



# **An evaluation of six Community Mental Health Pilots for Veterans of the Armed Forces**

**A case study series**

**A report for the Ministry of Defence**

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## EXECUTIVE SUMMARY AND RECOMMENDATIONS

### Background

The UK Ministry of Defence (MoD), in collaboration with the Health Departments for England, Scotland, Wales and Northern Ireland, provided set-up funding for six regional community mental health services pilots for armed forces veterans. These six pilots were evaluated via a comparison with three existing services: Combat Stress, Humber Traumatic Stress Service (NHS), and the UDR/Royal Irish Aftercare Service.

The service configuration of the six pilots differed as a function of design, available resources, and funding, as well as the particular service model of care envisaged. The pilot in Scotland received additional funding from the Scottish Parliament that bolstered available resources while the Welsh service received the same level of funding from Welsh Assembly after the pilot period. There was a differential learning process for each of the six pilots due to services starting at differing times.

### The task

The pilots were set up in response to the perception that the NHS does not understand veterans or always provide a good service to them and the evaluation was to consider what was done, what worked well (or not) and to provide information to help answer the question as to what an effective, culturally sensitive, cost effective and sustainable NHS led mental health service for veterans would look like.

The brief for this evaluation was to compare the six pilot services for veterans with three existing specialist veterans' services. We have been able to draw some conclusions from the differences between these nine services but were not asked to include any generic (non-veterans') services in the evaluation.

### Method

Data was collected from services as follows:

- The body of routinely collected and anonymised data for all clients seen during the life of each pilot
- Anonymised questionnaires sent to all clients who had been referred to a pilot service
- A telephone interview with a lead clinician or manager from each pilot service
- Sample diary activity data submitted by staff from the pilots
- Documentary data (e.g., annual reports and audit results) produced by the pilots in the normal course of their work

## Caveats

Although some pilot and pre-existing services gathered pre- and post-treatment outcome data, most did not. Therefore findings of the 'best-performing' services on the basis of improvements achieved in the psychological well-being of ex-service personnel cannot be made. Information is available for all pilots based on questionnaires returned by a subsample of their clients. Absolute numbers returned were small. Although the 8% return rate was respectable for a 'cold' postal survey in the field of mental health, statistical testing of findings has not been possible. The veterans whose opinions were canvassed in the questionnaire were mostly in their forties or older, and had been discharged from the Forces 10-20 years ago. Their accounts, by definition, describe their own experiences but may not always reflect the prevailing practice in the MoD, Forces or NHS. Where veterans expressed opinions about desirable changes that have, in fact, now taken pace (e.g., pre-operational psychological briefings), we have not stressed these points.

## Results

In defining successful components of the pilot services, we mean features either of a specific service that have been explicitly and favourably commented on by veterans or common features of services that have received favourable comments, maintained high levels of activity, and had fewer gaps in the information they gathered.

More successful features of pilot services included:

- Self-referrals being an option for accessing a service
- Availability of staff who were themselves veterans
- Staff with training and experience of working with veterans
- Availability of group work with other veterans
- Provision of multi-agency 'clinics' with advice on pensions, employment, housing, physical health, etc.
- Teams/buildings 'badged' as being for veterans
- Services offering assessment and treatment together with no wait in between
- Joint work and information-sharing with other agencies (e.g., NHS/Combat Stress) to support one another and prevent duplication
- Routinely accessing Forces' service records of new referrals

Less successful features included:

- Assessment-only services leading to treatment in generic NHS settings
- Pathways involving onward referral with a further waiting list at each stage
- Staff who had little or no experience of working with veterans
- Sole practitioner services where this led to discontinuity of service through having nobody in post at times
- Services requiring veterans always to travel long distances for assessment or treatment

The success of any service is likely due to a combination of factors although a robust service model and dynamic leadership clearly helped. However, although clear leadership was an asset, it also belies the vulnerability even of successful pilots as being overly dependent on a key person and may not be a sustainable approach. A key tension was the benefit, or not, of veterans seeing someone

with personal experience of service in the Forces. Veterans themselves expressed a strong preference for being seen in services staffed by veterans. Services differed in features such as the rate of referral from different sources (eg SPVA) and the frequency with which different diagnoses (eg PTSD) were seen. This is more likely to reflect services' methods of operation than a genuine difference in prevalence between localities.

A variety of innovations in services delivery appeared to work well. In particular, the use of open-ended psycho-educational groups was welcomed by veterans as fostering a sense of shared experience and comradeship. There was evidence of effective practice via, for example, good liaison work with local Combat Stress offices and making access to service records a standard part of the assessment. Some treatments were offered quickly, particularly where specialist services were available, but at other times referring on and subsequent time delays appeared to be problematic. The diagnosis of PTSD was variable and may reflect specific assessment cultures.

The level of data collection was inconsistent across pilot services and only one service collected outcome data at post-intervention, the findings of which indicated that treatments were effective and significant gains achieved by veterans. There was, however, sufficient qualitative data to draw conclusions about the acceptability of services to veterans and their satisfaction with them.

#### **Priority Recommendations (in order)**

1. Mental health services for veterans should provide both assessment and treatment. Where highly specialist treatment (e.g., alcohol detox) cannot be provided by the veterans' service, the priority for veterans should be invoked such that there is no further wait for specialist treatment.
2. It is essential that services be staffed by people with experience of working with veterans and knowledge of the culture of the Forces. Where practical it would be desirable for veterans to have the choice of being seen by veterans.
3. Services must have strong links at strategic level (board/chief executive) with other statutory and voluntary agencies, Forces' charities etc. This should then be reflected at operational level with provision of services/advice on housing, benefits, employment, joint clinics etc.
4. Groups for veterans were a cost-effective way of seeing larger numbers, and were highly regarded by veterans as a source of companionship and solidarity. All services should consider group work as an option to offer veterans.
5. Mental health services for veterans should routinely access service records of veterans so as to gain the full picture of the client's service history. This would also serve as a check on the occasionally reported instances of fabrication.
6. A common minimum data set should be established so that clear comparisons can be made across services. Financial support for the services should be dependent on effective systems being in place and data should be co-ordinated by an independent research group (i.e., a practice research network focusing on veterans).
7. Now it has been shown to be possible, routine pre- and post-treatment outcome data should be collected for all clients seen. This should become standard practice across services and a basic expectation of funders and commissioners.



8. Mental health services for veterans should accept self-referrals, with GPs being involved after referral rather than as gatekeepers. (Experience with IAPT has shown no inappropriate use or 'flooding' of services.)

#### **Further Recommendations (in order within sections)**

##### ***Identification and accessibility***

9. The existence of mental health services for veterans should be publicised widely, for example:
  - a. To all service personnel on discharge from the Forces
  - b. Nationally via information on websites and other directories of assistance to ex-service personnel
  - c. Locally within the ex-service, health and social care communities
10. A proactive follow-up of veterans should be carried out at a reasonable time (e.g., 6-12 months) to try to detect early signs of psychological difficulties in adapting to civilian life. Some veterans expressed the view that this continuity would ease the sense of being suddenly cut off from the service 'family'.
11. In sparsely populated areas, veterans' services should, where possible, travel closer to their clients rather than expecting clients always to travel to some central location.

##### ***Staffing and activity of services***

12. Raising the sensitivity of all NHS mental health staff to veterans' issues is helpful. However, veterans' experience of generic NHS mental health services, even where staff had received some brief training, was not ideal and did not appear to be the best way forward.
13. The promising growth of interaction between the pilot services and Combat Stress needs building on to prevent duplication and play to each organisation's strengths.
14. Services should comprise more than one person, in order to guard against gaps in continuity through holidays, sickness, promotion etc.
15. Services should examine their referral patterns regularly to maintain equal access by all veterans.
16. Where there is evidence of effective innovations in service delivery within mental health services for veterans, these should be shared amongst other services and consideration given to their adoption. A mechanism, such as a development of the four-monthly meetings of pilot services, should be developed to facilitate this activity.

##### ***Client data and evidence base***

17. There should be a strategic investment in securing better data collection via coordination of NHS IT and patient information systems to ensure that (a) veterans can be identified and flagged, and (b) data can be linked to other information within local services and also at a national level. Integration with the IAPT Minimum Data Set should be considered.
18. NHS mental health initial assessments should routinely ask and record whether the client is a veteran.
19. Specialist teams that work closely with veterans on mental health issues (e.g., NHS veterans' services, specialist trauma services and Combat Stress) should agree what information is to be gathered and how, in order that this can be shared, with permission, between services rather than repeatedly asking veterans the same basic questions at each onward referral.

## CHAPTER 1: INTRODUCTION

### 1.1 Background

The UK Ministry of Defence (MoD), in collaboration with the Health Departments for England, Scotland, Wales and Northern Ireland, provided funds to allow several NHS Trusts to deliver a new pilot community mental health service for Armed Forces veterans<sup>1</sup>. The Trusts concerned, in order of service commissioning, were:

- 1) South Stafford and Shropshire Healthcare NHS Foundation Trust
- 2) Cardiff and Vale University Local Health Board
- 3) Camden and Islington NHS Foundation Trust
- 4) Tees, Esk & Wear Valleys NHS Foundation Trust
- 5) Cornwall Partnership NHS Trust
- 6) NHS Lothian

There is an emerging literature from substantive data bases (primarily the Kings Centre for Military Health Research) indicating that the majority of service personnel return home healthy, but that those who do not have a poorer chance of rehabilitation, and that rates of depression are considerably higher than for PTSD with many personnel not seeking specialist help.<sup>2 3 4</sup> These findings have implications for how services are configured and how service personnel access treatment. A key issue focus is how to deliver effective psychological services which interface with the significant changes which are taking place within NHS psychological services in line with stepped care and the Improving Access to Psychological Therapies (IAPT) initiative.

The government investment in this pilot scheme of six treatment services aimed to meet such a need. Each site was to have a trained community veterans' mental health therapist. Veterans would be able to access this service directly or through their GP, ex-Service organisations, the Veterans' Welfare Service, or Social Service departments. The MoD required that these six services be evaluated in terms of relevant processes and outcomes employed in three existing services to be used as benchmarks:

- 1) The Traumatic Stress Service within Humber Mental Health NHS Trust
- 2) The URD/Royal Irish Aftercare Service medical services delivered by the Northern Ireland Police Rehabilitation and Retraining Trust (PRRT)
- 3) Combat Stress (the Ex-Services Mental Welfare Society).

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<sup>1</sup> This report will use the term 'veteran', although it is acknowledged that the term is not universally liked. It has at least the advantage of being briefer than alternatives such as 'ex-service personnel'.

<sup>2</sup> Iversen A., Dyson, C., Smith, N., et al. (2005). 'Goodbye and good luck': The mental health needs and treatment experiences of British ex-service personnel. *British Journal of Psychiatry*, 186, 480-486.

<sup>3</sup> Hotopf, M., Hull, L., Fear, N.T., et al., (2006). The health of UK military personnel who deployed to the 2003 Iraq war: a cohort study. *Lancet*, 367, 1731-1741.

<sup>4</sup> Iversen, A., Nikalous, V., Greenberg, N., et al., (2005). What happens to British veterans when they leave the armed forces? *European Journal of Public Health*, 15, 175-184.

An evaluation team from the University of Sheffield (UoS) was commissioned by the MoD to report on the pre-existing services and the new pilots, with the evaluation to cover the following areas:

- (a) Service structure: referral routes; resources of workforce and skill mix
- (b) Service processes: client<sup>5</sup> waiting times; numbers of clients entering the service; modality of treatments offered, chosen and received by clients; number and duration of therapy sessions attended
- (c) Client characteristics: diagnostic and demographic data on clients seen by the service
- (d) Client satisfaction: levels of user satisfaction; identification of aspects which users judge could be improved
- (e) Client outcomes: clinical outcomes relating to clients seen since the services were established
- (f) Clinical staff: experience, qualifications, expertise of staff; process of both service reconfiguration and delivery of care, including how the service meets the needs of clients (e.g. supporting them in work, providing effective rehabilitation if off work)
- (g) Similarities and differences in how the 6 pilots have been configured and stakeholders' views as to the effectiveness of service designs
- (h) Similarities and differences with the configuration of the 3 pre-existing sites
- (i) Range of treatments offered to users including use of medication
- (j) Interface of pilots with referring agencies
- (k) The users' experiences of the services – what worked for them and what didn't
- (l) The overall clinical outcomes for users
- (m) Benchmarking outcomes against other related standards in terms of NHS primary care
- (n) The feasibility of a stepped care service for veterans in terms of determining how many users need to be 'stepped up' for more intensive work
- (o) The identification of any patterns of service use (e.g., greater use by veterans having more recent active service)
- (p) The relative presentation of PTSD and depression as indicative of differential care pathways
- (q) Implications for medium and longer-term support/follow-up for users of the services
- (r) Recommendations concerning IT and measurement requirements in order to secure reliable data that will inform practice

The evaluation work was due to be completed over a 30-month period to finish in May 2011. However due to changing circumstances, unforeseen at the start of the evaluation, the MoD asked the UoS team to report six months early in order to be better able to use the information in a timely and effective way. This involved some rapid changes of plan and therefore while all the above areas have been addressed, they have not all been covered in the level of detail originally planned.

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<sup>5</sup> We have chosen to adopt the term 'client' rather than patient, service user or any other alternative, because it is more all-inclusive. It covers, for example, the receipt of services restricted to advice and information-giving on non-health related matters where the term 'patient' would not be appropriate.

Chapter 2 of this evaluation briefly describes the methods used to answer the above questions. Chapter 3 draws out overall themes and makes recommendations, linked to the chapters from which the recommendation emerges. Chapter 4 describes the operation of the three pre-existing services. Chapters 5-10 describe each of the pilot services in some detail, with some comparisons against the pre-existing benchmark services. Chapter 11 summarises the results and draws some comparisons between services, where these can sensibly be made.

## CHAPTER 2: METHOD

### 2.1 Data collection

To gather data to try and address the questions in Chapter 1, the following data were collected:

- 1) The body of routinely collected, anonymised client data for all clients seen during the life of each pilot
- 2) Anonymous questionnaires sent to all clients who had been referred to each pilot
- 3) An interview with a lead clinician or manager from the pilot
- 4) Sample diary activity data submitted by staff from the pilots
- 5) Documentary data (e.g. annual reports, audit results) produced by the pilots in the normal course of their work

It had also been planned to selectively interview veterans who had experienced the services, to more fully understand their experiences; however the time constraints brought about by the early finish to the evaluation did not permit this.

Ethical approval was sought from the NHS and was received from the Nottingham Research Ethics Committee 2, application reference 10/H0408/67. Subsequently local research governance approval was received from each of the NHS Trusts involved. The PRRT and Combat Stress, being outside the NHS, gave their own ethical and research governance approvals.

### 2.2 Routinely collected datasets

The six pilot sites and the three existing services met every four months during the pilot period to co-ordinate activity. Members of the evaluation team joined the meetings, facilitated by the Health and Social Care Advisory Service (HASCAS), and worked with the services to agree a common minimum data set (MDS) which would allow some data to be collected in standardised ways. This comprised basic demographic data such as age and gender, along with data about Forces service such as arm and branch of service, and clinical data such as diagnosis. An initial review was undertaken of what standardised clinical measures were being used by each service and a considerable range of measures was being used. There was no single measure being used by all services and after some discussion it was agreed to use two: the Patient Health Questionnaire (PHQ-9) and the Work and Social Adjustment Scale (WSAS). Both were elements of the MDS for the national rollout of Improving Access to Psychological Therapies (IAPT) services and this would allow some benchmarking against norms from these. A trauma-related scale such as the Impact of Events Scale (IES) was considered but the pilot services did not see themselves as exclusively, or even primarily, trauma focused and so decided on the PHQ-9 as a more generally applicable measure of mood disturbance.

The Sheffield evaluation team devised a database based on Microsoft Access which was distributed to services to allow them to collect data in a standard form. To make the

database operationally useful to services, it included personally identifiable data such as name, address, date of birth etc. However there was also a facility for these data to be automatically stripped out of the database before a snapshot download was forwarded on to the Sheffield evaluation team.

Data began to be formally collected by the pilots from the time the MDS was agreed (although several pilots had already started before the evaluation team was appointed.) In principle the pilot services aimed to collect the MDS throughout their two year operation. Pre-existing services planned to report data, as far as possible, from the beginning of January 2008 onwards. Not all services were able to use the MS Access database, but all adapted their own Trust systems to allow as much of the MDS as possible to be entered in that way. At the end of the evaluation period, anonymised data was extracted from the database (or whatever information system the Trusts were using) and forwarded securely to the UoS evaluation team for data cleaning and analysis.

The amount and the quality of data received varied between services. Differences in the number of cases recorded may be partly due to differences in the aims of services. For example a service may signpost most of its referrals and only record data for those who are assessed or treated, others may record some descriptive data on all those referred. There were some differences in the variables and how they were completed. This was largely due to differences in routine data collection systems and how each facilitated the recording of some data. An example of this would be the recording of 'physical problems' and whether there was a specific variable to complete or not. Some services had different categories and terminology on some variables (most notably, 'reason for discharge') and some did not collect any outcome measures at intake and most had no outcome measures at discharge. Notes on the downloaded data for each service are given in Chapters 3-9 and where the data are comparable, between existing services and pilots, and address a key issue this is presented within each pilot section. Other tables will be released as Appendices.

### **2.3 Anonymous questionnaires**

A short (3 sides of A4 paper) questionnaire was devised to elicit the views of veterans who had been referred to one of the services. It comprised a series of ten statements to be responded to on a five point agree-disagree Likert scale, as well as four open questions to be responded to with a free text response. Sufficient copies of the questionnaire were produced in order to be sent to all clients referred to each pilot service, and in the case of the pre-existing Humber and N Ireland services, to all clients referred from January 2008 onwards. Questionnaire packs were distributed by the services themselves, by addressing sealed packs provided by the Sheffield team (in order that clients' names and addresses should not leave the service's control.) Packs included an introductory letter from the service, an information sheet from the Sheffield team, the questionnaire itself and a Freepost envelope for return direct to Sheffield. Questionnaires carried no identifying data except for some general demographic information and a code to identify the site. Regrettably it was not possible to complete research ethics and governance processes in time to include Combat Stress clients in the survey.

A total of 1060 questionnaires were sent out, and within three weeks a total of 85 had been returned, a response rate of 8%. Typically such unannounced questionnaire surveys deliver a response rate of approximately 5%; the veterans surveyed were perhaps particularly keen to make their views known. The quantitative questionnaire data were used to generate mean scores on a range of satisfaction items, while the written qualitative data were subjected to a thematic analysis to identifying emerging common themes. The median satisfaction scores are illustrated for each pilot service in a 'box-and whisker' plot to illustrate their distribution (see chapters 4-9 for details). A box and whisker plot summarises the distribution of scores thus. The central line is the median (half of scores fall above this line and half below.) The box represents the middle 50% of scores and the whiskers the top and bottom 25%.

Qualitative data from the questionnaires were summarised into themes which are illustrated by quotes. Because these were responses to 'write-in' free text boxes, each response was personal to that individual and no percentages for those agreeing/disagreeing with these unprompted responses are given. Themes were identified where similar attitudes or experiences were reported by a number of respondents. Where an individual respondent made a statement that seems important to report (such as one going against the general trend) this is made clear in the results.

#### **2.4 Interview with service lead**

An audio recorded telephone interview was undertaken with a leader from each of the services, usually the veterans' therapist concerned or an immediate manager of the service, to complement the quantitative data from the download with a narrative account of the services commissioning, staffing and operation. Audio recordings were not transcribed word for word, but in summary form.

#### **2.5 Diary data from teams**

Teams were asked to complete diaries of activity during two sample weeks. During the first week, team members simply entered into a web-based survey an account of what they had done each day and how long each activity had taken. These free-text responses were inspected and collated into a smaller number of categories of activity. During the second diary-recording week, services entered data in the same way but using drop-down lists of activity categories to select from, to speed up data entry. Data from the two diary weeks together are reported within the chapters for each service.

## CHAPTER 3: SUMMARY, OBSERVATIONS AND RECOMMENDATIONS

### 3.1 Caveats

The data as presented are drawn from small and disparate services and reflect the status of their ability to collect and collate the necessary evidence. Our task was to collate and coordinate the existing data via the methods outlined in Chapter 2. In general the numbers are too small to permit statistical testing of similarities and differences observed, so the results reported in Chapters 4-10 cannot be regarded as definitive and final. Nevertheless the pattern of results from the data downloads and the quantitative and qualitative elements of the questionnaires are all in agreement.

The questionnaire responses, by their nature, reflect the views and opinions of ex-service clients about what elements of the service did or did not satisfy them. It is well known that satisfaction with services is poorly correlated with service effectiveness; NHS patients can be highly satisfied with services which produce little objective improvement. Nevertheless where clients report *differential* levels of satisfaction that is nevertheless an important result, regardless of the absolute levels of satisfaction reported. It is then possible to look at what features are more or less likely to make a person express satisfaction, and where outcome data exist these can be correlated with satisfaction data. In these results the trends of the satisfaction, service activity and service outcome data are all in the same direction, which adds to the confidence which the evaluation team places on these findings as a whole.

### 3.2 Summary of service characteristics, implementation, and impact

Drawing on the evidence from each of the pilot services, we summarise their main characteristics in relation to their service configuration, implementation, and impact

#### 3.2.1 South Staffordshire

- a. The Staffs service was the first to be commissioned. As the pathfinder it was less able to benefit from the accumulated knowledge of the pilot services than those commissioned last.
- b. The service was (like some other pilots) largely reliant on one individual with consequent risks to sustainability and continuity of service. Unlike other pilots, these risks were realised in Staffs and continuity suffered as a result.
- c. The service differed from others in that self referrals were not encouraged
- d. A low level of overall activity was observed, with the majority of clients referred being signposted to other agencies or services
- e. The Staff service was rated as having the fewest gaps of the six pilot services
- f. The Staffs service had the lowest level of approval from service users in terms of
  - i. how helpful they found it
  - ii. how highly they would recommend it to others
  - iii. whether it improved their situation
  - iv. whether it represented the best model for future services.
- g. Service users found lack of treatment choices unhelpful, as were the long waits when being signposted from one service to another
- h. However the results at e) and f) and g) above must be treated with extreme caution because of the low number of respondents.



### 3.2.2 *Cardiff*

- a. Almost half the referrals assessed by the Cardiff service were offered treatment within the service itself – although there appears to be a backlog of cases offered treatment which has not yet been delivered
- b. Initially, the service developed by offering a one-off assessment to veterans from throughout South Wales
- c. Lately the service has been adopted by the Welsh Assembly Government as the hub of an all-Wales hub-and-spoke veterans' service
- d. The service was rated by veterans as the physical place which was the least welcoming of the six pilots – although the score was still above the mid-point for satisfaction. (Based on quantitative scores only – no qualitative comments were made to expand on this rating.)
- e. Service users appreciated talking to staff with specialist/ex-Forces knowledge and experience
- f. When an assessment led to recommendations for treatment by others, and this was not forthcoming (or a long wait ensued) this was very unsatisfactory to service users.

### 3.2.3 *London*

- a. This pilot served a vastly larger population than any other pilot, with fewer whole time equivalent clinical staff
- b. Most referrals (those from outside the CANDI area or not suffering PTSD) were signposted to other agencies for treatment
- c. Specialist tertiary treatment for PTSD was available in the parent Trust
- d. Of those offered treatment within the CANDI Trust, a high proportion received this quickly
- e. The service took on a more proactive, advocacy role on behalf of veterans after it was discovered that recommendations for treatment by other services were not being followed up in a timely way
- f. The service was rated lowest for the choice of support offered
- g. Pilot service staff were experienced as friendly, supportive and competent

### 3.2.4 *Tees, Esk & Wear Valley*

- a. Unlike the other pilots, this service operated as a disseminated network with the actual client contact being undertaken by a pool of 150 clinicians within community teams, trained and supported by the pilot
- b. While the disseminated nature brings some training and expertise into every front line team, it makes recording and evaluating the activity of this pilot more difficult than others. In particular, no data exist on the treatment offered to or outcomes achieved by clients
- c. The size of the Trust and the variability of local teams and circumstances mean that the model has not been implemented evenly across the whole Trust

- d. The TEWV pilot was rated most poorly of the six for the degree to which staff seemed to be familiar with Forces' culture
- e. Although some questionnaire respondents were complimentary about the warm, non-judgmental treatment they received a larger number found that they did not feel understood by staff with no personal experience of serving in the Forces.
- f. Some respondents felt that waiting times were too long and clinical meetings too infrequent (no waiting time data are available to assess whether these complaints are justified.)

### 3.2.5 Cornwall

- a. Like some other pilots, the Cornwall service was very much a one-person venture rendering it potentially vulnerable to disruption. There was no dedicated admin support or parent service to rely on
- b. Unlike other pilots, a key feature in Cornwall was the use of open psycho-educational groups
- c. There was increasingly close liaison and joint working with the local Combat Stress community team
- d. More time was spent in travelling by clinical staff than in other pilots
- e. More data was collected on Cornwall clients than by other pilots (in particular end of treatment measures), permitting a fuller description and evaluation of the service
- f. Waiting times appeared lower than for any other pilot, approaching those of N Ireland whose waiting list was managed by an external agency
- g. For those clients who completed pre- and post-treatment outcome measures, significant improvements were seen on both the PHQ-9 and WSAS for a majority of clients
- h. The PHQ-9 and WSAS do, therefore, appear to be sensitive to change in this client group
- i. Some differences emerged between the pilot and other collaborators in terms of diagnosis – in particular the question of the presence/absence of PTSD and to what extent recovery should be expected
- j. The Cornwall pilot scored most highly among questionnaire respondents on the questions of:
  - i. How helpful users found the service
  - ii. Whether they would recommend the service to others
  - iii. How far this service should be the model for future developments. (The 12 respondents were nearly unanimous on this, all but one giving the highest possible score)
- k. Qualitative responses to the questionnaire indicated a desire for more staff, more frequent sessions and more access to the service
- l. The groups were particularly welcomed as fostering a sense of shared experience and comradeship
- m. There was some caution about the pace of trauma-related work, respondents suggesting that this needs to be paced more slowly

### 3.2.6 *Lothian (V1P)*

- a. Just as Stafford had the disadvantage of starting first, the Lothian service was the last to be commissioned and therefore had the chance to learn from the experience of other services
- b. A defining feature of V1P is the decision to recruit, as far as possible, staff members who are ex-service personnel. Clients commented very favourably on this feature of the service
- c. A second unique feature is the decision taken to routinely access, with permission, clients' service records as part of the assessment. Clinical staff report that this helps considerably during the assessment and decision-making phase
- d. The service was able to recruit more staff than other pilots because of matched funding from the Scottish Government
- e. Although all staff are NHS employees, V1P makes a point of being a 'one-stop-shop' with advice available on a range of social issues such as housing, finances and employment
- f. Joint clinics with other agencies (SPVA, Citizens' Advice) have been set up under the V1P umbrella
- g. Despite being an offshoot from a PTSD service, V1P report a low number of clients reporting with this diagnosis or related problems
- h. The service has attracted the highest rate of referrals of any of the pilots, largely by word of mouth within Lothian
- i. V1P scored more highly than all the other pilots (and the N Ireland service) on the questions of
  - i. whether staff seemed to be familiar with Forces' culture and experience
  - ii. how welcoming the place was to ex-services personnel (respondents were almost unanimous in this)
  - iii. the range of choice of support offered
- j. V1P users did not seem to identify the service as an exclusively NHS service, and indeed seemed to see it as more aligned to Forces culture than the rest of the NHS
- k. The positives of having ex-Forces staff within V1P were frequently commented on
- l. Users appreciated the open nature of the service and its accessibility as a drop-in

### 3.3 **Requested observations**

The evaluation team was asked by the MoD to address some specific questions and these are reported on below.

#### 3.3.1 *Comparison of sites with one another and with pre-existing services*

The three services in existence prior to the pilots reflect very different organisations and delivery models. In that sense, it is probably best to consider them as populating a range of possible delivery models and attempting to locate the six pilots in that context.

#### **Provision of treatment services within one team**

The three pre-existing services have in common the fact that they assess, manage and treat veterans from within their own resources. None relies on other teams or agencies to refer onward, which allows a speedy progression from referral to assessment and on to treatment.

Where this was not possible, delays always ensued and veterans' experience of onward referral to another team or organisation was uniformly poor. Not only was there a seemingly inevitable time delay, but the destination service (while perhaps being able to deliver a specialist treatment) would lack the military focus of the veterans' pilot. A PhD study undertaken in Combat Stress gave the stark example of a veteran who had previously joined a civilian PTSD treatment group and was required against his better judgement to recount extensive details of child battlefield casualties he had seen in Iraq. This was neither helpful for him nor the rest of the group as his experience was so different from theirs.

Pure 'signposting' activities by pilots were the least appreciated and the least successful activity undertaken by the services.

### **Range and choice of treatment services**

The PRRT service in N Ireland had a limited, NICE guideline driven range of treatments available compared with the wider range available in Combat Stress and Humber. We lack questionnaire data from the latter two services, but compared with the pilots the N Ireland service was rated very highly overall, albeit less highly for choice. In general, services rated as offering more choice (eg Cornwall and Lothian) were rated more highly than those offering a limited or no choice. Furthermore veterans described the 'by the book' application of some evidence based trauma-focused work as being insensitively paced. Overall, while evidence based treatments such as CBT and EMDR are clearly absolutely necessary, they may not be sufficient if veterans are to feel they have a real choice. Nor can these treatments be applied to veterans without sensitive modification for a veteran population.

### **Location and staffing of services**

Veterans were almost unanimous in describing a preference for services staffed by veterans, or at least by staff who are experienced and knowledgeable about Forces' life and experience. They did not however seem in the least concerned (or perhaps even aware) about what agency was in overall charge of the service. They commented particularly on how convenient it was when staff from different agencies (eg the pilot, RBL, SPVA and CAB) were all brought together for clinics or advice sessions tailored to veterans.

### **3.3.2 Referral rates**

Overall referral rates are low per head of population served. The maximum rate seems to be about 30 referrals per year per 100,000 population. These figures were approached by the Cardiff and Lothian services, and may represent a 'steady state' for locally based community services. Not all pilots managed to get near this level of annual activity. Annual referrals to Combat Stress, taking the UK population as a whole, approximate to 2 referrals per 100,000, which may be a reasonable proportion for a more centrally based and (up to now) residential model of service.

### **3.3.3 Profile of clients**

There was remarkable unanimity between all pilots and pre-existing services about the profile of clients seen. The typical client is male, in his forties, and was discharged from the

Army as a private – most likely having served in the Infantry. The most common theatre of operations is Op BANNER (N Ireland, 1967-2007) - this is unsurprising given the length of the operation and the numbers of units and service people involved. Length of time between discharge from the Forces and being referred to the pilot (or pre-existing service) is hard to calculate precisely but seems to be between 10-20 years, which is consistent with previous findings from audits of Combat Stress and Humber caseloads.

This typical client, like all averages, hides some extremes. A few WWII veterans are being seen by the pilots, as well as some who have been discharged having served since 2002-3 in Afghanistan (Op HERRICK) and Iraq (Op TELIC). Some veterans are therefore now being seen within a year or two of discharge from the Forces.

Several veterans describe having previously tried to access NHS services before the pilots existed. Some describe their experience of being referred to the pilot as the first time they felt that NHS has properly understood their circumstances.

### 3.3.4 *Diagnoses and prevalence*

There was less unanimity between all nine services in this evaluation about the relative prevalence of different problems and disorders. Some (e.g. Combat Stress, London, Cardiff) reported PTSD in the majority of their clients. Others (e.g. Lothian, Cornwall) reported a much lower prevalence. Overall the rates of PTSD reported in the pilots seem to average about 14% of those referred – although other problems such as sleep disturbances and intrusive thoughts are mentioned by others; these may be post-traumatic features short of full diagnostic criteria for PTSD. This is well above the prevalence figure of approximately 5% for PTSD in all veterans reported by the group at King's College London.

One explanation of this is that the King's figures are drawn from estimates of the prevalence rate in the population of veterans in the community as a whole – not the smaller population of veterans presenting to community mental health services. Figures recently submitted for publication (Palmer, 2010) report a PTSD rate of 15% among veterans referred to MAP, the Military Assessment Project. This is very close to the rates reported by the pilots overall. The rates that might be inferred from the data presented in this report are drawn from veterans who are presenting or have presented to the pilots. Hence the latter rate is bound to be higher than the rate among the wider population of all veterans.

However, there is also evidence that the use of the term PTSD may reflect the assessment culture of specific services. Pilots that were based on or emerged from a trauma service reported higher rates of PTSD (with the exception of Lothian). Combat Stress also reported high rates of PTSD – never below 50% among their client group. For these services the possibilities are:

1. That veterans are differentially referred to services on the basis of the service's real or perceived function – perhaps influenced by the service name or setting. The very name 'Combat Stress' in particular might invite a certain kind of referral.
2. That assessment practices are different between services and that some level of over- or under-diagnosis is happening.
3. Some combination of these two explanations.

### 3.3.5 *Staffing and costs*

Sites varied a little in their approach to using the resources allocated by the MoD. There had originally been a plan to appoint a Veterans' Therapist and a Veterans' Champion in each site, but the latter post was dropped by most sites. Only in Lothian, thanks to extra money from the Scottish Government, was something like this adopted with the Peer Support Workers – very successfully as it seems.

The lead clinician was employed at NHS rates varying between Band 7 and Band 8b, for a whole time equivalent varying between full-time and 2 days per week (0.4 wte). It is not obvious to the evaluation team that the demands of the job or the level of input required was so different between sites that the lead role was spread across three grades (7, 8a and 8b). There seems to be no obvious link between the staffing and costs of the service and the types of diagnosis seen, the care pathways employed or the interventions offered.

### 3.3.6 *Care pathways*

Sites definitely varied according to the care pathways they chose to offer. TEWV is something of a separate case from the other five, who occupy something of a continuum according to how much direct client treatment they undertook.

- TEWV – stands on its own in that the funded pilot staff acted as facilitators of a disseminated network, with all the actual client contact being undertaken by front line Trust team members trained by the pilot.

And as for the other five pilots:

- Staffordshire – smallest proportion of client treatment undertaken directly by pilot staff (and conversely greatest number signposted on to other services)
- London – most clients signposted back to referrers with recommendations, CANDI clients with PTSD seen for treatment
- Cardiff – South Wales clients from outside Cardiff sent back to referrer with recommendations, most Cardiff clients taken on for therapy
- Cornwall – few clients signposted on (mostly those needing input for social problems), great majority seen where mental health treatment indicated
- Lothian – service offered 'one-stop-shop' input for social problems as well as mental health problems

Very crudely it appears that the direction of this list correlates with the overall satisfaction scores reported for the pilots in the questionnaire returns; in other words the more of a care pathway was delivered under the umbrella of the pilot itself, the more satisfactory this was to clients. It is worth noting that the three pre-existing services would probably resemble the Cornwall-Lothian end of this continuum, undertaking the full range of assessment, treatment and support.

### **3.3.7 *Complementary welfare/support services***

Service users reported definite satisfaction with pilot services where a range of agencies could be brought together, for example having advice on mental health, housing, benefits and pensions all available under one roof (even if only on an occasional basis). Conversely, they reported great frustration at being passed ‘from pillar to post’, having to retell their story afresh to every new agency and wait long periods for referrals to take effect.

This multi-agency clinic model seems to be most easily set up when as many agencies as possible are represented on the steering group of the pilot – ideally at a senior level so that they can speak authoritatively for their agency.

### **3.3.8 *Fabrication***

Some services reported a small but significant number of referrals who either turned out not to be veterans at all, or who were veterans but who reported stories of military experiences that turned out to be greatly exaggerated. While this is not a widespread problem, it clearly indicates a level of psychological disturbance which would not be treated appropriately if accounts were taken at face value. Therefore both for the few ‘fabricators’ and the majority of more straightforward clients, some level of corroboration with service records is highly desirable.

### **3.3.9 *Interventions***

Most pilots reported delivering NICE recommended interventions such as CBT and EMDR. Some offered a wider range of interventions to increase client choice, particularly in the area of complex, multi-diagnostic presentations where NICE guidelines may not apply. Increased choice was generally valued by clients, although the most satisfied clients came from the service with arguably the most limited choice – N Ireland.

Waiting times varied greatly across the pilots, and were most strongly affected by being referred out of the service for further treatment. There was no waiting time at all for the pre-existing N Ireland service, because the waiting lists were handled at the referring agency; this speedy response may partly explain the levels of satisfaction just referred to.

Despite agreeing and intending to, most of the pilots did not in fact manage to collect outcome measures before and after treatment. There were practical problems (particularly if clients were seen once –or not at all – before being signposted elsewhere. TEWV had a particular problem in trying to centralise information. There was also some scepticism among services about the sensitivity of standardised outcome measures. However the one pilot service that did manage to collect outcome measures before and after treatment saw significant improvements on both measures, suggesting that it is possible both for measures to be collected, and for them to demonstrate improvement.

### **3.3.10 *Impact on other health services***

Given the relatively small numbers of clients referred (a maximum of 30 per 100,000 population per year) it is unlikely that even the most prolific mental health service for

veterans is going to impact on the caseload of its local IAPT service. Such services will expect to receive a volume of referrals 30 times higher than this. In any case it is unlikely that IAPT services designed for relatively uncomplicated, mild to moderate anxiety and depression would be the right place to see these clients anyway. However it may be the case that smaller, more intensive secondary or tertiary care services might be impacted by an extension of the mental health service for veterans. It is likely that a small number of the pilot sites' clients probably figure among the most complex clients of services such as drug, alcohol, forensic and personality disorder services. Although they will be small in number, they are likely to demand a disproportionate amount of NHS and other public service resource.

### 3.4 Recommendations

In light of the data presented, we derive the following recommendations.

#### Priority Recommendations (in order)

1. Mental health services for veterans should provide both assessment and treatment. Where highly specialist treatment (e.g., alcohol detox) cannot be provided by the veterans' service, the priority for veterans should be invoked such that there is no further wait for specialist treatment.
2. It is essential that services be staffed by people with experience of working with veterans and knowledge of the culture of the Forces. Where practical it would be desirable for veterans to have the choice of being seen by veterans.
3. Services must have strong links at strategic level (board/chief executive) with other statutory and voluntary agencies, Forces' charities etc. This should then be reflected at operational level with provision of services/advice on housing, benefits, employment, joint clinics etc.
4. Groups for veterans were a cost-effective way of seeing larger numbers, and were highly regarded by veterans as a source of companionship and solidarity. All services should consider group work as an option to offer veterans.
5. Mental health services for veterans should routinely access service records of veterans so as to gain the full picture of the client's service history. This would also serve as a check on the occasionally reported instances of fabrication.
6. A common minimum data set should be established so that clear comparisons can be made across services. Financial support for the services should be dependent on effective systems being in place and data should be co-ordinated by an independent research group (i.e., a practice research network focusing on veterans).
7. Now it has been shown to be possible, routine pre- and post-treatment outcome data should be collected for all clients seen. This should become standard practice across services and a basic expectation of funders and commissioners.
8. Mental health services for veterans should accept self-referrals, with GPs being involved after referral rather than as gatekeepers. (Experience with IAPT has shown no inappropriate use or 'flooding' of services.)



**Further Recommendations (in order within sections)*****Identification and accessibility***

9. The existence of mental health services for veterans should be publicised widely, for example:
  - i. To all service personnel on discharge from the Forces
  - ii. Nationally via information on websites and other directories of assistance to ex-service personnel
  - iii. Locally within the ex-service, health and social care communities
10. A proactive follow-up of veterans should be carried out at a reasonable time (e.g., 6-12 months) to try to detect early signs of psychological difficulties in adapting to civilian life. Some veterans expressed the view that this continuity would ease the sense of being suddenly cut off from the service 'family'.
11. In sparsely populated areas, veterans' services should, where possible, travel closer to their clients rather than expecting clients always to travel to some central location.

***Staffing and activity of services***

12. Raising the sensitivity of all NHS mental health staff to veterans' issues is helpful. However, veterans' experience of generic NHS mental health services, even where staff had received some brief training, was not ideal and did not appear to be the best way forward.
13. The promising growth of interaction between the pilot services and Combat Stress needs building on to prevent duplication and play to each organisation's strengths.
14. Services should comprise more than one person, in order to guard against gaps in continuity through holidays, sickness, promotion etc.
15. Services should examine their referral patterns regularly to maintain equal access by all veterans.
16. Where there is evidence of effective innovations in service delivery within mental health services for veterans, these should be shared amongst other services and consideration given to their adoption. A mechanism, such as a development of the four-monthly meetings of pilot services, should be developed to facilitate this activity.

***Client data and evidence base***

17. There should be a strategic investment in securing better data collection via coordination of NHS IT and patient information systems to ensure that (a) veterans can be identified and flagged, and (b) data can be linked to other information within local services and also at a national level. Integration with the IAPT Minimum Data Set should be considered.
18. NHS mental health initial assessments should routinely ask and record whether the client is a veteran.
19. Specialist teams that work closely with veterans on mental health issues (e.g., NHS veterans' services, specialist trauma services and Combat Stress) should agree what information is to be gathered and how, in order that this can be shared, with permission, between services rather than repeatedly asking veterans the same basic questions at each onward referral.

## CHAPTER 4: VETERANS' MENTAL HEALTH SERVICES BEFORE THE PILOTS

The MoD funded veterans' mental health pilots did not expand into a vacuum. Before they were set up there were a number of pre-existing services for this population, three of which were asked to join the steering group for the MoD funded venture: Combat Stress, Humber Traumatic Stress Service, and the Royal Irish Aftercare Service. Their purpose was to provide guidance as well as acting as the context within which the activity of the new services would be evaluated. The three existing services are briefly described here.

### 4.1 Combat Stress

Tyrwhitt House  
Oaklawn Road  
Leatherhead  
Surrey  
KT22 0BX

Tel: 01372 587000

Website: [www.combatstress.org.uk](http://www.combatstress.org.uk)

#### 4.1.1 *Summary pen-picture*

The largest and longest established charity for ex-service personnel with mental health problems, Combat Stress is moving from a residential-only treatment model to an integrated model including 14 community outreach teams covering the whole of the UK.

#### 4.1.2 *Historical account*

Combat Stress (CS) is a registered charity and was founded in 1919 as the Ex-Services Mental Welfare Society to provide care and treatment to veterans of WWI suffering from 'shell shock' and other mental health and associated problems. In the early years it provided permanent residential care and later an industrial rehabilitation service. In 1945 it opened Tyrwhitt House near Leatherhead to provide care in the form of shorter-term treatment. Similar venues were opened in 1985 at Hollybush House in Ayrshire and in 1996 at Audley Court in the Midlands. Also in 1999 the society closed its last residential care home, part of a further move towards a more treatment focused model. In addition to its residential services, CS has a well established network of Regional Welfare Officers covering the UK and the Republic of Ireland. CS is currently expanding its community based services by establishing multi-professional teams which include a Community Psychiatric Nurse and a Mental Health Practitioner in addition to the Regional Welfare Officer. Within the residential services provided by CS there is now also a significant shift in emphasis from one which traditionally provided respite care and support to one which is now provides structured evidence based treatment and which is much more goal-focused in its approach.

### 4.1.3 *Operation of the service*

New referrals are first seen by a Regional Welfare Officer, this would normally lead to a one-week admission to a residential unit for assessment. Based on this assessment, a treatment plan will be developed, which might include short stay residential inpatient treatment or offering the veteran community based treatment as an alternative - and as a way of reducing the need for repeated inpatient stays.

Veterans referred for inpatient treatment will typically be seen for three or four treatment admissions during the first year, followed by a formal review. Some clients attending on the traditional less structured approach may well have had up to 30 admissions during their contact with CS.

Residential treatment typically starts with patients being seen by a Consultant Psychiatrist and a diagnosis being made. They will then be allocated a nurse key worker, many of whom are trained in trauma focused Cognitive Behaviour Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR), who undertake interventions with the veterans. Many veterans are reported to require fairly long periods of stabilisation and preparation before EMDR work can begin.

Trauma-focused treatments include:

- Cognitive Behaviour Therapy (CBT)
- Eye Movement Desensitisation and Reprocessing (EMDR)
- Art Therapy
- Narrative Therapy
- Solution-focused Therapy
- Sleep Management

Other treatments include psycho-educational groups, covering areas such as:

- The effects of traumatic exposure
- Anxiety Management
- Anger Management
- Social Skills Training
- Coping Skills Training
- Alcohol and illicit Drug Abuse / Dependence

Finally there are activities-based rehabilitation groups such as:

- Physical Exercise and Outdoor Pursuits
- Occupational and Recreational Therapies
- Recreational art and writing

If it is agreed that there is no longer a need for care or support veterans are not formally discharged from the CS caseload, but may move from the 'active' to the 'inactive' list.

The activity of CS community based teams is still being developed, and as subsequent chapters will show, this is often in collaboration with the MoD-funded veterans' pilots.

#### 4.1.4 *Levels of activity*

In October 2010 CS had 4380 active cases and during the 12 months to 31st March 2010 they reported 1303 new referrals. Of these 82% are ex-Army, 7.6% ex-RAF, 7.1% ex-RN, 2.8% ex-RM, 0.4% ex-MN. The most common theatre of operation reported is Northern Ireland although CS is seeing a significant increase in veterans who have served in more recent conflicts. Some, having been seen by the Regional Welfare Officer, will need no further support and will not be taken on as active clients.

PTSD is the most commonly diagnosed problem, assessed as being present in approximately 66% of residential cases. Depression, anxiety and alcohol use are the next most frequent diagnoses identified.

Self referral including referral from the spouse (about 56%) is the main route of entry into the service. Of the remainder some 13% of referrals are from the NHS, social services or armed forces discharge boards, 24% come from other service charities, welfare organisations, and 7% from other agencies such as the prison and probation services. It is difficult to determine the precise number of referrals from GPs and the NHS as there is some evidence that health professionals advise veterans to self refer. The patterns of referrals are not changing significantly.

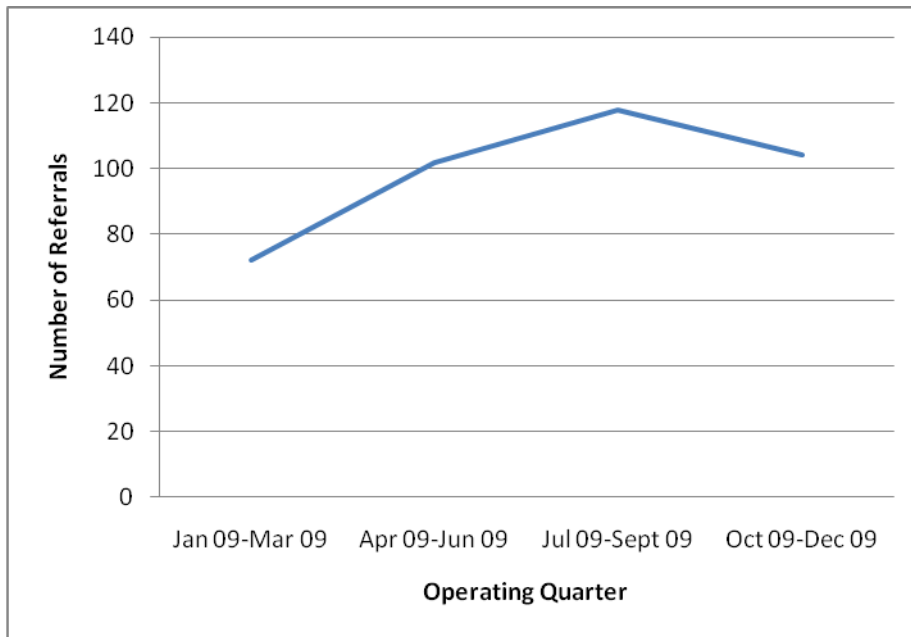
In 2000 the age profile of active veterans was an average of 71 – 80 years. The current age for veterans receiving the help of CS is 42- and seems to be reducing further. There is a significant time gap between someone leaving the service and contacting CS with the average being approximately 14 years. There has been little change to this figure despite a number of veterans from recent conflicts coming through the system. Combat Stress has been gathering data for several years including demographic and diagnostic data and intake data from self-report measures such as the Beck Depression Inventory (BDI) for depression, Beck Anxiety Inventory (BAI) for anxiety, the Impact of Events Scale (IES) for traumatic experiences, and the Alcohol Use Disorders Identification Test (AUDIT) for alcohol misuse. Service satisfaction measures are taken on leaving an episode of residential treatment but follow up self-report measures are not normally taken. For some veterans CS clinical staff have a degree of scepticism about the use of follow-up self-report measures as reports are shared with the MoD. There is an issue within the War Pension Scheme which militates against improvements in health so veterans may be reluctant to report improvements as the outcome could be a reduction in their War Pension. Calculation of pre-post effect sizes is therefore not possible using CS data – although to be fair most of the pilot sites, as will be seen, have not managed to collect follow-up data either despite taking a decision to do so.

Combat Stress has been collecting base line psychometric data in order to conduct a treatment outcome study. The data collection will take place after a two year follow up period. This study is ongoing, the reason for the two year follow up period being that clinical audit data has suggested that improvements are consolidated at the two year follow up point in this group of patients that are being treated.

Although data received from CS, was comprehensive in terms of intake measures and demographics, only two datasets were considered here; demographics from 1/1/09-

31/12/09 containing BDI-II measure data (taken as the most comparable to the PHQ-9 used by other services), and a complete demographics dataset from 1977-September 2009, from which a subset from January 2008-September 2009 was selected as covering the time period comparable to the pilot services. Coincidentally both dataset contained 396 cases; however it was not possible to cross reference veterans between the two databases therefore the latter was used primarily, while the former provided intake outcome measures, plus some additional variables. Although most descriptives were completed, there was no data on the 'flow' of veterans through the service or what mode of treatment they received. Referrals by year-quarter are shown below other data from CS is presented alongside data from the pilot services in chapters 4-9 below.

**Figure 4.1: Combat Stress referrals per quarter, 1/1/09-31/12/09**



#### 4.1.5 Questionnaires

Unfortunately it was not possible to complete ethical and governance review within CS within sufficient time to distribute questionnaires to a sample of their clients.

## 4.2 Humber Traumatic Stress Service

Humber NHS Foundation Trust

Victoria House  
Park Street  
HULL  
HU2 8TD  
01482 617760

[Jenny.Ormerod@humber.nhs.uk](mailto:Jenny.Ormerod@humber.nhs.uk)

[www.humber.nhs.uk/htss](http://www.humber.nhs.uk/htss)

### 4.2.1 *Summary pen-picture*

This community based service evolved out of a pilot trauma service for ex-service personnel but now sees a majority of civilian clients, although it continues to prioritise veterans' cases. A wide range of treatments is available including NICE recommended treatments together with other interventions for more complex presentations. Training, supervision and consultation are also available. Referrals are accepted only from NHS sources. Other referrals must be processed through the client's GP.

### 4.2.2 *Historical account*

The service dates originally from 1996 when a pilot service was set up in collaboration with a local ex-service group. In 1998 the service was formally established and has continued to the present day. Contacts and relations with other services have been built up and established over time. Within the Hull and East Riding of Yorkshire local area the service has offered training in trauma work and put on conferences and workshops regarding working with military veterans that has helped promote the team's work and networking. Locally a veterans' steering group has been established which brings together people from different agencies – lead NHS clinicians, Prison service, city council leads, Citysafe, Royal British Legion (RBL), military personnel, military Department of Community Mental Health (DCMH) links and NHS commissioner links. The service structure has changed as a result of changes within the local Trust – for example, the development of a single point of access means that many referrals are directed through this assessment gateway to the service. However, direct access by GPs is still possible in order to maintain this relationship.

Previously the service comprised a very small team - until the last two years where, at most, the equivalent of one whole time person was in post. However, now the team probably need more resources around marketing and promoting the service as they have the capacity to see more veterans.

### 4.2.3 *Operation of the service*

Referrals come either direct from the client's GP, through single point of access (referral system for all mental health problems), Community Mental Health Team or they can be stepped up through IAPT or counselling services. The service also has enquires from Combat Stress and RBL regarding veterans that are directed to the service via the person's GP as currently self-referrals are not accepted.

Currently there are eight staff within the team. However, all these staff also work with civilian referrals. Currently about 22% of referrals are veterans. During the initial pilot of the service from 1996-98, there were three members of staff – a specialist nurse, OT, and psychologist. Following the pilot phase this resource was reduced to a specialist nurse and psychologist and for periods of time the service has been resourced by only one person. The service has always prioritised ex-military personnel and this has been maintained in the current structure even though more civilian cases are seen now.

The team works closely with other NHS services. There is a dual diagnosis nurse working within the team who works closely with the addictions services, who is funded on a two year contract through the veterans challenge fund. The team also works with the crisis service and mental health team when there are concerns about risk, and the team works with external agencies such as housing and benefits.

The team has had positive feedback from stakeholders in recent years due to greater awareness of the service and press around military mental health. Service funding was increased by the PCT due to the service being valued at a local level. There is, however, still some way to go regarding developing awareness of the service across all sectors. The service has contact with Combat Stress, and has tried to establish more integrated care for those clients on caseload who also access residential care at Combat Stress, for example contacting prior to a visit and then following up afterwards. There is also contact with the Royal British Legion through the wardens in the area who will contact the team regarding veterans they see that may benefit from the team's service and likewise the team will refer to RBL for support. The team also have good links with SPVA in the area and with local TA branches.

The team can offer psychological interventions comprising cognitive behavioural techniques, EMDR (4 of the team are trained), psychoanalytic techniques, elements of Cognitive Analytic Therapy (CAT), and Transactional Analysis (TA). No one has completed full training in TA or CAT but team members receive supervision from professionals trained in these particular approaches to use with more complex clients. Also available are dual diagnosis assessment, motivational interviewing, brief techniques for alcohol and drug work, occupational therapy approaches and psychological formulation. Any treatment approach is discussed and decided in collaboration with the client as to what might work best for them. There might be certain times when approaches are not offered if not appropriate (e.g., a person needs to be stable to do EMDR).

The team uses a standard model (phase oriented approach to trauma) with all clients of stabilisation, reprocessing and reintegration. The extent to which a client can move through this model will depend on various factors. Hence, someone could just complete stabilisation.

There is no limit on the number of sessions, although this is reviewed regularly with the client. The client can be seen for as long as input is still proving productive.

Finally the team offers a consultation service to staff within the local area in which they can supervise or offer advice to someone working with a military veteran with psychological difficulties relating to trauma.

The current staff team comprises:

1. Clinical Lead – Consultant Clinical Psychologist – worked within trauma work 10 years, trained in EMDR to advanced level, provides supervision and training for trauma work and vicarious trauma. Attended various short training courses in trauma over the years.
2. Highly specialist Clinical Psychologist – trained in psychoanalytic psychotherapy, worked within trauma service for 6-7 years, trained in EMDR and has particular interest in complex cases.
3. Advanced Occupational Therapist – worked in trauma service for 5-6 years. Has extensive experience of working as an occupational therapist in various settings including several years in Psychological medicine.
4. Clinical Psychologist – been with the service for 1 year, completed EMDR training to intermediate level.
5. Dual Diagnosis worker – on a two-year contract funded by the MoD, extensive experience and training in working with drug and alcohol problems, also trained as CPN.
6. Specialist Nurse – completed EMDR training to intermediate level, previously worked in military setting, extensive experience of military work through working on the reservist mental health programme
7. Assistant Psychologist – on temporary contract, completed psychology degree and currently completing research masters in trauma in Sheffield.
8. Team Administrator – been with the team for a year, background of having worked in military settings (RAF) and completing course in social behavioural studies in own time

#### **4.2.4 Levels of activity**

The team sees more young people now than in the past, particularly ex-service personnel in their 20s who have only left the Forces relatively recently. This is probably because of improved links with military DCMH. The team's caseload is probably mostly from Iraq now whereas previously Northern Ireland would have been the most common theatre.

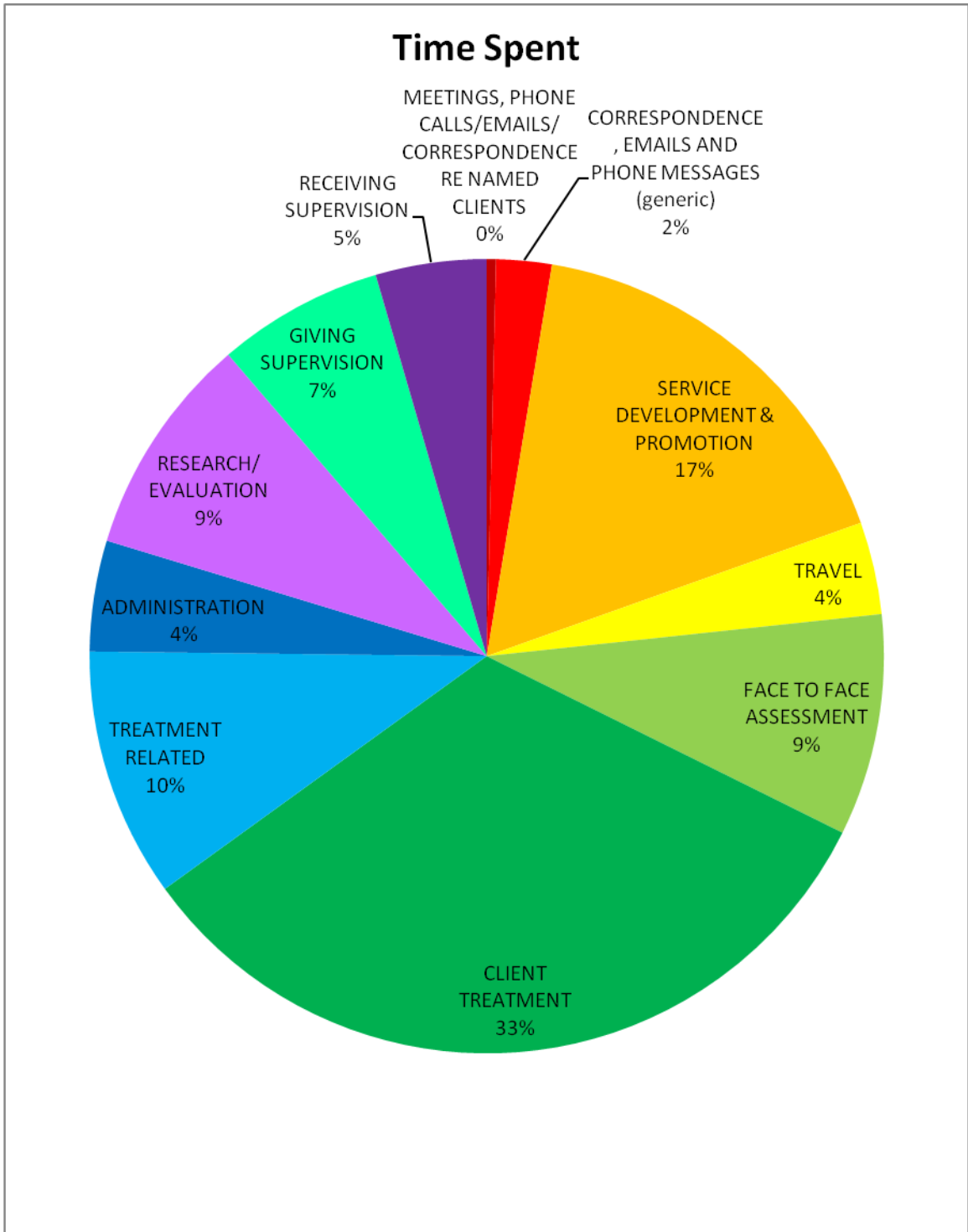
Because this is a trauma service the majority of people present with some trauma presentation even if not full PTSD. The service also sees a lot of drug and alcohol problems and some co-morbid depression and anxiety. Presentations of alcohol and drug problems are screened and the service routinely uses the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST). The team frequently see clients with relationship issues, though not always domestic violence and increasingly they are seeing people with forensic histories.

The team currently has an assistant psychologist who collates data. However, her contract comes to an end this year and it may be more difficult for the team to allocate time to this activity in her absence.



Figure 4.2 below shows the typical activity of a therapist, but data on client throughput in the download service data was sparse with only 5 clients included. Of these 4 were assessed and 3 were treated. No intake or outcome measure data was provided.

**Figure 4.2: Sample activity chart for therapist – Humber service**



#### *4.2.5 Questionnaire results*

Although questionnaires were sent out to veterans who had been seen by the Humber service, no returns were received.

## 4.3 Royal Irish Aftercare Service

Police Rehabilitation and Retraining Trust

Maryfield Complex  
100 Belfast Road  
Holywood  
Co Down  
BT18 9QY

Tel 028 90 393567

Email: [rehabadmin@prrt.org](mailto:rehabadmin@prrt.org)

### 4.3.1 Summary pen-picture

This service delivered NICE-recommended treatments to clients referred by the R IRISH Aftercare service, in other words there was only one source of referral and ex-service personnel all came from one single Regiment (and its successor). Fixed-length treatments were offered with particularly lengthy follow up for up to 1 year.

### 4.3.2 Historical account

The Police Rehabilitation and Retraining Trust (PRRT) was established in March 1999 to provide the Royal Ulster Constabulary and their families with a holistic service under one roof and offering support in four key areas: (1) careers advice to assist with identifying new career directions; (2) training to help them prepare for life in a civilian role; (3) physiotherapy; and (4) psychological support to manage the impact of their service.

After the disbandment of the Royal Irish Regiment (R IRISH) Home Service Battalions (successors to the Ulster Defence Regiment) in 2007, it was felt that a similar service should be offered to ex R IRISH/UDR soldiers and their families. In September 2007 PRRT accepted its first military referrals. A model similar to that functioning for Police Officers was set in place with four main exceptions as follows:

- No internal provision of careers guidance. This service was only available via the Aftercare service for a small eligible number of clients
- No cross referral to interdepartmental physiotherapy service
- No provision of satellite clinics for outlying areas (which would appear to have significantly contributed to DNA/CNA rates)
- No self-referrals permitted

It would be the service's view that these contractually imposed limitations potentially detracted from the overall service provision in contrast to that provided to policing colleagues. Links were made with colleagues on the MoD Pilot Site Programme. The Hull Trauma team have visited twice and PRRT staff have visited Hollybush House and have hosted several Combat Stress visits. To some extent the formation of links was minimised due to the

close liaison with the R IRISH Aftercare service welfare service that took on this function as a signposting service on clients' behalves as required.

The contract between PRRT and R IRISH Aftercare came to an end in August 2010 with psychological treatment being transferred to another provider.

#### **4.3.3 Operation of the service**

Clients were referred by welfare workers from the R IRISH Aftercare Service. Only former UDR/R IRISH soldiers and their family members were covered; veterans with other cap badges living in Northern Ireland were not eligible. Clients were invited to attend for an initial assessment within 10 days of referral being received. Initial assessment focused on presenting problems and any risk factors. Psychometric testing was carried out to clarify symptoms of mental health status, including the use of the CORE-OM. Other measures were used based on the therapists' clinical judgement. After the initial assessment, cases were presented to the psychology team at a referral meeting for agreement about suitability.

Once allocated to a therapist, clients attended for a fuller assessment process that included identifying historically significant incidents, impact of problems including level of functioning, mental state, and risk to self or others. Further psychometric testing included administering the Modified PTSD Symptoms Scale Self Report (MPSS-R), Beck Depression Inventory (BDI) and Work and Social Adjustment Scale (WASAS). The full assessment also included case conceptualization, identification and scoring of specific problems and goals.

Treatment model was based on NICE guidelines and many years experience working with similar populations. Focus is on quality of life and recovery. The service adopted the 3 phase model as outlined by Herman (2001). Often patients were encouraged to engage in other services prior to attending for psychological treatment at PRRT. Examples include Psychiatric Services, Community Addiction Teams, and Physiotherapy.

Therapists worked within a CBT framework focusing on the following: (1) psycho-education, stabilisation, (2) processing, and (3) integration. EMDR was also used for processing. All work occurred in partnership, clients made an informed choice to move into the processing stage.

All referrals come from the Aftercare service and there were no direct self-referrals. Clients would either contact the aftercare medical services officer or welfare officers on the ground. PRRT would receive the referral and then would contact the client to arrange an assessment. This contrasts with the police officer service, which is self-referral. There were a few issues such as some people being referred without their consent/knowledge, and people being unsure about the service. In response, PRRT developed a FAQ sheet for welfare officers to hand out to try and prevent these issues. However due the ongoing contractual difficulties the sheet was never rolled out. PRRT did however provide training sessions for Aftercare welfare officers on these issues.

R IRISH Aftercare service maintained control of the waiting list but as they were a non-clinical service and therefore saw people on a first-come first-served basis. However, this did not

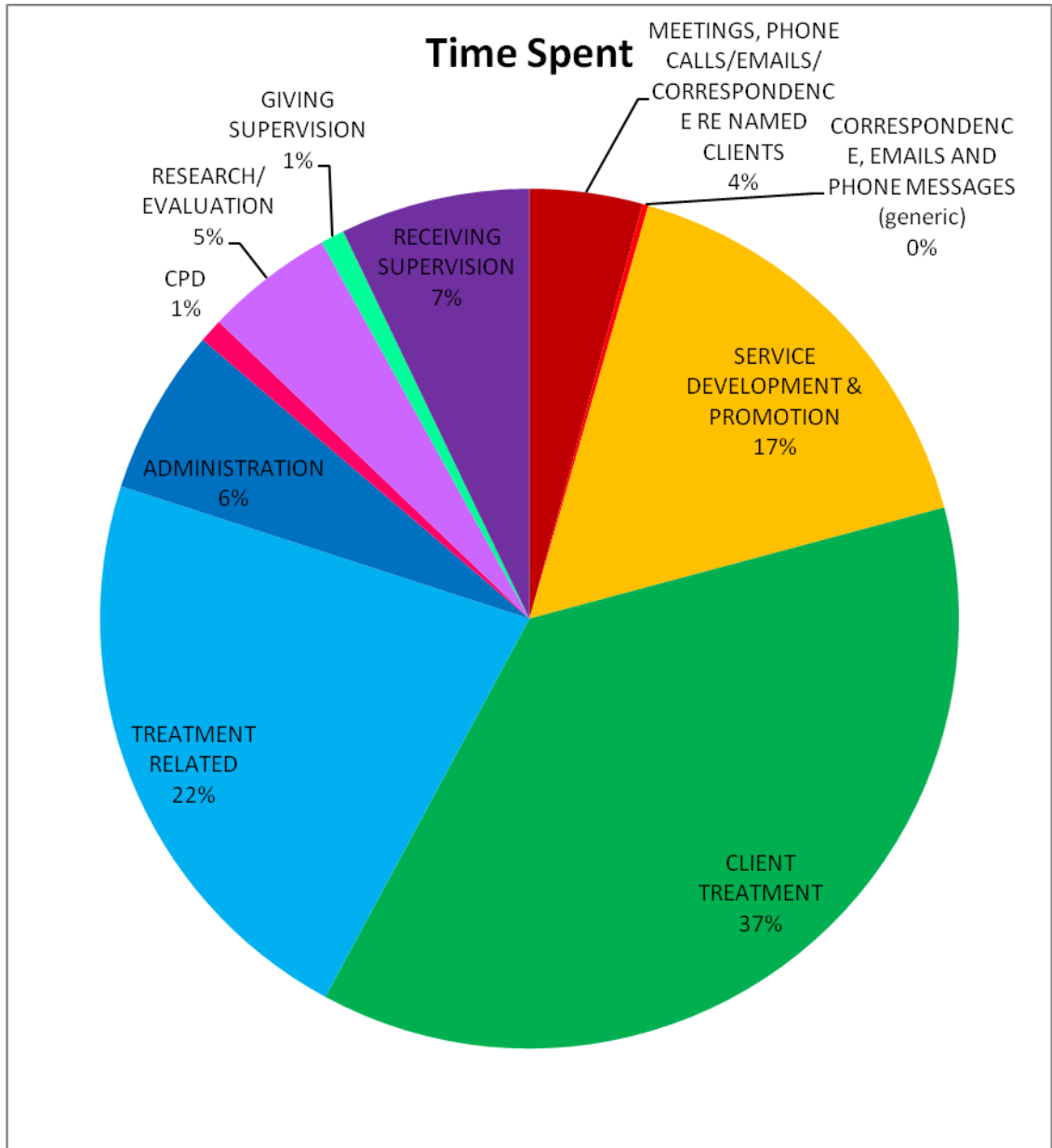
always reflect clinical need. On reflection PRRT staff feel that it would have been better to manage the waiting list by themselves (as they do in their service for ex-RUC officers) rather than the aftercare service being in control of referrals.

The service comprised a senior office manager and 2 admin staff, a clinical manager, and two full time CBT therapists. Clients reported positively about always speaking to the admin team as a first point of contact who were trained to give advice.

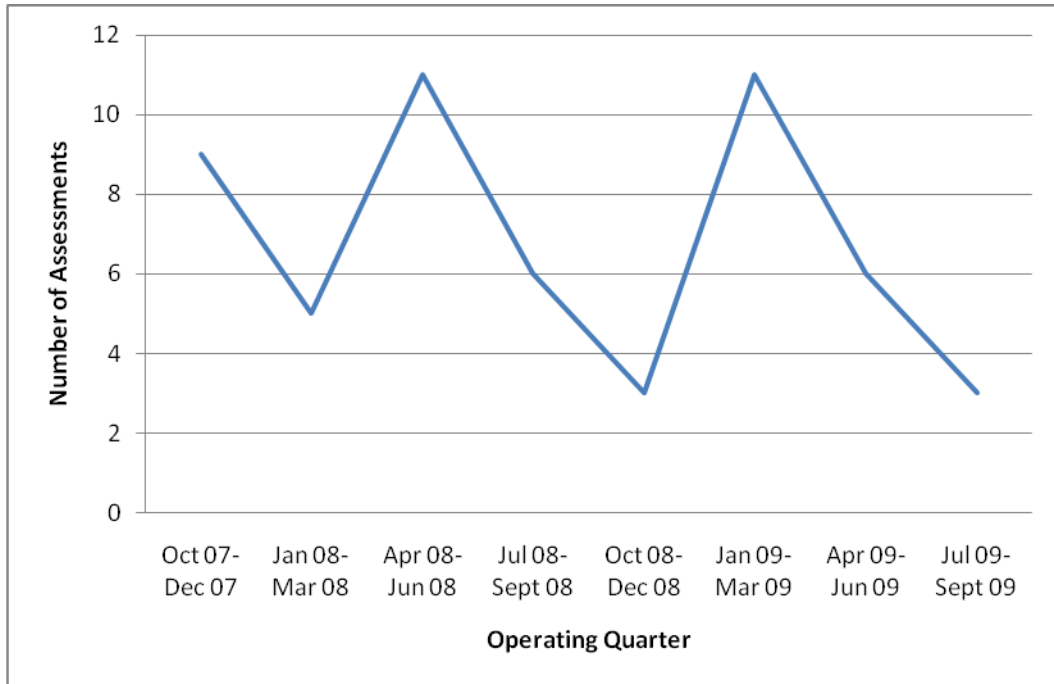
All clients were offered 1, 3, 6, and 12-month follow up appointments. Very rarely would a person be referred back to Aftercare. Normally clients would be discharged with a discharge report and would be back in the care of their GP and they would only be referred back to the aftercare service if they needed more help.

4.3.4 Levels of activity

Figure 4.3: Activity chart for therapist – Northern Ireland



Service download data contained demographics and information on problems and treatment for 54 veterans treated by the service between 2/10/07-14/9/09. Data were only available on those assessed for treatment who received at least one session and no data were available on the total number of referrals.

**Figure 4.4: Numbers Assessed per Quarter 2/10/07-14/9/09**

Thirty (55.6%) had a planned ending to treatment; for 5 (9.3%) treatment was considered inappropriate and 7 (13.0%) did not engage with treatment. A further 11 (20.4%) dropped out of treatment while 1 (1.9%) were referred on.

With regard outcome measures, most had CORE-OM (n=46), BDI-I (n=29) and WSAS (n=20) data pre treatment and around 40% had a measure at post treatment. Descriptive data and outcomes are presented within the pilot service sections.

#### 4.3.5 *Special circumstances of Northern Ireland*

The PRRT service was delivered on a guarded, secure site. Staff members were security cleared, as clients would have had concern about who had access to their personal details. Personal details were only shared where absolutely necessary. For example, in liaison with GPs name and DOB were used rather than name and address, and the service did not use headed notepaper. There was also the issue of people having personal protection weapons. Due to the security threat rising during this period, some people would have carried their weapons to and from sessions.

Threat and threat awareness were not necessarily communicated to the service well enough. Clients would say it was not safe for them to travel but the service had not been made aware of the threat.

None of the staff involved in the project were from a military background but they had a long history of treating combat related trauma. Hence they were respected for their expertise. Clients would say they had been referred by the military but would refuse to engage with the

service if the information would be passed back to the military. The service reports that it was reassuring to clients that PRRT was independent of the military.

The majority of clients served their whole military career in Northern Ireland and so were living at risk the whole time, both whilst serving and then when living within the community. Some veterans had served in other places or other regiments then joined R IRISH/UDR, but this was a smaller number. Northern Ireland service was reported as causing the most difficulties in terms of conflicts, due to less clarity and more political issues surrounding it, and more threat from off duty attacks.

In the case of any future service for ex-service personnel with other cap badges, it is the PRRT view that someone who had served in theatres other than Northern Ireland but was now living there would still have high security needs, as they would be seen as a 'legitimate' target similar to ex-UDR people. Therefore similar security considerations would be necessary.

#### **4.3.6** *Ending of contract*

The PRRT contract was due to finish in August 2010 but no decision about succession was reached until shortly before this time. Clients ending therapy were therefore left with less than full information about who would be responsible for their follow-up. Eventually, after a one-month hiatus, the contract for further R IRISH/UDR clients was awarded to a different provider in Northern Ireland. This uncertainty was commented on by some of the respondents to the evaluation questionnaire.

#### **4.3.7** *Questionnaire results*

The N Ireland service provided a challenging benchmark for the NHS pilots to set themselves against. The questionnaire results showed its clients to be the most satisfied overall of the seven services from which questionnaire returns were received. N Ireland also scored highest on the individual questions:

- Would recommend this service to a colleague
- I am in a better situation now than I was when first referred, thanks to the input from the service

N Ireland veterans were the most positive about being seen by someone from outside a Forces background. This was commented on by staff and clients and may result from the particular circumstances of all veterans being ex UDR/R IRISH. They may have had specific issues to address which they felt needed to be gone over with someone in a neutral position.



## CHAPTER 5: The Veterans' Mental Health Service (South Staffordshire)

South Staffordshire & Shropshire Healthcare NHS Foundation Trust

St George's Hospital  
Corporation Street  
STAFFORD  
ST16 3SR

Tel: 01785 221209

Website: [www.southstaffshealthcare.nhs.uk/services/veterans-mental-health/](http://www.southstaffshealthcare.nhs.uk/services/veterans-mental-health/)

### 5.1 Summary pen-picture

The service operates an assessment and signposting model. The service has been designed to make available, within the NHS, expert assessment for veterans with mental health problems. Following this assessment they will be signposted to appropriate services within the Trust (e.g., in a CMHT) or outside the Trust to other agencies or charities as appropriate. The service does not undertake care co-ordination but will provide advice, assessment, and guidance to NHS teams who do undertake this responsibility.

### 5.2 Development of service

#### 5.2.1 Historical account

The Service was initially set up as a signposting service in September 2007 by a Trust clinician who was also an armed forces veteran himself. The pilot was the first service to be set up of the six being evaluated in this study. Sadly, the founding clinician died nine months after the MoD funded pilot was set up. There was then a hiatus of several months until two new clinicians were identified to take up the reins, dividing the region geographically between them. One of these two clinicians was an army reservist with experience of active operations. While this doubtless added to the expertise available in the service, paradoxically he was also liable to be called up for active service, which indeed he was after being in post for six months.

During the setting up phase of the pilot, strong links were established with veterans' charities Combat Stress, Royal British Legion and SSAFA. Contact was also made with the Service Personnel and Veterans Agency (SPVA). Initial work was instigated within secondary care mental health teams in October 2008. Within the role of the signposting service, links have been established with interested veterans' groups. The pilot has worked with Combat Stress's community team ensuring that strong links have been developed between them and local CMHTs. Further to this, the Veterans' Therapist (VT) has met with the Sickness Absence management team at DCMH Donnington and, in addition with clinicians and veterans, identifying how to best meet their needs.

### 5.3 *Operation of the service*

Referrals are accepted from General Practitioners, other healthcare professionals and agencies. A decision is then made as to both the appropriateness of the referral and, if accepted, the degree of urgency. Appointments can be arranged within the client's own home (subject to risk assessment), at drop-in clinics, GP surgeries, or at their local NHS Trust. The aim is to assess clients within a four week timeframe.

For internal referrals within the Trust, in order to ensure that all veterans receive priority treatment and to maintain an accurate database, all SSSFT personnel are required to complete a Veterans Notification form and to forward it to the Veterans Mental Health Lead.

Once a referral (internal or external) is made the veteran will be seen by the VT and an assessment made of their needs. Mental health treatment will be by one of the existing Trust teams, such as a CMHT or specialist team such as a drug and alcohol service or in-client unit. The VT will provide advice and support to the Trust team but not carry care co-ordination responsibility. In the case of specialist treatment such as post-trauma psychological treatment, there is a clinical psychologist working within the Trust who can provide this service.

If the problem is more of a social nature such as housing, benefits, pensions or employment, then a referral onwards will be made by the VT to statutory or voluntary agencies, SPVA, RBL as appropriate.

An online training document has been produced to allow Trust staff to access basic information about veterans' mental health issues on the staff intranet.

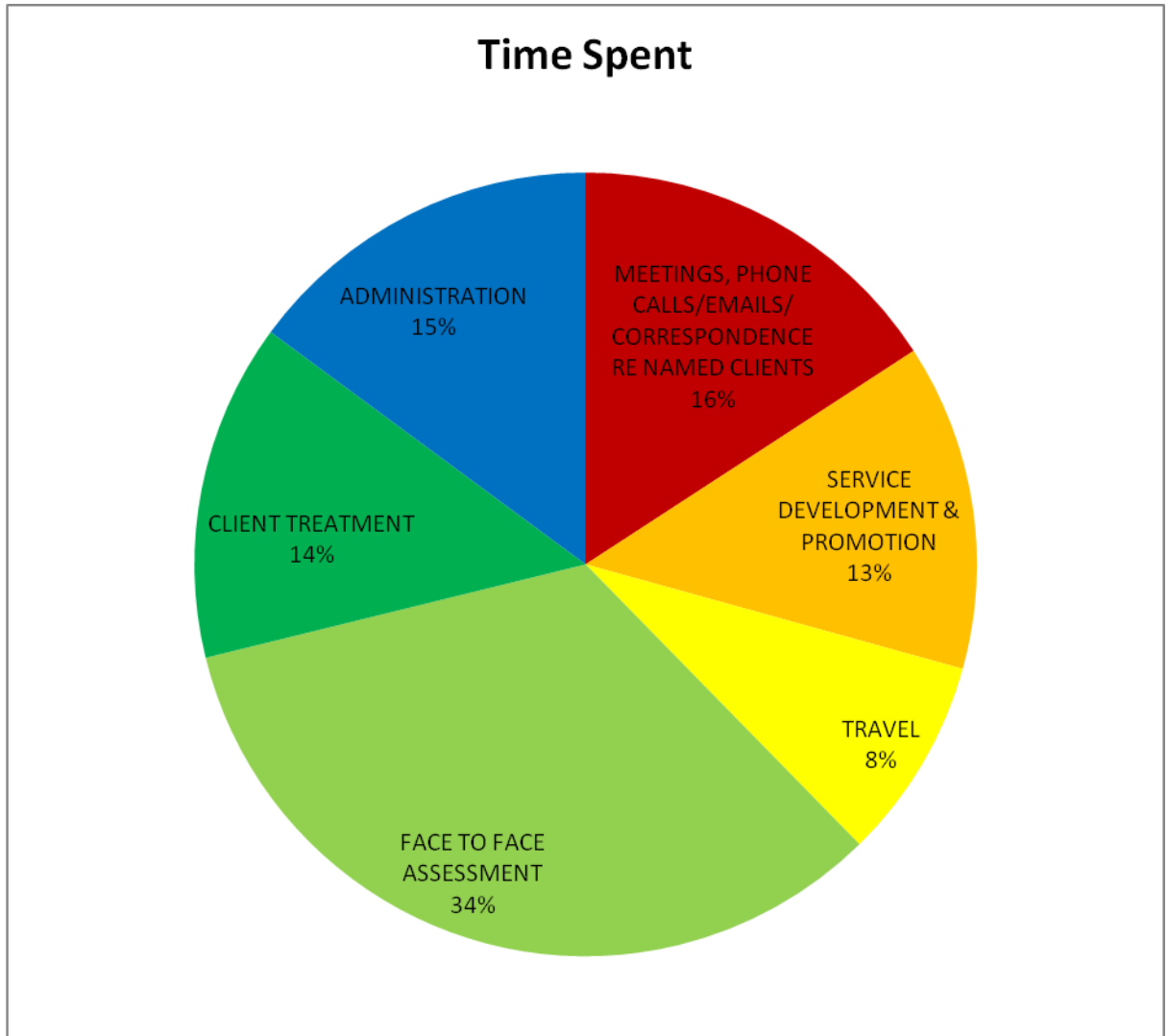
#### 5.3.1 *Service parameters*

- **OFFICIAL GEOGRAPHICAL COVERAGE AND POPULATION ESTIMATE**  
*(i.e., the area contracted or expected to cover)*  
A population of 1.1 million within South Staffordshire, Shropshire and Telford & Wrekin.
- **ACTUAL GEOGRAPHICAL COVERAGE**  
*(exceptions, out-of- area arrangements one-off cases...)*  
There have been a number of one-off cases including contacts from Birmingham, Derby, Stoke, Lincoln and Chester. Telephone advice has been given.
- **DATE SERVICE STARTED ACCEPTING REFERRALS**  
September 2007
- **DATE FUNDING ENDED**  
October 2009

#### 5.4 Levels of activity

Figure 5.1 provides a summary estimate of the range of activities of the VT. Client contact, comprising assessment and treatment, comprised 48% of the time while administration and support activities accounted for a total of 31% of time. The remaining time comprised 13% on service development and 8% on travel.

**Figure 5.1: Sample activity chart for therapist – Staffordshire pilot**

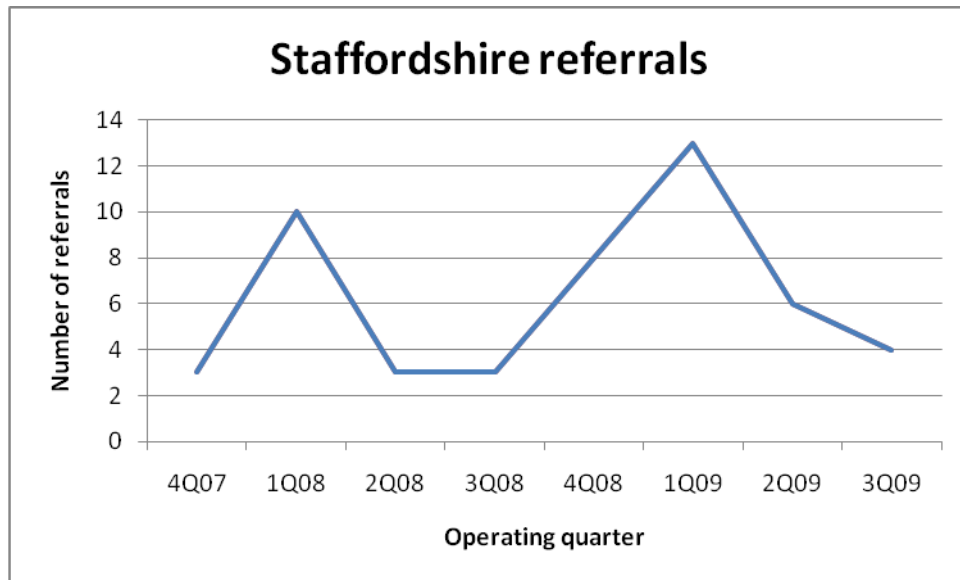


A total of 53 referrals were made to the service during the two years of the pilot. Figure 5.2 presents the rate of referrals across successive yearly quarters. The drop-in activity during the third and fourth quarters of operation appears to coincide with the discontinuity in staffing referred to above. The great majority of referrals (44) were internal referrals from other secondary care teams within the Trust. Only one self-referral was made during the life of the pilot. The peak age group for referrals was 40-49 years and most referrals (38) were ex-Army.

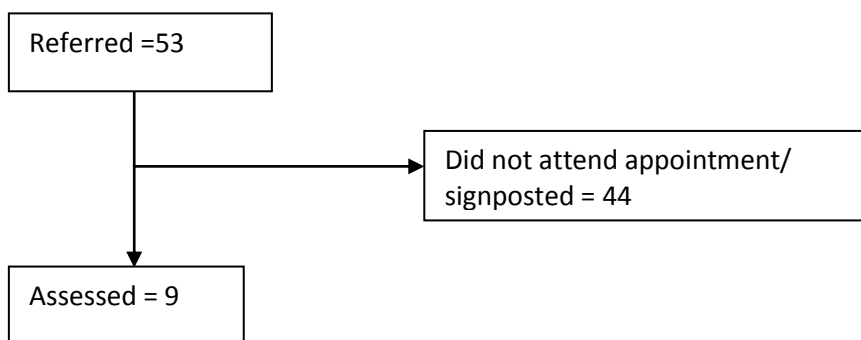
The most frequent diagnosis was depression (22 cases) followed by anxiety (9 cases). PTSD, personality disorder and schizophrenia were less commonly reported. The largest number of

onward referrals was to CMHTs (27 cases). Combat Stress (9) and Clinical Psychology (7) were the next largest destinations.

**Figure 5.2: Quarterly referrals to Staffordshire pilot during MoD funded period**



**Figure 5.3: Flow diagram of referrals to Staffordshire pilot during MoD funded period**



### 5.5 Difficulties in implementation

As already mentioned above, the principal obstacle to be overcome has been discontinuity in staffing. An experienced, well-connected and respected clinician died shortly after the service was commissioned and continuity has been difficult to maintain subsequently. In this respect, the vulnerability of the Staffordshire pilot is no different to others in this evaluation; several rely on one person being the lynchpin of the operation.

### 5.6 Sustainability and future plans

The service has now come to the end of the two-year Pilot. The Trust will continue to operate this service as a signposting service for the foreseeable future and hope that it can dovetail this into its Specialist Psychological and Counselling services in the longer term. The

Trust has recently won the contract for in-client treatment of serving Forces personnel, with obvious possibilities for synergy and developing expertise and credibility in military mental health.

### 5.7 Quantitative description of cases from data downloads

Data were only available on 10 clients (i.e., those assessed plus 1 other client). Such limited data makes comparisons with other services difficult, but the profile of Staffordshire clients seems to follow Combat Stress and Northern Ireland in many respects. The main differences appear to be: Staffordshire saw a greater proportion of female clients, 20.0% compared to 2.0% (Combat Stress) and 3.7% (Northern Ireland). They saw more RAF veterans (20% compared with 4.3% at Combat Stress) and a greater proportion of clients with physical problems and substance misuse 70% and 50% respectively compared with 2.4% and 19.5% (Combat Stress) and 48.0% and 16.7% (Northern Ireland).

No outcome measure data were available from Staffordshire.

### 5.8 Responses to client questionnaires

Responses were received from 3 clients from Staffordshire out of a total of 60 questionnaires distributed, a response rate of 5%. The 3 clients comprised 2 men and 1 woman and represented the age groups 18-29, 30-39, and 50-59. Two clients had served in the Army and one in the RAF.

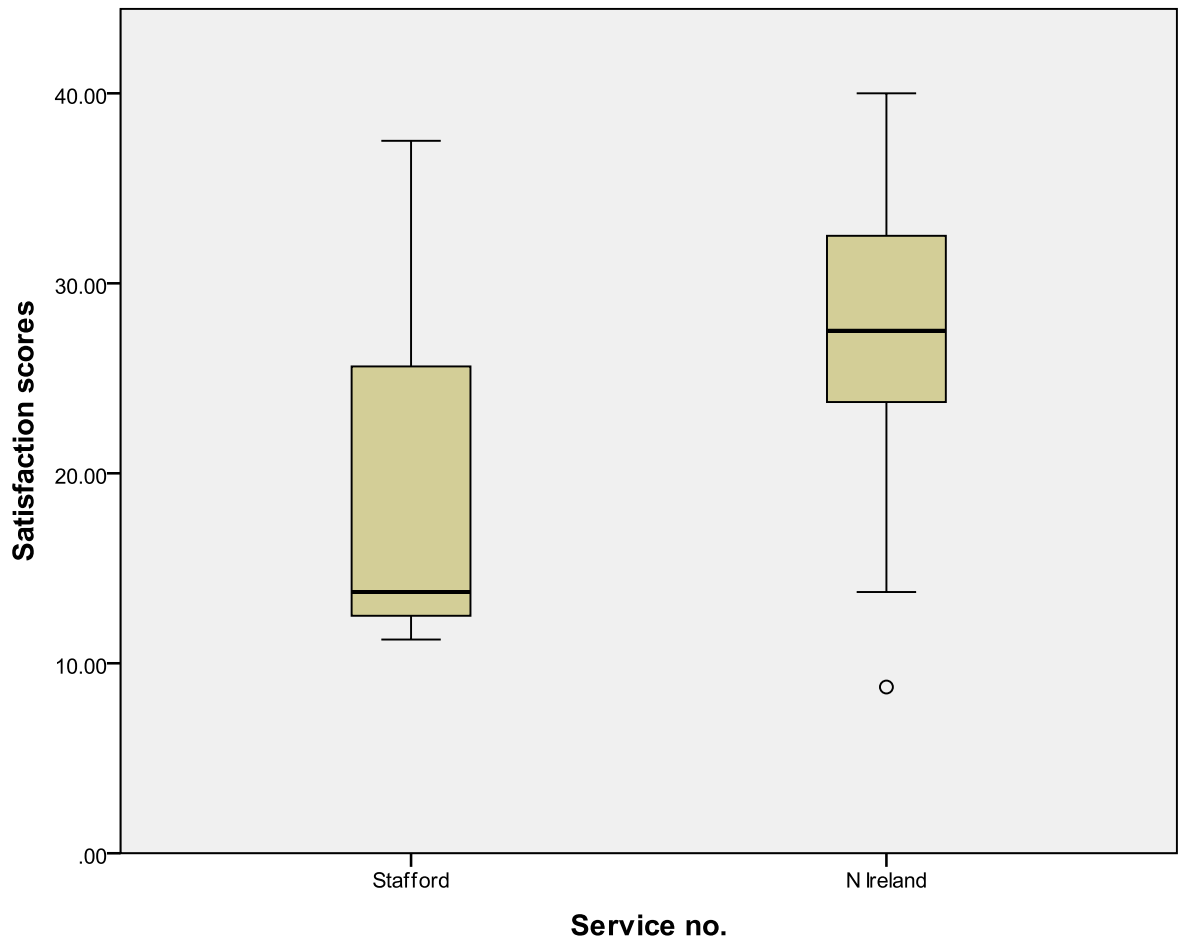
The Staffordshire service was rated the lowest of the six pilots on questions about:

- Being an appropriate model for future services
- The helpfulness of the service
- How far people would recommend it to colleagues
- How far it improved their situation

The service was rated highest of all the pilots for the degree to which there were no gaps in the service. However this finding and the four above must be treated with caution, being based on only three responses.

The median satisfaction score for Staffordshire was 13.7 compared to 27.5 for Northern Ireland. Because of the low number (N=3) from Staffordshire, caution should be exercised in interpreting these data.

**Figure 5.4: Box and whisker plot comparing distribution of satisfaction scores from Staffordshire pilot service with pre-existing Northern Ireland service as a benchmark**



*Note:* The bold horizontal line represents the mean score; the box represents the middle 50% of scores; the whiskers represent the full range of scores with each whisker representing the upper and lower 25% of scores. The single observation below the lower whisker on the N Ireland distribution represents an outlier – an untypically low value.

### 5.8.1 Themes emerging from questionnaires

The emergent themes were identified as follows:

#### ***Problem of seeing non-forces staff:***

*Example:*

- A forces person would understand

#### ***Need for assessments/treatments/information in and when leaving forces***

*Examples:*

- Need assessment when leaving forces
- I was told EMDR was unsuitable for me at the moment and was referred to consultant psychologist (which was a waste of time as only offered talking therapy which was not

appropriate). All support was withdrawn and I am again left to get on with it despite the promises.

- Gave me hope that I was finally getting help and when it was all withdrawn because the NHS did not do 'joined up writing' I was left devastated and without support. Compounding my problems again!
- I was only offered one therapy and because my illness was too deep rooted for that therapy I became 'outside' the service provided. Promises were made by the 'pilot scheme' but they were all broken by the NHS.
- Stop making assumptions about what the client is about before even meeting them. My psychologist only made 3 inputs during my treatment and they were all incorrect.

## CHAPTER 6: Veterans' Community Mental Health Service (Cardiff)

Cardiff and Vale University Local Health Board

University Hospital of Wales  
 Monmouth House (Second floor)  
 Heath Park  
 CARDIFF  
 CF14 4XW

Tel: 029 2074 2057 or Secretary 029 2074 2062

Website: [www.veterans-mhs-cvct.org](http://www.veterans-mhs-cvct.org)

### 6.1 Summary pen-picture

An assessment, treatment, case management and sign posting service – full-time offering a service from Sunday-Friday.

### 6.2 Development of service

The presence of an existing civilian NHS Traumatic Stress Service in Cardiff - led by Professor Jonathan Bisson - made Cardiff an obvious site for a pilot based in Wales. The team already had a nurse therapist with CBT training and this person was seconded as the lead clinician full-time to this post. There had always been a small number of veterans referred to the civilian service but, in order to change focus to an explicitly veteran client group a steering group was formed which met every six weeks. Membership came from within the Trust and from RBL, SPVA, Cardiff City Council (Homelessness Manager), Donnington DCMH, and from HQ 5th Division (the formation responsible for Army administration in Wales, the Midlands and the East of England). A further important member of the steering group was an advice worker from Citizens' Advice Bureau (CAB) based in Caerphilly but funded by RBL to work exclusively with veterans from across south Wales.

### 6.3 Operation of the service

The MoD funding for the pilot provided a 0.5 whole time equivalent clinical nurse specialist in CBT to work as the Community Veterans' Mental Health Therapist (VT) employed at NHS pay band 7. This funding was matched by the Welsh Assembly Government to make the post full-time. Other posts supported by the MoD funding included a 0.5wte NHS Band 2 admin assistant and 0.1 wte of a Consultant Psychiatrist.

The service was envisaged as an assessment, treatment, and signposting service for the Cardiff and Vale and Rhondda Cynon Taff areas of south Wales. Psychological treatment by the VT is available, comprising EMDR and/or CBT for PTSD or for other conditions for which these treatments are indicated (e.g., depression, anxiety disorders). Input from the Consultant Psychiatrist is available, principally to assess and advise on drug treatments.

Usually psychological treatment would be completed in a maximum of 16 sessions (which is the case in the civilian Traumatic Stress Service) but in the veterans' pilot this is often modified. It has been observed that veterans 'do not attend' (DNA) for sessions more frequently than non-veteran clients, and that they require a longer stabilisation and



relationship-building phase with the therapist. In the case of clients requiring more than 16 sessions, or where the clinical picture is more complex, clients will be referred to their CMHT for case management during or after treatment from the VT. Likewise, clients requiring specialist treatment such as alcohol detox or treatment for drug addiction were referred on to specialist Trust services.

It soon became clear that referrals were being made from outside the Cardiff and Vale and Rhondda Cynon Taff areas. Referrals came from across the whole breadth of south Wales and indeed from well up into mid-Wales. These often came from SPVA or RBL staff who were familiar with the pilot service from their work in the Cardiff area, but whose patches spread further afield in Wales. Rather than insisting on a formal Non-Contractual Agreement (NCA) with their PCT, it was decided to offer a one-session assessment to all out-of area referrals with a report to referrers making recommendations and signposting on to other services. Over the two years of the pilot approximately 25% of the referrals were from out of area.

There was no formal training programme provided by the pilot, but a road show presentation was made to Trust teams to raise their awareness of veterans' mental health issue and to encourage internal referrals of veterans from Trust teams to the pilot. Following these road shows, internal referrals did indeed increase.

Two family support groups were planned. One ran successfully but with the other, despite recruiting eight family members, failed due to no families attending. While the idea was welcomed in principle, practical problems seemed to intervene for all concerned.

Veterans attending the service are reported to say that they would not have accessed mental health services while still serving because of the stigma involved and the perceived threat to their position. While some have subsequently had negative experiences with other NHS services, it is reported that they respond well to an NHS service badged explicitly for veterans.

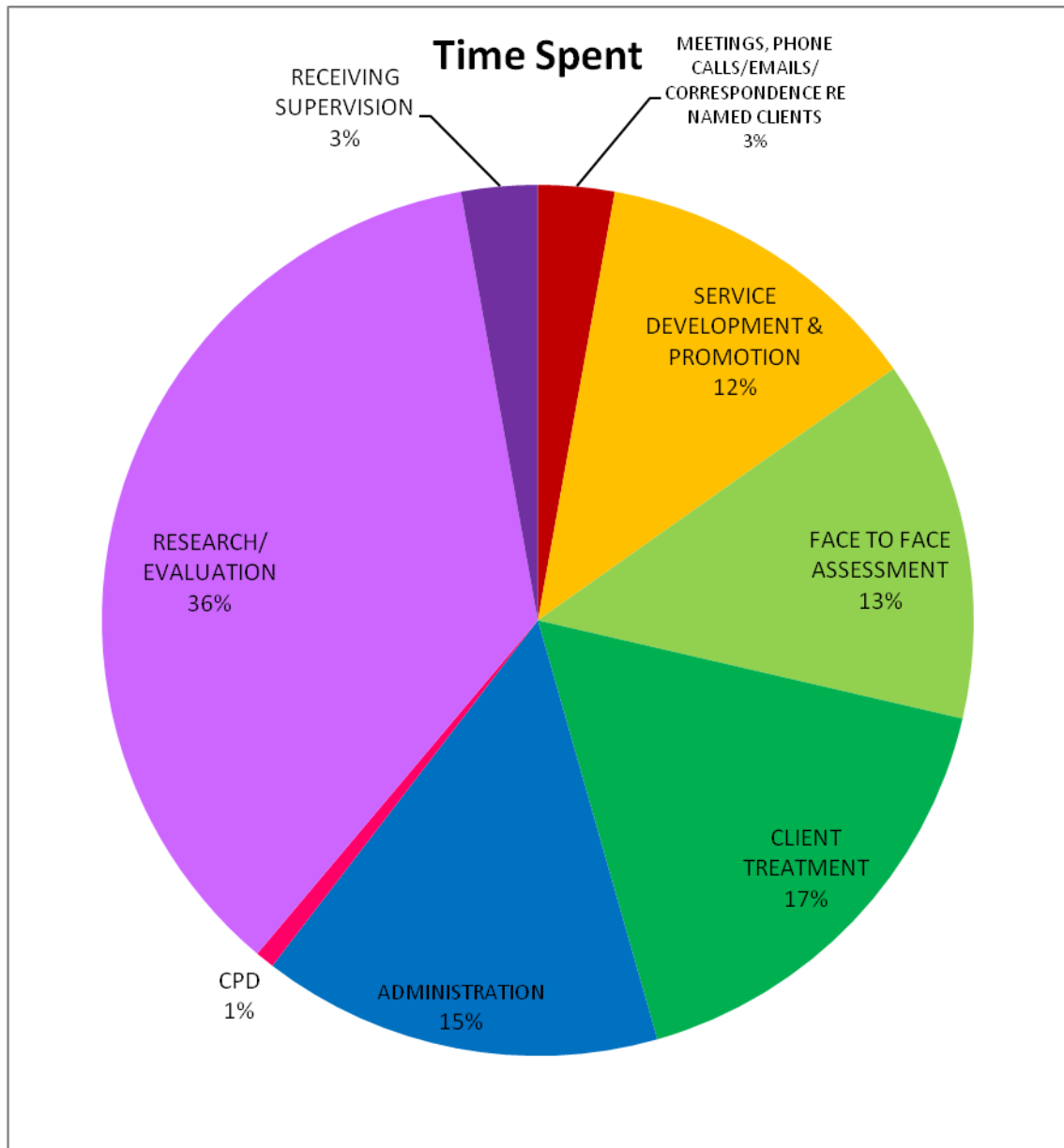
### 6.3.1 *Service parameters*

- **OFFICIAL GEOGRAPHICAL COVERAGE AND POPULATION ESTIMATE**  
*(ie the area contracted or expected to cover)*  
Cardiff and Vale and Rhondda Cynon Taff. 734,000 total population.
- **ACTUAL GEOGRAPHICAL COVERAGE**  
*(exceptions, out-of- area arrangements one-off cases...)*  
One-off assessments from throughout South Wales.
- **DATE SERVICE STARTED ACCEPTING REFERRALS**  
17/03/2008
- **DATE FUNDING ENDED**  
16/03/2010
- **STAFF FUNDED BY CVMHP MONEY (CLINICAL AND NON-CLINICAL)**  
1.0 wte Grade 7 CVMH Nurse therapist  
0.5wte clerical staff 2.5 days/week  
1 session (0.1 wte) psychiatrist

#### 6.4 Levels of activity

Figure 6.1 provides a summary estimate of the range of activities of the VT. Client contact, comprising assessment and treatment, comprised 30% of the time while administration and support activities accounted for a total of 18% of time. Research and evaluation accounted for 36% of time and 4% was accounted for by activities supporting the clinical and professional role of the VT (i.e., supervision and continuing professional development).

**Figure 6.1: Sample activity chart for therapist – Cardiff pilot**



It is the case that the VT in the Cardiff pilot spent more time on research than did staff in other pilots – see section 6.5 below. However the proportion of time spent on this activity shown above (36%) is likely to be an artefact of the short sampling period for the diaries. A more likely proportion is about 20% (one day per week.)

Figure 6.2: Graph showing referral rates 1/1/08 – 20/6/10

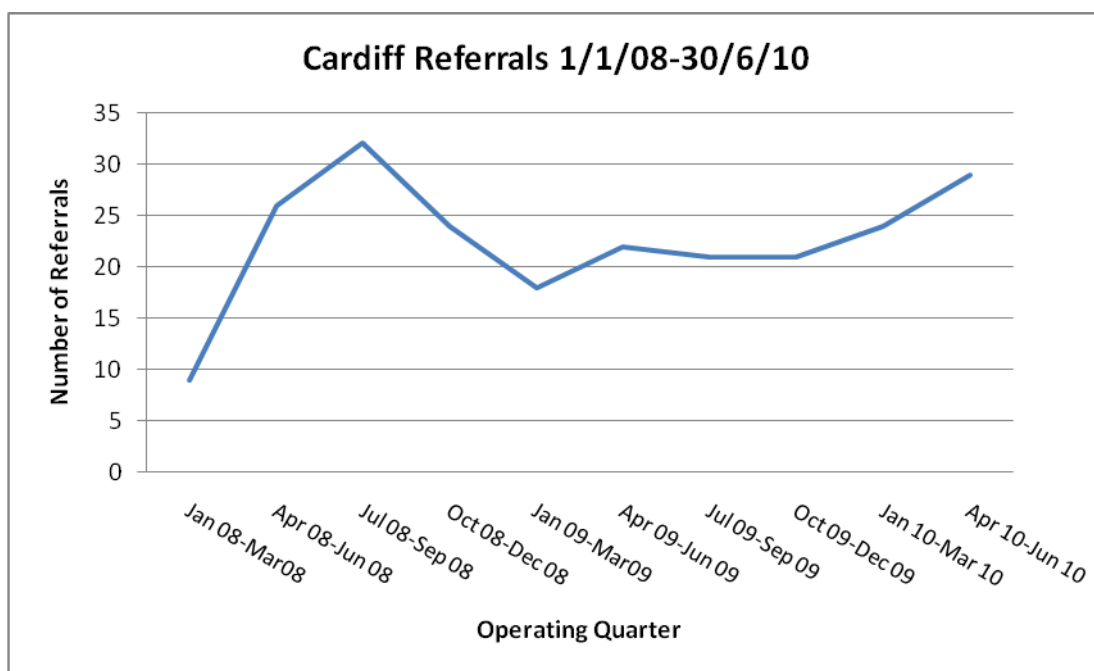
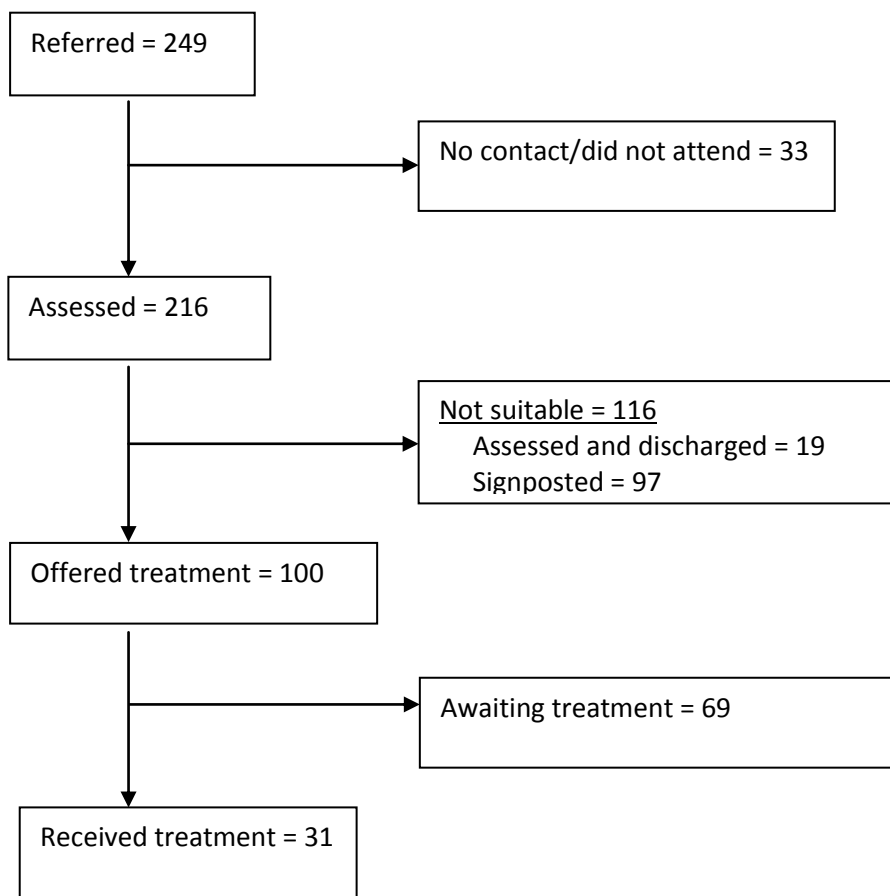


Figure 6.3: Flow diagram of referrals to Cardiff pilot during MoD funded period



## 6.5 Research and evaluation

The VT in post is undertaking a PhD to research the optimal psychosocial pathway for veterans with mental health problems. A consensus group devised the pathway which was then followed by ten clients who were interviewed and completed a series of pre-post outcome measures. The pathway was consequently redesigned and two further iterations of ten clients were undertaken. Results from the study will be available in early 2011.

## 6.6 Sustainability and future plans

Before the end of the pilot, the Welsh Assembly Government (WAG) requested that the service set up a project group over six months with key senior individuals across Wales to develop an "All Wales Veterans' Mental Health Service". This work was completed in December 2009 and was reported back to the WAG Minister for Health and Social Services. It recommended a hub and spoke model with Cardiff as the hub and five spokes to cover the Local Health Boards (LHBs) across Wales. Each spoke will have a Band 7 VCMH therapist with psychotherapy skills. The person would set-up a Veterans' mental health system in their area that would then report back to the hub. The hub, with an NHS Band 8 clinician and 2 sessions of a psychiatrist, will provide co-ordination, training, supervision and second opinions. The total cost of the future service for Wales is estimated at £482,000 per annum.

## 6.7 Quantitative description of cases from data downloads

Data was available for 236 clients. The mean (SD) waiting time was 8.8 (9.8) weeks considerably longer than Northern Ireland (2.3 (2.2)).

The mean (SD) age was 41.8 (13.8) slightly less than Combat Stress and Northern Ireland. The breakdown into age groups indicates that a greater proportion of clients under 30 were referred in Cardiff than Combat Stress and in particular Northern Ireland. While fewer 41-50 year olds were referred. More 51-60 were referred than in Northern Ireland but fewer over 60s.

### 6.7.1 Intake severity and outcomes

Nine PHQ-9 measures were completed prior to treatment. Although the number is small, veterans treated in Cardiff appear to be less severe at intake, compared to BDI clinical groupings for CS and N Ireland although in comparison with CORE groupings for N Ireland the proportions in each clinical group are similar.

**Table 6.1: Intake scores and clinical groupings for Cardiff, Combat Stress and Northern Ireland**

Measure	Cardiff (Received treatment)	Combat Stress	Northern Ireland**	
	PHQ-9	BDI-II	BDI-I	CORE-OM
N	11	396	29	46
Mean	16.6	32.2	33.8	20.9
(SD)	(5.32)	(12.45)	(12.18)	(6.34)
Clinical groups*N(%)				
Non-clinical/minimal	1 (9.1)	33 (8.3)	1 (3.4)	4 (8.7)
Mild-Moderate	7 (63.6)	109 (27.5)	8 (27.6)	29 (63.0)
Severe	3 (27.3)	254 (64.1)	20 (70.0)	13 (28.3)

Note\* PHQ-9: NC=0-9, MM=10-19, S=20-27; BDI-II: NC=0-13, MM=14-28, S=29-63;  
BDI-I: NC=0-9, MM=10-29, S=30-63; CORE-OM: NC=0-9, MM=10-24, S=25-40

## 6.8 Client experience from questionnaires

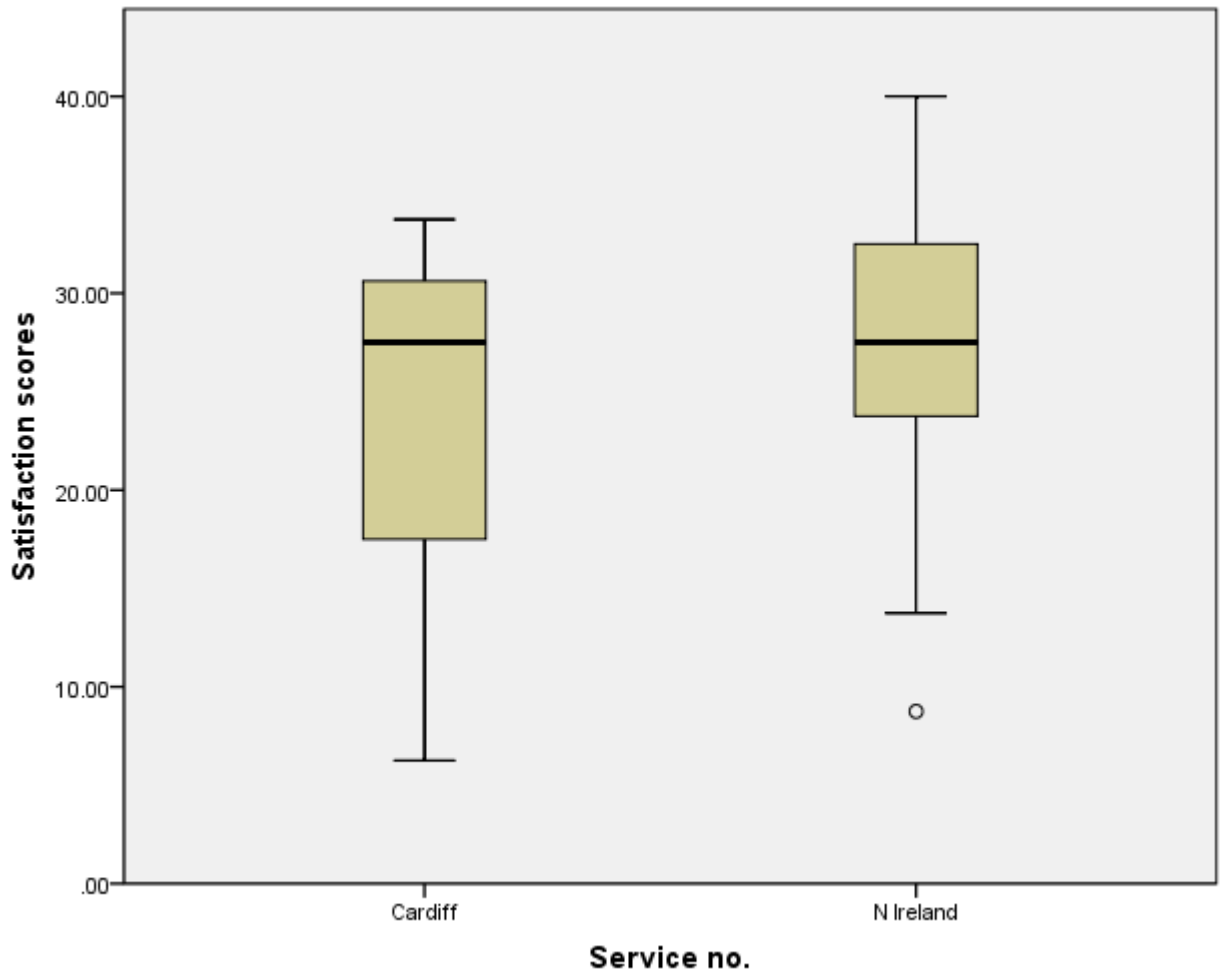
Responses were received from 10 clients from Cardiff, from a total of 150 questionnaires distributed, a response rate of 6.7%. Table 6.2 briefly summarises characteristics of the sample.

**Table 6.2: Demographic details for questionnaire respondents in Cardiff pilot (N=10)**

Demographics	N (%)
<i>Gender n (%)</i>	
Male	6 (60%)
Female	3 (30%)
<i>Age Group</i>	
18-29	1 (10%)
30-39	1 (10%)
40-49	4 (40%)
50-59	2 (20%)
60-69	2 (20%)
70+	0
<i>Service</i>	
Army	8 (80%)
RAF	0
RN	1 (10%)
RM	0
Other	1 (10%)

The Cardiff pilot was rated in the questionnaires as the least physically welcoming of the six. This was based on 'tick box' answers to a specific question, and was not elaborated on in the 'write-in' section of the questionnaire, so no rationale for people's ratings can be given. It should also be noted that this rating, at 2.1 on a 0-4 scale, was still above the mid-point.

**Figure 6.4: Box and whisker plot comparing distribution of satisfaction scores from Cardiff pilot service with pre-existing Northern Ireland service as a benchmark**



*Note:* The bold horizontal line represents the mean score; the box represents the middle 50% of scores; the whiskers represent the full range of scores with each whisker representing the upper and lower 25% of scores

The median satisfaction score for Cardiff was 27.5, equal to the median of 27.5 for Northern Ireland. However, the box plots reveal a greater spread of scores below the median for Cardiff as compared to Northern Ireland and a restricted upper range. This reduces the mean (average) score from Cardiff clients as shown in the distribution above.

### 6.8.1 *Themes emerging from questionnaires*

The emergent themes were identified as follows:

#### ***Need for more sessions/centres/staff***

*Examples:*

- More specialists in hospitals to reduce waiting lists
- Service is small and underfunded
- Need more long term funding
- My problem was that he could not dedicate any more time because of budgets and financial constraints so I stopped going to see them

#### ***Problem of seeing non-forces staff***

*Example:*

- It is important to understand ex-service culture when dealing with ex-service people
- Doctors wishing to study mental health should spend time with the services to gain experience on the way the services operate and how the military mind works, it is another world

#### ***Need for assessments/treatments/information in and when leaving forces***

*Examples:*

- Get people the help they so rightly deserve as quick as possible
- Make sure personnel know about help available on discharge
- Ex service personnel are reluctant to admit they have a problem until it goes beyond the limit, we do not want to be a burden and to be labelled as this is deemed to be a failure. All concerned should emphasise the importance and need to address mental health issues early for newly discharged persons.

#### ***Need to inform others***

*Examples:*

- GPs should be more informed about PTSD
- GPs don't have a clue

#### ***Need to let client set the pace of therapy***

*Example:*

- Don't make assumptions about clients

#### ***Positives of seeing someone with PTSD/services knowledge***

*Examples:*

- Good to talk to someone with forces knowledge
- I met Professor B\_\_\_\_\_, he was the first person who understood my plight as he was an army veteran himself

***Need for better information about services***

*Example:*

- More information about the services/help needed

***Positives of therapy 1: positives about services/staff***

*Examples:*

- They took great interest in what I had to say
- Welcoming, friendly, tried to understand
- Very approachable, professional, to have somebody I could build a trusting relationship with, to not be judged

***Positives about therapy 2: Feelings***

*Examples:*

- Finally having someone to talk to
- Recognition of problems
- Took a weight off my mind

***How services could be further developed to help more***

*Example:*

- Need more out of hours help

***Negatives about the service***

*Examples:*

- Need to be more professional
- Need to explain treatment process/refusals of treatment better
- All support was withdrawn and I am again left to get on with it despite the promises
- Offer of help later being withdrawn – devastated
- Complex cases need to be offered treatment too
- They have offered me many avenues of support and treatment, but personally I have not received what I needed.
- Progress is slow and decisions could have been made more quickly. There is a lot of talking but not much action

***What I would say to the MoD and NHS***

*Examples:*

- NHS and MoD must work together
- I believe ex-service personnel should be given priority treatment
- Personnel are discarded by the armed forces it is not their problem. The general attitude is that it is a civilian duty to look after ex forces personnel
- Why, after all the years I have patrolled the streets of Northern Ireland and served in major flashpoints across the world are they only starting to recognise veterans now? I had no support at all when I left the forces.



## CHAPTER 7: The Pan-London Community Veterans' Mental Health Pilot

Camden and Islington NHS Trust

The Traumatic Stress Clinic  
73 Charlotte Street  
LONDON  
W1T 4PL

0207 530 3666

Website: [www.candi.nhs.uk/veterans](http://www.candi.nhs.uk/veterans)

### 7.1 Summary pen-picture

A clinic based service providing an assessment and signposting service to veterans in the South east of England. Referrals are accepted from NHS and non-NHS sources together with self-referral.

### 7.2 Development of service

The pilot was established to provide an assessment, treatment, and signposting service. Referrals were initially very slow but picked up one calendar year into the project. The increased volume of referrals together with uncertainty about future funding of the project meant that the pilot was unable to maintain a treatment service and has only been assessing and signposting since summer 2009. The work attracted more media attention than was anticipated as well as being called upon to give expert advice (for example to a, then, opposition summit at the House of Commons in the summer of 2009). Key working links have been made with Combat Stress, SPVA, homeless charities, Veterans' Aid.

### 7.3 Operation of the service

For the two years of the pilot there was funding for one clinician (NHS Band 8b) for two days a week, plus one day of admin support (NHS Band 5). Other staff made input to management, admin support and additional clinical support from existing resources.

A defining feature of the London pilot is its size. It covers 32 PCTs in London but also accepts non-contractual activity (NCA) referrals from surrounding counties across the south east of England. There is a lot of work involved with co-ordinating this activity and liaising with the different PCTs and local services, needing to do a lot more proactive follow-ups. The pilot has moved to an internet based referral system allowing self-referrals and referrals from professionals. A website has been built to help access, which includes information videos for referrers and veterans.

The pilot was originally set up as an assessment, treatment, and signposting service, although treatment was not equally available to all. The pilot is a part of the Camden and North Islington (CANDI) Trust's Traumatic Stress Clinic. Veterans referred to the pilot who are CANDI clients and have a stress-related disorder can be seen automatically by the parent service. Clients from other Trusts within London and from the wider south-east can only be treated by the Traumatic Stress Clinic if NCA funding is agreed by their PCT. For other clients, where a treatment recommendation is made by the pilot but not funded by the PCT, the

recommended treatment must be provided by their local primary or secondary care mental health providers. An audit by the pilot suggested that this provision was very slow and the pilot has now taken on an advocacy role for veterans to try to speed up the adoption of treatment recommendations.

The assessment can be very detailed and can take up to three hours. More complex cases are seen over more than one session as it can even take longer than this. It is a clinical interview, asking about service history, current difficulties, and any attachment difficulties/childhood problems. Also a number of measures are used, looking at PTSD, alcohol use, and depression, together with other related presentations. The pilot service then produces a detailed report with clear treatment recommendations. This report is discussed with the veteran and then sent to GP or referrer and followed up. If the veteran was a self-referral, then the report would go to their GP.

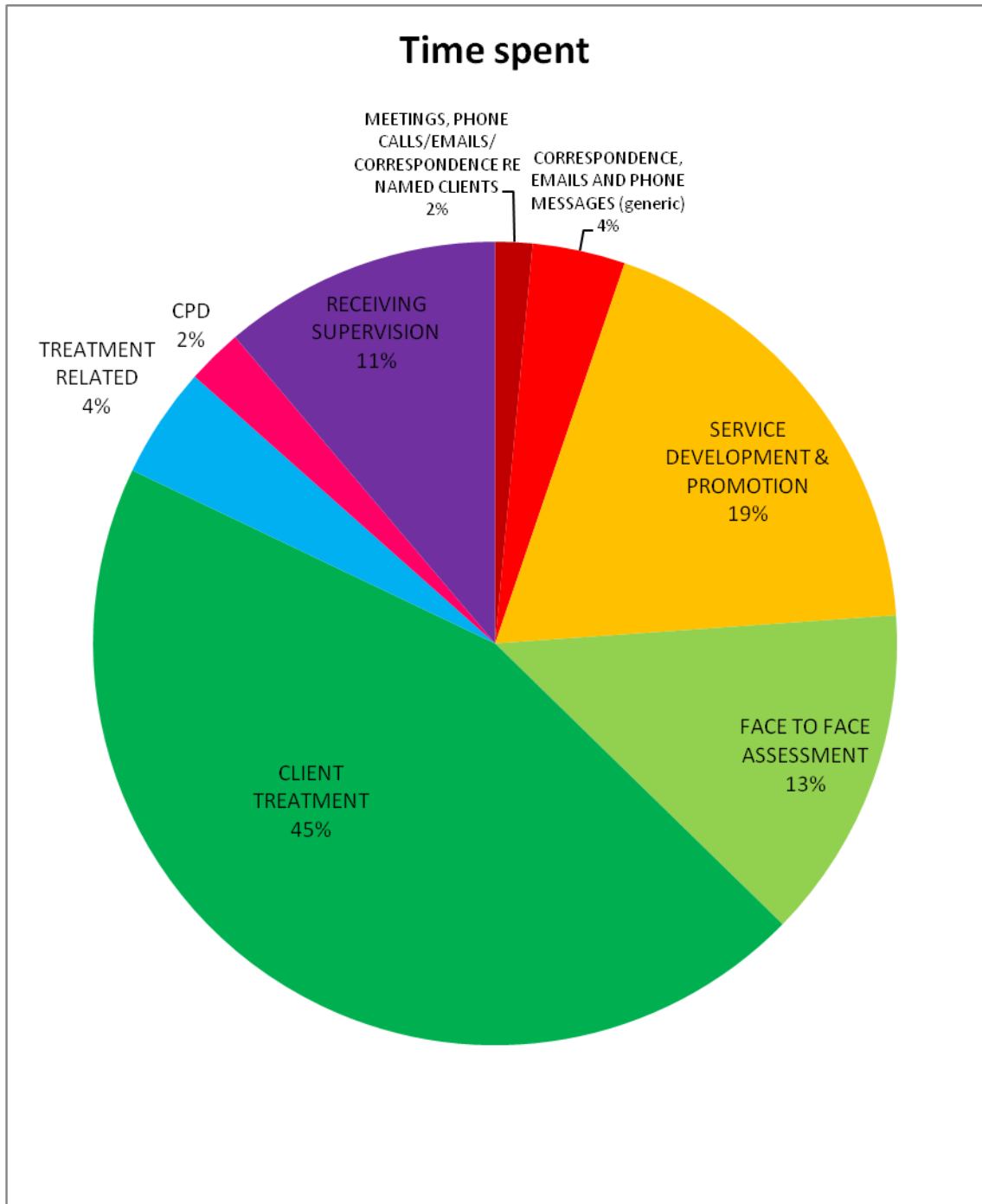
Where treatments are provided, these come from a specialist trauma service which tries to offer evidence based interventions. However, as the NICE guidelines do not provide a clear evidence base for complex trauma, a more flexible, adapted approach is adopted. The first stage is stabilisation while the second phase is trauma focused work comprising either trauma focused CBT or EMDR.

### 7.3.1 *Service parameters*

- **OFFICIAL GEOGRAPHICAL COVERAGE AND POPULATION ESTIMATE**  
*(ie the area contracted or expected to cover)*  
Greater London  
7,512,000 total population
- **ACTUAL GEOGRAPHICAL COVERAGE**  
*(exceptions, out-of- area arrangements one-off cases...)*  
South East of England
- **DATE SERVICE STARTED ACCEPTING REFERRALS**  
January 7th 2008
- **DATE FOR END OF FUNDING**  
January 6th 2010
- **STAFF FUNDED BY CVMHP MONEY (CLINICAL AND NON-CLINICAL)**  
0.4 wte Clinical Psychologist (Band 8B)  
0.1 wte Secretary (band 5)

### 7.4 *Levels of activity*

Figure 7.1 provides a summary estimate of the range of activities of the VT. Client contact, comprising assessment and treatment, comprised 58% of the time while administration related activities accounted for a total of 6% of time. Service development accounted for 19% while a combination of clinical supervision and CPD accounted 13%.

**Figure 7.1: Sample activity chart for therapist – Camden and Islington pilot**

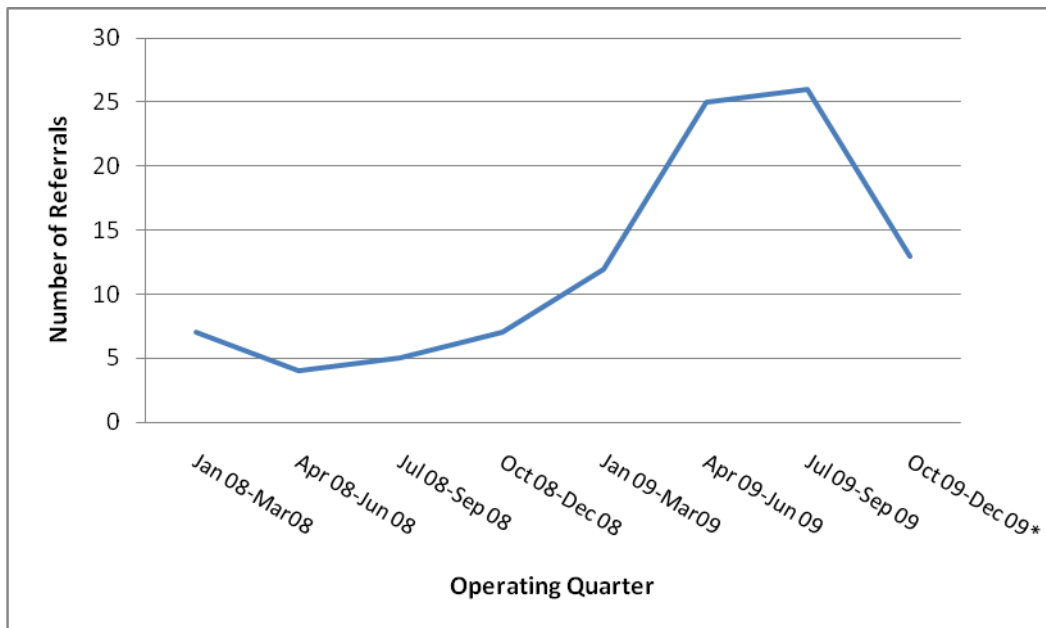
The most frequent clinical presentations seen are PTSD and depression, with alcohol misuse a problem for a smaller number. People who left the service a long time ago seem to have higher alcohol use; those who left more recently report less. There are frequent emotional regulation and interpersonal problems, anger and anxiety issues, also childhood and personality problems, along with some with adjustment disorders.

The service reports high presentations of PTSD, but there have been veterans who have presented with adjustment disorders (depression/alcohol etc), and in these cases veterans

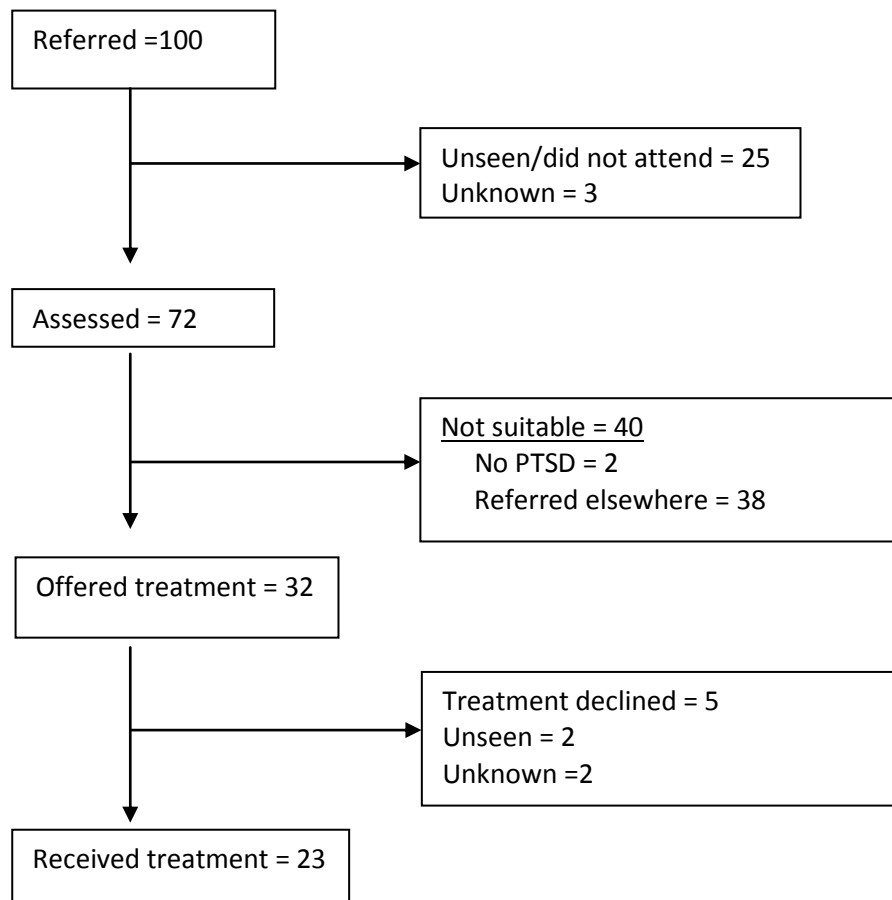
have referred back to local services. The treatment offered is that of a specialist PTSD service; the treatment team only works with people with treatable PTSD. The service would not exclude people with PTSD and other anxiety disorders, or PTSD and substance abuse - over 90% of people seen have other co-morbid conditions in addition to PTSD.

A total of 10% of referrals are from the NHS, 10% Veterans Aid (charity for homeless ex-service people), 30% Combat Stress, 30% SPVA, others self-referrals. The pilot liaises with RBL, Combat Stress, SPVA, MAP, and local NHS services, homeless hostels. NHS referrals are mostly from GPs, very few from secondary care. The service would have anticipated more NHS referrals, and staff believe this is because GPs and secondary care are not sufficiently aware of needs of veterans. GPs are often unaware that their client is a veteran. Combat Stress referrals have increased over time; CS welfare workers refer to the service directly and some veterans who come through have been on Combat Stress residential. It is the service's perception that Combat Stress does not offer the evidence based treatments for PTSD which the pilot service can offer, and that the service sees people with more complex mental health problems who are beyond CS's capacity to work with.

**Figure 7.2: Graph of referral rates from download data, 1/1/08 - 9/12/09, (n=99)**



**Figure 7.3: Flow diagram of referrals to Camden and Islington pilot during MoD funded period**



The evaluation team does not have the information about exactly why clients might have been considered 'not suitable'. However it is likely that the majority of this number were people assessed from outside the CANDI area and therefore referred back to their GP with recommendations for treatment.

## 7.5 Difficulties in implementation

An early obstacle within the pilot (as with many of the others) was having no previous reputation for working with veterans. Accordingly it took time to gain credibility and build networks, along with building trust with veterans as they often have mistrust of NHS services. The service feels these barriers have been overcome as referrals have slowly increased across the life of the pilot.

The geographical spread of 32 PCTs can cause difficulties with access also difficult as the clinic is in central London making driving difficult and a lot of veterans have problems using public transport.

Time was also an issue with four VT sessions a week being spread very thinly across the population compared to the resource available in other pilot areas.

The service does not offer treatments to veterans who do not have PTSD in some form. Also, it does not offer treatment to those outside CANDI if their PCT will not fund the treatment. For such clients the service originally gave veterans a detailed report for them to give to their GP. However a recent audit found that over 50% of veterans for whom local treatment had been recommended had received no treatment a year after referral to the pilot. Such recommendations are now being more assertively followed up in order to try and encourage a more thorough and timely response to recommendations.

## **7.6 Sustainability and future plans**

Camden & Islington made financial arrangements for the project to continue until January 2011. A business case was been put to London NHS commissioners for a service after April 1st 2010 to include up to 2.5 clinical psychologists. This arrangement would have involved the 32 London PCTs in a small investment from each to fund the service but the proposal was not supported by commissioners.

Currently the CANDI Trust is funding the service but apart from NCA funding for treatment of non-CANDI clients there is no funding for the pan-London element of the service. This is unsustainable and local commissioners are again being approached for support.

## **7.7 Quantitative description of cases from data downloads**

Data were provided for 100 clients referred to the Service between 18/12/07-9/12/09 of which 72 were assessed, 32 were offered treatment and 23 received treatment. The mean waiting time between referral and assessment was 7.0 weeks considerably more than Northern Ireland (2.2 weeks).

### **7.7.1 Age**

The mean (SD) age at referral was 47.6 (13.0) years, comparable to existing services but a smaller proportion in Camden & Islington (23.7%) were in the 41-50 age group, compared with Combat Stress and Northern Ireland (35.8% and 50.0% respectively), while more were in the 51-60 age group.

### **7.7.2 Intake severity and outcomes**

No outcome measure data were provided.

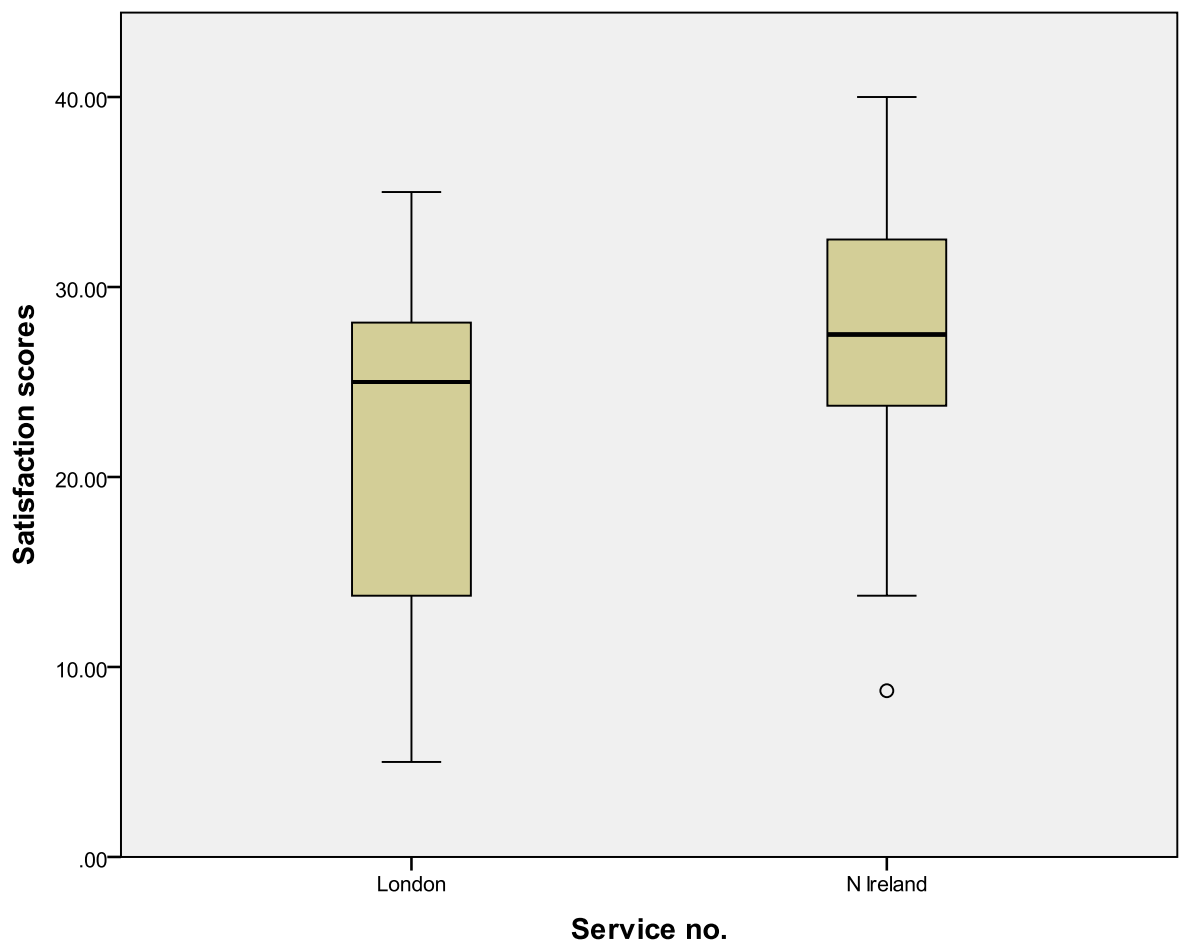
## **7.8 Responses to client questionnaires**

Responses were received from 11 clients from the London pilot, from a total of 110 questionnaires distributed; a response rate of 10%. Table 7.1 briefly summarises characteristics of the sample.

**Table 7.1: Veteran details for questionnaire respondents in Camden and Islington pilot (n= 11)**

Veteran characteristics	N (%)
<i>Gender</i>	
Male	10 (91)
Female	0
No data	1 (9)
<i>Age Group</i>	
18-29	0
30-39	0
40-49	4 (36)
50-59	4 (36)
60-69	3 (27)
70+	0
<i>Service</i>	
Army	8 (73)
RAF	0
RN	0
RM	2 (17)
No data	1 (9)

**Figure 7.4: Box and whisker plot comparing distribution of satisfaction scores from Camden and Islington pilot service with pre-existing Northern Ireland service as a benchmark**



*Note:* The bold horizontal line represents the mean score; the box represents the middle 50% of scores; the whiskers represent the full range of scores with each whisker representing the upper and lower 25% of scores

The median satisfaction score for Camden and Islington was 25 compared to 27.5 for Northern Ireland. However, the box plots reveal a greater spread of scores below the median for Camden and Islington as compared to Northern Ireland and a slightly restricted upper range.

The London pilot was rated as the one offering the least choice of support among the six services.

### **7.8.1 Themes extracted from questionnaire**

The emergent themes were identified as follows:

#### ***Problem of distance to services***

*Example:*

- Long distance to travel

#### ***Need for more sessions/centres/staff***

*Examples:*

- Issue – short-term treatment
- Want specialist long-term treatment
- This pilot should be rolled out UK wide.

#### ***Problem of staff turnover***

*Example:*

- Issue – staff turnover

#### ***Problem of seeing non-forces staff***

*Examples:*

- Veterans have done more than the average civilian can only read or dream about
- Services need to find out about force life

#### ***Need for assessments/treatments/information in and when leaving forces***

*Examples:*

- Not enough relevant info given on leaving forces
- This is only going to get bigger
- Help is needed but like me, some are too proud to admit there's a problem

#### ***Positives of seeing someone with PTSD/services knowledge***

*Examples:*

- I felt for the first time someone actually knew and understood what I was talking about



***Need for better information about services***

*Examples:*

- Need for better education about mental illness

***Positives of therapy 1: positives about services/staff***

*Examples:*

- They were open, friendly and non-judgemental. They had 'an open heart, mind and hand! They were willing to listen to me and my unconventional thought process which bore results. They were not averse to trying different approaches and they had a sense of humour too!
- Totally understood my fears and problems, gave moral and excellent strategies to deal
- I found it excellent

***Positives about therapy 2: Feelings***

*Examples:*

- Gave me hope
- They helped me begin to believe in myself and not accept second best. They gave me the courage to carry on, no longer was I alone

***Negatives about the service***

*Examples:*

- The service did nothing to help me, in fact it set me back by years
- Initial visit- I was told I would need 30 sessions of therapy. However not available in the area I live and they have to apply to my doctor to transfer funds outside area. Still waiting, almost a year now since initial visit

***What I would say to the MoD and NHS***

*Examples:*

- This is real, we are real
- The general NHS treats veterans as: offenders/drug users/alcoholics. They take away our dignity/pride/human rights. They neither know nor are equipped to help, let alone understand veterans
- Help them immediately do NOT let their problems go on and on
- Give them help quicker.

## CHAPTER 8: Community Veterans' Mental Health Project (TEWV)

Tees, Esk & Wear Valleys NHS Foundation Trust

St Aidans House  
2a St Aidans Walk  
Bishop Auckland  
Co Durham  
DL14 6SA

01388 646802

Website: [www.tewv.nhs.uk/veterans](http://www.tewv.nhs.uk/veterans)

### 8.1 Summary pen-picture

The Tees, Esk & Wear Valleys (TEWV) pilot involved the project lead recruiting 150+ veterans' champions from across the Trust's mental health teams. Champions receive familiarisation training in military mental health and lead individual teams' responses when a veteran is referred. The funded pilot service itself, therefore, has a training, network-building function rather than carrying out direct work with veterans. Direct treatment of veterans takes place in the existing mental health teams of the Trust.

### 8.2 Development of service

Once the service funding was awarded the project lead first promoted a vision of the project through the Trust management structure, from the Chief Executive down through general managers to local team managers. He then visited each key team presenting about veterans' needs and recruiting interest from the teams. The teams then put forward workers who would act as veterans' champions and undergo veteran awareness training. This group of people became the veterans' network. TEWV is a large Trust both geographically and in population terms. There are over 60 teams in adult mental health services across the organisation, comprising teams such as adult mental health teams, primary care, and substance misuse. The first wave of recruitment was aimed to have a veterans' champion in most teams. Subsequent second and third waves of recruitment have raised the numbers to approximately 150 across the Trust. The model is for each team to have at least one veterans' champion in it. Some (such as Community Mental Health Teams) will have two or more.

The second phase involved identifying workers who worked in trauma. Their interest was solicited and they attended training in military PTSD. They became the trauma network. Both networks overlap and work within their own teams but pick up veteran referrals whenever they pass through. Currently there are approximately 65 trained members of the network, half in specialist psychological treatment roles and half in general mental health roles (e.g., as a Community Psychiatric Nurse). Training has also been provided to IAPT trainees at Teesside University who go on to work in Trust IAPT services.

#### 8.2.1 Training and role of the veterans' champion

The project lead visits teams to describe the TEWV pilot and in particular to elicit volunteers to act as veterans' champions. Interested clinicians attend a one-day familiarisation training in military issues. The first of these was provided by the Defence Community Mental Health

Team from Catterick Garrison. Subsequent days have been provided by Military Mental Health, a community interest company (social enterprise) founded by two veterans from the north east of England. The aim of the training is to introduce someone without a forces background to forces culture in general, including film clips from combat situations and covering veteran adjustment/transition issues.

### 8.3 Operation of the service

In common with many Trusts, TEWV operates a 'single point of access' (SPA) for all referrals. Referrals come mainly from GPs or veterans' agencies. The service does accept self-referrals and a referral form is publicly available on the World Wide Web. Five SPA teams across the Trust's area take all referrals (including self-referrals) and assess which of the Trust's mental health teams is the appropriate place for the referral to be directed. Where a referral is already flagged up by the referrer as a veteran, the assessment within the SAP team will be carried out by a veterans' champion. Where this is not evident it is planned that all assessors within the SPA team would routinely ask the client whether they are a veteran and whether they think their mental health problems are related to their military service. If a veteran is identified either at referral or assessment, then the SPA assessor will contact the veterans' champion in the team to which the client is being referred on.

Once received by the treatment team from the SPA, the veterans' champion will hold the case and either deliver the care themselves or act as care co-ordinator if other team members' specialist skills are needed. Veterans do not receive treatment for their mental health problems which is fundamentally different to that received by any other client. Veterans are prioritised to the top of referral waiting lists, but treatment otherwise would be the same as for any other client. However, it is delivered by someone who has received the awareness training and can work in a manner sensitive to, and understanding of, forces' culture. Where trauma is the focus of the mental health problems, the actual treatment will likely be undertaken by a member of the trauma network.

The pilot reports that a significant rise in awareness of veterans has been achieved. Those who are not formally part of the project know about the project and occasionally contribute. Those who are offering an interest to work with veterans currently outweigh the means to train them. Additionally, two virtual networks have been built into the infrastructure of the Trust. The existence of the project appears to have been a key part of the Trust's successful application to deliver an IAPT service, and senior managers are said to regard the existence of the veterans' network as an asset to the Trust that has positive knock-on effects in other areas of business.

There has been significant media interest in the project, including the inclusion of the project in Tyne TV's Northern Eye, two BBC Radio Tees interviews and one BBC Newcastle interview on their breakfast shows, a half-page spread in the Northern Echo newspaper, and several smaller newspaper articles.

A significant achievement has been winning the Military and Civilian Health Partnerships Award 2009 caring for veterans category.

### 8.3.1 *Service parameters*

#### **OFFICIAL GEOGRAPHICAL COVERAGE AND POPULATION ESTIMATE**

*(ie the area contracted or expected to cover)*

Durham County, North & South Teesside, North East Yorkshire.

I.e. Chester-le-Street, Durham, Hartlepool, Bishop Auckland, Stockton, Middlesbrough, Darlington, Redcar, Whitby, Scarborough.

Total population 1,238,000

- **ACTUAL GEOGRAPHICAL COVERAGE**

*(exceptions, out-of- area arrangements one-off cases...)*

Same

- **DATE SERVICE STARTED ACCEPTING REFERRALS**

The service has always accepted veteran referrals as a part of the civilian population it serves. However, the formal service launch was 2<sup>nd</sup> July 09.

- **END OF FUNDING**

7<sup>th</sup> January 2010

- **STAFF FUNDED BY CVMHP MONEY (CLINICAL AND NON-CLINICAL)**

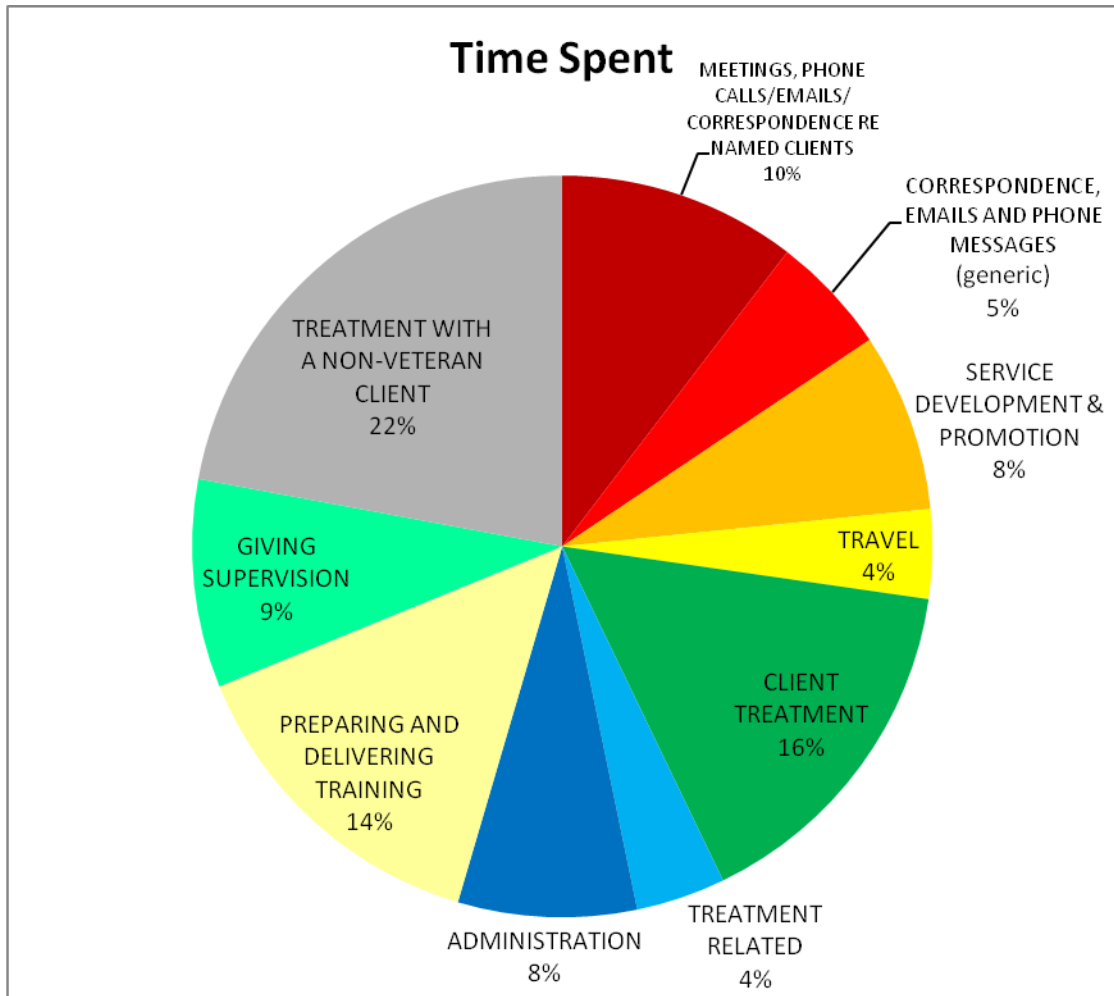
0.6 wte Band 8c post

- **OTHER STAFF CONTRIBUTING TO WORK OF PILOT**

Approx 150 clinical staff distributed around the Trust, and their managers. This is organised into a virtual “network” which is in constant flux as people move from post to post or join/leave.

### 8.4 *Levels of activity*

Figure 8.1 provides a summary estimate of the range of activities of the VT. Client contact, comprising treatment and treatment-related activities comprised 42% of the time although this included non-veteran contact time. Administrative related work accounted for 23% of time while a combination of training preparation and supervision also accounted for 23% of time. Service development accounted for 8% of time.

**Figure 8.1: Sample activity chart for therapist – Tees, Esk and Wear Valleys pilot**

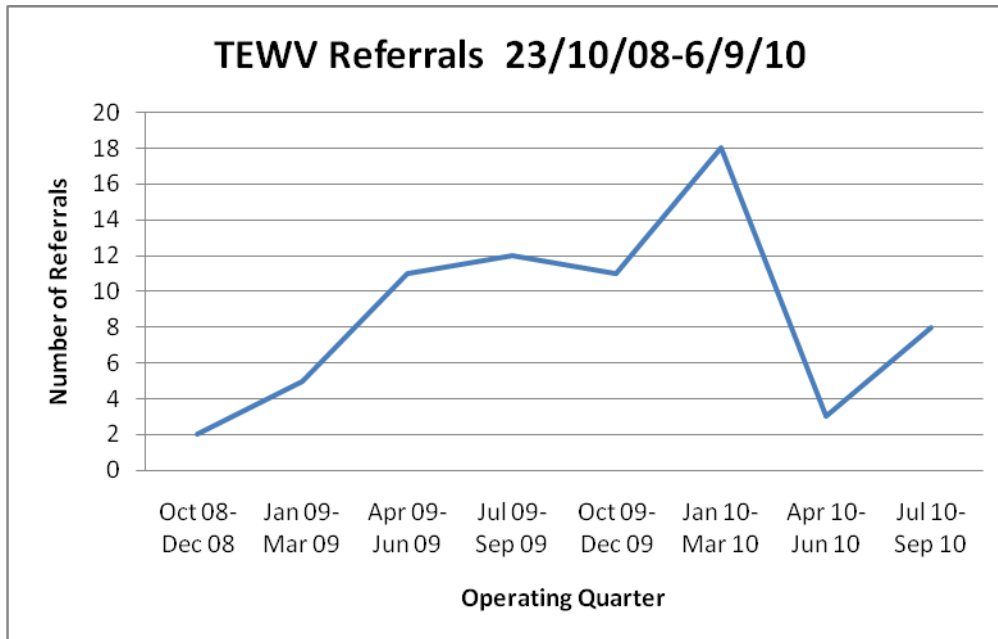
It is harder with the TEWV model than with any of the other pilots to be certain of the numbers of veterans seen. The disseminated nature of the work, with clinical interventions being undertaken by front line teams rather than a separate veterans' service, makes information gathering difficult. This has been further hampered by Trust IT systems, which up until recently had no means of centrally recording whether a client was a veteran, even when this was known to the clinician making the assessment. This has now changed and if assessors do reliably ask about veteran status, and then record the answers accurately, it will be possible to assess the numbers of veterans being seen.

Furthermore, Trust central IT systems do not presently allow for outcome measures to be recorded and compared across time, so that although veterans may be identifiable in future, at present their progress cannot be monitored as a group. Trust IT services for IAPT do allow for recording of repeated measures, but have no data field for identifying veterans! Thus one system can identify veterans but prohibits monitoring of change; the other allows monitoring but cannot identify veterans as a subgroup.

With these caveats, referrals to TEWV are reported to be at the rate of approximately 10-12 veterans per quarter, or up to 50 a year, a rate supported in the year April 2009 to end of

March 2010 in the downloaded data. (see Figure 8.2). However, other than referral date, no other data was available to plot client flow.

**Figure 8.2: Quarterly referrals from download data (n=70)**



### 8.5 Difficulties in implementation

With the project lead working single-handed it took time to work across the Trust's geographical and service structure. In recent years the structure of all NHS Trusts has been subject to constant change and TEWV was no exception; this meant that in some cases Trust reorganisation undid some of the veterans' networks which had been set up, requiring this work to be revisited.

Additionally, there is one locality of the Trust's work where a separate NHS provider is responsible for primary care mental health work (TEWV is responsible for both primary and secondary care throughout the rest of its area.) This means that at present veterans in that locality who present to primary mental health services will not be seen by a TEWV veterans' champion unless they are ultimately referred on to secondary services. This is a clear inconsistency across the Trust's area and is an artefact of NHS commissioning arrangements rather than being a response driven by client needs.

The size of the Trust's area and the number of teams and managers has meant that uniformity of delivery and activity across the entire Trust area has not been easy to achieve. Some teams and managers value their independence highly and it has not always been possible to implement developments evenly across the Trust.

### 8.6 Sustainability and future plans

There is a degree of in-built sustainability in this system because, even if the central training and networking function were to stop, there would be no immediate change in referral and treatment arrangements for veterans. That is, the networks would still exist and function. However like all new NHS treatment initiatives, this is a system that would decay over the

longer term as people change jobs and new staff join. Continual input of refresher and top-up training will be required.

At present the veterans' network and trauma network have no existence beyond a list of names and contact details. Further training, meeting, skill sharing, and supervision would be possible but only by drawing people 'out of the line' for a period, however short. It is planned that the Trust will work towards a tiered model where generic team members stabilise clients and then trauma workers are able to deliver treatment. Both of these developments would require input from the project lead and commitment from the Trust.

The funding for the three days per week project lead came to an end in January 2010 but was then picked up for two days per week by the Trust. The same person works for the rest of the week in a specialist role in trauma for the Trust.

In future it is hoped to provide the one-day familiarisation training in-house. While the existing arrangement with an external provider has worked reasonably well, staff feedback has been that the best of all solutions would be to use trainers who are familiar both with forces culture and also with the realities of NHS work in the current climate. The present training has provided the former but not always the latter.

## **8.7 Quantitative description of cases from data downloads**

Data were available on 70 clients referred between May 2008 and September 2010. No waiting time data were available. A slightly higher proportion of females were referred than existing services (4.3% compared with 2.0% for Combat Stress and 3.7% for Northern Ireland) and the mean (SD) age was younger, 38.2 (10.86) compared with 44.0 (10.31) and 47.3 (9.84). TEWV had a greater proportion of referrals under 40 and a smaller proportion over 40 than existing services.

### **8.7.1 Intake severity and outcomes**

No outcome measure data were provided.

## 8.8 Responses to client questionnaires

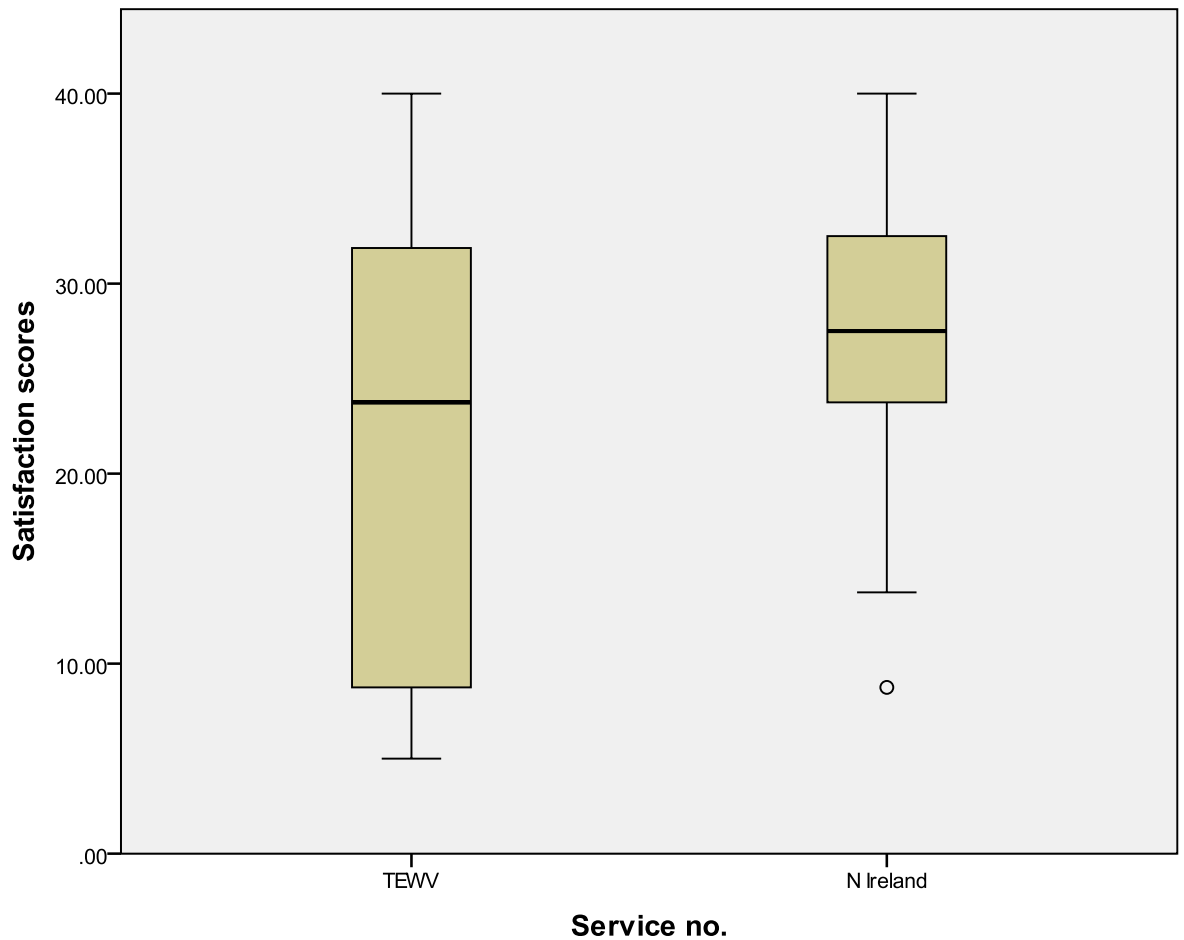
Responses were received from 13 clients from TEWV, from a total of 70 questionnaires distributed, a response rate of 18.6%. Table 8.1 briefly summarises characteristics of the sample.

**Table 8.1: Veteran details for questionnaire respondents in Tees, Esk and Wear Valley pilot (n=13)**

<b>Veteran characteristics</b>	<b>N (%)</b>
<i>Gender</i>	
Male	12 (92)
Female	1 (8)
<i>Age Group</i>	
18-29	0
30-39	3 (23)
40-49	1 (8)
50-59	5 (39)
60-69	1 (8)
70+	2 (15)
No data	1 (8)
<i>Service</i>	
Army	9 (69)
RAF	1 (8)
RN	2 (15)
RM	0
Army & RAF	1 (8)



**Figure 8.3: Box and whisker plot comparing distribution of satisfaction scores from Tees, Esk & Wear Valleys pilot service with pre-existing Northern Ireland service as a benchmark**



*Note:* The bold horizontal line represents the mean score; the box represents the middle 50% of scores; the whiskers represent the full range of scores with each whisker representing the upper and lower 25% of scores

The median satisfaction score for TEWV was 23.8 compared to 27.5 for Northern Ireland. However, the box plots reveal a considerably greater spread of scores below the median for TEWV as compared to Northern Ireland and a restricted upper range.

The TEWV pilot was rated as the lowest of the six in terms of clinicians' perceived familiarity of Forces culture and experience.

### **8.8.1 Themes emerging from questionnaires**

The emergent themes were identified as follows:

#### ***Problem of distance to services***

*Examples:*

- Long way to travel, need more centres

***Need for more sessions/centres/staff***

*Examples:*

- Need more frequent meetings
- Long waiting times
- More counsellors and more sessions. Then seeing a nurse afterwards to keep the treatment ongoing

***Problem of seeing non-forces staff***

*Examples:*

- They had no clue about the armed forces
- NHS need help to train staff – forces are from a different planet to civilians
- Problem understanding the military/tours/PTSD, army. You must have been there to understand. PERIOD
- Sat, listened, talked, advised. Did not understand, all above is good but we need to be understood. Again, if you have not been there you will not know
- The service needs ex soldiers to treat soldiers, that's it. A soldier can and will relax with a soldier as they have both seen the same crap and shared the same time. That is a key factor to what this service needs

***Need for assessments/treatments/information in and when leaving forces***

*Examples:*

- Need to see people just as they leave the forces
- MoD need to be more aware of mental health problems and deal with them earlier
- Help ex-service personnel before things get so bad

***Need to let client set the pace of therapy***

*Examples:*

- Let client set the pace

***Positives of therapy 1: positives about services/staff***

*Examples:*

- Service was exceptional
- They wanted to help me
- I found it all very helpful
- It helped me to be able to talk to somebody about my problems in confidence without being mocked or made to feel I was mad

***Positives about therapy 2: Feelings***

*Examples:*

- Made me feel good again about me
- Immediately afterwards I felt a huge weight had been lifted but only temporarily. It was a welcome start
- Thanks to the help I was given I am a different person now
- Helped me understand the nature of my illness- gave me coping strategies

***How services could be further developed to help more***

*Examples:*

- Make direct contact available to veterans don't have to go through GPs

***Negatives about the service***

*Examples:*

- Service needs to stop patronising
- Very poor service all round
- Nothing was done too well

***What I would say to the MoD and NHS***

*Examples:*

- Do something practical to meet up with the words
- Help mental health as well as physical injuries
- Personally I would of got a lot more help if I had lost a limb rather than my mind
- Listen to what is said to you, help with housing, transport to appointments, do not judge people because they have a problem, give people as much support as you can
- Listen to ex-service personnel and to offer more help and support. They also need more financial help, not less
- I am keen to support this service. I would be willing to learn how to guide soldiers through these troubled times, get a degree and become part of the team. I have nearly 20 years of tours in Bosnia, Afghan, Iraq, Kosovo, Africa, this is the link this system needs to work. I as an ex soldier can talk the same language as soldiers. A connection is the hardest part of talking and the first step is also a tough move to make. Feel free to call me any time

***Positives of speaking to someone outside forces/outside NHS***

*Examples:*

- I personally felt better not speaking to anyone from the armed forces but a civilian, as it was easier to speak to them on level terms

## CHAPTER 9: Cornwall Countywide Community Veterans' Mental Health Service

Cornwall Partnership NHS Trust

Trevillis House  
Lodge Hill  
LISKEARD  
Cornwall  
PL14 4NE

01579 335260

### 9.1 Summary pen-picture

The service comprises one Veteran's Therapist (VT) working four days per week across the whole of Cornwall. Veterans are assessed and the VT may act as care co-ordinator of treatment provided by other Trust teams, or provide the therapy directly. A particular feature of the service is the group therapy provided, both for veterans and also for carers. There is close liaison and joint working with the Combat Stress personnel.

### 9.2 Development of service

The veterans' therapist (VT) entered post August 2008 but was able to start planning before taking up the post. The service was set up by the VT to a specification agreed between the Primary Care Trust and the MoD. A steering group was formed including a therapist from Combat Stress, Trust line manager, project sponsor (consultant psychiatrist), town councillor with an interest in veterans' affairs, Trust CPN, service user veteran, Veterans Agency, British Legion. Strong links were initially established with the DCMH team at HMS Drake (HM Naval Base Devonport), spending time in their team meetings. Meetings were held with veterans to see what they felt was missing and would be helpful in a new service. One outcome from these meetings was the group work that formed a key feature of the pilot's work. Working independently, the VT produced advertising and posters, which were subsequently revamped with help from the Trust communications department. The press and local BBC were involved, and meetings held with local GPs, CMHTs, voluntary and statutory agencies. It was a major task to get the message out that the service was being commissioned. This phase took up most of time for the first 4-6 weeks.

An integrated model was always planned with the pilot originally to be based in St Austell. However this location is not central, or convenient. Although now based in Liskeard, the rural nature of the area had to be considered. Accordingly, treatments are taken to the veterans, within reason. The VT 'hot desks' in different parts of the County on different days, using mainly CMHT or GP bases. The VT will visit homes if appropriate and after completing the necessary risk assessments for such visits. This is mainly for anyone not being able to travel or has a problem using mental health bases.

### 9.3 Operation of the service

The service comprises one 0.8 wte (4 days per week) Veterans' Therapist employed at NHS Band 7. Input from other teams and individuals in the Trust are by agreement from existing services (e.g., by negotiation with CMHT managers). Interested individuals from within the Trust occasionally contribute their time. While this is not a sustainable solution, it helped with the start-up. This was particularly important to get groups going – from a health and safety/lone working viewpoint, when it is useful to have second group worker available (e.g., if a group member becomes upset and needs to leave group). There is no dedicated administration support to the VT, although the advent of electronic record keeping in the Trust since August 2010 has made the situation easier.

Once a referral is received by the VT, the veteran is contacted within two weeks to arrange a convenient time/location for assessment/screening by the VT. Referrals can be made directly to the service by telephone, fax, email, or letter. The VT will make a decision about where the case is best handled - which might be to remain in primary mental health services. The VT takes on secondary care cases as a care co-ordinator if they can be managed solo, but in a complex case needing more input a CMHT might take on the co-ordination while the VT provides some specific treatment.

Following an assessment, if specialist services are required, an agreed therapeutic plan will be developed with the veteran. If the veteran meets the criteria for secondary services, the VT will offer therapy if there is space on the small caseload. If not, the VT will signpost to the CMHT or other specialist secondary care. If the veteran does not meet the secondary care criteria, but requires treatment, the VT will refer to primary care counselling if necessary, or other veteran support organisations, or general support organisations.

Once therapy is completed, a long-term group is available. If the veteran does not attend the group, the VT will contact them after 2-3 months by telephone. If they need follow up in practical areas, then Return to Work or the British Legion (BL) may become involved. The BL welfare officer visits annually. Clients will be given contact numbers and website details at discharge and after discharge they can, of course, re-refer themselves.

#### 9.3.1 Treatment groups

A particular feature of the Cornwall model is the groups that are offered. These were initially called Post Traumatic Support Groups – but this name is now felt to have been misleading as it presupposes a trauma focus that is not necessarily always applicable. The groups are now called Service Veterans Treatment and Education Groups. The groups are CBT based, covering depression, anxiety, trauma, anger management, and other topics as raised by the group. At present the groups are open, rolling groups – that is, people may join at any time and stay for as long as they wish. This model is welcoming and open and puts people at ease because newcomers can be eased in by those who have been attending longer. However, with this model often the same people come each time and the group can develop a social focus.

The group is a valuable resource for those who have been through a period of 1:1 treatment. It provides a supportive setting to move them on to at the end of individual treatment rather than facing an abrupt discharge.

It is felt that closed, fixed term groups might have focused from the start on problems and interventions. From the VT's point of view, there may be a group who are treatment focused and want to move on, but there are others whom the open groups model may simply maintain in their status quo. The intention is to start some closed groups with Combat Stress for anger management - closed, focused groups running for a maximum of 8 weeks.

The VT is able to provide some support and sign posting for carers. There have been 3 carers' days run by the pilot so far, each of which has resulted in some referrals of veterans to the pilot.

### 9.3.2 *Links with Combat Stress*

While several pilots have overlapping caseloads with Combat Stress, none reported the same level of close working as Cornwall. This is therefore more fully described here than for other services. At present about half of the pilot's clients are also on the books of Combat Stress (CS), a proportion that has increased since the start of the service. During initial meetings with veterans they said they felt everyone was working separately, and felt they were being 'assessed to death'. The VT therefore met with the regional CS therapist and agreed where possible to assess together. When a new referral comes in to the VT and it is clear that CS were involved, a joint assessment would be arranged. Equally, some referrals come direct from CS, either from the regional therapist or Welfare Officer (WO). The latter is not clinically trained so is not always able to assess suitability for groups.

There seems to be a differential policy between CS and the pilot with regard to referrals and discharges. Some veterans may be on the CS books and go for residential periods at Tyrwhitt House in Leatherhead, remaining on the CS caseload more or less permanently. They might be referred to the pilot treatment group and may be discharged from the pilot after that but might carry on going to CS three times a year even if that was not strictly indicated.

A second difference between the perspective of the pilot and of CS relates to the diagnosis of PTSD. It appears that most clients referred from CS will describe their problem in terms of this disorder, when this would not always be the view taken by NHS staff. NHS treatment might be more focused on addictions, anxiety management or anger management, but clients can be reluctant to move away from seeing problems through the PTSD 'filter', once it is in place.

### 9.3.3 *Service parameters*

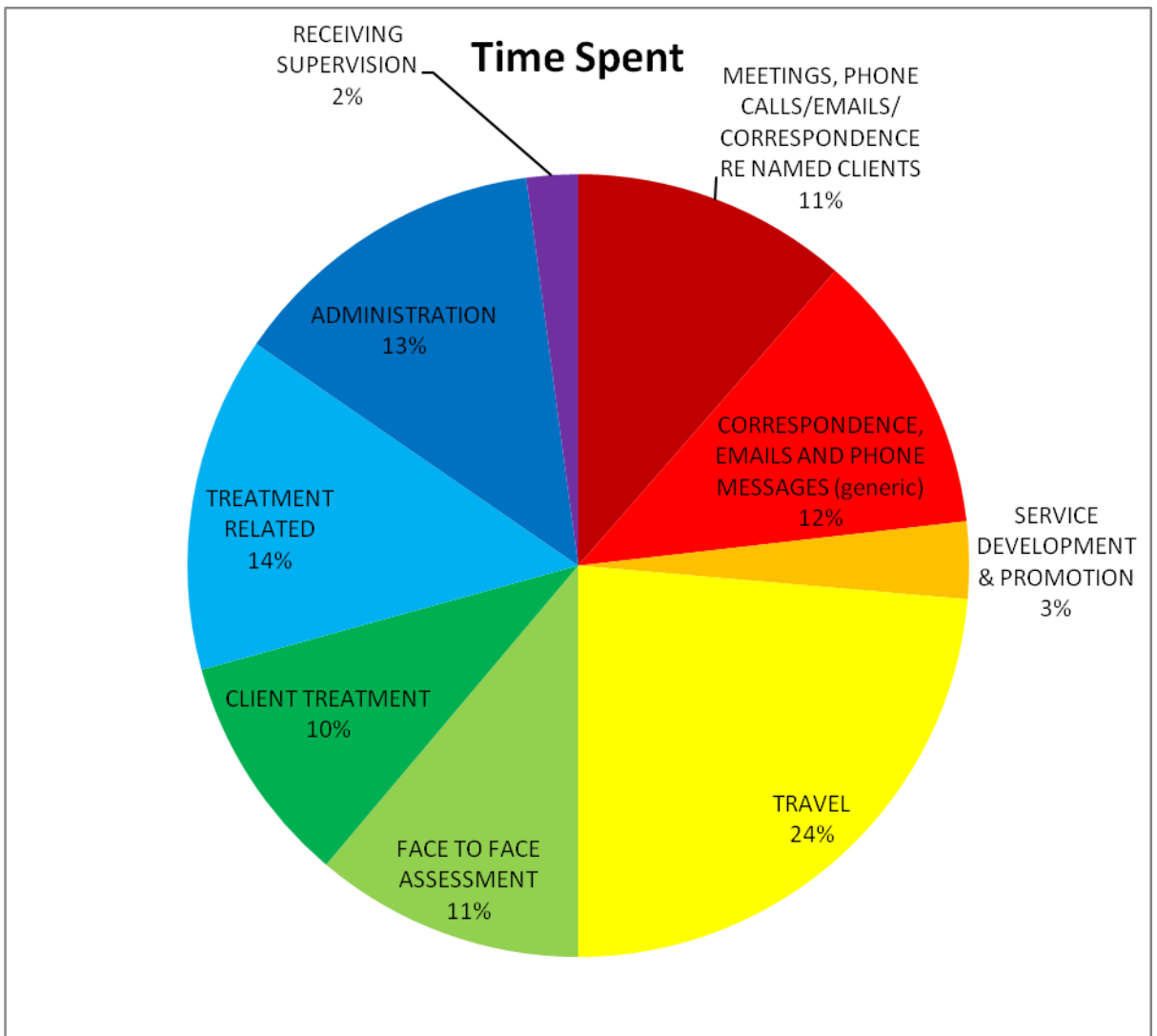
- **OFFICIAL GEOGRAPHICAL COVERAGE AND POPULATION ESTIMATE**  
(*ie the area contracted or expected to cover*)  
Cornwall and Isles of Scilly  
Total population 530,000
- **ACTUAL GEOGRAPHICAL COVERAGE**  
(*exceptions, out-of- area arrangements one-off cases...*)  
Same

- **DATE SERVICE STARTED ACCEPTING REFERRALS**  
31/08/08
- **END OF FUNDING**  
August 2010
- **STAFF FUNDED BY CVMHP MONEY (CLINICAL AND NON-CLINICAL)**  
Community Mental Health Veterans' Therapist; Part-Time 30hrs per week , Band 7.

**9.4 Levels of activity**

Figure 9.1 provides a summary estimate of the range of activities of the VT. Assessment and treatment related activities account for 35% of time with administrative related activities accounting for a further 36% of time. Travel made up 24% of time with service development and supervision accounting for 3% and 2% respectively.

**Figure 8.1: Sample activity chart for therapist – Cornwall pilot**



Initially the biggest single source of referrals was CS (22%), with primary care and self-referrals together making a further 30%. Now self and carer referrals have gone up – word of

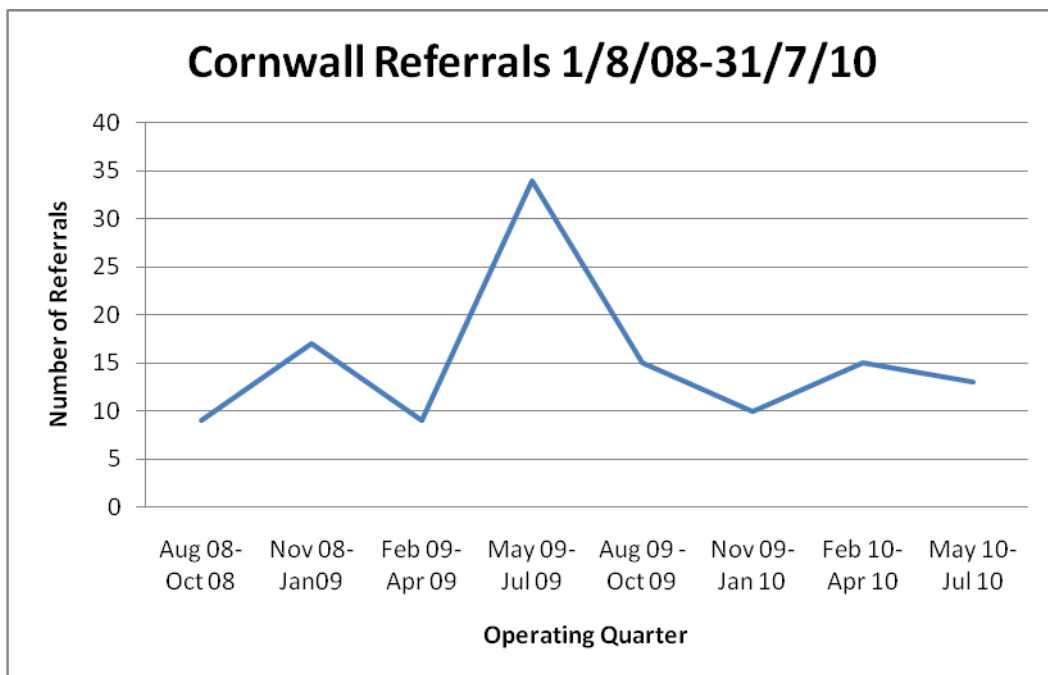
mouth and carers support groups have influenced this. CMHT and secondary care NHS referrals amount to about 15% of the total.

Like the other pilots, referrals of ex-Army personnel predominate. However the pilot sees a higher proportion of ex-Navy personnel than other pilots - probably because of the recruiting patterns locally and the proximity of HMNB Devonport nearby and of other Navy facilities in the county.

The Falklands, Northern Ireland and first Gulf War are the theatres of operations most commonly cited by veterans. Many will arrive with diagnoses of PTSD which may sometimes be accurate, but at other times problems are better described as adjustment difficulties, addiction, relationship problems in civilian life, depression and anxiety (maybe alcohol linked). With all those things anger is potentially a complicating factor.

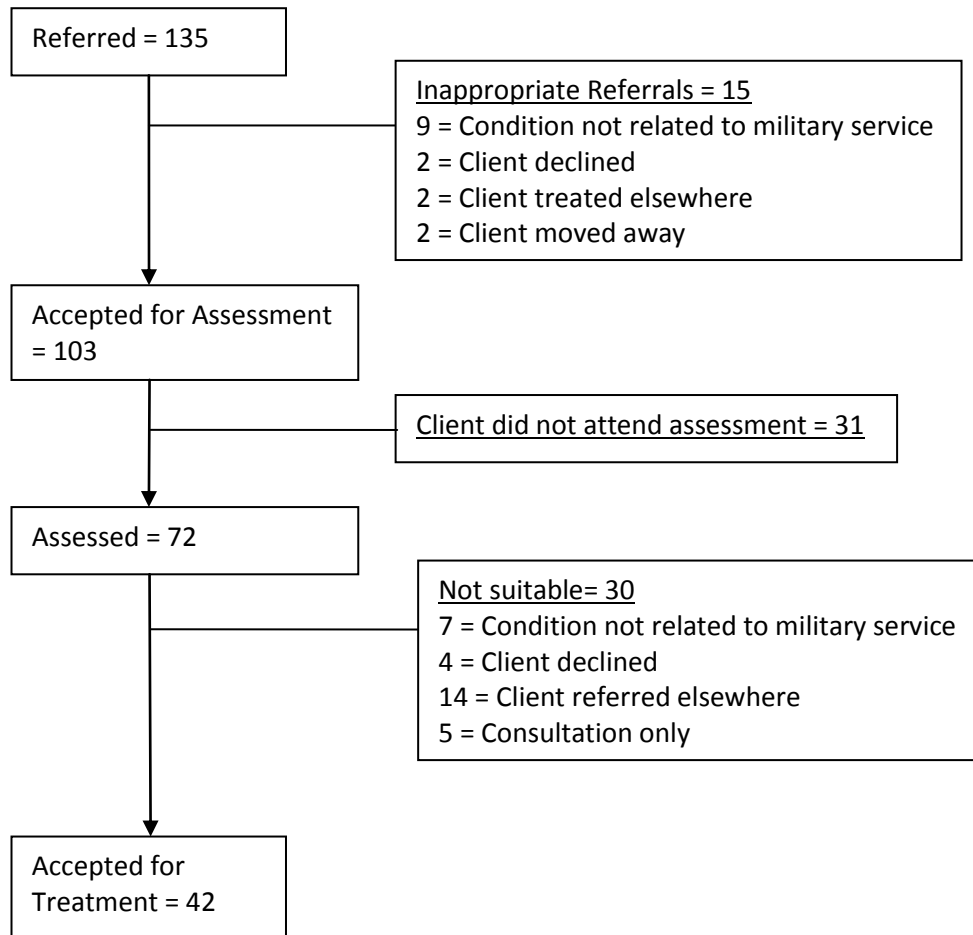
The service data provided suggests referral rate is approximately 60 per year. Referrals for a two-year period (1/8/08 – 31/7/10) by operating quarter are shown in Figure 9.2. The rates of referrals appear fairly consistent apart from a sharp rise in the period May – July 2009.

**Figure 9.2: Quarterly referral rates from download data (n=122)**



The Service provided referral data for 25 months (1/8/08 – 31/8/10), a total of 135 clients. The flow of these through the referral process to the receipt of treatment is shown in Figure 9.3.



**Figure 9.3: Flow chart of referral through put – Cornwall service**

### 9.5 Quantitative description of cases from data downloads

The service provided data on 135 clients referred between 1/8/08 and 31/8/10. There are fuller descriptions of the Cornwall caseload than for most of the other pilots because more data were collected and forwarded by the service.

The mean (SD) waiting time between referral and assessment for Cornwall was 2.8 (2.6) weeks, compared to 2.3 (2.2) weeks in Northern Ireland. Of the 72 clients assessed, 25% were seen within a week, 45.8% within 2 weeks and 15.2% waited longer than a month. For Northern Ireland the figures were as follows; 24.1% 55.6% and 7.4%. Other key differences between Cornwall referrals and clients referred to Combat Stress and Northern Ireland are considered below.

**Table 9.1: Referral Source**

		Cornwall	Combat Stress	Northern Ireland
	N	132	396	51
Referral source	Self	29 (22.0)	199 (50.1)	n/a
	GP	16 (12.1)	10 (2.5)	n/a
	Combat Stress	27 (20.5)	n/a	n/a
	MH Services	25 (18.9)	4 (1.0)	n/a
	British Legion/Regt. Assoc./Welfare Orgs.	14 (10.6)	91 (22.9)	51 (100.0)
	Partner/relative/friend	4 (3.0)	43 (10.8)	n/a
	Other	17 (12.9)	49 (12.3)	n/a

Strictly exclusive comparisons are not possible, in part due to cross-over between Cornwall and Combat Stress, but these figures indicate a smaller proportion of self-referrals and more GP and MH Service referrals in Cornwall compared with Combat Stress.

In 42 (31%) cases, other NHS, Non-statutory and military services and organisations involved in concurrent treatment were indicated and the figures show that multiple services were often utilised

**Table 9.2: Use of other Services concurrent with treatment by the Cornwall Service**

		Cornwall
	n	42
NHS Services	CMHT	7 (16.7)
	Psychiatrist	4 (9.5)
	Addiction Service	2 (4.8)
	Primary Care	15 (35.7)
	Physical	6 (14.3)
	Other	2 (4.8)
Forces Services	Regt/Corps Assoc.	2 (4.8)
	Royal British Legion	19 (45.2)
	Combat Stress	20 (47.6)
	SSAFA	8 (19.1)
	Veterans Agency	15 (35.7)
Non-Statutory Services	Housing Services	5 (11.9)
	Other	2 (4.8)

Twenty two (52.4%) of clients also had involvement from other NHS services, 25 (59.5%) had involvement from forces services while 5 (11.9%) had involvement from non-statutory services.

Eleven (26.2%) used only the Cornwall service while 16 (38.1%) used a combination of NHS services, forces services and non-statutory services. 9 (21.4%) used forces services only, while 6 (14.3%) used additional NHS services only.

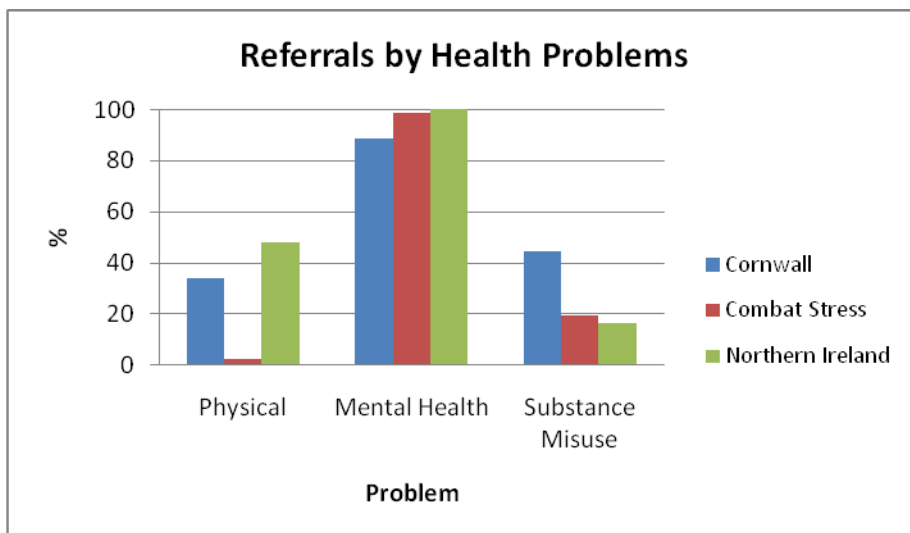
### 9.5.1 Age

For Cornwall, the mean age of referrals at 47.4 (SD = 12.5) years of age was similar to that of Northern Ireland (M = 47.3; SD = 9.84) and slightly higher than Combat Stress (M = 44.0; SD = 10.31). However, Northern Ireland had a greater proportion in the 41-50 age group (50% compared with 28.5%) and smaller proportions under 40 and between 51-60.

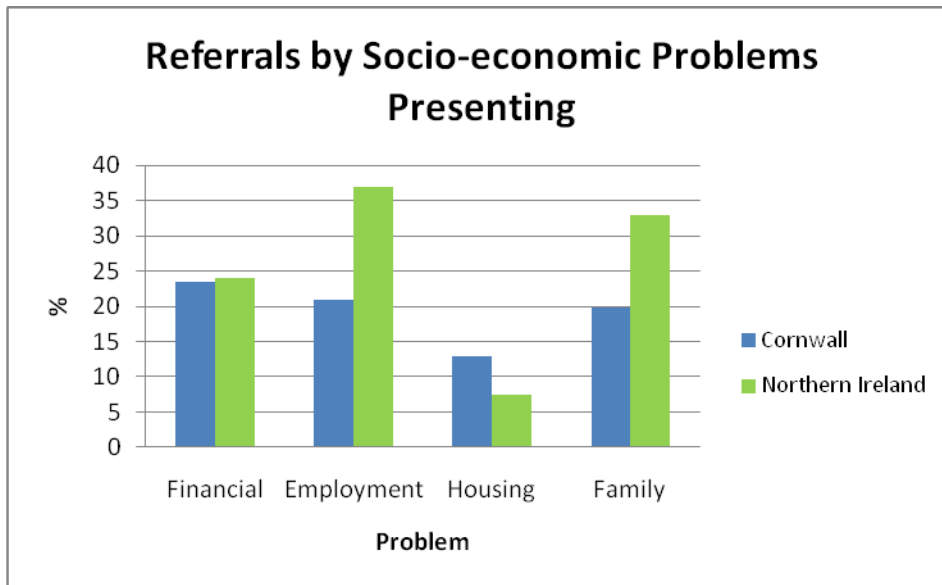
### 9.5.2 Problems presenting to service

Cornwall clients reported a larger proportion of substance misuse problems than those from N Ireland and CS while N Ireland and Cornwall clients reported more physical problems although the CS data for the latter may be unreliable. (see Fig 9.4 below).

**Figure 9.4: Referrals by health problems – Cornwall, Northern Ireland and Combat Stress**



Cornwall clients reported a larger proportion of housing problems than those from N Ireland. But employment and family problems were reported much less often by Cornwall clients and the proportions were similar for financial problems.

**Figure 9.5: Referrals by social problems – Cornwall and Northern Ireland Services**

#### 9.5.4 Severity of referrals at assessment

In Table 9.3 and Fig 9.6, intake scores on the different symptom measures and (to make better comparisons) clinical groupings for the measure (non-clinical/minimal, mild – moderate and severe) were compared across Cornwall, Combat Stress and N Ireland. The data indicates that in Cornwall a greater proportion of patients scored ‘non clinical/minimal’, and fewer ‘severe’ than in the pre-existing services, particularly at referral, although those who ‘received’ treatment in Cornwall (a closer comparison to the N Ireland data) tended to be the more ‘mild-moderate/severe’ patients.

Table 9.3 below indicates the grouping (into minimal, mild to moderate, and severe categories) of cases from Cornwall, Combat Stress and N Ireland. Cornwall clients appeared to have slightly less severe symptoms than those in the pre-existing services.

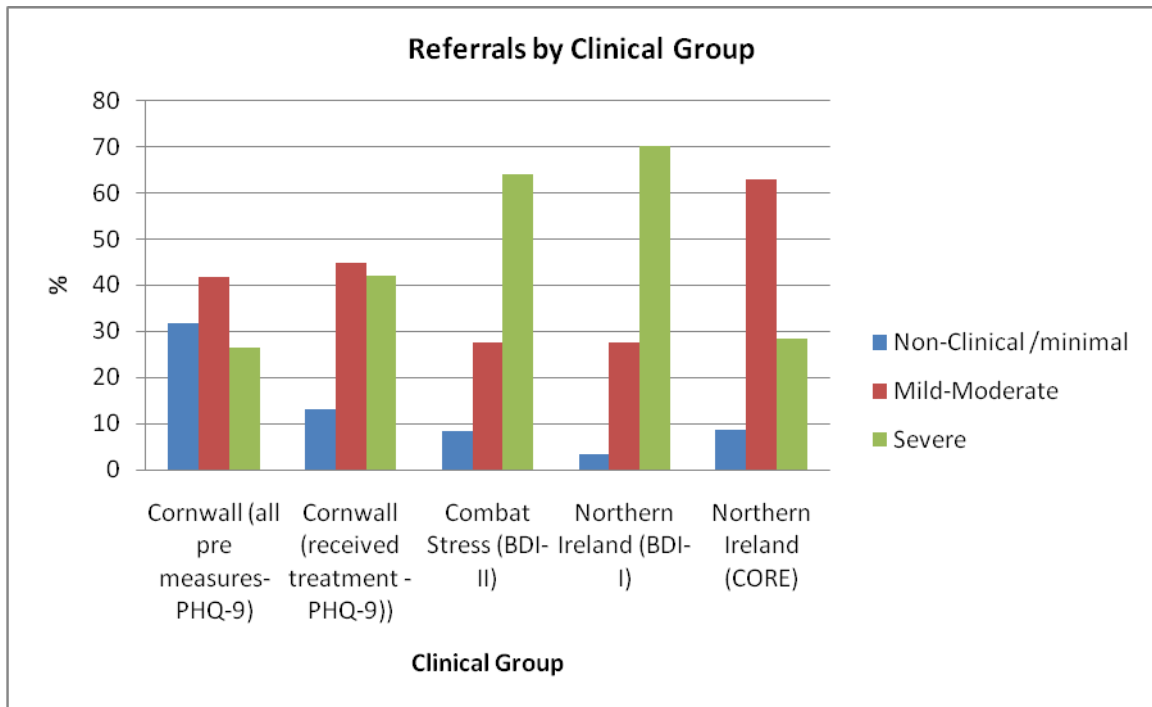
**Table 9.3: Intake scores and clinical groupings for Cornwall, Combat Stress and N Ireland**

	Cornwall (all Pre measures)	Cornwall (Assigned to receive treatment)	Combat Stress	Northern Ireland**	
Measure	PHQ-9	PHQ-9	BDI-II	BDI-I	CORE-OM
N	72	38	396	29	46
Mean	13.9	16.9	32.2	33.8	20.9
(SD)	(6.67)	(5.52)	(12.45)	(12.18)	(6.34)
Clinical groups*N(%)					
Non-clinical/minimal	23 (31.9)	5 (13.2)	33 (8.3)	1 (3.4)	4 (8.7)
Mild-Moderate	30 (41.7)	17 (44.7)	109 (27.5)	8 (27.6)	29 (63.0)
Severe	19 (26.4)	16 (42.1)	254 (64.1)	20 (70.0)	13 (28.3)

Note\* PHQ-9: NC=0-9, MM=10-19, S=20-27; BDI-II: NC=0-13, MM=14-28, S=29-63;  
BDI-I: NC=0-9, MM=10-29, S=30-63; CORE-OM: NC=0-9, MM=10-24, S=25-40

Note: In N Ireland 28 clients completed both a BDI-1 and a CORE measure pre treatment. For these the means (SD) for BDI-I and CORE-OM respectively were 33.1 (11.82) and 21.6 (5.94). For the BDI-I, NC, MM and S percentages were 3.6, 28.6 and 67.9 respectively while for the CORE-OM they were 7.1, 60.7 and 32.1 respectively.

**Figure 9.6: Referrals by clinical groupings – Cornwall, Combat Stress, & Northern Ireland services**



With regard to WSAS scores at intake, the patients in Cornwall score more severely than in Northern Ireland (Table 9.4).

**Table 9.4: Intake scores and clinical groupings on the Work and Social Adjustment Scale for Cornwall and Northern Ireland**

	Cornwall	Cornwall (Received Treatment)	Northern Ireland
	N = 72	N = 38	N = 20
WSAS Mean (SD)	26.6 (9.20)	30.1 (8.11)	22.6 (11.59)
<b>WSAS Clinical groups n(%)</b>			
WSAS-Sub-Clinical (0-9)	3 (4.2)	1 (2.6)	3 (15.0)
WSAS-Sig. Functional impairment, less severe symptoms (10-20)	18 (25.0)	4 (10.5)	5 (25.0)
WSAS-Mod/sev or worse psychopathology (>20)	51 (70.8)	33 (86.8)	12 (60.0)

### 9.5.5 Outcomes

Post-treatment measures were completed for 18 clients allowing some estimate of the effect of treatment effect together with comparisons with data from the Northern Ireland service.

**Table 9.5: Intake scores and clinical groupings based on PHQ-9 and CORE-OM outcome Measures for Cornwall and Northern Ireland**

	Cornwall		Northern Ireland		Northern Ireland	
	PHQ-9 (n=18)		BDI-1 (n=19)		CORE-OM (n=26)	
	Pre	Post	Pre	Post	Pre	Post
Mean	17.1	4.6	34.7	14.68	22.0	10.9
(SD)	(5.63)	(2.64)	(12.02)	(13.50)	(6.14)	(7.82)
Clinical groups*N(%)						
Non-clinical/minimal	2 (11.1)	17 (94.4)	0	8 (42.1)	2 (7.7)	15 (57.7)
Mild-Moderate	10 (55.6)	1 (5.6)	5 (26.3)	8 (42.1)	15 (57.7)	9 (34.6)
Severe	6 (33.3)	0	14 (73.7)	3 (15.8)	9 (34.6)	2 (7.7)

\* PHQ-9: NC=0-9, MM=10-19, S=20-27; BDI-I: NC=0-9, MM=10-29, S=30-63  
CORE: NC=0-9, MM=10-24, S=25-40

In Cornwall, of the 16 clients meeting a threshold for caseness (a PHQ-9 score >9) at pre-treatment, 15 (93.8%) scored below the caseness cut-off at post-treatment and all 15 improved their scores by more than 7 points indicating they all made statistically reliable improvement. This proportion, 93.8% may be considered 'recovered'. For Northern Ireland, of the 24 scoring above clinical cut-off on CORE-OM (score of 10 or more), 15 (62.5%) scored below 10 post-treatment. Of these, 12 (80%) also made statistical and reliable improvement and therefore may be considered as 'recovered'.

Pre and Post WSAS scores also indicate that patients in both Cornwall and N Ireland made considerable improvement (Table 9.6).

**Table 9.6: Pre- and post-intervention Work and Social Adjustment Scale scores for Cornwall and Northern Ireland**

	Cornwall (n=18)		Northern Ireland (n=8)	
	Pre	Post	Pre	Post
WSAS Mean (SD)	31.3 (6.85)	11.4 (9.81)	23.9 (12.4)	6.1 (7.36)
Clinical groups n(%)				
WSAS-Sub-Clinical (0-9)	0	9 (50.0)	1 (12.5)	5 (62.5)
WSAS-Significant functional impairment but less severe symptoms (10-20)	2 (11.1)	6 (33.3)	2 (25.0)	3 (37.5)
WSAS-Mod/severe or worse psychopathology (>20)	16 (88.9)	3 (16.7)	5 (62.5)	0

### 9.6 Difficulties in implementation

As mentioned above, the question of open groups (more welcoming but harder to maintain a therapeutic focus) versus closed groups (easier to move people through but less socially supportive) remains unresolved.

The geography of the county means that the VT spends virtually one-quarter of their time travelling between bases. This means 'hot-desking' in various community NHS premises to do administration and borrowing clinical facilities for individual and group work.

One specific problem arises from the treatment-focused nature of the way the pilot tries to work. This assumes that veterans are suffering from mental health problems that are treatable and therefore by definition not permanent. However some veterans appear to the service to have become 'career' PTSD sufferers, perhaps because of the messages they have been given in the past by other agencies, and they may be reluctant to give up this identity even though it seriously affects their functioning and quality of life.

### 9.7 Sustainability and future plans

The planned period of MoD-funded pump-priming for the pilot ended in August 2010. As agreed, a business plan for continuation was submitted to the NHS in March 2010. The PCT are reported to be enthusiastic about the pilot but have no money for it and want the Foundation Trust to continue to provide the service from their own resources. The Trust has agreed a 6-month extension to March 2011 to allow for this evaluation to report and will make its decision after that date.

An aspiration for the future is to extend the VT's hours to full time, thereby enabling more return to work initiatives and also giving time to do training with other people in GP practices etc. Such training (along the lines of the TEVV model) has not been possible within the



current level of funding. In the future it is felt important to get access to service records on the Lothian model. This is not so much to guard against potential fabrication but to get the whole picture of someone's service history. The implications of accepting referrals from and making reports to the Veterans Agency may need examining in the future. Does this link the service, in the veteran's mind, too closely with agencies responsible for benefits?

## 9.8 Responses to client questionnaires

Responses were received from 13 clients from Cornwall, from a total of 120 questionnaires distributed; a response rate of 10.8%.

**Table 9.7: Demographic details of questionnaire respondents (n=13)**

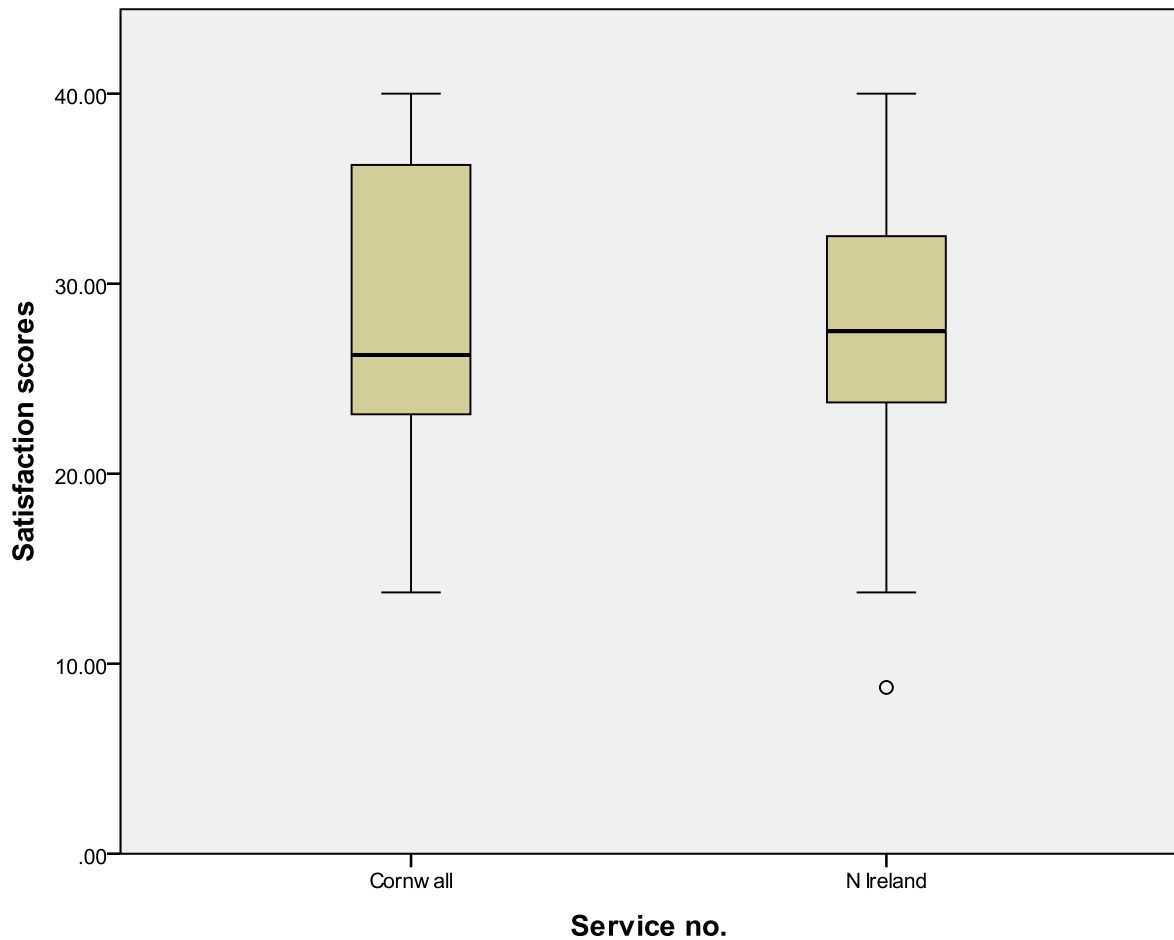
Veteran characteristics	N (%)
Gender	
Male	11 (85)
Female	0
No data	2 (15)
Age Group	
18-29	0
30-39	3 (23)
40-49	1 (8)
50-59	5 (39)
60-69	1 (8)
70+	2 (15)
No data	1 (8)
Service	
Army	5 (39)
RAF	1 (8)
RN	4 (31)
RM	2 (15)
Data Missing	1 (8)

The median satisfaction score for Cornwall was 26.3 compared to 27.5 for Northern Ireland. The overall distribution of scores from the two services are little different however.

The Cornwall service was rated the best of the six on questions concerning:

- Whether this service should be a model for the future (scored at 3.9 on a 4 point scale, indicating virtual unanimity)
- How helpful the service had been
- How far people would recommend it to colleagues (equal with N Ireland)

**Figure 9.7: Box and whisker plot comparing distribution of satisfaction scores from Cornwall pilot service with pre-existing Northern Ireland service as a benchmark (N=13)**



*Note:* The bold horizontal line represents the mean score; the box represents the middle 50% of scores; the whiskers represent the full range of scores with each whisker representing the upper and lower 25% of scores

### 9.8.1 Themes extracted from questionnaire

The emergent themes were identified as follows:

#### **Need for more sessions/centres/staff**

*Examples:*

- Services need more time and money
- Pilot should be made permanent and expanded nationally
- Need more frequent appointments
- Access. The times were too inflexible and I was unable to attend many sessions
- Group meetings need to be more frequent
- Need more opening hours and staff
-

**Problem of staff turnover**

*Example:*

- Changes of therapist, can't start again

**Problem of seeing non-forces staff**

*Example:*

- Therapist knew nothing of service life

**Need for assessments/treatments/information in and when leaving forces**

*Examples:*

- The MoD need to spend as much time and money helping individuals adjust to civvy street as they do training them on entry to the armed forces
- Need quicker action

**Positives of group therapy**

*Examples:*

- Group therapy good
- Comradeship
- Meeting other ex-service men

**Need to inform others**

*Example:*

- Carers/partners need more PTSD info

**Need to let client set the pace of therapy**

*Examples:*

- Don't push for 'root cause' too much in therapy
- Build up to the bigger issues
- One size does not fit everyone
- No two people are the same

**Positives of seeing someone with PTSD/services knowledge**

*Example:*

- Therapist had experience with PTSD

**Need for better information about services**

*Example:*

- Let more people know about service available

**Need to work with other agencies**

*Example:*

- Involve more veterans agencies

### **Positives of therapy 1: positives about services/staff**

*Examples:*

- Therapist is a 'god send', always there to help
- They listened even if they did not fully understand
- Lack of judgemental attitude
- Felt welcome

### **Positives about therapy 2: Feelings**

*Examples:*

- Therapy made me realise that I was not unique
- Knowing we're not forgotten
- Helped me understand some of the reasons why I was having these problems
- Reassurance of not being alone

### **How services could be further developed to help more**

*Example:*

- Would like a helpline to call to talk to someone

### **What I would say to the MoD and NHS**

*Examples:*

- There are far more out there than you think
- MoD- you don't care enough about us
- Don't treat PTSD as depression

### **Negatives of service**

*Examples:*

- The NHS service was slow and in the end I was forced to seek help via the British Legion. It was months from referral to the time I was to be seen. As it was I was not treated by the NHS
- I was mentally made to remember even more of the difficult time in my army life than I had been having problems with. I had to stop my treatment as I felt I was getting worse instead of better

## CHAPTER 10: Veterans' First Point (Lothian)

NHS Lothian

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Edinburgh  
EH2 4AW

enquires@veteransfirstpoint.org.uk

Website: [www.veteransfirstpoint.org.uk](http://www.veteransfirstpoint.org.uk)

### 10.1 Summary pen-picture

A one-stop shop for veterans and their families for any issues that may affect them. Fundamentally a mental health service but providing support and signposting to the full range of social-welfare support pathways. The service has been designed by veterans to deal with a wide range of problems including finance, benefits, housing, employment, physical health and so on. All core staff are ex-service personnel.

### 10.2 Development of service

The project dates back to early 2007, before MoD funding was available. A well established NHS trauma service in Edinburgh was seeing about one third of their clients as ex-service personnel, taking up lots of time due to wide ranging needs making treating their mental health problems difficult.

A special veterans' trauma group was established to advise on what the issues facing veterans were. Three issues were identified: Access, Credibility and Co-ordination of mainstream services. The issue of access was noted because ex-service personnel do not always know what civilian services are available or how to get them. The credibility issue arose because the group felt that veterans would be reassured if most of the staff were ex-service themselves. The co-ordination issue was in response to veterans feeling that there was a plethora of agencies working separately. These issues lead to the one-stop-shop model staffed by veterans.

It took about two years to work up the model, during which time the MoD pilot funding became available. NHS Lothian applied to run the pilot, but as this would not provide sufficient funding, also applied to the Scottish government who have been major funder and major support throughout. Scottish government funding has come directly to Veterans' First Point (V1P) rather than through NHS commissioners. The NHS has provided services rather than money.

In addition to the veterans' group, V1P set up an advisory/steering group as there were a large number of voluntary services in this area. They were able to make contacts at senior levels (board, chief executive) within these organisations. It was a large steering group containing around 25-30 organisations (e.g., Veterans Scotland, RBL, Citizens Advice

Scotland, and the NHS). The advice of the steering group has been extremely helpful. The strategic input from NHS has meant that the service has been integrated within the broader NHS strategy of NHS Lothian. Involving other organisations has improved credibility and helped avoid some of the mistakes that could have been made had these organisations not been involved.

### 10.3 Operation of the service

The service comprises three peer support workers (PSWs) who are part time (2.2wte), a full time Veterans Therapist (VT), full time manager, full time secretary and 0.2wte clinical psychologist. The PSWs and VT are all ex-Services personnel. There is also a researcher working full time, plus one day a week input from a psychiatrist. A volunteer counsellor is also available. All employed staff are NHS employees.

All veterans are initially allocated a PSW who will conduct an initial assessment and see them through the process. PSWs deal with social and practical problems and refer to clinicians within the team for mental health issues. If a veteran is already engaged with local services, V1P encourage them to remain engaged, if not they try to facilitate involvement. Where necessary V1P conduct a specialist assessment, with an assessor who can look at problems in a military context and decide treatment plan which can then be fed back to any other services the veteran may be involved with.

V1P routinely obtains service records, which has proved extremely helpful and staff cannot now imagine running the service without doing this. It is felt important to obtain service records as there can be a mismatch between the information provided by the veteran and the information in their records – it is crucial to know service history. It is also helpful to know of pre-existing problems which would be documented in service medical records. Having the records enables V1P staff to complete a thorough assessment, assess what the problems are and decide on the best treatment. Almost all veteran clients readily consent to their service records being accessed by V1P.

The routine assessment process applied by PSWs is a needs assessment using a checklist that runs through all areas they might have problems in – housing, employment, physical health mental health etc. When mental health problems emerge in process of working with the PSW for practical issues, case referrals are given to psychologists to assess and if necessary treat. The clinical interventions have a fixed number of sessions specified initially then they go to review. PSWs work in parallel to the clinical interventions, then take over as primary care person once the intervention is completed.

Formal mental health interventions are mainly CBT based, with the CBT aimed at mainly mood or anxiety disorders. Staff are trained in trauma therapy and EMDR but report seeing very little frank PTSD. Trauma is not the problem in the vast majority of people presenting to V1P with clinical problems.

If stepping up is required because of complexity of problems, the VT asks for further assessment from psychiatrist and psychologist, so this would be stepping up within V1P. If alcohol abuse or similar is becoming a problem, V1P will try to put people in touch with local services if they are not already. Similarly V1P do refer people to mainstream drugs and

alcohol services, or mental health services like the local clinical psychology department. V1P rarely need to refer to psychiatrists as this can be provided in-house.

To elicit referrals V1P has relied somewhat on word of mouth. At the launch they had a fairly widespread marketing campaign; sending information packs to GPs, A&E, police, etc – which generated interest. However no further formal marketing has been undertaken since then.

At the end of active treatment V1P see it as routine for veterans to stay on their caseload to be monitored steadily. People will drop off the active list when formal work ceases, but the model is more like a GP surgery, once someone is on the books they stay there. It is assumed that people will come back when they need more help.

V1P records are currently on paper, not scanned into any electronic format. Live cases are kept in locked filing cabinets, then archived, then eventually returned to NHS central medical records. As all cases are NHS cases, even if person does not have a health problem when seen at V1P, they still become a case and eventually will go to NHS records.

It is the opinion of V1P staff that standard psychometric tests are not particularly useful and these are being used less now. They have used the measures contained within the minimum dataset (PHQ-9 and WSAS), and have also used other tests such as the BDI. However the service is doubtful about the value of symptom based measures, arguing that people may often respond to these as a way of communicating distress, and that this often does not correlate with progress which has been made. The service prefers to use measures of functioning – specifically the ‘Star’ outcome measure devised by the London Housing Foundation (see [www.homelessoutcomes.org.uk/The\\_Outcomes\\_Star.aspx](http://www.homelessoutcomes.org.uk/The_Outcomes_Star.aspx)). V1P uses this to track progress throughout treatment on the main areas of dysfunction.

### 10.3.1 Service parameters

- **OFFICIAL GEOGRAPHICAL COVERAGE AND POPULATION ESTIMATE**  
*(ie the area contracted or expected to cover)*  
The Lothians  
Total population: 788,000
- **ACTUAL GEOGRAPHICAL COVERAGE**  
*(exceptions, out-of- area arrangements one-off cases...)*  
Aberdeen 2  
Glasgow 2  
Fife 4  
Dumfries and Galloway 3  
Ayrshire 1
- **DATE SERVICE STARTED ACCEPTING REFERRALS**  
23 April 2009
- **PRESENTLY ANTICIPATED DATE FOR END OF FUNDING**  
March 2011

- **STAFF FUNDED BY CVMHP MONEY (CLINICAL AND NON-CLINICAL)**
  - 1.0 Therapist
  - 1.0 Project Manager
  - 0.2 Psychologist
  - 2.2 Peer Support Workers
  - 1.0 Secretary

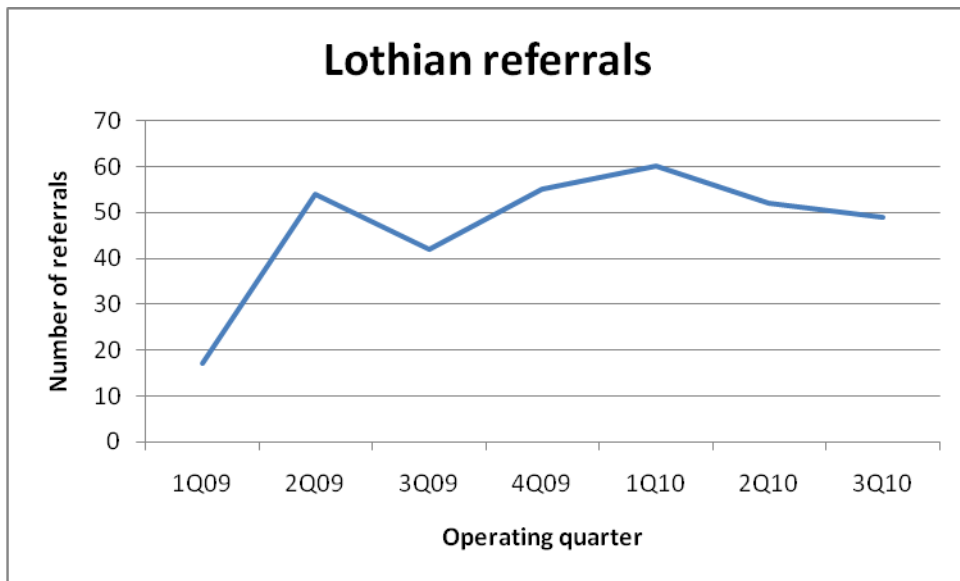
**10.4 Levels of activity**

No referral dates were available in the downloaded data, therefore quarterly figures were obtained from routine referral logs kept separately by the service.

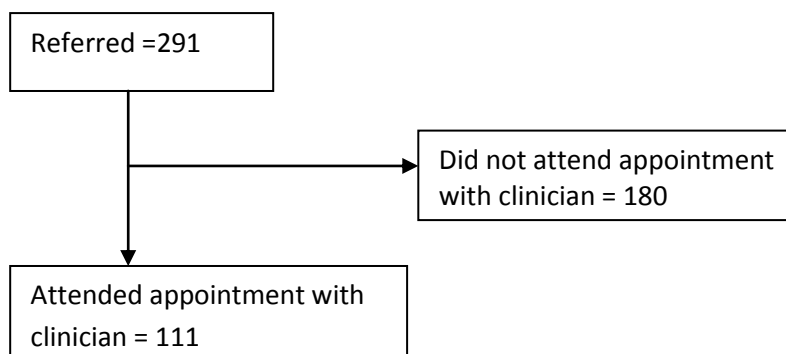
The only client throughput information was whether a referral was seen by a clinician.

A pie chart of staff activity types was not available because the V1P service started later than the others and there was not sufficient time for staff to complete a survey.

**Figure 10.1: Quarterly referrals to Lothian pilot during MoD funded period**



**Figure 10.2: Flow diagram of referrals to Lothian pilot during MoD funded period**





Referrals are running steadily at about 50 per quarter, or 200 per year. Just over half have been self referrals; a proportion which has been gradually increasing. Other referrers include 15% from NHS secondary care, then less than each 10% from sources such as Combat Stress, local authorities, other Forces' charities, SPVA and NHS primary care.

The service is currently (October 2010) working at capacity. There is a small waiting list for psychological/psychiatric assessment, but this is very manageable compared to NHS waiting times. Veterans will see a peer support worker within a few days, meaning they are able to start working on the practical side of things.

Around 80% are ex-Army, 9% ex-Royal Navy and 7% ex-RAF. Two thirds were private soldiers (or equivalent) on discharge, and most of the rest junior NCOs. The majority have served fewer than 8 years, 5-8 years is the average service length, though there is a full spectrum including those who have served up to 22 years. The average time since discharge to seeing V1P is 19 years, with the most frequent period 12-17 years. The average time is above this modal value because a small number have waited 40 years or more since discharge before coming to V1P. The most common deployment is Northern Ireland, followed by Op GRANBY (1st Gulf War, 1991) but many have had multiple deployments. The service has recently seen its first Op HERRICK (Afghanistan) referral.

The most common mental health problems are sleeping difficulties and low mood, followed by anxiety disorder, distressing memories/flashbacks and difficulties with anger. The most common problem seen by PSWs is financial, followed by physical/medical problems and then employment and housing. V1P had not anticipated financial issues being as prevalent, nor had they anticipated the complexity of people's problems. The service reports that nobody they see only has one problem/need. This is the advantage of being a 'one stop shop', all needs can be looked at under one roof, meaning nobody is sent away with a leaflet, and PSWs can 'buddy' the veterans through things. V1P hosts surgeries through links with other services/agencies such as CAB and SPVA, which is experienced as helpful by the veterans, as the whole spread of needs can be met in one location.

### **10.5 Difficulties in implementation**

An issue has recently started to emerge which had not been a problem until recently- this is most likely due to the current financial climate. This is the question of NHS staff providing what in many cases is not solely (or even mainly, in some cases) a service for health problems. It has been suggested that local authorities or other health boards should contribute, as the service sees a fair proportion of out of Lothian veterans. This issue may become more important in due course.

### **10.6 Sustainability and future plans**

There is a promise of continued funding from the Scottish government once the pilot ends in March 2011, but not for the full amount required. There is therefore a potential funding shortfall that the NHS is working to try and meet. The aim is to secure the funds to continue

operating at current level. In terms of the focus of the operations, VIP aims to help to develop mainstream local services through teaching and training; this is not a current function but it is felt it would be useful to disseminate what has been learned about the veterans' population more widely.

## 10.7 Quantitative description on cases from data downloads

Data were available on 291 referrals and although reasonably complete on many variables some key data were not provided (i.e., Age and referral date). Some notable comparisons regarding Lothian referrals are:

There is a particularly high rate of divorce, 39%, compared with CS (27%) and N Ireland (13%) – but could be partly due to other categories (separated, cohabiting, partner) not being used.

There was a slightly smaller proportion of Army referrals (77.4%) and a greater proportion of RAF (9.7%) and Royal Marine (2.8%) referrals compared to CS (82.4%, 4.3% and 0.3% respectively).

The data also indicates a greater proportion of referrals had served 0-4 years (30.6%) and fewer over 10 years (31.1%) than CS (12.7% and 48.7% respectively) and a greater proportion were Privates or equivalent (65.4% compared with 42.6%) with fewer from higher ranks.

### 10.7.1 Initial severity and outcomes

Pre treatment PHQ-9 and WSAS were collected for 30 clients seen by the Service. Lothian clients seemed to be reporting slightly fewer mood disturbance symptoms than the pre-existing services, though WSAS scores were very similar. In Tables 9.1 and 9.2 and Fig 9.3, PHQ-9 and WASA scores and clinical group are compared to intake scores and groups at Combat Stress and Northern Ireland.

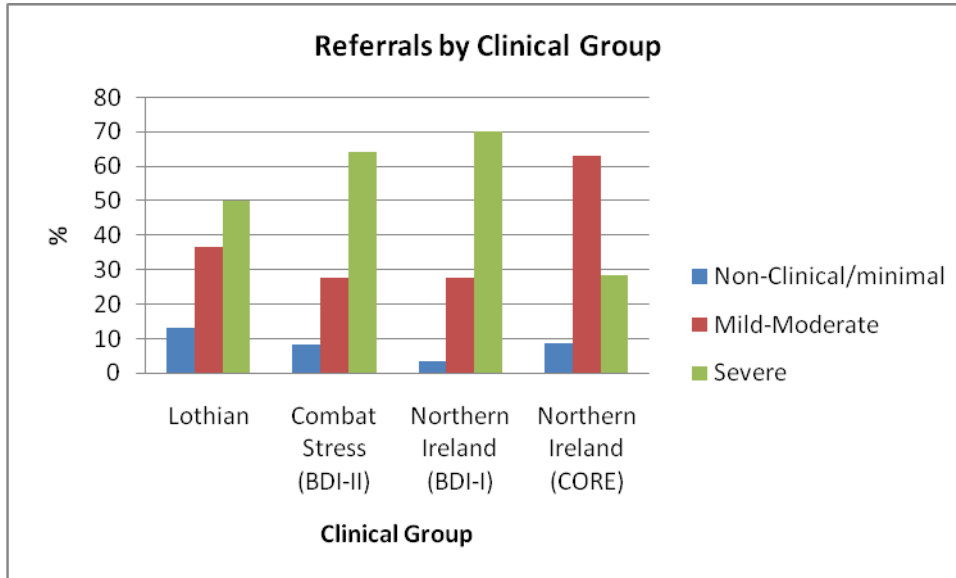
**Table 10.1: Intake scores and clinical groupings for Lothian, Combat Stress and Northern Ireland**

Measure	Lothian (all Pre measures)	Combat Stress	Northern Ireland**	
	PHQ-9	BDI-II	BDI-I	CORE-OM
N	30	396	29	46
Mean	17.5	32.2	33.8	20.9
(SD)	(6.68)	(12.45)	(12.18)	(6.34)
Clinical groups*N(%)				
Non-clinical/minimal	4 (13.3)	33 (8.3)	1 (3.4)	4 (8.7)
Mild-Moderate	11 (36.7)	109 (27.5)	8 (27.6)	29 (63.0)
Severe	15 (50.0)	254 (64.1)	20 (70.0)	13 (28.3)

Note\* PHQ-9: NC=0-9, MM=10-19, S=20-27; BDI-II: NC=0-13, MM=14-28, S=29-63;  
BDI-I: NC=0-9, MM=10-29, S=30-63; CORE-OM: NC=0-9, MM=10-24, S=25-40

Note: In N Ireland 28 clients completed both a BDI-1 and a CORE measure pre treatment. For these the means (SD) for BDI-I and CORE-OM respectively were 33.1 (11.82) and 21.6 (5.94). For the BDI-I, NC, MM and S percentages were 3.6, 28.6 and 67.9 respectively while for the CORE-OM they were 7.1, 60.7 and 32.1.

**Figure 10.3: Referrals by clinical groupings – Lothian, Combat Stress, & Northern Ireland services**



**Table 10.2: Intake scores and clinical groupings on the Work and Social Adjustment Scale for Lothian and Northern Ireland**

	Lothian	Northern Ireland
	N = 30	N = 20
WSAS Mean (SD)	23.0 (10.38)	22.6 (11.59)
<b>WSAS Clinical groups n (%)</b>		
WSAS-Sub-Clinical (0-9)	3 (10.0)	3 (15.0)
WSAS-Sig. Functional impairment, less severe symptoms (10-20)	6 (20.0)	5 (25.0)
WSAS-Mod/sev or worse psychopathology (>20)	21 (70.0)	12 (60.0)

No outcome measures data were available, as no post-treatment scores on PHQ-9 and WSAS were provided.

## 10.8 Responses to client questionnaires

Responses were received from 13 clients from V1P, from a total of 160 questionnaires distributed; a response rate of 8.1%.

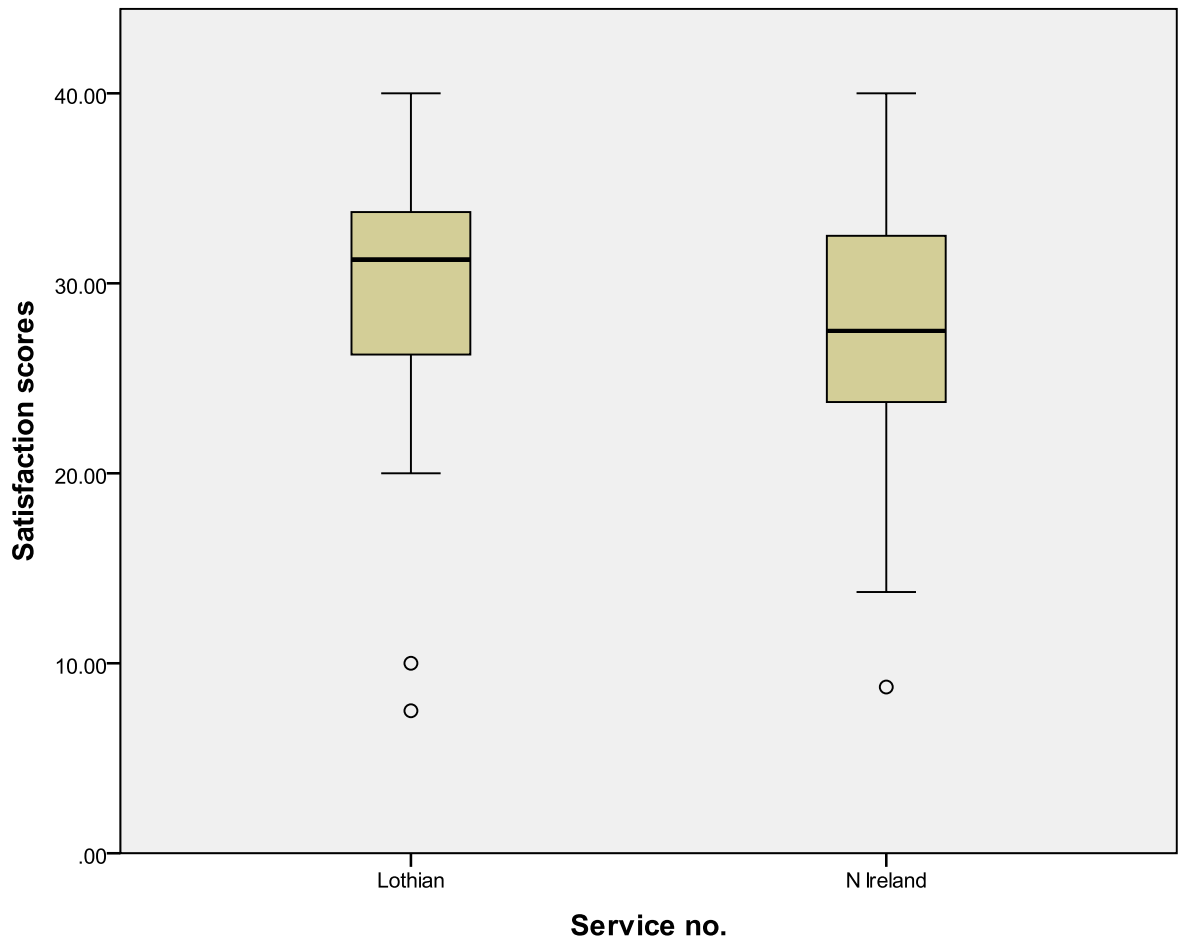
**Table Number 10.3: Demographics for questionnaire respondents ( n = 13)**

Veteran characteristics	N (%)
<i>Gender</i>	
Male	12 (92%)
Female	1 (8%)
<i>Age Group</i>	
18-29	0
30-39	2 (15%)
40-49	5 (39%)
50-59	5 (39%)
60-69	1 (8%)
70+	0
<i>Service</i>	
Army	9 (69%)
RAF	1 (8%)
RN	2 (15%)
RM	1 (8%)

The median satisfaction score for Lothian was 31.3 compared to 27.5 for Northern Ireland (see Figure 10.4 below). The Lothian service was rated most highly of the six on questions relating to:

- How welcoming the place was (3.8 on a maximum 4 point scale)
- The degree of staff familiarity with Forces culture and experience
- The choice of support offered
- How far it has improved the client's situation (highest score of the six pilots, but exceeded by the pre-existing N Ireland service)

**Figure 10:4: Box and whisker plot comparing distribution of satisfaction scores from Lothian pilot service with pre-existing Northern Ireland service as a benchmark (N=13)**



*Note:* The bold horizontal line represents the mean score; the box represents the middle 50% of scores; the whiskers represent the full range of scores with each whisker representing the upper and lower 25% of scores

### **10.8.1 Themes emerging from questionnaires**

The emergent themes were identified as follows:

#### **Need for more sessions/centres/staff**

*Examples:*

- Wants more counselling
- Not enough counsellors. Also a shorter time between appointments, more local clinics as it was hard for me to get to Edinburgh

**Problem of seeing non-forces staff**

*Examples:*

- Leave ex-services to service personnel - same traumas, different psyche! Service personnel generally benefit by being with other service personnel

**Need for assessments/treatments/information in and when leaving forces**

*Examples:*

- Need more information while still in the forces
- About civilian integration – deprogramming

**Need to let client set the pace of therapy**

*Examples:*

- Allow time to recover/stabilise
- I could go at my own pace and never felt pressured

**Positives of seeing someone with PTSD/services knowledge**

*Examples:*

- People who listened, were ex-service personnel also
- Staff were veterans themselves – I don't believe this project would work if this was not the case
- They listened and understood, as they are ex-servicemen too

**Need to work with other agencies**

*Examples:*

- Need to work with other organisations

**Positives of therapy 1: positives about services/staff**

*Examples:*

- If there was organisations such as this when I was medically discharged in 1981, things could have been different in my life
- Trust and understanding is very important to a veteran
- Peer support staff were patient and understanding
- Welcoming - easy to talk to
- From the viewpoint of the pilot scheme, I do not know what else THEY could have done
- I know I can go anytime for a chat and a coffee
- I was glad those people were and are there now. Good service
- Good all round advice, and the door was always open for a chat, they took the time to listen to all I had to say
- Helpful advice. Therapy. Someone to listen to my problems

### **Positives about therapy 2: Feelings**

*Examples:*

- Made me feel there was help out there
- They made me feel I was part of a team again, and not a waste of space

### **How services could be further developed to help more**

*Examples:*

- Improve by adding outreach or follow ups
- Need home outreach
- Would like refuges/accommodation for ex-service personnel

### **Negatives about the service**

*Examples:*

- It's a waste of time
- Service was 'unhelpful, inefficient'
- Being passed between NHS doctors – negative
- I was not seen enough by my counsellor

### **What I would say to the MoD and NHS**

*Examples:*

- MoD should start telling the truth about mental conditions instead of hushing it up
- Need to treat them as human beings, not as a sufferer
- Become more person based, listen
- Each human being has the right to be listened to
- Need to be more open about ex service problems
- Take time to listen to our problems, they are not all in our heads, they are real. I was not listened to back in my military days (I was asking for help)
- Make the service more locally and widely available and not just rely on veterans charities.

## CHAPTER 11: OVERVIEW OF PRESENTING PROBLEMS AND SERVICE FEEDBACK

### 11.1 Satisfaction with services

In this chapter we take an overview of the 6 pilot sites as a totality by considering the data as a single group. We focus on the feedback from the satisfaction survey.

Table 11.1 and Figure 11.1 present the age and gender distribution of respondents. Altogether there were 87 respondents to the questionnaire, of whom 72 gave at least some demographic data to allow an assessment of how representative they were.

**Table 11.1: Demographics for satisfaction questionnaire respondents**

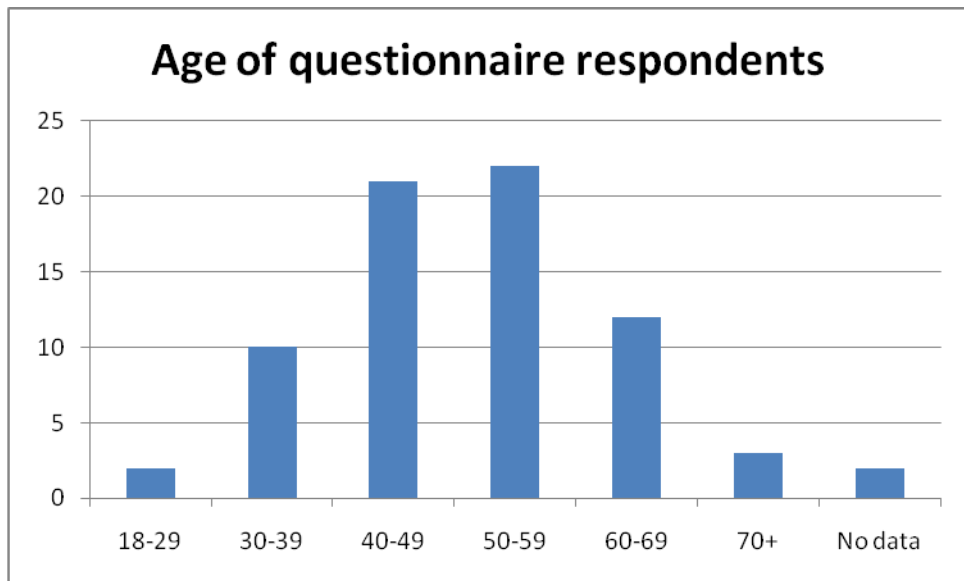
Veteran characteristics		N (%)
Gender		
	Male	61 (84.7)
	Female	6 (8.3)
	No data	5 (6.9)
Age Group		
	18-29	2 (2.8)
	30-39	10 (13.9)
	40-49	21 (29.2)
	50-59	22 (30.6)
	60-69	12 (16.7)
	70+	3 (4.2)
	No data	2 (2.8)

The proportion of females is greater in this questionnaire sample of 72 compared with the downloaded service data. The latter showed 613 (97.1%) to be male and 18 (2.9%) female. These figures compare with 98% and 2.0% at Combat Stress and 96.3% and 3.7% at the Northern Ireland Service. This in line with other studies which suggest that women are slightly more likely to complete postal questionnaires than men.

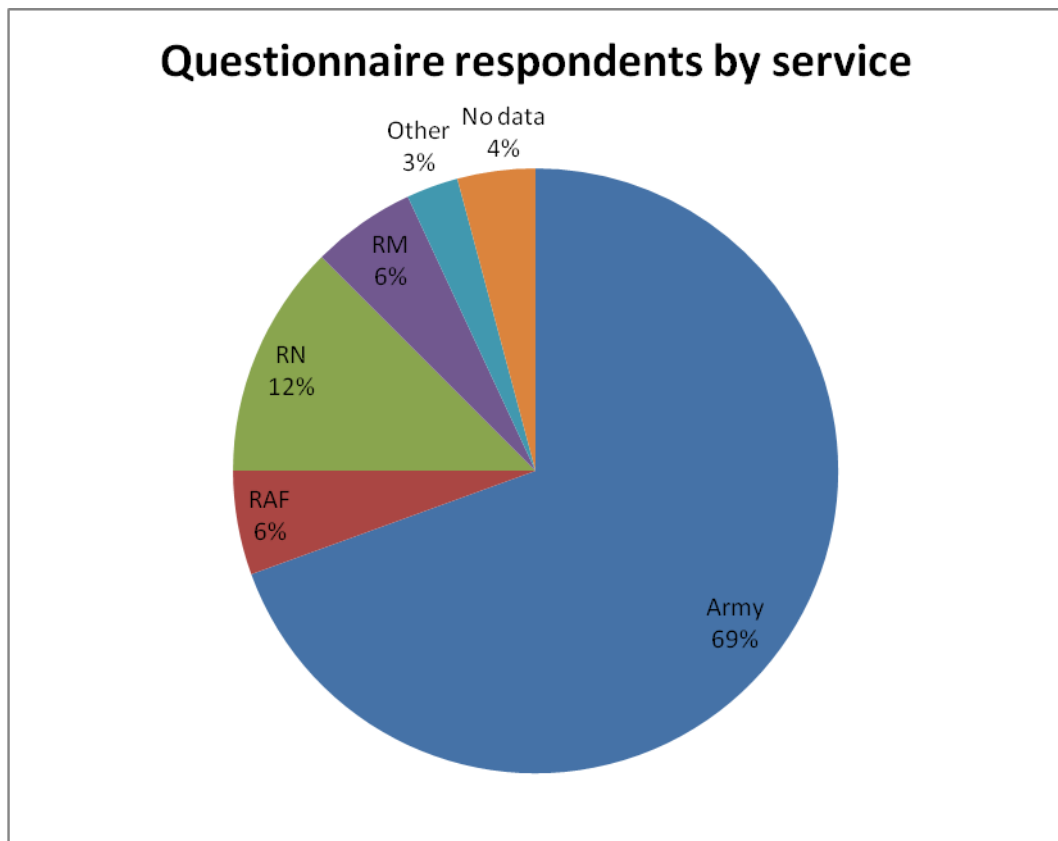
The downloaded data also had a higher proportion of veterans under 40, compared with the questionnaire sample, 37.3% compared with 16.7%, and fewer over 50 (34.6% compared with 51.5%). The 40-49 age group was similar (28.2% compared to 29.2%)



**Figure 11.1: Demographics for satisfaction questionnaire respondents (n= 72)**



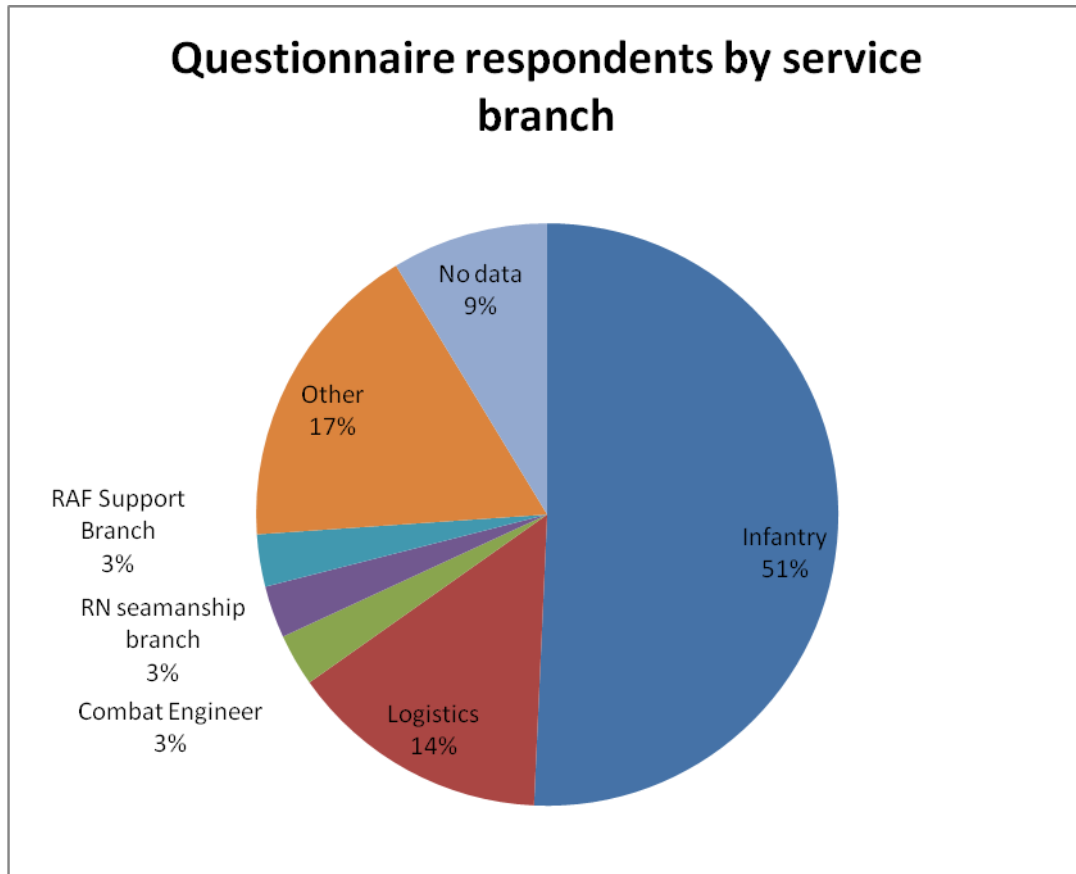
**Figure 11.2: Demographics for satisfaction questionnaire respondents - service (n= 72)**



The downloaded sample also had a higher proportion of Army personnel , 77.7% compared to 69% here. It had slightly more RAF personnel (8.2%) and fewer RN and RM (8.5% and 2.4% respectively).

Although there are differences between the questionnaire sample and the larger download population, these are not large and it seems safe to assume that the former is a reasonable sample of the latter.

**Figure 11.3: Demographics for satisfaction questionnaire respondents - service (n= 72)**



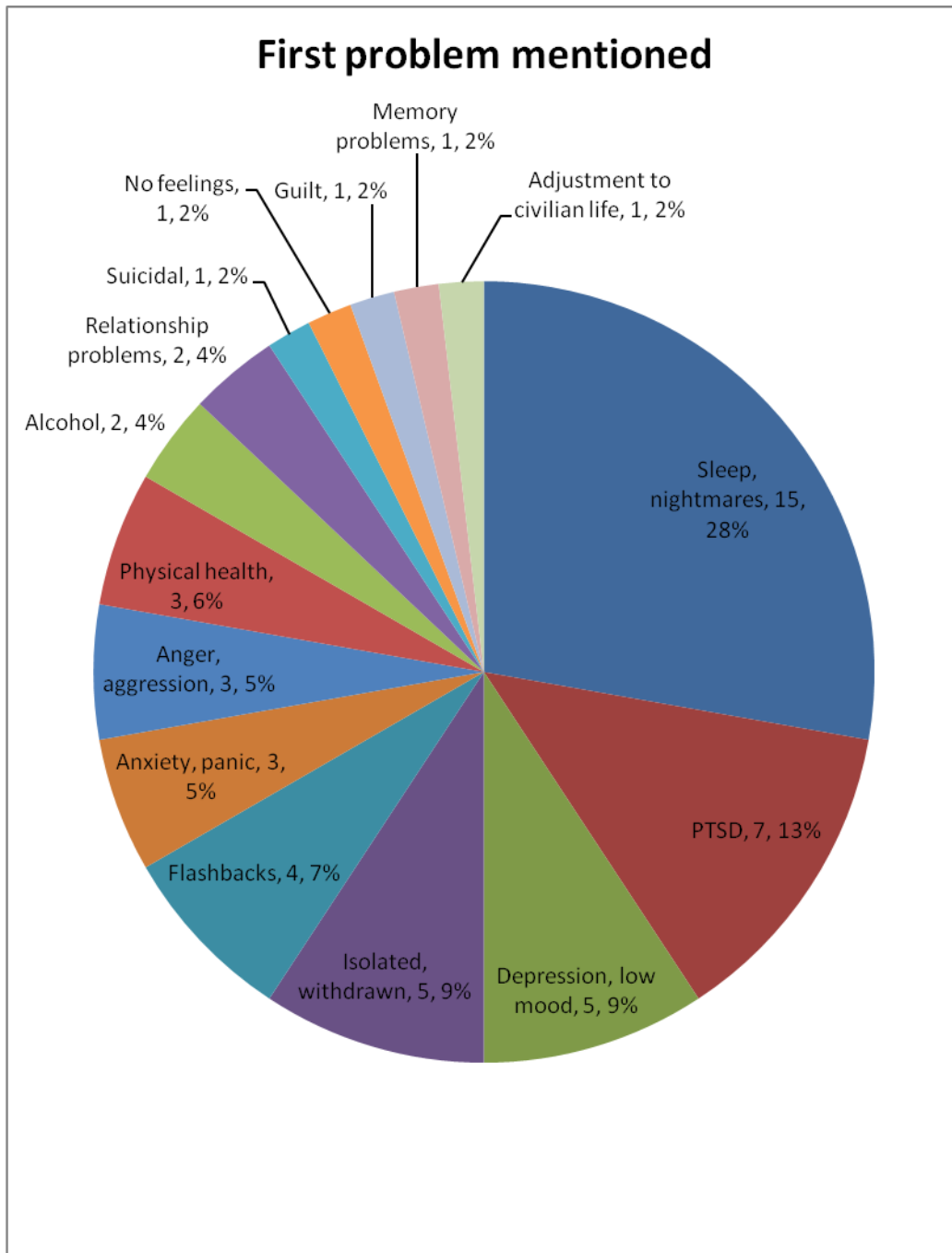
**Figure 11.4: Presenting problems according to those first mentioned**

Figure 11.4 shows the range and percentage of first problems mentioned by veterans in the questionnaire sample. Given these are based on first problems; they are mutually exclusive in that an individual's problems contribute to only one category. The range of problems is unsurprising. However, the occurrence of sleep and nightmare problems (28%) is twice that of the next highest category, namely PTSD (13%). However, the latter is a diagnosis and may reflect a specific culture of assessment. If taken at face value, together with the highly specific presentation of flashbacks, these two categories account for 20% of the first mentioned problems without including any contribution from the sleep/nightmares category.

**Figure 11.5: Presenting problems according to all those mentioned**

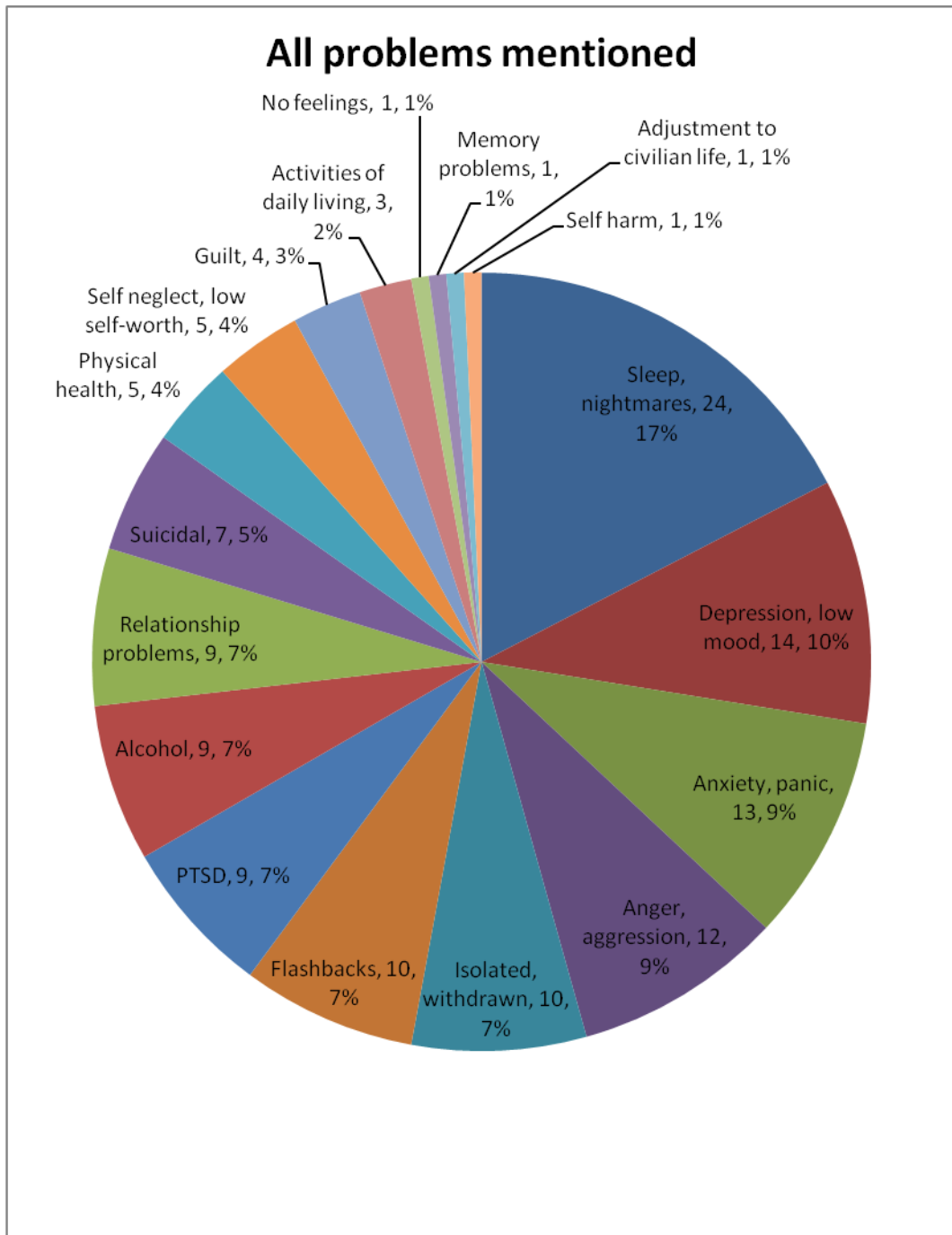


Figure 11.5 presents data based on all problems listed – some veterans did not list any problems that could be coded, other mentioned one or two while some mentioned several. It also counts all problems that were ever mentioned (and thus over-emphasises the contribution of those who listed many problems.)

Within the questionnaire there were ten questions posed in the form of statements to which participants were asked to show how far they agreed/disagreed. From these ten questions a

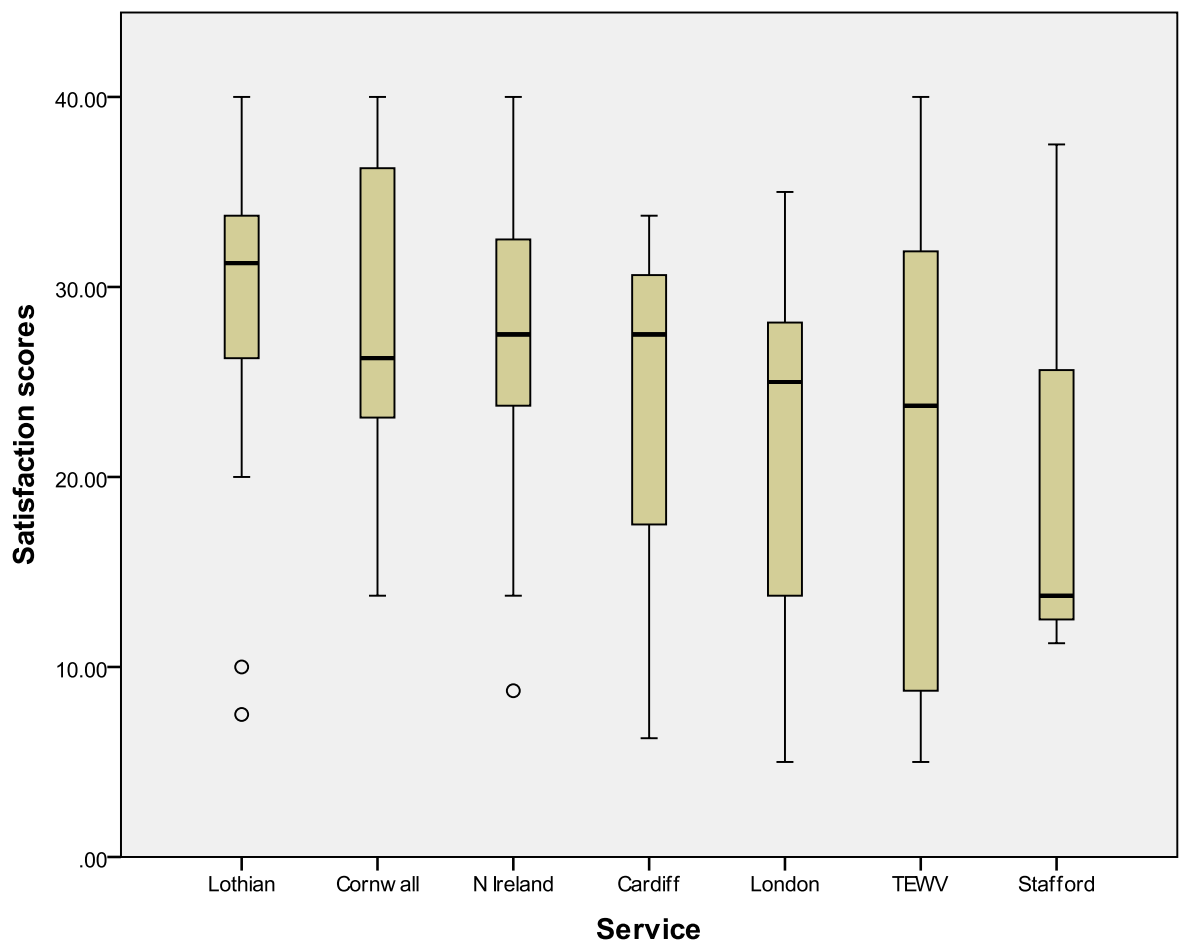
score for overall satisfaction with the service could be calculated. Table 11.2 below shows the mean satisfaction scores across all clients of the services.

**Table 11.2: Mean satisfaction score by service**

Pilot	Mean score
Lothian	28.6
Cornwall	28.2
N Ireland	27.4
Cardiff	23.9
London	22.0
TEWV	21.7
Stafford	20.8

These mean figures conceal the considerable overlap in the distribution of scores between services, which is illustrated in the figure below where services are arranged in order of mean satisfaction score.

**Figure 11.6: Overall satisfaction scores by site**



These satisfaction scores should be regarded with caution as the numbers replying from each service were low – a maximum of 22 responses from N Ireland and only three from Staffs. (See Table 11.3 below.)

**Table 11.3: Numbers of questionnaires sent and returned**

Pilot	Number sent	Number returned
N Ireland	280	22
Cornwall	120	13
TEWV	70	13
Lothian	160	13
London	110	11
Cardiff	150	10
Staffs	60	3
Humber	110	0

Table 11.4 below describes the scores on individual questions on the questionnaire, reported by service. The highest score/s for each question are highlighted in green, and the lowest scores in yellow.

**Table 11.4: Ratings on individual questions by pilot service**

	N Ireland	Staffordshire	Cardiff	London	TEWV	Cornwall	Lothian	Mean score
Pilot should be a model for the future	3.6	2.7	3.1	2.9	3.1	3.9	3.4	3.2
Welcoming place	2.7	2.3	2.1	3.1	3.0	3.1	3.8	2.9
Helpfulness of service	3.0	2.0	2.4	2.5	2.4	3.7	2.9	2.7
Would recommend to ex-service colleagues	3.2	2.0	2.6	2.4	2.5	3.2	2.8	2.7
Familiarity with Forces' culture and experience	2.9	2.0	2.9	2.6	1.7	2.8	3.4	2.6
Has improved my situation	2.7	1.3	1.9	1.8	1.8	1.9	2.3	2.0
Choice of support offered	2.0	2.0	1.8	1.5	1.8	1.6	2.3	1.9
No gaps in service	1.9	2.3	2.2	0.9	1.1	1.9	1.8	1.7

The minimum score possible on each question is 0 and the maximum is 4. As a whole, the six pilots (and the pre-existing Northern Ireland service) were felt to be a good model for the future and to be welcoming places. Even the lowest mean score was above the halfway mark of 2.0. On the other hand, the choice of support offered and the completeness of the service were rated less well, even for the best-rated services.

### 11.2 Qualitative correlates of satisfaction and dissatisfaction

Questionnaire respondents were arranged in decreasing order of their overall satisfaction scores with the service they received. Qualitative (written) responses from those at the top of the list (most satisfied) were compared with those at the bottom (least satisfied). The following patterns of experience emerged.

**Table 11.3: Themes emerging from qualitative replies to questionnaire**

Theme	Experience of most satisfied veterans	Experience of least satisfied veterans
<b>Human qualities of staff</b>	<p>Talking to someone that cares (Camden)</p> <p>They were open, friendly and non-judgemental. They had 'an open heart, mind and hand!'. They were willing to listen to me and my unconventional thought process which bore results..... Most of all they understood 'veterans black sense of humour'. (Camden)</p> <p>All personnel have done everything well, they listening (sic) even if they did not fully understand. (Cornwall)</p> <p>Felt welcome (Cornwall)</p> <p>Very open professional staff who listened, challenged and guided through difficult emotional pathways. (TEWV)</p> <p>I felt that they wanted to help me and that I wasn't wasting their time. (TEWV)</p>	<p>The therapist I saw was not helpful nor did he seem interested in what I said. (No site given)</p> <p>[Staff should] Listen to the veteran more, understand them more, don't be too quick to rule them out. (Camden)</p> <p>It was only when I eventually, of my own initiative, got a referral to the Traumatic Stress Clinic that I felt for the first time someone actually knew and understood what I was talking about. It was like somebody off this huge burden on troubles that I had been carrying around for a couple of decades for the first time. (Camden)</p> <p>Stop patronising when they meet you (TEWV)</p> <p>They were unhelpful, unstructured, inefficient, unempathetic - gave false and wrongful information to my needs, had a time lapse of helping me with my needs, detrimental to my health condition. (Lothian)</p>
<b>Recognition of veterans' status</b>	<p>Recognising the service I have given to my country. (Cardiff)</p>	

	Knowing we're not forgotten. (Cornwall)	
<b>Recognising there is more than just the military aspect to an individual</b>	They need to know/have knowledge of the individual outside of the military. If one has a whole/360 degree picture of an individual, one is better placed to assess/help that individual. (Camden)	
<b>Instilling hope and optimism</b>	They helped me begin to believe in myself and not accept second best. They gave me the courage to carry on, no longer was I alone. (Camden)  Made me feel good again about me (TEWV)  They made me feel I was part of a team again, and not a waste of space. (Lothian)  I received info on PTSD, and it helped me realise I wasn't on my own. (Belfast)	
<b>Flexibility and range of options offered</b>	They were not adverse to trying different approaches (Camden)  They have offered me many avenues of support and treatment (Cardiff)	I was told EMDR was unsuitable for me at the moment and was referred to consultant psychologist (which was a waste of time as only offered talking therapy which was not appropriate)... I was only offered one therapy and because my illness was too deep routed for that therapy I became 'outside' the service provided. (Stafford)  None - just told me basically to get a job and that. (Lothian)
<b>Confirmation of diagnosis</b>	Recognition of possible PTSD and recognition of severe depression. (Cardiff)	I now hear public criticism that individuals certified with PTSD - which is what the Traumatic Stress Clinic diagnosed immediately (after all those years of soul searching) at my first meeting two years ago- are doing so for the 'easy way' in order to get benefits. (Camden)
<b>Understanding veterans' military experience</b>	The majority of staff were veterans, relaxed atmosphere, the peer support staff were patient and understanding carrying out front line	Veterans have seen and done more than the average civilian can only read or dream about. (Camden)



	<p>support, form filling etc. (Lothian)</p> <p>They listened and understood, as they are ex-servicemen too. (Lothian)</p> <p>I personally felt better not seeing anyone from the armed forces but a civilian, as it was easier to speak to them on level terms. (TEWV)</p>	<p>I felt that if the professional I spoke to was from the forces he would have understood what I had to say. (Stafford)</p> <p>They did not know what an ex forces human is like compared to civilian. Not a clue. (TEWV)</p> <p>Sat, listened, talked, advised. Did not understand, all above is good but we need to be understood. Again, if you have not been there you will not know..... The service needs ex soldiers to treat soldiers, that's it. A soldier can and will relax with a soldier as they have both seen the same crap and shared the same time. That is a key factor to what this service needs. (TEWV)</p> <p>They have not served. NHS don't know what mental torture the job was even though you are out it doesn't stop. Things you cant tell NHS for security reasons so you just get half counselling, the MoD question your incidents over and over as if you are making it up. (Belfast)</p>
<p><b>Collaborative working</b></p>	<p>1st discussed a treatment plan that worked for us both, finding a coping mechanism that worked then finding things that interested me and finding ways of doing them (Cornwall)</p>	
<p><b>Pacing</b></p>	<p>Give me a stable platform to then start dealing with bigger issues which is took at your own pace and a push where needed. (Cornwall)</p> <p>They took the time to listen to all I had to say. (Lothian)</p> <p>Don't try to force the client to open up too quickly. Let the client do this at their own speed as confidence builds. There are things I haven't talked to my wife about let alone virtual strangers. (TEWV)</p>	

<b>Consistency and continuity</b>	Regular treatment with the same VCPN. This has been of great help, this is once a month (Cornwall)	Don't change the person you have been seeing for years, when they changed my lady I thought about ending it!!! (Cornwall)  I saw a consultant, but disappointingly quickly I found myself seeing other people in the absence of the consultant, away on courses, 'secondment'. I would have to go through the same painful rigmarole of recounting past history of events to each new person. (Camden - describing experiences before coming to pilot)
<b>Specific interventions</b>	Having a group meeting with the other Vets. (Cornwall)  [EMDR helped me] to lock away the problems causing me to be the way I was. Thanks to the help I was given I am a different person now. (TEWV)	The treatment was obscure. I was mentally made to remember even more of the difficult time in my army life than I had been having problems with. (Cornwall)
<b>Accessibility</b>	Good all round advice, and the door was always open for a chat (Lothian)  I know I can go anytime for a chat and a coffee. (Lothian)	Relocate the office as it is claustrophobic to get to with a small lift on the fifth floor. (No site given)
<b>Conflict with other agencies</b>		Because of my case it was difficult for them to really help, as the army were and still are running my life (Cardiff)
<b>Co-ordination between elements of service</b>	A very good service as previously you get passed from pillar to post to other people who do not understand or care what happens to you. (Cardiff)	After 6 months I got to see a doctor still awaiting other help 1 year on (TEWV)  Initial visit- I was told I would need 30 sessions of therapy. However not available in the area I live and they have to apply to my doctor to transfer funds outside area. Still waiting, almost a year now since initial visit. (Camden)  My psychiatric support was a bad experience as it did not appear to be coordinated with my GP. (Belfast)  Gave me hope that I was finally

		<p>getting help and when it was all withdrawn because the NHS did not do 'joined up writing' I was left devastated and without support. Compounding my problems again! .... Promises were made by the 'pilot scheme' but they were all broken by the NHS. (Stafford)</p> <p>Being passed person to person one diagnoses an illness you spend months trying to get it in waiting for the next person you go to hospital no one understands what you are going through they think you are lying or exaggerating. (Belfast)</p>
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### 11.3 Commentary on qualitative themes

The theme attracting most comments seems to be around straightforward issues of **human qualities** that would define any psychological service – or indeed a customer-focused service of any kind. It is no surprise that people want to feel valued, welcomed, listened to and that they rate highly services which manage to do this **collaboratively**. A closely allied theme is that of **instilling hope** – an oft-cited *sine qua non* of a successfully psychological treatment. Veterans giving a high satisfaction rating also described **sensitive pacing**, being able to tell their story in their own time without undue haste. Traditional, once-weekly therapy was too fast-paced for at least one person, who commented: “Sessions were pushed into a 7 week, 1 hour per week. I would have liked it over longer period after each session you felt really shit.”

For some respondents it was an absolute given that **services should be staffed by veterans**. The Lothian service makes a point of this and this was favourably commented on twice; equally, other services were criticised on the basis that civilian staff with no experience of forces’ life can never be expected to fully understand a veteran. However the evidence here is still equivocal; veterans commented favourably on the experience of **recognition of veteran status** that came from services badged explicitly as veterans’ services, but not necessarily staffed by veterans. Furthermore the lack of veteran status among staff did not prevent the positive comments mentioned above about their positive human and professional qualities. A warm, empathic civilian might be preferred to an unhelpful, unempathic veteran member of staff. Indeed one respondent said “All [civilian NHS] personnel have done everything well, they listening (sic) even if they did not fully understand”, suggesting that listening does in fact trump experience. However, respondents to the questionnaire would probably comment that the ideal staff member would meet both criteria. One respondent cautioned that a veteran’s military experience is not the sum total of his or her life, and another positively preferred to see a civilian clinician. Perhaps the key here is the availability of choice, and on the evidence here many (but not all) veterans would

choose a service staffed by veterans if this was on offer. The desirability of **flexibility and choice** was highlighted by several people.

For many respondents, even if their experience of the pilot was positive, things fell down when **co-ordination between NHS services** was poor – as it often seemed to be. This was particularly the case when onward referrals were made from one service to another, resulting in one long wait after another. A related area seems to be **continuity of staffing** that was valued when it was provided, and problematic when it was not. Like the previous point, this experience of the NHS is not confined to veterans but could have been described by almost any client group. However with a largely male, ex-military group who have been socialised to ignore discomfort and push on regardless, it would not be surprising if this were a group who took time to build up trust and needed a particularly high level of continuity.

Other valuable features of services were their **accessibility**, the reassurance given by **expert diagnosis** and some **specific treatments** such as group work and EMDR.

#### 11.4 Comparison of outcome measures with other services

Only Lothian and Cornwall reported intake measures on the PHQ-9 and WSAS, and only Cornwall had both intake and follow up measures. Nevertheless there are useful comparisons to be made with the pre-existing services and with other NHS services such as the IAPT demonstration sites.

**Table 11.4: Pre-post PHQ scores in pilot sites and NHS IAPT services**

Site	Mean (SD) Intake PHQ-9 score	Mean (SD) outcome PHQ-9 score
Cornwall	17.1 (5.6)	4.6 (2.6)
Lothian	17.5 (6.7)	Not available
Doncaster IAPT	16.1 (6.2)	8.8 (7.3)
Newham IAPT	14.7 (6.0)	8.7 (7.0)

On these figures (although the numbers from the pilot sites are small) the pilot sites appear to be treating clients with more severe mood problems than the IAPT demonstration sites. Moreover the outcomes look particularly good for Cornwall, though care must be taken since the standard deviation of the sample is small. This suggests it may be an unusual sample; nevertheless the performance and sensitivity of the PHQ-9 in this client group seems to be promising.

#### 11.5 Comparison of sites on other parameters

This study was asked to evaluate the pilot sites with pre-existing services; they were not in a ‘horse race’ with one another and their different starting conditions and circumstances make direct comparisons invidious. Nor are these possible in many cases, since the data collected

by sites differed in several respects one from another. However there Table 11.5 below gives some indication of features across sites where there are sufficient data to simply describe similarities and differences:

**Table 11.5: Descriptive features of sites**

Pilot	Referrals during 2 year period	Mean waiting time (weeks)	Mean time from Forces discharge to referral (years)
Humber		4.4	10.3
N Ireland	280	2.4	4.2
Staffs	60		10.5
Cardiff	150	8.8	12.9
London	110	7.0	
TEWV	70		13.6
Cornwall	120		
Lothian	160		
N Ireland	280		

## 11.6 Envoi

The Sheffield evaluation team is grateful to the MoD for the opportunity to conduct this evaluation of an important topic in psychological services. It has been a challenge to complete this evaluation on a shorter timescale than that originally proposed, and there are some limitations in this study as a result. However the evaluation team plans to publish further material in due course which will expand on what has been presented here and will hopefully add to the debate on this topic of national importance.

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