diagnosis pathway is working in practice; and how best to meet the needs of veterans currently using drugs/alcohol and therefore excluded from services.

14: Develop a strategic national approach across sectors to meet the needs of veterans with mental health needs within the CJS, including learning from current/forthcoming initiatives in this area in Wales; sustain and develop local level partnerships to the benefit of both veterans and services themselves.

15: Recognise and appropriately cater for the practical, social and emotional support needs of the families of veterans with mental health problems including safeguarding issues particularly around domestic violence and the long-term wellbeing of children; capacity build family resilience and knowledge, to fulfil their key role in prevention, identification and sustainable treatment of veterans' mental and related health problems.

Chapter 1: Introduction

CHAPTER SUMMARY
Chapter One sets out: • **the background to the review, its methods and the report structure** • **the Welsh context i.e. structure of the healthcare system, and key national strategies: the Welsh Government Package of Support for Veterans, and 'Together for Mental Health'.**

1.1 Background

Call to Mind: a Framework for Action. Findings from the review of veterans and family members mental and related health needs assessments (Forces in Mind Trust and CIE, June 2015) reviewed veterans and family members' mental and related health needs assessments in England. The review was commissioned by Forces in Mind Trust (FiMT), in collaboration with NHS England. The scope of the review was restricted to England as one of its primary aims was to inform commissioning for NHS England and Clinical Commissioning Groups (CCGs).

The England review highlighted the importance of not exaggerating problems such as severe mental illness, imprisonment and homelessness among the veteran population; and the positive impacts serving in the armed forces could have on health particularly among recruits from deprived areas (at least while serving). It also highlighted however increased concerns about veterans' mental and related health needs, and identified some significant gaps e.g. in assessment processes to identify and meet these needs. It identified priorities for action to be taken forward in addressing these gaps and meeting the mental and related health needs of veterans and family members.

FiMT subsequently commissioned CIE to undertake reviews in the devolved nations of Northern Ireland, Scotland and Wales, with a view to producing a stand-alone report for each country and a UK wide report once all reviews are complete. Bespoke plans for each nation were developed through a scoping stage in autumn 2015 and the Wales review took place January-April 2016.

1.2 Methods

The Wales review consisted of a desktop review of key documents, such as national strategies and Local Health Board plans; and in-depth qualitative research with stakeholders in the statutory, voluntary and independent sectors, and with veterans and family members themselves. Seventeen statutory sector organisations across Wales took part in the review including the Welsh Government, the Cross Party Group for the Armed Forces and Cadets, Veterans' NHS Wales, Local Health Boards (including some Armed Forces Champions and Executive Leads or their representatives), local Councils, Public Health Wales (national and Powys Teams), Health Inspectorate Wales, Community Health Councils Wales and the Ministry of Defence (MOD)'s Veterans Welfare Service.

Fourteen voluntary and independent sector organisations across Wales participated including the Royal British Legion (RBL), the Warrior Programme, Combat Stress, CAIS' Change Step and Listen In projects, Defence Medical Welfare Service, Alabare Wales Homes for Veterans, LINKS, West Wales Action for Mental Health, West Wales Ex-Service Personnel Mental Health Voluntary Sector Network, the VC Gallery, Cardiff and Vale Action for Mental Health, G4S and a GP.

Sixty-one individuals were involved in total across Wales in interviews and focus groups. The fieldwork comprised of a mix of telephone and face to face in-depth interviews lasting 30-90 minutes (36 people); and focus groups lasting 60-75 minutes (25 people). Twenty-four were veterans and family members (mainly in focus groups); 37 statutory, voluntary and independent sector stakeholders (however some of these stakeholders were also themselves veterans or family members of service personnel/veterans). The time at which the veterans/families had experienced discharge from services varied widely, from decades ago to recently.

Participants were invited to name up to three priorities for change over the upcoming year. These were analysed in two ways: first, the top three priorities of all participants in the review were identified; then, the top three priorities for each of the three sub-groups involved in the review - statutory sector stakeholders, voluntary/independent sector stakeholders, and veterans/families.

1.3 Report structure

The report sets out:

- Chapter 2: Assessment and planning/commissioning processes
- Chapter 3: Care pathways
- Section 4: Multi-agency working
- Section 5: Families and carers
- Section 6: Priorities for change
- Section 7: Conclusion

1.4 Context

Healthcare system

Since 1999 health has been a devolved matter in Wales, with the National Assembly for Wales determining both the budget for most healthcare (within a block grant from the Government in Westminster) and how services are organised. Healthcare is delivered through NHS Wales and is the responsibility of the National Assembly for Wales. Seven Local Health Boards (LHBs) were created in 2009 following a reorganisation of NHS Wales. Three NHS Trusts, called 'all-Wales trusts', operate nationwide agencies and services. Healthcare services are regulated and inspected by Healthcare Inspectorate Wales (HIW).

Decision-making at a national Wales level relates to specialist services only. Each LHB in Wales is responsible for delivering NHS healthcare services within a geographical area. Unlike England, where CCGs commission services from providers, the internal market in healthcare has been removed from the Welsh Health Service, and the division of purchasing from providing health care was abolished.

LHBs therefore both plan and provide all health services in their areas:

"*Simple structure in Wales … if you engage with the seven Health Boards, you engage with the seven organisations you need to."* (Statutory stakeholder)

Public Health Wales (PHW) aims to protect and improve health and wellbeing and reduce health inequalities. At a local level, each of the LHBs employs a Director of Public Health. Public Health Wales, health boards and local authorities are expected to work closely together to promote public health in their areas and to jointly set local strategic agendas.

Key national strategies

Welsh Government Package of Support for Veterans

In 2011 the UK Government revised the Armed Forces Covenant[i] (AFC). The revised Covenant gave greater emphasis and priority to veterans' mental health and related health needs. It states that veterans should receive priority NHS treatment under specific conditions, including clinical need:

- "where it relates to a condition which results from their service in the armed forces, subject to clinical need … For those with concerns about their mental health, where symptoms may not present for some time after leaving service, they should be able to access services with health professionals who have an understanding of armed forces culture."

The Welsh Government published in 2011, as a complementary document to the Covenant, the Welsh Government's *Package of Support for the Armed Forces Community in Wales*[ii]. The commitments relevant to mental health include:

- access and support for veterans through funding of the all-Wales Mental Health and Well-Being Service for Veterans (now Veterans' NHS Wales);
- Wales-wide publicity and information on the service and a website with information for each LHB area for veterans, and free 24 hour phone mental health Community Advice Listening Line available to veterans;
- Annual Quality Framework target requiring LHBs to specifically consider the health needs of veterans/service personnel when planning services;
- health bodies and their staff reminded of their obligation to offer priority treatment and care for veterans whose health problems result from their service;
- Champions for Veterans and Armed Forces established in every LHB and NHS Trust in Wales;
- Welsh Government/Ministry of Defence transition protocol and pathway for injured/ill Service personnel leaving the armed forces and being discharged into Wales. Wales-specific care pathway included in the UK-wide transition protocol pilot scheme for severely injured personnel, including transfer of medical records from Ministry of Defence to GPs;
- Public Health Wales commissioned to produce a Substance Misuse Treatment Framework module for the treatment of veterans by October 2012;

- Healthcare Inspectorate Wales (HIW) review of the adequacy, availability and accessibility of health provision for armed forces personnel, their families and veterans in Wales.[iii]

Together for Mental Health

The Welsh Government's cross-Governmental *Together for Mental Health* Strategy was launched in 2012)[iv], at the heart of which was the Mental Health (Wales) Measure (2010)[v].

The first delivery plan for *Together for Mental Health* was for the period 2012-16. Action 12.5 of the plan was:

- "To ensure veterans receive services appropriate for their mental health needs."

The 2012-16 Delivery Plan specifies under 'How Will We Do It?':

- "Local Health Boards to continue to commission and/or provide specialist community Health and Well Being Services for veterans in each area.

- Develop care pathways for veterans to access substance misuse services.

- LHBs to establish Armed Forces Forums and Mental Health Clinical Networks.

- The All Wales Veterans Health and Wellbeing Service [now Veterans' NHS Wales] steering group to work with LHBs and other partners to develop and implement a multi-agency pathway for veterans requiring mental health services."

The draft 2016-19 delivery plan[vi] was under consultation at the time of the review, with a view to being finalised after the May 2016 National Assembly for Wales elections, and published in summer 2016.

Chapter 2 Assessment and planning/commissioning processes

CHAPTER SUMMARY:

Chapter Two sets out:

- **key plans/structures at regional level in Wales: the Health Board Integrated Intermediate Medium Term Plans (IIMTP); and the Health Board and Local Authority Armed Forces Forums and Champions**

- **stakeholder views on the need to engage veterans who are mental health users in the IIMTP planning process; and to make the Armed Forces Forums and Champions structures more clearly focused and purposeful, and working more effectively and consistently across the country**

- **issues relating to the national and local level data available for assessment and planning/commissioning; and stakeholders' views that while improvements have been made regarding the availability and quality of data, gaps remain particularly in terms of data to inform long-term local level planning/commissioning processes**

- **stakeholders' views that a more strategic and co-ordinated approach to planning/commissioning needs to be taken across regions and across sectors and organisations. This is needed to ensure that the improvements made by services and multi-agency partnerships are not placed at risk; and to ensure that the needs of all areas including urban and rural areas can be met on a long-term, sustainable basis**

- **the importance of the new assessment and planning/commissioning mechanisms being established over the next year under the Social Services and Wellbeing (Wales) Act 2014 and the Wellbeing of Future Generations Act 2015; and stakeholders' views on the need take steps to ensure that they take account of the needs of veterans.**

KEY ISSUES IDENTIFIED IN CHAPTER

1: ensure veterans' mental health and related health needs are factored into the development of Health Boards IIMTPs, with broad engagement around veterans' issues including with mental health users and their families/carers.

2: achieve more consistency and clarity around strategic structures such as Armed Forces Forums/Champions; and more integration between the work of Health Boards and Local Authorities, responsible for many of the key wider determinants of mental health and wellbeing such as housing and employment.

3: continue to improve quantitative and qualitative data on veterans for local level needs assessment and planning/commissioning, including on specific sub-groups such as: female veterans; veterans with a dual diagnosis; veterans within the CJS; and veterans' families.

4: strengthen leadership and accountability mechanisms at national level to: • **drive forward a co-ordinated, strategic and effectively implemented approach across Wales as a whole to assessing and planning to meet veterans' and families' mental health and related health needs** • **maximise the overall national spend on veterans' mental health across sectors, including ensuring high quality services are appropriately and sustainably funded** • **provide quality, effective services meeting the variety of needs of those living within both rural and urban areas sustainably and prudently.**
5: work with key partners to seek to improve quality assurance/governance and reduce confusion/duplication within the voluntary sector, particularly those offering treatment solutions to which individuals can self-refer.
6: highlight in precise and sensitive terms the needs of veterans as a group and ensure they are factored into the new assessment and planning/commissioning mechanisms being implemented over the coming year under the Social Services and Wellbeing (Wales) and Wellbeing of Future Generations Acts.

2.1 Regional plans and structures

Health Board Integrated Intermediate Medium Term Plans

The Local Health Boards' key planning tool is the Integrated Intermediate Medium Term Plan (IIMTP), developed annually by Health Boards as a rolling three-year plan, and signed off by the Welsh Government. Some stakeholders took the view that it was unrealistic that specific reference would be made to population sub-groups such as veterans in these plans and that the key rather was to engage with a wide range of groups:

"*Won't be in depth – mental health services are there to provide a range of services, whether veteran or not." (*Statutory stakeholder)

"*People would like all their groups included – you just end up with a meaningless list. Key is to have a mechanism for meaningful engagement."* (Statutory stakeholder)

Others however felt that if veterans' mental health was not mentioned in the plans this meant it was not a high priority overall; or that more needed to be done to ensure veteran mental health users were engaged in the engagement process underlying the plans:

"*If veterans are not being covered explicitly in those plans [IIMTPs] that will mean they are not on the high level radar."* (Statutory stakeholder)

"*Mental health services in general are perhaps not high enough up the priority list. And veterans are not regarded as high priority even within mental health.* (Statutory stakeholder)

"*More consultation with veterans is needed. Health Boards undertake involvement and consultation with people with personal experience of mental health but they don't specifically target veterans."* (Statutory stakeholder)

Some stakeholders felt that a broader and more open engagement was needed in regard to veterans' mental health and related needs, with a wider range of perspectives involved than military charities and individual veterans with 'loud voices':

"Some superb military charities but they come in with preconceived ideas about what veterans want. Younger male and female veterans' exposure to the military will be more limited than someone who's done 20 years, who is more entrenched and whose comfort blanket needs a harder wrench to drag off." (Statutory stakeholder)

The IIMTPs, and the local population needs profiles/assessments on which they are based (where available), were reviewed and analysed to see what if any reference was made to veterans. The results are below. (Betsi Cadwaladr University Health Board is not included: it has not yet produced a comprehensive three-year integrated medium-term plan, as the Welsh Government has placed it into special measures.[vii])

Abertawe Bro Morgannwg University Local Board

Changing for the better Integrated Medium Term Plan April 2015[viii] *– March 2018* makes no reference to veterans or the armed forces. It states that its planning assumptions are built from a Strategic Needs Assessment produced in 2013[ix]; this also makes no reference to veterans or the armed forces.

Aneurin Bevan University Health Board

In the *2015/16 – 2017/18 Integrated Medium Term Plan Technical Plan*[x], a reference to veterans is included within a table providing an overview of Mental Health and Learning Disability services community (Table 2.3 page 12). The chapter on the local population and its health needs (Chapter 3) makes no reference to veterans or the armed forces.

Cardiff and Vale University Health Board

Progressing Our Future Integrated Medium Term Plan 2015/16 – 2017/18[xi] makes no reference to veterans or the armed forces, including Appendix 1 which sets out a detailed local population/health needs profile.

Cwm Taf University Health Board

Three Year Integrated Plan 2015/16 - 2017/18 Cwm Taf Cares[xii] makes no reference to veterans or the armed forces, including Chapter 4 which sets out details of the local population profile/health needs. The plan further refers the reader to the Cwm Taf Public Health Strategic Framework 2012-13[xiii], which also makes no reference to veterans or the armed forces.

Hywel Dda Health Board

Our Health, Our Future Hywel Dda Integrated Medium Term Plan 2016/17 to 2018/19[xiv] makes no specific reference to veterans, but makes the following reference to armed forces:

- "Over the past 5 years we have invested heavily in partnership working, starting from a low base and building trust, relationships and networks with a range of public and third sector partners. …...

- …We now have long established, mature relationships with all our partners whether Local Authorities, Police, Fire and Rescue, Universities, the Third sector, Armed Forces and other patient groups."

The plan available on the website (Jan 2016 revision) was still at the draft stage at the time of the review and the 'Health Needs Assessment Summary' listed as Appendix 1 in the Table of Contents was not yet included.

Powys Teaching Health Board

Planning for a Healthy Future Integrated Medium Term Plan 2015[xv] makes no reference to veterans or the armed forces. The plan states that it is based on the Joint Strategic Needs Assessment 2014. A copy of the JSNA was not found on the HB or Powys County Council website. The JSNA was led by the Health Board and undertaken with other Local Services Board partners, as the basis of the *One Powys Plan 2014-2017,* which gives some detail about its key findings. No reference is made to veterans or the armed forces.

Key Issue 1: ensure veterans' mental health and related health needs are factored into the development of Health Boards IIMTPs, with broad engagement around veterans' issues including with mental health users and their families/carers.

Armed Forces Forums

Local Health Boards have Armed Forces Forums (AFF), as well as a non-executive Armed Services Champion and an Executive Lead. The establishment of these Forums was a key recommendation of the 2012 Health Inspectorate Wales report on the *Armed Forces Community and Healthcare*. The Health Board Champions meet together on a twice-yearly basis as the All Wales Network of Champions, chaired by the Welsh Government. There are also Forums and Champions at Local Authority level.

Statutory stakeholders who participated in the review generally welcomed the establishment of these structures. Benefits identified included a broader responsibility for veterans within Health Boards; a wider range of issues covered in relation to meeting their health needs, on a more sustained basis; and giving the armed forces sector a voice within Health Boards, which in turn provided useful local and national intelligence to feed into the planning/commissioning process:

"*The Welsh Government has done well – local Forums, Champions meetings across Wales, ministerial expert group – good structure."* (Statutory stakeholder)

There was a widespread view among statutory and voluntary/independent stakeholders however that in practice the effectiveness and impact of the structures varied. As well as individual knowledge and commitment, the strength of local partnerships, especially between the Health Board and Local Authorities, was seen as a key factor. While some statutory and voluntary/independent sector stakeholders reported close working between Health Boards and Local Authority Forums towards jointly agreed strategic objectives, others reported issues such as irregular/non-attendance from some Local Authorities at the Health Board Forum, and/or unnecessary duplication between the activities of Local Authority and Health Board Forums.

A recent survey of GPs in Wales found some of the key drivers of mental distress or mental wellbeing for their patients to be issues falling within the Local Authority remit, such as education, employment, isolation and housing.[xvi] Stakeholders involved in the review took the view that this is equally if not more true of veterans and that their problems in this regard needed to be recognised:

"*The bigger issues are finance, housing, chronic conditions – with veterans it's not just about mental health."* (Statutory stakeholder)

"*Housing is huge for mental health – your home is your safe zone."* (Veteran)

Veterans stressed the responsibility of local authorities for these issues, feeling there was over-reliance on the charity sector. They felt Local Authorities needed to become more aware of veterans' needs and of their own Armed Forces Covenant responsibilities; and to become more speedily accessible to them, particularly at times of financial and/or housing crisis. Suggestions included having an emergency service within Local Authorities for veterans in financial and/or housing crisis, e.g. an emergency phone number for veterans or a flat available for homeless veterans if needed.

Some statutory stakeholders reported and welcomed work currently taking place in some regions to merge the HB and LA Forums to work together jointly. This was seen as a more effective way of working in terms of reducing burden and focusing on action rather than "*talking shop"* meetings. It was also seen as useful in that it enabled work on the variety of determinants of mental health and wellbeing to be brought together and reduce "*silo working"*.

Some statutory stakeholders also reported, and welcomed, work "*in gestation"* nationally to formalise and make more consistent the work of the Health Board Armed Forces Forums across Wales. It was hoped that this would enable the Forums to become "*more bureaucratic but more purposeful, focused".*

Armed Forces Champions

While some Champions were described as '*fantastic'* or '*passionate',* others were described as rarely seen/heard and/or too busy to devote time to the role.

Statutory stakeholders consistently highlighted the need for greater clarity around the nature and purpose of the Armed Forces Champion role and felt that a clear brief on this had been lacking from the outset. As the quotes below show, interviews revealed that the role has been largely individually/locally interpreted. Some focus on monitoring and service provision:

*"Trying to champion the services professionals were providing within the Health Board and get the priority the professionals thought they deserved." (*Statutory stakeholder)

*"As a non-executive role, it is intended to keep oversight of what Board is doing specifically for veterans and families re services, but also the priority treatment arrangements for veterans re service related injuries … Part of Champion role is to make staff aware of that." (*Statutory stakeholder)

"To really make a difference for the armed forces community and the veterans – otherwise just a tick box role. … monitoring against the [local action plan to deliver the WG Package of Support], that's the usefulness of the Champion/Executive Lead roles." (Statutory stakeholder)

Others however see the role in more general terms e.g. as a point of external signposting/encouragement/help:

"Ensure meetings took place, attended, and to liaise with Local Authority Forums and give them encouragement and give them support. … If someone has an issue they can get name and number – try and signpost them." (Statutory stakeholder)

"*Wouldn't define the role in any particular way other than Champion is there to help … veterans contact Champion directly, help with issues they have. Champion goes to groups to talk about role, say if you need help please get in touch … chair the Forum meetings."* (Statutory stakeholder)

Statutory and voluntary/independent stakeholders emphasised the importance of a clearer focus, with some calling for guidance to be issued on the Champion role. This should include recognition of Champions' constraints and limitations as single individuals and as part-time, non-executive members of the Health Board:

"*Champions can make a difference … but mustn't be invested in one person – the whole organisation must understand the commitments made by Welsh Government and the Covenant. But executives and non-executives have too many Champion roles … Non-execs have very limited time. … non-exec Champions feel frustrated they can't do more. It's never been clear from Welsh Government what the Champion role should be. … made it work but no real guidance. Different people will have done different things. … clear guidance on what expected of Champion … would be helpful." (*Statutory stakeholder)

Key issue 2: achieve more consistency and clarity around strategic structures such as Armed Forces Forums/Champions; and more integration between the work of Health Boards and Local Authorities, responsible for many of the key wider determinants of mental health and wellbeing such as housing and employment.

2.2 Data for planning/commissioning

Public Health Wales estimates

The Public Health Wales Observatory, using datasets from the Royal British Legion and MOD, has produced estimates of the number of veterans currently living in Wales together with projections of the future number of veterans likely to live in Wales. [xvii] The data includes an uprating of 1.38 to take account of higher recruitment levels in Wales compared to the rest of the UK. According to these estimates, there were about 212,000 veterans living in Wales in 2014. The projected figures show a marked decline in these numbers over the next 15 years, falling to 154,000 (2020); 119,000 (2025); and 94,000 (2030).

MOD pension/compensation data

A Statistical Bulletin published by the Ministry of Defence[xviii] provides information relating to the location of Armed Forces Pension and Compensation recipients. The number of veterans in receipt of pension or compensation payments per 1,000 residents within LHBs and LAs in Wales is shown in Tables 1 and Table 2 below. As expected some of the highest rates are to be found in areas where there are Defence establishments.

Table 1: Number of veterans per 1,000 residents in each Health Board area in Wales

Health Board area	Number of veterans per 1,000 population
Abertawe Bro Morgannwg University	5.77
Aneurin Bevan University	5.64
Betsi Cadwaladr University	7.20
Cardiff and Vale University	5.61
Cwm Taf University	5.46
Hywel Dda University	6.73
Powys Teaching	8.12
WALES	6.24

Table 2: Number of veterans per 1,000 residents in each Local Authority area in Wales

Local Authority area	Number of veterans per 1,000 population
Blaenau Gwent	4.58
Bridgend	8.62
Caerphilly	5.34
Cardiff	3.29
Carmarthenshire	5.66
Ceredigion	4.68
Conwy	8.07
Denbighshire	6.67
Flintshire	8.20
Gwynedd	5.17
Isle of Anglesey	11.10
Merthyr Tydfil	5.61
Monmouthshire	9.09
Neath Port Talbot	5.51
Newport	4.94
Pembrokeshire	9.60
Powys	8.12
Rhondda Cynon Taf	5.42
Swansea	4.29
The Vale of Glamorgan	11.96
Torfaen	4.72
Wrexham	5.56
WALES	6.24

Data improvements

Improving the data/evidence base, most often expressed as improving the identification of veterans by services, was the second top priority among statutory sector stakeholders who participated in the review.

Statutory stakeholders took the view that improvements had been made in terms of the availability and quality of data on veterans in Wales:

"*We have moved on quite a bit from having no data at all ... we are further along than we were." (*Statutory stakeholder)

"*Optimistic it's improving."* (Statutory stakeholder)

Some continuing gaps however were highlighted e.g. information on service leavers returning to local areas; stratification along age lines at local level; taking account of varying local patterns of recruitment within Wales; and further information on particular sub-groups such as families, the dual diagnosis population and veterans involved in the criminal justice system (CJS). While females were not highlighted by stakeholders as one of these sub-groups on which further information is needed, 10% of the serving population are women and this will need to be taken into account in assessing and planning to meet mental health needs.

The importance of having more robust data at local level was particularly emphasised by statutory stakeholders as key to enabling veterans to be taken into account in local planning/commissioning. One statutory stakeholder described determining the number of veterans resident within the Health Board area as an *"impossible task",* while another highlighted that Boards were overly reliant on national reports and that locally-based research was needed to provide *"precise planning data locally".* The time-lag between trauma and veterans coming forward for help was also cited as a complicating factor, so that the current demand on services could not be taken as an accurate yardstick of *"the actual demand out there"*. Other statutory stakeholders emphasised that the lack of information had a knock-on effect on the extent to which veterans' needs could be taken into account by planners and commissioners, particularly on a long-term, sustainable basis, compared to other more easily identifiable population groups:

"*Veterans as a population group aren't high on the list in terms of need. E.g. children with disabilities can be identified – we can't identify all our veterans."* (Statutory stakeholder)

*"We know there's an ageing population – whereas supporting veterans is a jump into the unknown – don't know who they are, where they are, whether demand is there … fine for commissioning a couple of projects, but not ongoing – becomes a bigger risk. Other things are all done on evidence/need – this isn't – fragile … have signed up to the Covenant but it's done as best will in the world rather than an educated decision based on need." (*Statutory stakeholder)

*"Difficult to do a needs assessment as we don't know who our veterans are in our area … it's all guesswork … till we can identify veteran community, we can't demonstrate need." (*Statutory stakeholder)

The potentially most useful health data for numbers of veterans residing in an area would be that contained in GP registration lists. GP practices can identify veterans registered with their practice using Read codes.[xix]

Both statutory and voluntary/independent stakeholders highlighted that while work had been done to make improvements in this area, there were still gaps - particularly in relation to patients already on the system, whether in terms of GPs asking the question or veterans understanding the importance of/being willing to give the information. Stakeholders felt that while work had been done to raise the awareness of both veterans and GPs of the importance of GPs knowing if a patient was a veteran, e.g. through regular Chief Medical Officer letters to GPs, and charities encouraging veterans to self-identify to their GP, this remained 'work in progress'. Some highlighted that even where GPs were asking the question of patients, the problem remained that many already on their practice list would remain unidentified:

"*Problem is that coding to date has been poor. Wasn't on list, is now but question whether asked routinely. And veterans already registered and stable, won't be retrospective analysis." (*Statutory stakeholder)

It was also pointed out that ensuring the information was collected by GPs did not in itself solve the problem, as incompatible Health Board/GP IT systems meant that even those veterans who had been identified as such within the local system could not be determined to feed into local planning.

Some stakeholders also pointed to resistance among veterans in coming forward to self-identify, whether through lack of awareness of the benefits and/or a general reluctance to seek help, requiring an assertive outreach approach:

*"if you can't identify your population you can't commission your service… In Wales all the Health Boards keep saying this nationally – and national keep saying to deal with it locally. Partly about raising awareness of benefits of saying you have served so people willing to self-identify." (*Statutory stakeholder)

*"One if big challenges for us is identifying our veterans, working with our GPs to flag the veterans – many don't want to come forward. … need to go out and seek, not expect people to come to your door … difficult for veterans to come and say 'I need some help'." (*Statutory stakeholder)

Key issue 3: continue to improve quantitative and qualitative data on veterans for local level needs assessment and planning/commissioning, including on specific sub-groups such as: female veterans; veterans with a dual diagnosis; veterans within the CJS; and veterans' families.

2.3 A more strategic approach to planning/commissioning

Several statutory and voluntary/independent stakeholders highlighted the lack of a co-ordinated, strategic and sustainable approach to planning/commissioning for veterans' needs across Wales as a whole. It was considered that this put under threat the progress made in establishing effective care pathways (see chapter 3) and multi-agency partnerships (see chapter 4). The lack of co-ordination across Wales as a whole, and competition between partners across sectors over funding, was widely felt to be confusing and to be acting against partnership working in the best interests of patient outcomes:

"Good deal of provision out there – but for some reason not well enough designed. Lot of confusion about what people are doing." (Voluntary/independent stakeholder)

"*Need a proper professional service where everyone knows what they do and all work properly together. People still terribly protective of their ground owing to funding."* (Statutory stakeholder)

"Everyone's of the view that agencies should be working in collaboration – but ultimately … are in competition with everyone else." (Voluntary/independent stakeholder)

Both statutory and voluntary/independent stakeholders emphasised that there was an "*awful lot of money and resources"* in the armed forces charity sector. However while third sector bodies were encouraged to work collaboratively, they were effectively competing between themselves and with statutory sector partners for short-term funding. Although short-term funding could act as a useful incentive for them to provide innovative, creative solutions, they were not given the longer-term funding to then provide these solutions on a sustainable basis.

This short-term approach to planning/commissioning meant that some key bodies within partnerships and pathways, recognised as providing high quality services, were "*scrabbling round for cash"* and at risk of dropping out at any time; rather than being seen, and funded, as part of an overall delivery framework across the country. This was seen as putting at risk the great steps forward that are being made in Wales with regard to veterans' mental health:

"Don't need more, just need to manage better and manage in partnership better – huge amount of duplication." (Statutory stakeholder)

*"Needs recognition that collectively agencies across sectors are delivering a national service which would previously be delivered as a national entity … because we are ahead of the game in Wales, really good partnership working – there is more to lose if one bit of it went, would dismantle the whole thing." (*Voluntary/Independent Stakeholder)

Several review participants, both among stakeholders and veterans and families, expressed strong concern about quality assurance and governance issues within the armed forces charity sector. Some cited specific cases in Wales where harm had been caused to vulnerable individuals. For example this was as a result of: well-meaning individuals lacking necessary technical expertise; 'rogue' organisations seeking to exploit public good will and readiness to donate money for veterans; organisations lasting for a short time only then leaving clients "*in the lurch, abandoned";* and organisations offering "*untested treatments and therapies".*

One statutory stakeholder emphasised that such organisations were not subject to the 'due diligence' and governance processes of Health Board or Local Authority commissioned services, and highlighted the dangers of individuals self-referring to them.

The effect on the lives of two individual veterans of becoming involved with inexperienced or 'rogue' charities was vividly described:

"*They were putting people through what they called therapy, he came out of it 'I'm going to be doing this and that, they're going to send me for training' – and none of it happened and he absolutely crashed. False – these people had no intention of doing it, they just dumped him and he literally fell apart, he was on the floor crying like a baby."* (Family member)

"I'm having to unpick the work of an individual, well-meaning but who clearly didn't understand the dynamics of the benefit system; he got a client monies which he was very proud of, but it meant they got taken off the client's housing benefit and he lost his house." (Statutory stakeholder)

Strong frustration was expressed by statutory and voluntary/independent stakeholders that attempts to bring these problems to the attention of the regulators of the charity sector had so far proved fruitless.

For some statutory stakeholders, charities having a strong local presence offering practical support to local people was an important aspect of quality, i.e. working effectively with local partners (enhancing oversight), and having knowledge/understanding of the specific legal framework, language and culture of Wales:

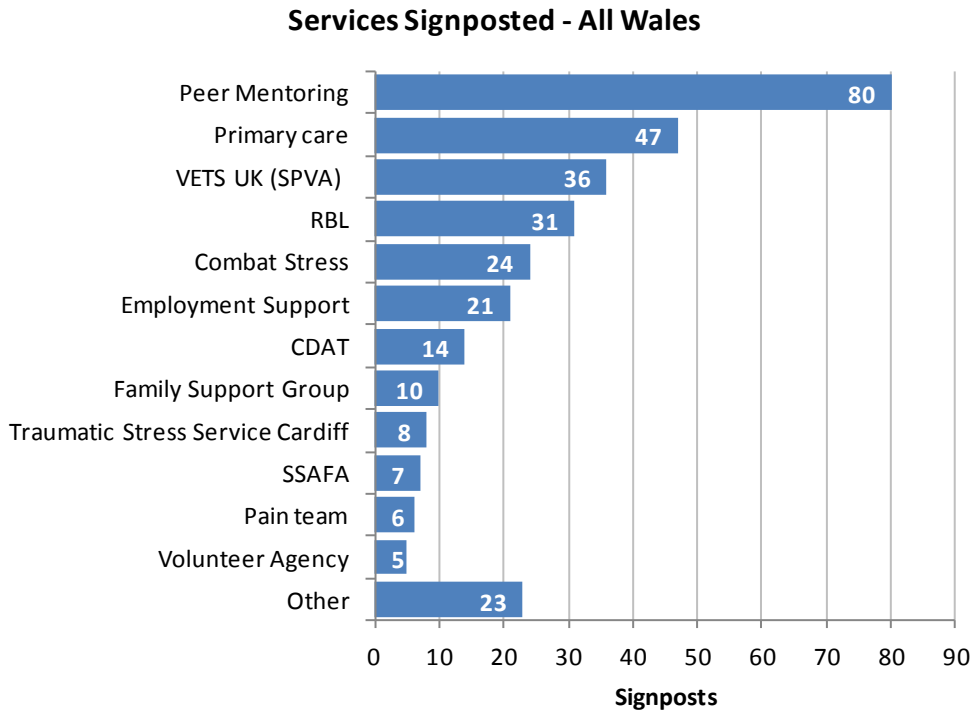
"*Good relationships with the larger organisations but that shouldn't undermine the relationships with the smaller local groups - the strength is having the balance between the two. … Services that support are most helpful – not just raising money."* (Statutory stakeholder)

One statutory stakeholder cited CAIS' Change Step and Listen In projects as "*managed by people with strong local presence and local footprint*" which "*contributes to good governance, if there's a problem we know who to phone*". They contrasted this with *"the national England-based organisations such as Combat Stress and Help for Heroes*" who "*don't always get the Welsh context"*, although pointing out that other England-based organisations i.e. RBL and SSAFA had a strong local presence in Wales and "*good relationships based over time.*"

CAIS' Change Step project trains and employs veterans to act as peer supporters to other veterans, with their work ranging from befriending, taking them to appointments, signposting them to services and crisis support, and offering leisure/exercise activities. Over half of their service users have declared mental health problems, mainly common mental health problems but also a minority with PTSD. There is also a complementary but separate project, Listen In, which works with families.

Change Step is the outside agency with which VNHSW works most closely, forming a significant proportion of its outside referrals. As Figure 1 below shows, referrals to Change Step (peer mentoring - 80) were a significant proportion of the outside referrals made by VNHSW in 2014-2015; followed by primary care (47), Veterans UK/SPVA (an executive agency of the MOD -36), Royal British Legion (31) and Combat Stress (24).

Figure 1



Change Step was also the voluntary sector service most frequently cited by stakeholders as useful and effective in the field of veterans' mental health during the review. Its sister project Listen In was cited during the review as the only service operating across the country to meet the needs of the families of veterans with mental health problems. The projects were valued not only for their quality and effectiveness but also as 'homegrown' in Wales and unique within the UK:

"*Change Step … very good work, getting support from all around the Health Board Forum table recognising the work they are doing."* (Statutory stakeholder)

"*Change Step … are the glue for a lot of services … go the extra mile."* (Statutory stakeholder)

"I know Change Step is skilled, supervised … guys with PTSD are vulnerable." (Voluntary/independent stakeholder)

It was announced[xx] during the course of the review that CAIS' Change Step and Listen In projects had run out of funds. A further 12 months funding was subsequently announced in the Westminster Budget.[xxi]

The financial problems facing these 'best in class' projects, particularly around long-term sustainable funding, were frequently highlighted by stakeholders across sectors and also by veterans and families involved with the projects. They brought the issues regarding the perceived lack of strategic and co-ordinated planning and commissioning into sharp focus. Statutory and voluntary/independent stakeholders argued that lower level, early interventions such as Change Step were highly cost effective in the long-term, e.g. in terms of taking pressure/helping wean people off the NHS and reducing waiting list fall-out rates.

Sustainable funding for the Change Step/Listen In projects was the joint third top priority for change identified by veterans and families.

"*Keep Change Step. Paramount … They're the people when you come out, you go there, they've got the contacts. Plus you're dealing with people who've been there too. Fantastic agency – they need to be kept more than anybody. RBL and SSAFA are ok but they're not dealing with the nitty-gritty problems."* (Veteran)

Some suggested that there urgently needed to be more effective and strategic commissioning responses, either within the statutory or voluntary sector, to the issues its lack of funding raised; but felt that this would require action and leadership at national level. Specific suggestions included:

- Welsh Government fund Change Step funding for peer mentors to 'hand-hold' while veterans are waiting for assessment, embedded in VNHSW (linking therapy provision and the retention rate/engagement model as in Scotland).

- Pool the plethora of armed forces charities' pots of money to have "*a really big Change Step".*

- Identify what veterans need, and then provide one pot of money across Wales to deliver it through a preferred provider list, measured on success, outcomes and performance management/monitoring.

"There's a lot of money sloshing around … but feels as if someone needs to be accountable … otherwise will have more and more organisations trying to access the same money with no evidence of an effective approach in Wales … doesn't feel like there is anyone leading on that. Welsh Government happy to say 'this is framework, how we want things to work' – but no one enforcing that." (Voluntary/independent stakeholder)

It was suggested that such an integrated, strategic approach to planning and commissioning across Wales could also help address issues such as the needs of rural areas – "*Powys in particular, and outlying areas around North, South and West Wales"* - where service poverty was highlighted as a key issue by some statutory and voluntary/independent stakeholders. Having shared resources and more co-ordination across Wales would "*help with contingencies",* which was a live issue regarding the Veterans' NHS Wales service in West Wales (see chapter 3).

Some stakeholders suggested that having a Veterans' Commissioner, or more co-ordinated and practically-focused working across Armed Forces Forums, would help bring a more strategic focus and leadership across Wales.

It was stressed however that a Commissioner figure would need to understand issues such as planning and commissioning processes and how to build and manage relationships across agencies and sectors, rather than just being knowledgeable about the needs of veterans.

Key issue 4: strengthen leadership and accountability mechanisms at national level to:

- **drive forward a co-ordinated, strategic and effectively implemented approach across Wales as a whole to assessing and planning to meet veterans' and families' mental health and related health needs**
- **maximise the overall national spend on veterans' mental health across sectors, including ensuring high quality services are appropriately and sustainably funded**
- **provide quality, effective services meeting the variety of needs of those living within both rural and urban areas sustainably and prudently.**

Key issue 5: work with key partners to seek to improve quality assurance/governance and reduce confusion/duplication within the voluntary sector, particularly those offering treatment solutions to which individuals can self-refer.

2.4 New planning/commissioning mechanisms

New mechanisms are being established over the course of the next year that will have a potentially significant impact on the future promotion, planning and delivery of services in Wales relating to mental health and wellbeing:

- the Social Services and Wellbeing Act (Wales) 2014[xxii], whose aims include improving co-ordination and partnership working between public authorities, and giving service users greater independence and control

- the Wellbeing of Future Generations (Wales) Act 2015 (WFG Act).[xxiii]

There will be a separate needs assessment undertaken for each Act: the WFG Act needs assessments are due for completion by May 2017 and the Social Services and Wellbeing Act by April 2017. (Some areas are however planning to undertake them together.)

The WFG Act aims to make public bodies think more about the long-term, work better with people and communities and each other, look to prevent problems and take a more joined-up approach. The Act establishes a statutory Future Generations Commissioner for Wales, whose role is to act as a guardian for the interests of future generations in Wales, and to support the public bodies listed in the Act to work towards achieving the well-being goals. The Act also establishes Public Services Boards (PSBs) for each local authority area in Wales. Each PSB must improve the economic, social, environmental and cultural well-being of its area by working to achieve the well-being goals. These include: a healthier Wales; a more equal Wales; a prosperous Wales; a Wales of vibrant culture and thriving Welsh language; and a Wales of cohesive communities.

Given the significance of the WFG Act, the outcomes of the Together for Mental Health draft 2016-2019 delivery plan are mapped in the delivery plan against the relevant well-being goals of the WFG Act. The WFG Act is also referenced widely in Local Health Board Integrated Intermediate Medium Term Plans.

Several stakeholders reported that knowledge of the potential impact of the Social Services and Wellbeing (Wales) and Wellbeing of Future Generations Acts, and the new integrated assessment and commissioning mechanisms they establish, was patchy. This was also reflected in review interviews where awareness of the legislation varied:

"*WFG Act is such a different way of doing things than many of us have been used to in local government and health. There may be some problems in understanding how things can be done better and sustainably under the WFG Act. … Don't think many people have understood yet the full implications."*
(Statutory stakeholder)

"Passionate about both Acts. Presents huge challenge but Health Board are embracing it, excited." (Statutory stakeholder)

Those stakeholders who were aware of it however saw the new legislation as potentially transformational:

- through its establishment of integrated health and social care assessment and care planning, consolidation of legislation and giving people entitlements, the SSWW Act was seen as particularly relevant to ensuring the needs of mental health users are met by health and social care agencies;

- the extensive scope of the WFG Act was seen as having even more potential impact, as it mirrors the holistic nature of mental health and wellbeing – encompassing not just health and social care but matters very relevant to mental health and wellbeing such as employment, environment and leisure and housing;

- both Acts were seen as driving forward improvements in needs assessments and the planning/commissioning process.

One statutory stakeholder noted that the regional Armed Forces Forum's work plans would in future be structured against the goals of the WFG and that both Acts were highly relevant to work on veterans' health: the WFG Act as it had potential to make the planning/commissioning process a *"more complete, more informed and intelligent way of using information about the population in Wales"*; and the SSW Act as it could enable the range of veterans' "*complex needs as a result of service*" to be met. Some stakeholders felt that the benefits of the new legislation should extend to all so that no one is left behind, rather than singling veterans out as a specific group. Some felt it was unrealistic to expect guidance to specify all population groups, including veterans, as it would be difficult to give an exhaustive list of those potentially affected:

"*Probably focusing more on the groups named in the Act – older people form the greatest bulk who need joint assessments. But … confident Health Board won't as an organisation be forgetting people who are small in number, but great in need."*
(Statutory stakeholder)

Some stakeholders took the view however that if veterans' issues do not feed into the new Acts' upcoming 2016-7 assessment and commissioning cycle, another opportunity will not present itself for some years. This was significant as the WFG assessment process would now be the most strategically important local mechanism:

"Missed opportunity that WFG guidance doesn't task the Public Services Board PSB to undertake a needs assessment including veterans. Have mentioned other groups but not veterans … people won't think about that group … now the main strategic document for local area." (Statutory stakeholder)

Specific suggestions included stronger advocacy to have veterans mentioned in the final version of the guidance, or if too late for that, in an annex; and/or influencing the WFG Commissioner.

One statutory stakeholder reported that the MOD and the armed forces voluntary sector had expressed the view that veterans would not like to be included in a list of minority groups with whom public bodies should seek to engage as a matter of course. Their omission meant however that they risked being overlooked:

"*Don't think veterans would cross the radar of most Public Service Boards. … would have made people think about them."* (Statutory stakeholder)

Some stakeholders emphasised that it would be important if veterans were highlighted as a specific group in WFG guidance, or in an annex, to be precise in the way in which this was done:

- both statutory and voluntary/independent stakeholders stressed the importance of not exaggerating the prevalence of mental health problems among veterans. Not only was this not an accurate picture of veterans as a group, but it could have a detrimental effect e.g. on their access to employment;

- another highlighted the need to make the link between the Covenant commitment to priority treatment and clinical need more clearly understood. Some executives in their Health Board saw it as 'queue jumping' and "*veterans relying on being veterans rather than being normal citizens*"; with the broad definition of a veteran (someone who has served for a day) *"seen as not helping the situation";*

- another suggested that the most effective way to specify veterans as a group in WFG guidance or an annex would be to express this in terms of their specific and distinctive health risk factors, based on occupational exposure.

This is backed up by research evidence, which shows that "veterans are considered one of the highest risk occupational groups for exposure to traumatic and adverse events, particularly when deployed to war zones." [xxiv]

Key issue 6: highlight in precise and sensitive terms the needs of veterans as a group and ensure they are factored into the mechanisms being implemented over the coming year under the Social Services and Wellbeing (Wales) and Wellbeing of Future Generations Acts.

3. Care pathways

CHAPTER SUMMARY

Chapter Three sets out:

- **the further improvements stakeholders, veterans and families identify as needed relating to prevention and early identification, particularly within services and at the resettlement stage**
- **views on Veterans' NHS Wales, widely seen by both stakeholders and veterans as providing a high quality service, unique to Wales within the UK. It reports however stakeholders and veterans' strong concerns about VNHSW capacity and its ability to meet demand robustly and sustainably across the whole of Wales**
- **the strong importance attached by voluntary/independent stakeholders and veterans/families to making improvements in mainstream services, and particularly community services - seen as key to combatting isolation, early identification of problems and supporting/sustaining treatment. Stakeholders highlighted the need to address barriers to veterans and families accessing GPs and other services, such as reluctance to seek help and frustration at waiting times/waiting lists, and to support them to be more willing to access civilian services. The importance of building the cultural competence of mainstream services to ensure veterans' needs are met on a long-term and sustainable basis was emphasised, but the ability of Veterans' NHS Wales to help in this task is limited by its own capacity problems**
- **concerns that common mental health needs may be overshadowed by over-emphasis on PTSD; and about the diagnosis of and treatment response to PTSD within mainstream services. The importance of an appropriate and timely response to related health needs, such as physical health and dementia, is also highlighted.**

KEY ISSUES IDENTIFIED IN CHAPTER

7: continue improvements at the point of serving and/or resettlement, particularly around: early identification and appropriate treatment of problems; and better liaison between military and civilian services to ensure continuity of care.

8: ensure Veterans' NHS Wales has appropriate capacity on a sustainable basis across the whole of Wales.

9: identify veterans as a population group with specific clinical risks, barriers to accessing services and cultural needs within services, and undertake:

- **assertive outreach to veterans and families**
- **capacity-building within mainstream services to meet their needs in a culturally competent manner**
- **working with them around their expectations of civilian services and support them to be willing to access them**
- **achieving an appropriate balance between specialist and generalist services across sectors.**

10: ensure the focus of planners and providers nationally, regionally and locally is on all types of conditions among veterans, physical and mental.

11: address concerns about the diagnosis of and treatment response to PTSD within mainstream services.

3.1 Prevention and early identification

Some stakeholders and veterans took the view that considerable improvements had been made recently in resettlement compared to previous years; both in terms of mental health and the preparation made for areas of life affecting mental health and wellbeing such as education, welfare and employment:

"*Transition process is getting better ... e.g. learning credits, resettlement process excellent now in 160 Brigade – welfare, work, social side – making sure all those things are in place before someone walks out of the gate with a young family. And if someone has mental health issues in armed forces … Veterans Welfare Service will meet them and explain Veterans' NHS Wales … they do a lot of work preparing the ground for the discharge … If a guy was discharged with chronic problems in the 1980s – transition was non-existent … Better now than even 3-4 years ago."* (Statutory stakeholder)

Both stakeholders and even more so veterans and families strongly emphasised however the need for further improvements to be made.

Making improvements while personnel were serving, and/or at the resettlement stage, was:

- **the top priority for change identified by all review participants when analysed as a whole; and**
- **the top priority of veterans and families when analysed as a group.**

Specific areas of improvement highlighted include:

- culture change within the armed forces, to reduce both the stigma around mental health/seeking help and the prevalence of alcohol:

"When you're in the Army any mental illness is frowned upon, it's embarrassing." (Veteran)

- work to reduce institutionalisation and prepare veterans to cope better with the practical daily demands of civilian life, especially around managing finances:

"For many who come to our mental health self-management course it's about managing their health – for the veterans it's about managing their life – they come out with no skills, it's manifest." (Voluntary/independent stakeholder)

"*Forces should give them mandatory counselling that real life exists – they're in a bubble … they don't teach them about money."* (Family member)

"*My son came out from Afghanistan with a nice sum of money – has been pissed ever since – in debt ever since."* (Family member)

These were seen as key factors both in identifying early and preventing mental health problems.

Further improvements identified by stakeholders and veterans/families included:

- setting up systems to ensure mental health problems are identified, and the care pathway commenced, well before discharge from services, particularly for those who have served in war zones:

"*If you have problems when serving – Army should be nailing it – that's when you need the help."* (Veteran)

"Regular mandatory counselling sessions one-to-one while people are still serving … before they come out, so the problems won't be as bad when they come out." (Family member)

"*Screening, mental health questionnaire in the Forces where they can't pull the wool over people's eyes, done regularly, and especially if they've served in war zones."* (Family member)

- improving the diagnosis and treatment of mental health problems while serving, with the armed forces working in partnership with experts to achieve this:

"My life changed when I had a daughter – the Army didn't like it that the Army wasn't the first priority … after my daughter was born … my Colonel doctor told me I had 'young mum' syndrome and told me to buck my ideas up … I've had depression ever since." (Veteran)

"*Would like to see the Army not just acknowledge their deficits but do something about it … would like to see them working in partnership with people who know, and de-railing the problem at source."* (Voluntary/independent stakeholder)

- listening to and acting on feedback from families about any changes in mental health they may have observed:

"Nobody knew my husband was ill but him … Families should be listened to more when they're serving. They may spot changes when he's on leave. If you told a serving unit that now – you'd be dismissed." (Family member)

Stakeholders reported that some improvement had been made in liaison between the MOD and NHS e.g. better information coming from the former on where leavers are likely to come back to thus assisting in Health Board planning, although continued improvement in this area was desired. They reported however that proactive work was needed to get a better handover of care from the military to the civilian GP, both for leavers and returning reservists, with access to military medical records highlighted as a particular problem. One stakeholder suggested it would be helpful to add the MOD number to NHS forms.

Key issue 7: continue improvements at the point of serving and/or resettlement, particularly around: early identification and appropriate treatment of problems; and better liaison between military and civilian services to ensure continuity of care.

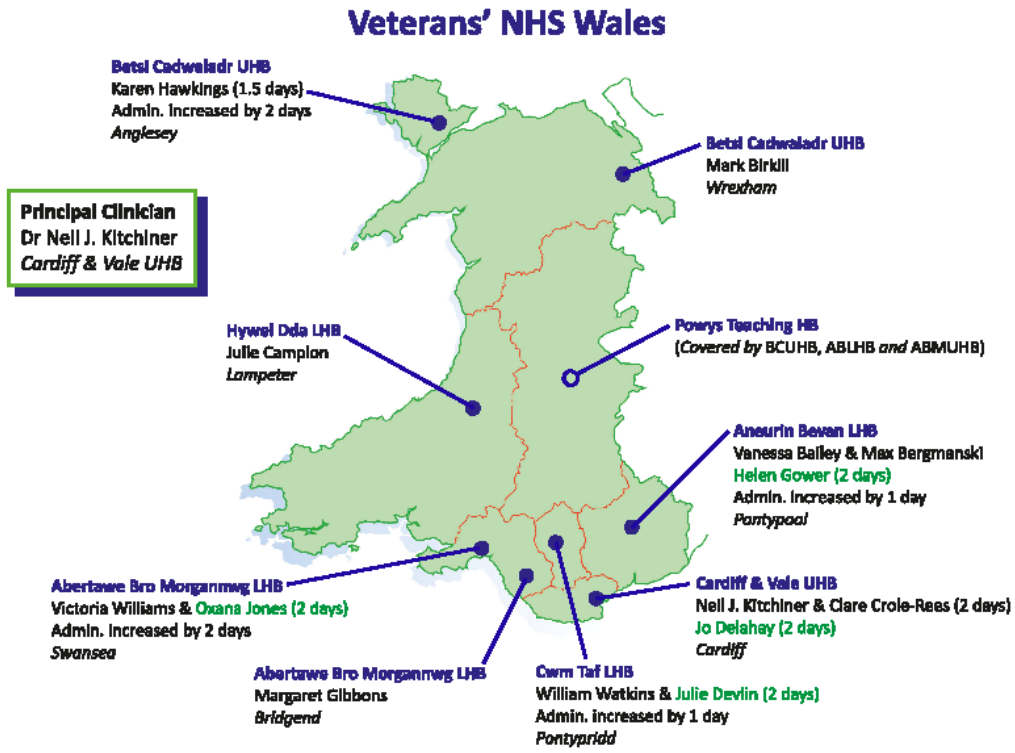
3.2 Veterans' NHS Wales

Veterans with any service-related mental health problem are eligible for outpatient treatment from Veterans' NHS Wales. Veterans with non-service related mental health problems referred to VNHSW are signposted to other appropriate services for treatment. The VNHSW's primary aim is to improve the mental health and wellbeing of veterans residing in Wales with a service related mental health injury. The secondary aim is to achieve this through the development of sustainable, accessible and effective services that meet the needs of veterans with mental health and wellbeing difficulties who live in Wales. [xxv]

VNHSW operates on a 'hub and spoke' model with the service led by Dr Neil Kitchiner, based at Cardiff and Vale University Health Board (UHB); but with funding charged back to each LHB[xxvi], who are responsible for appointing one or two experienced clinicians as their local Veteran Therapist (VT). The VTs are mental health professionals (e.g. from nursing, psychology and social work backgrounds), with additional post-graduate training in psychological therapies (mainly Cognitive Behavioural Therapy and Eye Movement De-sensitistion Reprocessing Therapy).

The majority of VNHSW staff have worked for the service for approximately 4-5 years. At the end of March 2015, VNHSW had ten VTs in post (see Figure 2 below) and a further four part-time seconded therapists funded by an additional £100k provided by Welsh Government on top of its original £485k funding for the Service.

Figure 2



Referrals

In 2014-15 VNHSW received 542 referrals across all regions. By the end of this period, 339 (63%) of these had received an assessment with a VT; and 139 (26%) had begun out-patient psychological treatment with a VT.

Of those referred to and assessed by VNHSW in 2014-15:

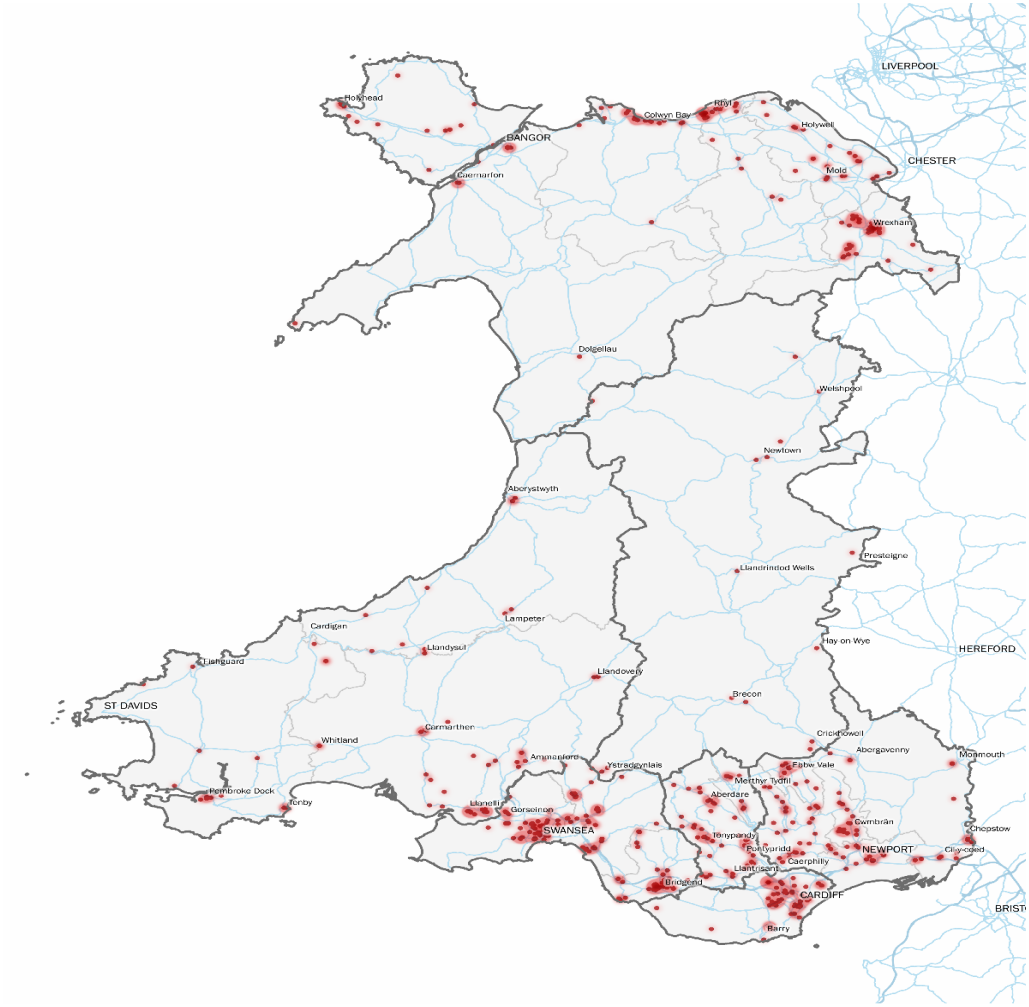
- 64% were given PTSD as a primary diagnosis
- 14% had a primary diagnosis of mixed anxiety and depression
- 11% had a depressive episode.

The ‘heat map’ at Figure 3 below shows the distribution of referrals across Wales in 2014-15, and shows that:

- the highest number of referrals were to Betsi Cadwaladr, Abertawe Bro Morgannwg and Aneurin Bevan Health Boards

- the majority of patients referred live within a close distance to major conurbations and in South and North Wales, with a small proportion living remotely in Powys and West Wales.

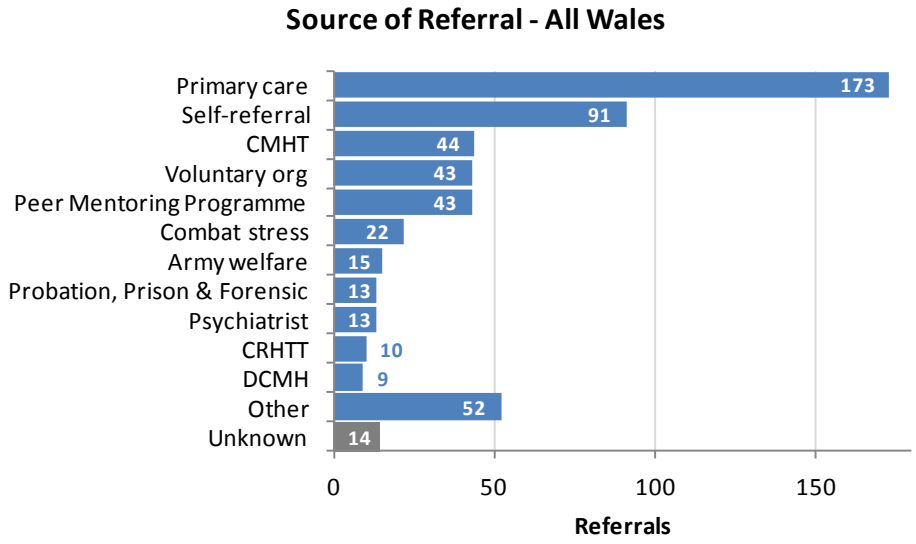
Figure 3



Referrals to VNHSW arrive via several routes, including primary care, self-referral and several veterans' charities/agencies. The VNHSW clinical team refer to other primary, secondary or tertiary health services when indicated by level of risk and clinical need.

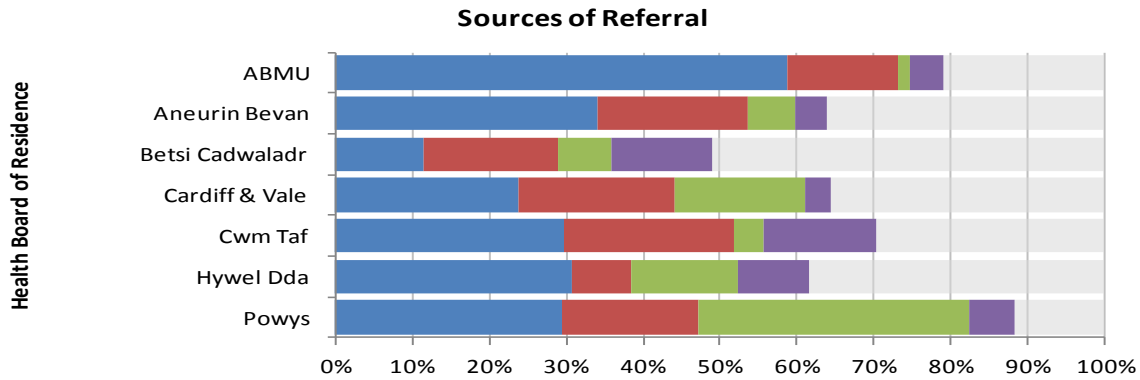
As Figure 4 below shows, in 2014-2015 by far the greatest sources of referral to VNHSW across Wales as a whole were from primary care services and self-referrals, together accounting for half of referrals received during that period.

Figure 4 – Source of referral to VNHSW



As figure 5 shows, Betsi Cadwaladr has relatively high rate of self-referral (shown in red), but a low rate of referral from Primary Care (blue), while the converse is true of Hywel Dda.

Figure 5 – Sources of referral by Health Board

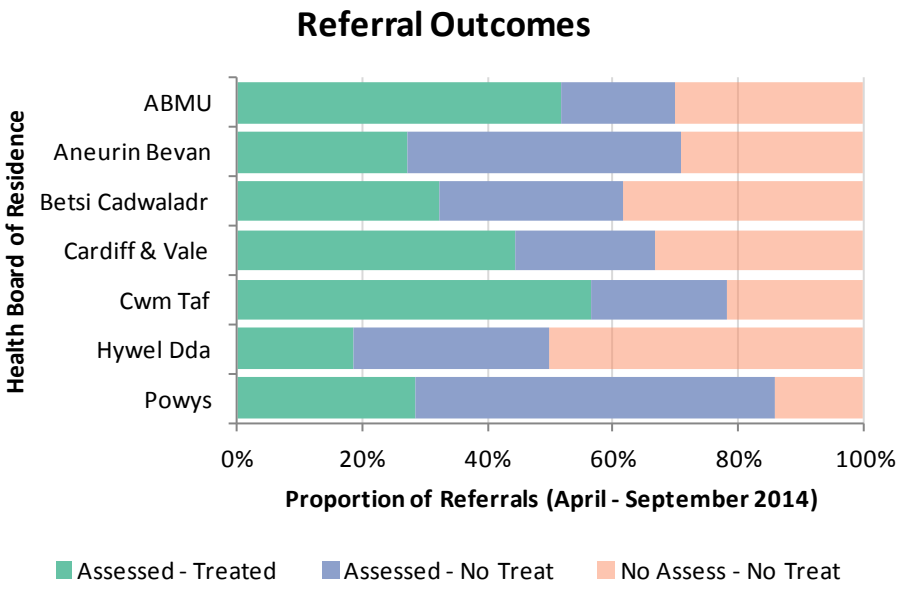


	Powys	Hywel Dda	Cwm Taf	Cardiff & Vale	Betsi Cadwaladr	Aneurin Bevan	ABMU
Primary care	5	20	16	14	15	33	70
Self-referral	3	5	12	12	23	19	17
CMHT	6	9	2	10	9	6	2
Peer Mentoring Programme	1	6	8	2	17	4	5
All Others	2	25	16	21	67	35	25

The waiting times for a VNHSW assessment vary across Health Boards, with waiting times generally longest in South Wales. Overall, in 2014-15 50% of initial appointments took place within 36 days of referral, and 75% within 58 days of referral. The mean time from referral to first appointment was 42 days (the target for a primary care service being 28 days). Referral outcomes also vary across Health Boards.

As Figure 6 below shows, there is considerable variation in 'attrition' rates. From the point of view of the veteran who is referred or refers himself/herself to the service for treatment, the likelihood of this referral resulting, after a waiting period, in the outcome of being assessed but not treated (blue) is stronger in some parts of Wales (Powys, Aneurin Bevan) than in others (Cwm Taf, ABMU, Cardiff and Vale). The likelihood of the referral not even resulting in an assessment (orange) is also higher in some parts of Wales (Hywel Dda, Betsi Cadwaldr) than in other (Powys, Cwm Taf). The VNHSW annual report for 2014-15 suggests that this variation needs further exploration, with inconsistent thresholds for assessment/treatment being operated by VTs in different LHBs cited as a potential cause. Another possible driver might be that veterans and local partners in different areas of Wales have differing levels of understanding of the service and its criteria.

Figure 6



Capacity

Many stakeholders in the review, particularly within the statutory sector, expressed pride in the existence of Veterans' NHS Wales as a high quality national service unique to Wales within the UK:

"Big advantage for Wales, one service which covers the whole nation." (Statutory stakeholder)

"*Fact you have VNHSW is fantastic – Welsh Government should be applauded. National service, connected, visible in each Health Board, can provide intelligence to Government – excellent thing … fact we have a national pathway in Wales is really good."* (Statutory stakeholder)

"*A good model … have enormous pride in the service."* (Statutory stakeholder)

When asked about or highlighting services in Wales that were high quality and innovative, stakeholders were most likely to mention VNHSW, and the Change Step project. High satisfaction was expressed with the quality of the service in terms of both the national care pathways it had established and the quality of the Veteran Therapists:

"*The local VT is a dedicated, passionate individual." (*Statutory stakeholder)

"*VNHSW has been brilliant – we are so privileged to have that. You know the calibre of what they are doing is good … good quality care, proactive and passionate." (*Statutory stakeholder)

"*I got referred to the local VT – she's brilliant. NHS is very good."* (Veteran)

"VNHSW has always been the ultimate gold standard – I always hear positive things about it from GPs, patients who've used it." (Voluntary/independent stakeholder)

Strong concern however was expressed by several stakeholders (particularly but not only within the statutory sector) and by some veterans about the service's capacity across the whole country:[xxvii]

"*A very fragile service across Wales."* (Statutory stakeholder)

Increasing the capacity of VNHSW was the top priority for change identified by statutory sector stakeholders who participated in the review.

Specific concerns identified included:

- VNHSW's therapeutic and administrative capacity, and ability to meet demand within appropriate waiting times - with knock-on effects on waiting lists and relying on charities to fill gaps. This was of particular concern where it raised the risk of veterans self-referring to charities offering speedy access to non-evidence based treatments (see chapter 2 above):

*"They are underfunded, waiting lists … so end up relying on charities e.g. Combat Stress, Change Step – not ideal … not a given that charities will be around … we are over-reliant on them to cater for people who need help in the short term." (*Statutory stakeholder)

"*Issues re shortage of supply, deficits in VT provision – certain areas are not as plentiful as they should be. In our Health Board demand considerably outstrips supply. … Services that are provided are probably insufficient but highly effective. … we would not want to compromise the quality we get ... Don't want to spread the VT even further."* (Statutory stakeholder)

- VNHSW's ability to put in place contingency arrangements e.g. to cover long-term staff absences, especially as the geography of Wales makes it difficult simply to deploy VNHSW staff from other regions when needed. This was consistently highlighted as a live issue in Hywel Dda by stakeholders, veterans and families, where there had been no VT provision for over a year:

"No robustness in VNHSW … veterans in Hywel Dda call … and say 'we've got nothing". (Voluntary/independent stakeholder)

"I was referred to the Hywel Dda VT three times. I was on her list … got seriously poorly in that time." (Veteran)

"*Apparently the VT is very good. We just need more of them. The quality is there but that person is spread to the four winds."* (Veterans)

"*Would be unfair to require people to have to work 200 miles from their homes. … No problem in being loaned out to the neighbouring Health Boards but not a completely different part of Wales."* (Statutory stakeholder)

- coverage in rural areas such as Powys, which does not have its own VT and literature, but rather is served by the three neighbouring Health Boards. Some reported this can lead to difficulties in gaining an accurate perspective on need in Powys, and delays in providing services to patients:

"*All literature they produce doesn't mention Powys … referral rates are low – don't know if accurate reflection of need, or because awareness of service is low … or too far away." (*Statutory stakeholder)

"*Had a suicide risk patient in Powys while the Health Boards were arguing over who should see him."* (Voluntary/independent stakeholder)

VNHSW is starting to roll out web-based screenings and assessments to avoid the need for patients to travel to appointments, which it is hoped will help better meet the needs of patients in rural areas.

Key issue 8: ensure VNHSW has appropriate capacity on a sustainable basis across the whole of Wales.

3.3 Mainstream services

Value of mainstream/community services

Improving health services other than VNHSW was the joint second top priority for change identified by all review participants, when analysed together as a whole.

When analysed by group, improvement in health services other than VNHSW was also the joint second priority for:

- **voluntary/independent sector stakeholders; and**
- **veterans/families.**

Statutory sector stakeholders as a group tended to focus on the importance of VNHSW when discussing veterans' mental health needs - and indeed some Health Board stakeholders did not discuss any other means of meeting these needs.

In contrast voluntary/independent sector stakeholders and veterans and families stressed the importance of mainstream services, particularly community services. These were seen as vital for:

- supporting treatment and sustaining its benefits in the long-term:

"*The real life help I needed after my PTSD treatment was from my community, not the professionals, integrating again with people. So important to have that after treatment and between treatment sessions – can be days, months."* (Voluntary/independent stakeholder)

- combatting the isolation which could cause/exacerbate mental health problems, as emphasised by veterans accessing a support group at a mainstream mental health charity:

"Places like this offer activities, give you confidence to leave the house in a safe place." (Veteran)

"I come here most days so I'm not on my own in the flat. If I sit there I get worse." (Veteran)

"When you're on your own you think if I took something who would notice? My son is the only thing that stops me, and this place." (Veteran)

- picking up and dealing with problems early, before crisis point:

"A more proactive approach to preventive measures … e.g. more social meetings for veterans. So if people start sliding, it gets picked up quicker. And it's cheaper for NHS than picking up the pieces when people get really ill, e.g. other veterans can spot if you're quiet. Get it picked up before it kicks off, screaming for Crisis Team. (Veteran)

"My husband has had no help at all from … the NHS, no counselling help at all. He has had a little bit of counselling – some organised by the RBL, some through people at local charity – from that other things that happened in his past, childhood have come up – and now he has been left again to deal with that. Almost like he's been made worse, little doors have been opened." (Family member)

Sometimes the improvements needed to mainstream services were expressed as for veterans specifically, e.g. having a *"Forces version of the Samaritans"*. Sometimes they were expressed as general improvements benefiting everyone including veterans, such as quicker access to physical and mental health services across the board, or making improvements to services for all groups of people who have suffered trauma.

Overcoming barriers to access

Evidence suggests that veterans who experience mental health problems can face barriers in accessing with and engaging successfully in services:

"Engaging veterans in mental health treatment programmes remains to be challenging because of stigma, perceived weakness in acknowledging emotional difficulties, and military macho cultures."[xxviii]

GPs are a key initial point of contact for people with mental health problems. Managing mental health problems and promoting mental health and wellbeing is a significant part of GPs' workload.[xxix]

Some stakeholders highlighted veterans' low tolerance of waiting lists/waiting times as a barrier to accessing health services, and felt that awareness raising on both sides was needed so that veterans had more realistic expectations of the civilian world. This was borne out in discussions with veterans and families who strongly valued immediacy of help, and expressed strong frustration at waiting times/lists particularly in secondary and crisis care services. This frustration could lead to dropping out of waiting lists and/or exacerbate distrust of services:

"I got referred by GP to [local] mental health clinic … I was waiting so long I decided to bin them and do it myself." (Veteran)

"It takes too long to see a professional. I was begging for help from my GP for 18 months. I ended up breaking the law, getting a court order to see a psychiatrist." (Veteran)

"If someone is told they can be seen in six months they'll think 'how can that help me?' So they won't seek help next time because they will think 'I will have to wait six months'. Soldiers take people at their word – as soon as they break their word, they won't trust them again." (Veteran)

Veterans' reluctance to seek help, and/or lack of awareness of civilian services available to them, were seen as posing barriers to access. One stakeholder had found veterans to be more reluctant than the general population to see the GP about mental health problems; particularly older veterans who did not wish to speak to either their family of the GP, having *"the attitude 'that's what happened, we don't talk about it'"*. The armed forces culture of self-reliance and 'stiff upper lip' were identified as exacerbating veterans' low awareness of and willingness to access the civilian services available to them:

"*Gap in awareness/use of what is already out there – people not asking for help, trained to be self-reliant. Veterans are unaware of the GP as the first port of call … their training is to get on with it, and have view that 'no-one who hasn't served in the forces understands me'."* (*Statutory* stakeholder)

"We're not supposed to ask for help, show emotion – that's what we've been trained to – takes a lot for us to ask for help." (Veteran)

Actual or perceived lack of cultural competence or appropriate expertise within mainstream services was also reported as a barrier to access, and as having impacted detrimentally on the assessment, diagnosis and treatment of veterans, sometimes in the long-term. It was suggested that GPs and other health professionals needed to be made aware not only to ask if someone was a veteran, but also how to discuss their history with them appropriately and sensitively in order to support/refer them effectively:

"*If you go to the doctor they should ask if you're military. So if you're a fuck up they ask you why you're a fuck up. I had 24 years of self-medication [i.e. alcohol] before I got help."* (Veteran)

"*I used to go for counselling. I told her something I'd never told anyone before – she brushed it under the carpet. It had been eating at me for years, suddenly realised what I'd done out there, why I was feeling guilty – she just totally ignored it."* (Veteran)

Some stakeholders took the view that improving the cultural competence and capacity of generalist health professionals within mainstream services is vital if veterans' needs are to be met on a long-term sustainable basis - especially in more isolated and rural areas where specialist services such as VNHSW may be an unaffordable luxury except for a small minority of cases:

"*Long-term sustainable model is to have generalists who develop expertise, and leave the specialist to do the specialist stuff … need all mental health and physical health professionals to know their clients have a variety of issues … it's about blend, getting the balance right for sustainability. … the whole continuum of crisis resolution."* (Statutory stakeholder)

One stakeholder noted that the Public Health Wales' 2014 evaluation report[xxx] of VNHSW had recommended that there should be a Clinical Champion for veterans working within general mental health services, to raise awareness of:

- veterans' increased health risks;
- cultural issues such as their perception of civilian life and the impact of being an early service leaver.

One of VNHSW's outcomes includes training mainstream health professionals to enable them to deliver culturally competent services to veterans. This outcome is an important one both in the long-term (creating an NHS which is culturally competent in the needs of the armed forces community) and short-term (mainstream NHS being able to respond when VNHSW has capacity problems). The fact that the VNHSW does not currently have capacity across Wales to deliver its core function of assessing and treating clients (see above), potentially significantly limits its ability to deliver this outcome.

Specialist v generalist provision

One stakeholder suggested that the existence of specialist services such as VNHSW could mean that the 'eye was taken off the ball' in terms of planning to meet veterans' needs within mainstream services:

"*Dilemma – any specialised badged service can be a good and bad thing. Good – specialised service for particular group in the community; bad - seen as you dump everyone in it.* (Statutory stakeholder)

Several stakeholders and veterans and families emphasised the value of statutory and voluntary sector services in which other members of the armed forces community could support veterans and families:

"*Lots of veterans won't access mainstream services – GPs, counselling, CMHTs – I thought that was a myth – but have met many veterans who are vehement on that."* (Voluntary/independent stakeholder)

"People that have never been in the Forces don't understand how it runs, the mindset. If someone's been in your situation, they have an empathy with you, so you don't need to find the right words." (Family member)

Others however emphasised that some veterans wished to move away from involvement with the military:

"*Lots of veterans who contact us don't want to talk to another veteran … I presumed they would only want to talk to other veterans but not the case.*" (Voluntary/independent stakeholder)

"I've had several guys saying 'I'm a civilian, I don't want to remember my service time, sit in a room with other veterans talking – I want to move on'." (Veteran)

The experience, skills and perspectives of professionals without a military background were also valued, especially those with qualities such as empathy, technical expertise, professionalism and the ability to gain trust:

"Current veteran clients are getting on really well with all the support workers and have a good relationship with them even though none have an armed forces background." (Voluntary/independent stakeholder)

"*Am recognising more and more that some veterans want issues resolved and are not precious about who does it … want somebody competent to do it especially when it comes to money … especially the younger ones want a solution but not delivered by the usual suspects i.e. military organisations."* (Statutory stakeholder)

"If all charities working with veterans are exclusively veterans that's not a good thing, replicating in community what happened in services … definitely need veterans involved, speak the language, but need other people who can offer experience, skills and a wider lens of exclusively ex-servicemen." (Voluntary/independent stakeholder)

Some advocated that work needed to be undertaken to support veterans to be more willing to access support from civilian, non-veteran specialist primary care services; arguing that from a point of view of health economics this was essential if their needs were to be met on a sustainable, long-term basis:

"*I've got a feeling there's not enough people coming forward from GPs … veterans need to be supported to become more ready to accept the general support for mental health that's out there. Then focus the specialist support for veterans on the more specialist issues arising from becoming veterans … on the 10% acute need that primary care can't deal with. It's a matter of health economics."* (Statutory stakeholder)

Some suggested a step approach based on the level of need and/or barriers. In such an approach, a veteran-specialist focus would be initially important to encourage access, and in the longer-term for people with complex needs (see chapter 4); but the ultimate goal would be to move them into civilian, mainstream services:

"*When someone is on their beam's end, e.g. coming out of a drugs/alcohol problem period – someone who knows 'which end the bullet comes out of' is enormously useful … but when you lift someone out of that silo you need to encourage them to see there's a big world out there, with help available, and friendly faces – getting that person to accept that is the key."* (Statutory stakeholder)

This step approach was observed in a mainstream mental health charity visited during the review, which offered a mix of mainstream activities and veteran-focused meetings.

Veterans reported that the provision of the latter had made them feel welcome, and encouraged them to take the difficult first step to access the service. This had then enabled them to become involved more widely in the centre's mainstream activities.

Key issue 9: identify veterans as a population group with specific clinical risks, barriers to accessing services and cultural needs within services, and undertake:

- **assertive outreach to veterans and families**
- **capacity-building within mainstream services to meet their needs in a culturally competent manner**
- **working with them around their expectations of civilian services and support them to be willing to access them**
- **achieving an appropriate balance between specialist and generalist services across sectors.**

3.4 Meeting the range of health needs

Although VNHSW treats any mental health problem related to service, there was a notable tendency among some stakeholders particularly those in Health Boards to equate VNHSW solely with PTSD treatment. This is reflected at national level in the *Together for Mental Health* strategy's draft 2016-19 delivery plan, which focuses on VNHSW's PTSD treatment. The draft plan's goals include at 7.7, under priority goal 7: *People with a mental health problem have access to appropriate and timely services*:

- "to ensure mental health services for Veterans in Wales who are experiencing mental health problems are sustainable and able to meet that population's needs in a timely and appropriate manner."

The draft 2016-19 plan specifies one 'key action' to achieve this goal:

- "Health Boards continue to support Veterans' NHS Wales to deliver timely and appropriate services for Post-Traumatic Stress Disorder (PTSD) for veterans".

Some stakeholders and veterans emphasised the importance of VNHSW catering for a wide range of mental health issues and not just focusing on PTSD, which some felt could overshadow other needs:

*"VT can provide that extra care to people with conditions related to being a veteran – not just PTSD, range of things in terms of coping – anxiety, stress, substance misuse. Not just about trauma from going to war – can be range of issues. People leaving army, finding 'what do I do now?" (*Statutory stakeholder)

"*They give priority to those on the frontline with PTSD – not us with other mental health issues … I feel for the PTSD people but there are people with other conditions related to their service."* (Veteran)

PTSD diagnosis/treatment

The quality of VNHSW's work with PTSD patients, and its model of treating PTSD within rather than away from the community, attracted praise from stakeholders. Some stakeholders and veterans/families reported problems however with the diagnosis and treatment of PTSD within mainstream statutory and voluntary sector mental health services. This was expressed both in terms of under and over-diagnosis, and in being able to recognise symptoms/medication and provide an appropriate treatment response:

"I was diagnosed as ____ and got the correct treatment. Today I would have been diagnosed with PTSD – quick get-out for GPs." (Veteran)

"Most GPs don't know about PTSD – military side PTSD. My GP didn't know my meds I was on when I came out of jail … most GPs I've seen don't know anything about PTSD, the right meds, the right channels of help … I went to a GP about a recurring nightmare in Iraq – he just offered sleeping tablets." (Veteran)

"I went to the GP first – they said I was depressed, I got anti-depressants. … I went from the GP to a mental health charity … it was crap. I was trying to explain about flashbacks – she said she didn't know anything about the military – so I binned them off. The next step was Change Step – they referred me to the VT, he was a veteran, understood." (Veteran)

It was felt by stakeholders and particularly by veterans that these problems could be exacerbated by wider factors such as:

- self-diagnosis by veterans/families/friends;
- PTSD being seen by veterans as a more acceptable mental health problem than common mental health problems, associated with civilians;
- financial drivers.

"*I've been told by ex-forces and serving people I have PTSD – people label as PTSD far too soon, I don't think that's what it is … PTSD has become a blanket cover."* (Veteran)

"Sometimes the partner or mother have heard of PTSD, read up upon it – pushing that it's PTSD, start arguing with the NHS … some people wrongly diagnosed with PTSD, and some being missed. And some people are saying they have it to get benefits." (Veteran)

Dementia

Dementia is a growing health problem within Wales where the number of people with dementia is projected to increase by 39%.[xxxi] It has been highlighted that two key factors in terms of managing dementia are using your brain, and keeping socially engaged.[xxxii]

One stakeholder emphasised that veterans are a significant part of the population with dementia; and that knowing that a patient has served in the military can be of great value because this memory can be vivid enough to access. This facilitates communication, combats isolation and enables the patient to feel of value.

"*You can use it as an additional talking point when conversing with them, talking about their service, that older memory is still there … Even if have just done national service, it has had quite an impact on their memory and identity.*"
(Voluntary/independent stakeholder)

Physical health

The RBL Household Survey found that a significant number of veterans live with other health conditions such as multiple conditions, musculoskeletal problems and sensory impairments. In this review the link between physical and mental wellbeing was only touched upon by a few stakeholders and veterans, but those who raised it saw it as being of key importance. They emphasised both the negative and positive effects of physical wellbeing on mental health (e.g. the positive effects of exercise and the detrimental effect of back pain) and on the key determinants of mental health such as employment (e.g. the inability to work after leg injuries exacerbating depression):

"Exercise helps me more than meds." (Veteran)

"*I had back and leg injuries. I lost everything in one accident – my life just ended – all took away. Medically discharged. I took to drinking. Only recently getting any help. I'm just on medication. My therapy is the gym, the boxing, I found my own release."*
(Veteran)

One statutory stakeholder emphasised the problems veterans and families coming to the local area after discharge could have accessing services such as dentistry, and the work done to try to improve this. Another stakeholder described the effects of such problems on the mental health of one veteran:

"Abscess in tooth for nine months, can't get to see a dentist. He has serious PTSD. He's saying 'this wouldn't happen if I was in the fucking Army' making him worse. Nearest place they could see him was Manchester – he's skint. Now the whole tooth is broke – still can't get him into dentist. Makes him more and more angry."
(Voluntary/independent stakeholder)

Key issue 10: ensure the focus of planners and providers nationally, regionally and locally is on all types of conditions among veterans, physical and mental.

Key issue 11: address concerns about the diagnosis of and treatment response to PTSD within mainstream services.

4. Multi-agency working

CHAPTER SUMMARY

Chapter Four sets out:

- **the need for multi-agency responses to complex psycho-social needs, particularly for high need groups such as Early Service Leavers, dual diagnosis patients and veterans with mental health problems involved in the criminal justice system (CJS)**
- **stakeholders and veterans/families' views that simpler, clearer, more efficient and better co-ordinated assessment and referral pathways are needed across Wales as a whole**
- **stakeholders' concerns about the operation of the dual diagnosis pathway and how to meet the needs of veterans currently using drugs/alcohol; exacerbated by concerns about the future of the Change Step project, currently a vital bridging mechanism between these patients and VNHSW and other services from which they are excluded**
- **the importance of developing a strategic national approach and close working relationships at local level to address the needs of veterans with mental health problems who become involved with the CJS.**

KEY ISSUES IDENTIFIED IN CHAPTER

12: build/support/sustain Clinical Networks of agencies, including both mainstream and specialist services across sectors, to provide better co-ordinated and more effective and efficient assessment and referral processes across the whole of Wales.

13: address concerns about how well the dual diagnosis pathway is working in practice; and how best to meet the needs of veterans currently using drugs/alcohol and therefore excluded from services.

14: develop a strategic national approach across sectors to meet the needs of veterans with mental health needs within the CJS, including learning from current/forthcoming initiatives in this area in Wales; and sustain/develop local level partnerships to the benefit of both veterans and services themselves.

4.1 Complex needs

A multi-agency response is vital to meeting the needs of veterans who can have a range of complex health and social needs. Veterans and families' reluctance to seek help and unfamiliarity with the demands of daily life in the civilian world (see chapter 3) can exacerbate problems associated with deprivation. For example, stakeholders reported considerable and complex needs, sometimes 'hidden', around areas such as housing and finance:

"*We asked veterans if they had accommodation problems, we found they weren't declaring themselves as homeless but sofa surfing or sleeping in tents.*" (Voluntary/independent stakeholder)

"We have had to work on considerable welfare cases for many veterans who've come to us – distribute food parcels, work with all benefits … We work closely with SSAFA on that – e.g. where people homeless." (Voluntary/independent stakeholder)

VNHSW data shows that of the veterans assessed in 2014-15, only 34% described themselves as working either part-time or full-time. Nearly half (49%) described themselves as unemployed and not fit for work; and 13% as medically retired due to ill health. Further, 'Early Service Leavers' (ESL - veterans who have served between 0-4 years), who are recognised as potentially having more complex health and social presentations and needs, accounted for 18% (48) of the veterans assessed (and where the time in service was recorded). A further 52 had 5 or 6 years in service:

"*Early Service Leavers are particularly vulnerable to mental health problems. And homelessness, employment problems exacerbate these."* (Voluntary/independent stakeholder)

About one-third of the Change Step project's service users are also Early Service Leavers.

Statutory stakeholders observed that the financial/practical support and assistance, along with emotional/social support, offered by charities was of vital importance in terms of promoting mental health and wellbeing and ultimately eased pressure on the NHS:

"*The support of the local voluntary sector is absolutely key – sometimes individuals, sometimes groups – people drop in for coffee, telephone advice. … Lot of low-level stuff – if they don't have support for that, can become a more significant illness. Someone you can talk to, advise on paying bills, house, not sit and worry."* (Statutory stakeholder)

However although such support can be strongly valued by veterans and families, it can also be perceived as shameful and damaging to pride and self-reliance:

"Went to see a veteran on streets. He didn't want anything from any charity … didn't want any charity help. We offered him help in return for working in a food bank – he accepted that." (Veteran)

The stigma around seeking practical help can also deter veterans and families from claiming financial assistance e.g. benefits to which they are entitled.

Charities can also be a source of employment opportunities. Veterans, including veterans with mental health problems, involved with charities such as LINK and the Change Step project can be provided with training to progress into unpaid volunteering and paid employment roles buddying/mentoring others. As well as providing a pathway to employment, such opportunities have beneficial effects on mental health and wellbeing:

"*Buddying gives him a purpose – other people are relying on him, makes him feel so much better about himself – he's done something useful, helping people."* (Family member)

4.2 Improving multi-agency pathways and networks

While multi-agency working is vital to meet the range of complex needs, stakeholders, veterans and families called for more to be done to improve the working relationship between agencies across sectors around the assessment, referral and treatment of individuals' needs. They cited duplication, unnecessary delays and confusion for both professionals and patients.

Improving multi-agency working to meet the needs of individuals more effectively, e.g. through better co-ordinated and simpler assessments and referral pathways, was the top priority for change identified by voluntary/independent sector stakeholders.

"Making sure that GPs have a simple way of referring/directing to the relevant services – whether third sector or statutory – making that as simple as possible is by far the top priority." (Voluntary/independent stakeholder)

Some veterans and families described themselves as being "*pulled from pillar to post"* and "*bounced around"* between different teams, services and organisations across sectors who they saw as lacking "*connection"* and "*unity"*:

"*Local Authorities, substance misuse team, NHS, local housing – need to have a knowledge of what is going on in people's lives, signpost to someone else of not their responsibility i.e. to help individuals … not just show them the door."* (Veteran)

"A lot of services were passing me round like a puppet … There seem to be organisations and people who pass you round." (Veteran)

As noted in Chapter 2, the size and diversity of the armed forces charity sector was seen as contributing to confusion among practitioners and individuals. Too many organisations were in essence offering potential support to the same individuals and "*competing for business and patients*":

"Hard for Health Board to navigate – so even more so for individual patients and families." (Statutory stakeholder)

"*Need a coherent charitable … capability that isn't as confusing as it is at the moment … so veterans, families and GPs know where to go."* (Statutory stakeholder)

One statutory stakeholder suggested that easily accessible online information in one place on the range of services available to veterans at a local level would be helpful for both professionals and veterans/families, especially those new to the area.

Stakeholders concomitantly highly valued the work done in some areas to ensure VNHSW and key partners worked more closely on individual assessments and referrals to prevent duplication and promote greater consistency.

One statutory stakeholder explained how *"operational problems and frustration from practitioners"* and "*a lot of duplication, not a multi-disciplinary approach"* had led the Local Health Board to bring together VNHSW, CAIS/Change Step and Combat Stress to ensure information sharing and multi-agency assessments took place. This had proved highly productive so that all referrals were now being collected in a single point to ensure that the initial referral was made to the most appropriate agency based on the needs of the individual.

There was therefore concern that if the Change Step project were not to be sustainably funded (see Chapter 2 above) this progress in appropriate assessment and establishing referral pathways would be at risk.

Stakeholders reported patchy progress in terms of establishing Veterans' Mental Health Clinical Networks, which are intended to take place in each Health Board. These should hold regular meetings between key partners across sectors to discuss individual cases where there is a shared interest. However one stakeholder reported confusion between their local Clinical Network meetings and those of the Armed Forces Forum, with the same people attending both despite their very different purposes; while another stated that their local Clinical Network had "*died a death"* owing to non-attendance:

"Need to get those Clinical Networks bought into and utilised, doing the really important mental health stuff." (Voluntary/independent stakeholder)

The importance of an integrated, flexible and transparent approach to multi-agency working with information sharing between all services involved across sectors was emphasised by one stakeholder. This should provide a 'pick and mix' approach to meet individual need, which might change over time, rather than the traditional 'tick box' needs assessment. Another stressed that third sector agencies needed to work closely with generic mainstream services, and not just with VNHSW:

"Change Step and Listen In locally don't have links to the Community Mental Health Team. Hugely important for referral flow, two-way signposting – gap."
(Statutory stakeholder)

Key issue 12: build/support/sustain Clinical Networks of agencies, including both mainstream and specialist services across sectors, to provide better co-ordinated and more effective and efficient assessment and referral processes across the whole of Wales.

4.3 Dual diagnosis pathway

Some statutory stakeholders highlighted particular concern about the dual diagnosis pathway for veterans (i.e. those with both mental health and substance misuse problems), who have particularly complex needs.[xxxiii] While the pathway for dual diagnosis veterans is led by Community Mental Health Teams with both substance misuse and mental health problems treated together, concern was expressed at how well this pathway was actually working in practice. It was reported that anecdotal evidence suggested that general pressures on CMHTs were affecting its effectiveness:

"*Veterans and alcohol and drug problems – patchy." (*Statutory stakeholder)

Some voluntary/independent and statutory stakeholders expressed concern that dual diagnosis veterans, who have high needs, have reduced access to services in both the statutory and voluntary/independent sectors e.g. mental health and housing services, owing to entry criteria which exclude people who are currently using drugs/alcohol:

"*People are under the impression it's covered as VNHSW and Combat Stress are dealing with it. People don't understand a lot of people aren't eligible for support from them – because drinking, chaotic."* (Voluntary/independent stakeholder)

"*If veterans are by themselves they fall back to old coping mechanisms – drugs, alcohol … don't see why VNHSW won't treat people who are drinking."* (Voluntary/Independent stakeholder)

The Change Step project is seen by some stakeholders as an important bridging step for dual diagnosis clients and other clients who are not yet ready to enter therapy, and whom it may be difficult to keep engaged while waiting for treatment. CAIS, the agency which set up and managed Change Step, began as a counselling service for people with drugs and alcohol problems; it now offers support to people with psycho-social problems e.g. support around employment, homelessness and mental health problems. About a fifth of Change Step service users admit to an alcohol problem but it is felt possible that there is a degree of under-reporting, as many veterans do not see their drinking as problematic owing to the drinking culture within the armed forces.

As shown in Chapter 2, Change Step is the outside agency to whom VNHSW makes most referrals. Similarly, a mental health charity with a veterans support group does not allow people currently using drugs/alcohol to access its services as it "*would affect the equilibrium of the place*" and be unfair to other service users. They referred such people to the local drugs/alcohol charity; or, "*if the individual wanted military-focused provision"*, to Change Step.

Stakeholders therefore felt that the lack of sustainable funding of Change Step (see Chapter 2 above) was particularly important for dual diagnosis veterans and others with highly complex problems, whose needs risked being left unmet:

"*Change Step service users have complex problems … at level where a lot of other charities/services won't see them … Change Step fits in as stabilisation, to get them to the point where they can access services."* (Voluntary/independent stakeholder)

Key issue 13: address concerns about how well the dual diagnosis pathway is working in practice; and how best to meet the needs of veterans currently using drugs/alcohol and therefore excluded from services.

4.4 Criminal justice system

More integrated partnership working at both national and local level was seen as particularly important where veterans with mental health needs had become involved in the criminal justice system (CJS):

"*In Wales everyone across the private, statutory and voluntary sectors need to get over themselves and have a collaborative strategy to work together re veterans and the CJS."* (Voluntary/independent stakeholder)

Some veterans and families described how veterans' mental health problems had only been identified and/or addressed once they had become involved with the CJS:

"*I waited years for counselling for non-service related PTSD … I'd already been arrested, in a cell – took years to see anyone."* (Veteran)

"*I went off the rails and punched a copper so I went to CAIS for support and they said they were starting Change Step. They referred me to VNHSW and I was diagnosed with PTSD."* (Veteran)

"I ended up going to jail, got diagnosed with PTSD there by VNHSW." (Veteran)

Stakeholders emphasised the importance of breaking down silos to "*join the dots up*" between prison, health, social care and housing – "*the sharp end stuff*" - and work creatively to achieve systemic and individual change.

Prisons

The Welsh Government and partners published in 2013 guidance on improving the health and wellbeing of prisoners who are veterans.[xxxiv]

For various reasons, including non-disclosure on the part of the individual, there are no accurate figures for the number of prisoners in Wales who are also veterans. The Welsh Government estimated in 2013 that based on what is known, and UK estimates, the proportion is likely to be about 3 – 4% of the adult male prisoner population.[xxxv] 2013-14 figures from Her Majesty's Inspectorate of Prisons for England and Wales[xxxvi] estimated that 6% of the prison population are veterans. Veterans therefore form a distinct and highly vulnerable sub-group within the prison population:

"*Hero to zero situation, can go down quickly emotionally and psychologically."* (Voluntary/independent stakeholder)

During the course of the review it was announced that the National Probation Service in Wales had secured a £390k grant from the Covenant Large Grants Fund, under the Former Service Personnel in the CJS Priority, for a Veteran Pathfinder project for Integrated Offender Management Cymru.[xxxvii]

Some stakeholders praised the innovative work being done in Wales by G4S at HMP Parc, whose Endeavour Unit opened in January 2015. Based on a template used for its Family Intervention Unit, the Endeavour Unit houses (on a voluntary basis) first-time in custody prisoners and veterans in custody, limiting their contact with other prisoners with a view to reducing the likelihood of re-offending. There are bespoke interventions within the Unit including an intervention supporting their mental health needs.

Work in other areas was also mentioned by stakeholders e.g. Armed Forces Champions operating within Cardiff Prison; and prison and probation staff attending meetings at Cardiff and the Vale HB Armed Forces Forum.

Police

Veterans identified the police as a key agency, which would benefit from having more awareness of and training on mental health needs in general; and how to identify and handle people in distress:

"*You can keep going in police, getting in trouble – but they never ask any reason for it."* (Veteran)

In December 2015 the Welsh Government, police forces, the NHS, councils and other agencies signed a new agreement to improve the system of care and support for people in a mental health crisis. The Concordat is structured around:

- access to support before crisis point;
- urgent and emergency access to crisis care, (whilst using the least restrictive options) by both face-to-face and 'hear and treat' services;
- quality treatment and care when in crisis;
- recovery from crisis and staying well in the future.

Partnerships of health, criminal justice and local authorities will set out the required actions to help deliver the Concordat aspirations, including setting out ways to reduce the use of police cells as a 'place of safety' under the Mental Health Act.

Stakeholders and veterans made clear the importance of local partnerships between the third sector and the police in effective crisis care relating to veterans, based on individual relationships of trust being built up over time. Examples cited included:

- local police and the staff at Alabare Wales Homes for Veterans in Carmarthen;
- local police and the Change Step veteran peer mentors in North Wales.

In both cases these good working relationships had enabled veterans with mental health needs who found themselves in police custody to be dealt with quickly and appropriately, to the benefit of both the veteran and the police.

"*We had a case where the police couldn't control a veteran, kicking off – one of the Change Step peer mentors went in and he calmed down instantly."* (Veteran)

Key issue 14: develop a strategic national approach across sectors to meet the needs of veterans with mental health needs within the CJS, including learning from current/forthcoming initiatives in this area in Wales; and sustain/develop local level partnerships to the benefit of both veterans and services themselves.

5. Families and carers

CHAPTER SUMMARY

Chapter Five sets out:

- **the practical, emotional, and support needs of families of veterans with mental health problems; including partners/spouses, parents, children and older carers, and 'new' families as well as those who 'served alongside' the veteran**
- **stakeholders and families' view that this is currently a gap both in terms of the evidence base, information and service provision, particularly if the Listen In project is not sustainably funded**
- **reported safeguarding issues around domestic violence and around the long-term effect on children's mental health and wellbeing, requiring a structured, holistic response**
- **the important role families play in supporting and sustaining the recovery of the veterans, and identifying problems/needs**
- **the need to capacity build them so they have the resilience and knowledge to play this role, and help prevent family breakdown which can lead to the veteran becoming isolated.**

KEY ISSUES IDENTIFIED IN CHAPTER

15: recognise and appropriately cater for the practical, social and emotional support needs of the families of veterans with mental health problems, and for safeguarding issues particularly around domestic violence and the long-term wellbeing of children; and capacity build their resilience and knowledge, to fulfil their key role in prevention, identification and sustainable treatment of veterans' mental health problems.

Doing more to meet the needs of the families and carers of veterans with mental health problems was the joint second priority of all participants in the review, when analysed together as a whole. When analysed by group, it was: the joint second priority of voluntary/independent stakeholders; and the joint third priority of veterans/families:

"*If you don't help the family, how can you help the person?"* (Family member)

Few statutory stakeholders discussed the needs of the families of veterans with mental health problems, and only three identified it as one of their priorities for change (two of whom were local authority stakeholders).

Those who did cover this issue however saw it as a major gap, citing this as an agenda, which was entirely left to the voluntary sector, and in Wales to CAIS' Listen In project in particular (about whose funding there were significant concerns – see Chapter 2 above). It was highlighted that VNHSW works only with the individual veteran, not the family as a whole. (VNHSW has trained VTs in conjoint CBT for couples where the veteran has PTSD and it is affecting their relationship, but this is not yet widely used.) This was seen as a limitation both in terms of the significant pressures the families were facing, and the treatment of the veteran:

"They've all got to support one another in the household … The family is the key." (Statutory stakeholder)

The issue was also identified as a gap in terms of the evidence base; again in terms of achieving not only a better understanding of the adverse consequences for the families themselves, but also of their significant role in veterans' recovery process. One statutory stakeholder emphasised however that this research need required a national body such as MOD to take the lead, and it would be unrealistic to expect regional Health Boards to commission research into it.[xxxviii]

Stakeholders described the effect on family members' own mental health and wellbeing of supporting veterans with mental health problems, e.g. as leading to anxiety, stress, depression and/or drink problems. This could affect not only partners/spouses but also parents, children and older people caring for older veterans; and required practical, emotional and social support:

"*Lots of older carers struggling without really knowing what they can do and where they can get support. More publicity needed."* (Voluntary/independent stakeholder)

"Families need support – trauma within the family too … Practical support – not just emotional." (Veteran)

Families who participated in the review (mainly partners and parents) highlighted the detrimental effect on their own mental health and wellbeing, and the strong concerns they felt for the long-term effects on their children:[xxxix]

"*I just broke … You absorb that illness … I was drugged for four months. There was no-one for the families."* (Family member)

"If you can't get that break, you're carrying on and carrying on and you pop." (Family member)

"*All I could think about was getting my children away from my husband, had to think of their life and future."* (Family member)

Families who had accessed practical, emotional and social support strongly valued it but emphasised that it needed to be more accessible and well-publicised to meet the future demand for such services. In general it needed to be easier to find support to enable them to feel strong enough to continue to support the veteran within the family unit:

"*Listen In is not a well-known service. After Afghanistan and Iraq there are going to be more families that are going to need these services."* (Family member)

"I looked online, it all seems veteran-focused." (Family member)

Further, it should not be assumed that they would wish simply to access the same service as the one, which was helping the veteran. A mental health charity, which participated in the review, had tried to set up a partners' support group alongside their veterans' support group, and it had not taken off for this reason:

"That is my husband's place – where he feels good about himself." (Family member)

Both stakeholders and families stressed that, like veterans, armed forces families could be reluctant to seek help. This was exacerbated by the fact they were often pre-occupied with the needs of the veteran rather than of themselves:

"At first I thought 'I don't want a load of do-gooders' … The focus of the family is on helping the veteran – 'I'm fine'. As a mum, that's what you do." (Family member)

"The Army 'I can cope' attitude rubs off on you too … I don't like asking for things." (Family member)

Most stakeholders discussed the needs of families who had gone through the armed forces with the veteran, "*adapting to civvy world alongside their partner*". Some emphasised however the need also to consider the needs of 'new' families created since the veteran had left the armed forces, "*finding it difficult to see it from the veteran's point of view."*

Some voluntary/independent stakeholders felt strongly that the needs of families, particularly children, needed a more structured and holistic response, e.g. the early identification of and support for children who were at risk themselves of developing mental health problems:

"Families supporting veterans with PTSD would benefit from wellbeing programmes / education / relaxation – something more structured than just peer mentoring or social support." (Voluntary / independent stakeholder)

"Change from Military Wives Choir focus to something tangible in terms of support for families and children of veterans … measure and monitor school attendance, outcomes at school, wellbeing for children of servicemen and veterans." (Voluntary/independent stakeholder)

A family member echoed this, feeling that it would be helpful to have a range of support for children, including: trips and social events with children in a similar situation, "*so they can talk to each other*"; involvement in the counselling and therapy process, to "*help them realise that nothing that is happening is their fault*"; and access to a network of people helping the family unit*, "all the people in the family getting help, from different people who then come together and help the whole family rather than just one individual."*

During the course of the review it was announced that Barnardo's, in partnership with RBL, SSAFA and Prison Liaison Officers, had secured a £438k grant from the Covenant Large Grants Fund (under the Former Service Personnel in the CJS Priority) for the Veterans Family Support Service, a pilot project within Wales. This will focus on the needs of the children and family members of veterans who are in prison.[xl]

Strong concerns were expressed in discussions with stakeholders and to some extent veterans/families about safeguarding issues:

"*Families are not an issue I've been made aware of other than it's very difficult for the families and some of them are in grave danger."* (Statutory stakeholder)

"Partner may have gone through terrible mental abuse from veteran's traumas." (Voluntary/independent stakeholder)

"*Domestic abuse – seem to be hearing quite a lot more of it.*" (Voluntary/independent stakeholder)

Proactive steps need to be taken to address this, given that families could be reluctant to seek help about such issues. It was felt families might initially feel more comfortable within informal peer support than formal professional structures:

"The loyal partner won't disclose the domestic abuse going on … they can be reluctant to take up offer of more formal support. More comfortable talking to other armed forces family members. Don't feel betraying partner – whereas going to see the listening worker, or a counsellor would be." (Voluntary/independent stakeholder)

Review stakeholders emphasised that helping the family also helped the veteran, by strengthening the family unit and helping prevent family breakdown, which in turn could lead to veterans 'spiralling down' into loneliness, despair and severe, long-term problems:

"*If veteran is married with children, and with good strong relationships, they have a fighting chance.*" (Voluntary/independent stakeholder)

"A lot of lads are divorced, estranged from family – craving contact, but don't know how." (Voluntary/independent stakeholder)

The severe effect of family breakdown on mental health was reinforced in discussions with veterans:

"*I don't have any family … I don't have friends … my marriage ended really badly four years ago, my husband was in the services too. It ended so I left the forces environment and had no marriage – alone with two kids.*" (Veteran)

"I live alone, I don't have any family, just me… two years ago I was happily married. Two years is a long time – for me, separation and a nervous breakdown." (Veteran)

To avert family breakdown, families need to be resilient enough to be willing/able to cope with the stresses and risks placed upon them by the veteran's mental health problems. The challenges this presents, and the importance of support in strengthening resilience, was clear in discussions with families:

"*Kids and I put on a brave face but sometimes you've just had enough of it.*" (Family member)

"When I couldn't be in A and E the Change Step peer mentor was at the end of my son's bed, at midnight … I've never felt so alone as I did then – and have never felt as supported as I do know. I'm petrified Listen In and Change Step's funding will finish … Listen In has helped me take it. It won't stop, there's no end, but Listen In helps me cope." (Family member)

Stakeholders also emphasised the need to capacity-build families to play a role in sustaining the recovery of the veteran. While this could be best delivered by the voluntary sector, as a less clinical setting, it would require investment:

"*Talking about supporting veterans is an easy win. But it's the families who will be the sustaining factor long-term.*" (Voluntary/independent stakeholder)

Helping families understand the veteran's mental health condition better, e.g. through provision of Mental Health First Aid Training, could enable them to support the veteran in the long-term and also spot danger signs/recurrence of symptoms:

"*We were hearing the same old story everywhere – veteran disappearing for days on end, going off, possibly drinking …family didn't pick up on warning signs … So we offered families Mental Health First Aid Training. … First port of call for veterans are families – if they don't have understanding of the needs, they will go nowhere quickly."* (Voluntary/independent stakeholder)

Some stakeholders also saw families as a key means of identifying and accessing veterans whose needs had so far gone unrecognised, and reported instances where families coming forward for help had enabled the veteran's own problems to be identified:

"Veterans are hard to reach – assertive outreach techniques needed – an effective way is when family comes … for help and through them we get the veteran to access help. And sometimes vice versa." (Voluntary/independent stakeholder)

Key issue 15: recognise and appropriately cater for the practical, social and emotional support needs of the families of veterans with mental health problems, and for safeguarding issues particularly around domestic violence and the long-term wellbeing of children; and capacity build their resilience and knowledge, to fulfil their key role in prevention, identification and sustainable treatment of veterans' mental health problems.

6. Priorities for change

Chapter Summary

Chapter Six sets out the top three priorities for change identified by all those who participated in the review, analysed together; and of each of the three sub-groups i.e. statutory stakeholders, voluntary/independent stakeholders and veterans/families.

While statutory sector stakeholders strongly prioritised increasing VNHSW resources and improving data to inform commissioning/service provision, the focus of both voluntary/independent sector and veterans and families was on improving mainstream services, and on doing more to support families and carers.

Stakeholders, veterans and families were asked to identify up to three priorities for change over the coming year. These were analysed all together to identify the top three priorities of all review participants as a whole. The priorities of each sub-group were then analysed, to identify the top three priorities of statutory stakeholders; of voluntary/independent stakeholders; and of veterans/families. (NB statutory stakeholders as a group only had two clear top priorities.)

As Table 3 below shows, the priorities of statutory sector stakeholders are very different from those of the two other groups. While statutory sector stakeholders strongly prioritise increasing VNHSW resources and improving data to inform commissioning/service provision, the focus of both voluntary/independent sector and veterans and families is on improving mainstream services and on doing more to support families and carers.

Table 3

PRIORITIES	All participants	Statutory stakeholders	Voluntary / independent stakeholders	Veterans/ families
Improvements at serving or resettlement stage	1			1
Improved access to / support / investment within general health services	2 (joint)		2 (joint)	2
Improved support for families and carers	2 (joint)		2 (joint)	3 (joint)
Increased capacity in / resources for VNHSW		1		
Better identification of veterans within services / improved data/evidence		2		
Improved multi-agency assessments and referral pathways			1	
sustainable funding for Change Step / Listen In projects				3 (joint)

7. Conclusion

Chapter Summary

Chapter Seven concludes that while much progress has been made in recent years in Wales with respect to meeting veterans' mental health and related health needs, there are a number of opportunities over the next year for further improvement including:

- **the new commissioning and assessment mechanisms under the Social Services and Wellbeing (Wales) and Wellbeing of Future Generations Acts**
- **the next round of Health Boards' business plans**
- **the new Together for Mental Health delivery plan.**

It identifies key risks to the progress made in this area including:

- **lack of strategic focus and co-ordination across Wales in terms of planning/commissioning of services across sectors in relation to veterans' mental health**
- **inconsistent and variable implementation across Wales of the various strategies and structures established such as Armed Forces Forums and Champions**
- **issues around long-term sustainability/capacity within services identified as 'best in class' in Wales by stakeholders, i.e. VNHSW and Change Step, which threaten the progress made in:**
    - **establishing effective local multi-agency partnerships to improve assessment and referral pathways**
    - **meeting the needs of veterans with highly complex needs particularly those with dual diagnosis and those involved in the CJS**
    - **unmet need among veterans and among families, with more prevention, identification and early intervention needed within generalist/mainstream services to prevent pressure on crisis services.**

To mitigate these risks a more strategic, co-ordinated and effectively led approach needs to be developed across Wales to assessing and planning to meet veterans' and families' mental health and related health needs.

The chapter lists all the Key Issues identified in the report.

7.1 Progress and risks

Stakeholders in the review identified that much progress has been made in recent years in Wales with respect to meeting the needs of veterans in respect of mental health and related health needs, including:

- the establishment of structures, strategies and partnerships to meet these needs at national, regional and local level, involving a number of key players within the statutory, voluntary and independent sectors. This includes not only the service community but also some generalist/civilian organisations with specific expertise/networks relating not only to mental health but also key related issues such as substance misuse, psycho-social needs, safeguarding, and the CJS;

- the establishment of some services and models unique to Wales within the UK in which people take pride;

- in some areas, effective multi-agency partnerships being established to prevent confusion and duplication and ensure individuals are not 'passed around' different services;

- reported improvements in transition/resettlement arrangements in recent years, although further work in this area is still needed;

- improvements in data for commissioning, although again further work is still needed;

- innovative work underway and partnerships established to meet the needs of veterans with mental health problems within the CJS.

There are a number of opportunities over the next year for further improvement including:

- the new commissioning and assessment mechanisms under the Social Services and Wellbeing (Wales) and Wellbeing of Future Generations Acts, to be implemented by 2017 through the newly created Public Service Boards bringing together key bodies including Health Boards and Local Authorities;

- the opportunity to influence/become engaged in the next round of Health Boards' annually refreshed Integrated Intermediate Medium Term Plans;

- the new Together for Mental Health delivery plan, to be finalised after the May 2016 elections; along with a general opportunity post-election to influence the direction taken in/priority given to these issues.

The review identified a number of key risks to the progress made in this area, including:

- lack of strategic focus and co-ordination in terms of planning/commissioning of services across sectors in relation to veterans' mental health – both generalist and specialist – across Wales as a whole;

- inconsistent and variable implementation across Wales as a whole of the Armed Forces Forums and Champions, including a lack of clarity and consistency as to what they entail and seek to achieve;

- issues around long-term sustainability/capacity within services identified as 'best in class' in Wales by stakeholders i.e. VNHSW and Change Step. These threaten the progress made in establishing effective local multi-agency partnerships and assessment/referral pathways; and in meeting the needs of veterans with highly complex needs, particularly those with dual diagnosis and those involved in the CJS;

- unmet need among veterans and, even more so, families, with more prevention, identification and early intervention needed within generalist/mainstream services to prevent pressure on crisis services.

To mitigate these risks a more strategic, co-ordinated and effectively led approach needs to be developed to assessing and planning to meet veterans' and families' mental health and related health needs across the whole of the country. This is needed if the overall national spend on veterans' mental health across sectors and services is to be maximised to ensure high quality, effective services are adequately funded to meet the variety of needs of veterans and families living within both rural and urban areas sustainably and prudently.

7.2 Key issues

The individual key issues identified throughout the report are listed below.

1: ensure veterans' mental health and related health needs are factored into the development of Health Boards IIMPTs, with broad engagement around veterans' issues including with mental health users and their families/carers.

2: achieve more consistency and clarity around strategic structures such as Armed Forces Forums/Champions; and more integration between the work of Health Boards and Local Authorities, responsible for many of the key wider determinants of mental health and wellbeing such as housing and employment.

3: continue to improve quantitative and qualitative data on veterans for local level needs assessment and planning/commissioning, including on specific sub-groups such as: female veterans; veterans with a dual diagnosis; veterans within the CJS; and veterans' families.

4: strengthen leadership and accountability mechanisms at national level to:

- **drive forward a co-ordinated, strategic and effectively implemented approach across Wales as a whole to assessing and planning to meet veterans' and families' mental health and related health needs**
- **maximise the overall national spend on veterans' mental health across sectors, including ensuring high quality services are appropriately and sustainably funded**
- **provide quality, effective services meeting the variety of needs of those living within both rural and urban areas sustainably and prudently.**

5: work with key partners to seek to improve quality assurance/governance and reduce confusion/duplication within the voluntary sector, particularly those offering treatment solutions to which individuals can self-refer.

6. highlight in precise and sensitive terms the needs of veterans as a group and ensure they are factored into the new assessment and planning/commissioning mechanisms being implemented over the coming year under the Social Services and Wellbeing (Wales) and Wellbeing of Future Generations Acts.

7: continue improvements at the point of serving and/or resettlement, particularly around: early identification and appropriate treatment of problems; and better liaison between military and civilian services to ensure continuity of care.

8: ensure Veterans' NHS Wales has appropriate capacity on a sustainable basis across the whole of Wales.

9: identify veterans as a population group with specific clinical risks, barriers to accessing services and cultural needs within services, and undertake:

- **assertive outreach to veterans and families**
- **capacity-building within mainstream services to meet their needs in a culturally competent manner**
- **working with them around their expectations of civilian services and support them to be willing to access them**
- **achieving an appropriate balance between specialist and generalist services across sectors.**

10: ensure the focus of planners and providers nationally, regionally and locally is on all types of conditions among veterans, physical and mental.

11: address concerns about the diagnosis of and treatment response to PTSD within mainstream services.

12: build/support/sustain Clinical Networks of agencies, including both mainstream and specialist services across sectors, to provide better co-ordinated and more effective and efficient assessment and referral processes across the whole of Wales.

13: address concerns about how well the dual diagnosis pathway is working in practice; and how best to meet the needs of veterans currently using drugs/alcohol and therefore excluded from services.

14: develop a strategic national approach across sectors to meet the needs of veterans with mental health needs within the CJS, including learning from current/forthcoming initiatives in this area in Wales; and sustain/develop local level partnerships to the benefit of both veterans and services themselves.

15: recognise and appropriately cater for the practical, social and emotional support needs of the families of veterans with mental health problems, and for safeguarding issues particularly around domestic violence and the long-term wellbeing of children; and capacity build their resilience and knowledge, to fulfil their key role in prevention, identification and sustainable treatment of veterans' mental health problems.

Footnotes

[i] *The Armed Forces Covenant*, MOD, 2011
[ii] https://www.gov.uk/government/news/support-package-for-welsh-service-community-launched
[iii] Subsequently published as Healthcare and the Armed Forces Community in Wales, Health Inspectorate Wales, 2012.
[iv] http://gov.wales/topics/health/nhswales/healthservice/mental-health-services/strategy/?lang=en
[vv] http://gov.wales/topics/health/nhswales/healthservice/mental-health-services/measure/?lang=en
[vi] http://gov.wales/docs/dhss/consultation/160118documenten.pdf
[vii] http://gov.wales/about/cabinet/cabinetstatements/2015/betsicadwaladrupdate/?lang=en
[viii] http://www.wales.nhs.uk/sitesplus/documents/863/IMTP%20refresh%2015%20-%2016%20V73.pdf
[ix] http://www.wales.nhs.uk/sitesplus/863/document/224685
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[xi] http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/CVUHB%20IMTP%202015-16%20final%20draft%20010415%20with%20appendix.pdf
[xii] http://www.cwmtafuhb.wales.nhs.uk/sitesplus/documents/865/Final%20Draft%20%202015-2018%20UHB%203%20Year%20Plan%20for%20submission%20to%20WG%2031%20March%20201....pdf
[xiii] http://www.cwmtafuhb.wales.nhs.uk/sitesplus/documents/865/Item%20No%2012%20Cwm%20Taf%20Local%20Public%20Health%20Strategic%20Framework%20-%20Annual%20Refresh%202012-13.pdf
[xiv] http://www.wales.nhs.uk/sitesplus/documents/862/Item6iiHywelDdaIntegratedMediumTermPlan2016-17to2018-19WorkinProgressJanuary2016.pdf
[xv] http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/PTHB%20Everyday%20IMTP%202015.pdf
[xvi] Presentation by Dr Mark Boulter, Chair Wales Mental Health in Primary Care, Policy Forum seminar, November 2015. NB speakers did not have the opportunity to check/make any corrections to the seminar transcript.
[xvii] http://www.wales.nhs.uk/sitesplus/888/page/74140
[xviii] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449660/20150727-_Location_Stats_March_15_FINAL_-_O.pdf
[xix] Read Codes are a coded thesaurus of clinical terms. They provide the standard vocabulary by which clinicians can record patient findings and procedures in health and social care IT systems.
[xx] http://www.bbc.co.uk/news/uk-wales-north-west-wales-35789735
[xxi] http://www.bbc.co.uk/news/uk-wales-north-west-wales-35825031
[xxii] http://www.senedd.assembly.wales/mgIssueHistoryHome.aspx?IId=5664
[xxiii] http://gov.wales/topics/people-and-communities/people/future-generations-act/?skip=1&lang=en
[xxiv] See 'Integrated Care Pathway', Neil Kitchiner and Jonathan Bisson, *Military Medicine*, 2015.

[xxv] All data on VNHSW unless otherwise stated is taken from its 2014-15 Annual Report. Our thanks to Dr Neil Kitchiner for making the report available to the review in draft form.
[xxvi] Other than Powys Teaching Board – VNHSW services for Powys are provided by the three neighbouring Health Boards.
[xxvii] Stakeholder concerns about capacity were however not only limited to the VNHSW service, with e.g. concerns raised about the reliance on locums in mental health services in some parts of Wales or the difficulty in attracting health professionals such as GPs to work in the most deprived areas.
[xxviii] 'Integrated Care Pathway', Kitchiner and Bisson.
xxix Dr Mark Boulter presentation, Policy Forum seminar.
[xxx] www2.nphs.wales.nhs.uk
[xxxi] *National Dementia Vision for Wales,* Welsh Government/Alzheimer's Society, 2011.
[xxxii] Dr Mark Boulter presentation, Policy Forum seminar.
[xxxiii] The RBL Household Survey 2014 found that the military has higher rates of alcohol misuse than the general population, particularly among the 16-54 age group.
[xxxiv] 'Veteran Informed Prisons: a guide to improving the health and well-being of prisoners in Wales who are veterans', Welsh Government, 2013. http://www.veteranswales.co.uk/assets/Veterans-in-Prisons.pdf
[xxxv] *Veteran Informed Prisons A guide to improving the health and well-being of prisoners in Wales who are veterans* (2013) NHS Wales and Welsh Government
[xxxvi] *Ex-Service Personnel Supplementary Paper: Veteran data from HMIP inspection surveys* HMIP, 2014.
[xxxvii]
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/509120/Covenant_Fund_Awards_2015-16.pdf
[xxxviii] The perceived health and wellbeing of 76 partners in Australia was investigated via focus groups of Vietnam veterans diagnosed with PTSD who were members of a Partners Veterans Association. Living with a veteran with PTSD appeared to have a direct impact on the partner's physical and mental health. Participation in a partner-only support group was reported as allowing "healing through talking with others and gaining social support". Cited in Dr Neil Kitchiner, **'**Phase I development of an optimal integrated care pathway for veterans discharged from the armed forces', 2012.
[xxxix] There is clear evidence that significant mental disorder starts in childhood and of the importance of the early identification of children at risk of poor mental health outcomes: presentation by Dr Clare Lamb, Policy Lead and former Chair, Child and Adolescent Faculty, Royal College of Psychiatrists in Wales, Policy Forum seminar. NB speakers did not have the opportunity to check/make any corrections to the seminar transcript.
[xl] http://www.govwire.co.uk/news/ministry-of-defence/new-£10m-covenant-fund-awarded-to-176-armed-forces-projects-4167