

Call to mind: A framework for action

**Findings from the review of veterans and
family members mental and related health
needs assessments**

**Final Report
October 2015**



Community Innovations Enterprise



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Preface

This report provides for the first time a summary of the extent to which the mental and related health needs of veterans and family members are being addressed in Joint Strategic Needs Assessments (JSNAs) in England. This is important because JSNAs are the means by which Clinical Commissioning Groups and Local Authorities understand the needs of different groups and communities and what kind of services should be commissioned to meet those needs. As the report shows, the mental and related health needs of veterans and family members often do not feature strongly enough in these needs assessments.

But the report provides more than a summary of what we now know; it includes a framework for action for everyone to work together on ensuring that full account is taken of the mental and related health needs of veterans and family members. The framework sets out three building blocks which will not only help improve the way in which needs are identified but will ensure that commissioning and service responses are appropriate and sensitive and that veterans and family members are included and able to participate in the process.

As the report points out, this is not something that any single agency can achieve. It requires the full range of stakeholders including commissioners, service providers, the armed forces charities and veterans and family members themselves to work together in ensuring that their mental and related health needs are fully recognised and responded to in an effective and integrated way.

**Professor The Lord Patel of
Bradford OBE**

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

Foreword

NHS England welcomes the valuable work done by Community Innovations Enterprise (CIE) funded by Forces in Mind Trust (FiMT). The foundation of great commissioning starts with a good understanding of the needs of the population and this report illustrates the continued work required to review and improve commissioning and services for the needs of veterans and their families in our communities.

We welcome that the Call to Mind report has been developed alongside a broad consultation with service users, families, armed forces charities, stakeholders and partners and we are now working jointly with both Public Health England (PHE) and the Local Government Association (LGA) to ensure continued improvement in the commissioning of services for armed forces and their families and working with Clinical Commissioning Groups and Local Authorities to improve this vital area for veterans and their families including mental health and specialist services.

The report also makes clear that there is more to a needs assessment than a narrow focus on numbers and populations, it is also about the needs and services identified and valued by patients, carers and service users. NHS England looks forward to providing leadership and improved engagement with the armed forces community to ensure that all services are designed and commissioned around patient and carers voice and involvement.

We recognise that veterans and their families health needs are best met locally and with the exception of some specific requirements are frequently similar to the needs of the general population. Therefore we will work alongside the national Mental Health Taskforce to identify the environmental factors and different presentations of the armed forces community that require improved access, removing inequality and delivering the Armed Forces Covenant.

Kate Davies OBE

Head of Public Health, Armed Forces
and their Families and Health &
Justice Commissioning

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Forces in Mind Trust

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

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

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

NHS England

NHS England's mission is to improve health and secure high quality care for the people of England now and for future generations. The NHS Five Year Forward View and NHS England's priorities include upgrading the quality of care and access to mental health and dementia services. NHS England has two separate but related roles with regards to the commissioning of care for the armed forces community. It directly commissions services for those individuals registered with Ministry of Defence GPs and it assures (local, GP led) Clinical Commissioning Groups (CCGs) to ensure that they look after service families, reservists and all veterans.

NHS England also helps and supports the transition of services personnel from their service healthcare into civilian life, especially if service personnel are leaving following injury or illness. Finally NHS England leads on the delivery of the central funding for bespoke veterans' mental health services to enhance local commissioning.

As part of their assurance and support NHS England has worked with the Forces in Mind Trust to gain a greater understanding of mental and related health needs assessments and Joint Strategic Needs Assessments with respect to the local health needs of veterans. This will then support NHS England and local commissioners to ensure that the best possible services and patient quality is available for our armed forces community, families and veterans.

Community Innovations Enterprise

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

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

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

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Army Families Federation; Avon and Wiltshire Mental Health Partnership NHS Trust; Big White Wall; Birmingham Community Healthcare NHS Trust; Blesma; Combat Stress; Coventry & Warwickshire Partnership NHS Trust; Defence Medical Welfare Service (DMWS); DMRC Headley Court; Dudley and Walsall Mental Health Partnership NHS Trust; Help for Heroes; King's College London; London Veterans' Assessment & Treatment Service (LVS), Camden and Islington NHS Trust; Medical Advisory Committee (MAC) Council of World Veterans; Mental Health First Aid England; Military Veterans' Service (NW), Pennine Care NHS Foundation Trust; Ministry of Defence; Naval Families Federation; NHS England Armed Forces Clinical Reference Group; NHS Birmingham South and Central Clinical Commissioning Group; NHS Warrington Clinical Commissioning Group; NHS Wiltshire Clinical Commissioning Group; North Essex Partnership University NHS Foundation Trust; Ripple Pond; Royal Air Forces Association; Royal British Legion; Royal British Legion Industries; Soldiers, Sailors, Airmen and Families Association (SSAFA); Tom Harrison House; University of East London (UNSWIS); University of Salford; Veterans Aid; Veterans and Families Institute, Anglia Ruskin University; Walking With the Wounded; Warrior Programme.

We would also like to thank all the veterans and family members who participated in focus groups and interviews.

Executive Summary

Introduction

This report sets out the findings from the review of veterans and family members mental and related health needs assessments in England. The review was designed to support NHS England in building on its track record of success in meeting the health needs of armed forces personnel and veterans through the single operating framework for commissioning. In addition, the project seeks to support wider NHS partners such as Public Health England, Clinical Commissioning Groups (CCGs) and Local Authorities to better meet the mental and related health needs of veterans and their families.

The review was sponsored by the Forces in Mind Trust in collaboration with NHS England to address gaps in knowledge and understanding about the assessment of mental and related health needs of veterans and family members. The primary focus of the review has been on Joint Strategic Needs Assessments (JSNAs). The purpose of JSNAs is to provide analysis of the health needs of populations in order to inform and guide commissioning of health, wellbeing and social care services within local authority areas. The need for JSNAs to adequately include and address the health and social care needs of veterans is supported by the commitments on health in the Armed Forces Covenant and the Health and Social Care Act 2012.

This report sets out the key findings from the project and identifies areas for priority action and development that will improve the assessment of need and inform commissioning and service delivery to meet these needs.

Methods

The summary review of JSNAs consisted of a desktop review of all the 150 JSNAs across England in order to determine whether the mental and related health needs of veterans were included in these assessments.

The review also involved a focused consultation with key individuals from commissioning and provider statutory services and armed services charities including lead managers and clinicians with particular expertise in meeting veterans' health needs. In addition three focus groups and some telephone interviews were held with veterans and family members. In total 71 respondents were included in the focused consultation:

- 23 individuals from statutory health services e.g. veterans' mental health services, CCGs, NHS Trusts and Universities;
- 20 individuals from the armed forces charities;
- 28 veterans and family members.

For the purposes of this review a veteran has been identified as someone who has spent one day or more in the armed forces including reservists. The review has also taken into consideration the health needs of family members including children and carers of veterans.

Assessment of mental and related health needs

Fewer than half (40%) of JSNAs across England include a reference to the health needs of veterans. There are also variations in the way that the JSNAs address the health needs of veterans e.g. amongst the 40% that do include veterans the majority (82%) have no more than the word 'veteran' somewhere in the assessment as either a vulnerable group or one whose specific health needs should be addressed. Amongst the 18% that do have more detailed information only a handful cover the full range of health needs including mental health needs.

The significant gaps in coverage of veterans' health needs in the JSNAs for England have implications for local area commissioning and whether veterans' health needs will be adequately addressed in Health and Wellbeing Strategies. This may have an impact on local authorities meeting their statutory duties for public health in line with the Health and Social Care Act 2012. These include a duty to take steps for improving the health of the people in their area, and responsibility for providing a range of public health services previously provided by the NHS. It is also possible that if veterans and family members are not included in JSNAs then CCG commissioning plans may be affected if they are unable to more fully address this population's health needs. Some of the methodological problems with JSNAs addressing mental and related health needs of veterans include:

- veteran status is not routinely recorded in primary and secondary care health statistics and rarely features in social care statistics;
- veterans are dispersed across the country and while there is some intelligence and data about their residence this is not uniform or robust or sufficiently detailed at CCG or local authority area levels;
- while the status of a veteran may be recorded in a few primary care records those of family members and reservists are very seldom recorded;
- veterans themselves may occasionally be reluctant or unlikely to identify themselves as veterans even when offered the opportunity;
- veterans are a heterogeneous group and assumptions about health need may not apply equally to all those classified as a veteran.

Incidence and Prevalence of mental health problems

The global incidence and prevalence of mental health needs amongst the veteran population is challenging to assess accurately due to variances in the methods used in different studies. It is also important to note that incidence and prevalence are likely to differ according to age, gender and occupational status e.g. reservists may experience higher rates of mental health problems following combat compared to regular serving personnel and early service leavers are known to be at greater risk of developing mental health problems.

However, some key indicators from the available research suggests that:

- those aged between 16 and 54 are more likely to experience common mental health problems e.g. depression and anxiety than comparable age groups in the general population;
- veterans are almost twice as likely to experience alcohol problems as those in the general population;
- veterans who have experienced combat are more likely than other veterans to experience Post Traumatic Stress disorder (PTSD) and there is growing evidence that some PTSD amongst veterans involves the late onset of symptoms;
- there is likely to be an association between physical health problems such as musculoskeletal problems, chronic pain and unspecific symptoms and the experience of common mental health problems and/or alcohol and drug use;
- the mental health problems of family members including children and carers are sometimes associated with living with a veteran who has mental health and related problems, and the needs of family members including children are often under-identified or over looked;
- pre-service vulnerabilities play a part in subsequent incidence and prevalence of mental health and related problems including early childhood deprivation, poor educational attainment and parental neglect or abuse;
- mental and related health problems amongst veterans and family members are often aggravated or associated with social care needs including debt, housing and employment.

The care pathway and presenting health needs

Access to services can be problematic for veterans as a result of presenting health needs. For example, veterans may present with a complex range of behavioural problems that do not fit service access criteria such as anger and excessive or problematic alcohol use combined with social care problems.

For those veterans with mental health problems their presenting health needs often do not fit existing mental health services criteria. They may have complex behavioural problems that result in primary mental health care services such as step one and two IAPT (Increasing Access to Psychological Therapies) services being unable to take the referral, or they may not fit the criteria for serious mental illness that is required by secondary community mental health services.

Problematic alcohol use can also result in veterans being unable to access mental health services, while at the same time presenting mental health needs may mean that they cannot access alcohol support services.

These problems may not be unique to veterans but given the evidence for prevalence and incidence of mental health problems amongst veterans it is reasonable to suppose that these are common barriers to service access for this community. Problems in accessing appropriate support and services amongst veterans are also influenced by their awareness, perceptions and experiences, for example:

- reluctance to admit to perceived weakness or being in a position of having to ask for help;
- having unrealistic expectations about waiting times and service responses and perceptions that civilians can't or don't understand military culture;
- lack of awareness and understanding about the options for help and which services are provided either in the armed forces charities or statutory services in the NHS and local authorities.

All of the above contribute to a common experience reported by veterans and other stakeholders that veterans with mental health problems struggle to engage with services and often fall out of the care pathways.

There are no nationally recommended care pathways for veterans with mental and related health needs. The common assumption amongst commissioners and service providers has been that veterans do not need a separate care pathway, as their problems are perceived to be the same as those in the general population with the exception of combat PTSD. However, evidence from this review suggests that there are significant barriers for veterans in accessing and benefitting from current services and that the care pathway for veterans may in fact be more problematic than had been supposed.

Even with respect to combat PTSD the care pathways are not straightforward. There are questions about suitable diagnosis that is evidence based; and there is a wide range of treatment options for PTSD for veterans that may not be adequate or appropriate.

Other key gaps in the current care pathways for veterans and family members have been identified in this review:

- lack of understanding and sensitivity about military culture amongst GPs and other key health care professionals;
- poor understanding and inconsistency about commitments made under the Armed Forces Covenant regarding prioritisation of clinical needs;
- the need to strengthen prevention activities and engagement in earlier interventions within care pathways, particularly in primary care;

- restrictive access criteria to services that exclude people with more complex problems e.g. it is a common stakeholder view that veterans rarely present with a clear single mental health problem;
- the need for alcohol problems to be included as part of an integrated care pathway for mental health;
- the wide range of service options across the statutory and charitable sectors can be confusing to navigate and result in uncertainties about which services are providing evidence based treatments;
- poor or under developed integration of armed forces charities with lack of recognition of their vital role in supporting engagement and providing wrap around support services as part of an integrated care pathway;
- the need to ensure that care pathways are not developed in isolation and that there is increased recognition amongst clinicians and commissioners of the need to provide integrated care for mental and related physical conditions;
- concerns that mental health services need to be able to work more effectively with a broad range of problems for veterans including integration of health and social care needs e.g. employment support is viewed as one of the main gaps in service responses.
- one of the largest care gaps perceived by stakeholders is for families and carers including recognising and addressing the needs of children of veterans. Particular concerns are expressed about access to Child and Adolescent Mental Health Services (CAMHS).

Most stakeholders believe that some specialist mental health service provision for veterans should exist but that these services can never capture the full level of need nor meet the full levels of demand that would likely arise in a single CCG service area. There is a need to improve mainstream mental health service provision so that it can meet the mental and related health needs of veterans in a culturally sensitive and appropriate way as required by the Armed Forces Covenant.

Improving the care pathways for veterans and family members is not something that can be done by any single agency. Commissioners, service providers, armed forces charities and veterans and family members need to work collaboratively on co-designing an effective framework for action on assessment of health needs and improving the care pathway.

A framework for action

The following framework for action is proposed in order to address the gaps that have been identified in JSNAs and to ensure that commissioning and service provision for veterans and family members is effective and appropriate. The framework consists of three building blocks:

1. Targeted and intelligent use of data and information

The variations in coverage of veterans' mental and related health needs in JSNAs across England may mean that national guidance on how to effectively ensure these needs are addressed is required. This could take the form of a practical resource with specific advice on how to address the methodological issues identified in this report such as making appropriate use of data and ensuring that veterans and family members are engaged in the assessment.

Public Health England would welcome the opportunity to take a leadership role in supporting the development of this guidance. The resource would need to address the following areas:

- primary and secondary care data collection of veterans and family members;
- training and awareness of GPs and primary care staff;
- adopting a population based approach to health inequalities for veterans and family members.

2. Appropriate and sensitive evidence based services

There are a number of specialist veterans' mental health services some of which have been developed locally through the initiative of individual NHS Trusts or CCGs, and some through NHS England's specialist commissioning role. These services should continue to form an important part of the care pathway but they will never be able to meet the full levels of need or demand. It is important that there are improvements in generic mental health services at local area levels including greater integration and collaboration with the armed forces charities.

The further development of appropriate and sensitive evidence based services for veterans and family members including reservists requires the following improvements in care pathways:

- less restrictive access criteria that can enable services to better respond to complex needs;
- clear referral routes for alcohol services as part of an integrated care pathway;
- recognition of the needs of family members including children and parents of veterans that takes account of the wider determinants of health such as access to employment, and adequate housing;

- greater integration in service responses for meeting both physical and mental health needs;
- clarity on liaison and partnership working between statutory services and the armed forces charities.

There is potentially an untapped resource of clinicians who are veterans or family members of veterans working in the NHS and who may be willing to act as champions and lead advisors within a structured learning programme. For example, learning collaboratives could be developed for GPs and primary care staff members alongside those working in Mental Health NHS Trusts.

3. Involvement and participation of veterans and family members

Effective involvement and participation of veterans and their family members is essential for improving data collection and the successful development of appropriate and sensitive evidence based services. NHS England has been recognised for its commitment to the involvement of veterans and family members in commissioning and this has already formed a key component of NHS England's Veterans' Mental Health Networks. However, there is a need to further strengthen the involvement of veterans and family members in local area service developments to ensure that there is a strong service user voice.

To be effective this requires a structured and supported programme building upon the existing networks but seeking to underpin these with a more comprehensive development of local area veterans and family members' networks. In order to ensure meaningful and active involvement a structured programme of support would need to include capacity building for network participants through training and education e.g. information and knowledge about policy and legislative drivers and understanding about standards and frameworks for commissioning and service provision. This approach would ensure that participants are equipped with the knowledge, skills and experience to be meaningfully and actively engaged with a programme of lasting change.

In addition, the networks will need to be adequately resourced with appropriate facilitation and recognition for practical expenses e.g. travel, catering and room hire. Facilitators could be drawn from a wide variety of sources including lead clinicians, armed forces charities and from amongst veterans and family members themselves. An adequately resourced and facilitated programme of involvement and participation that takes a capacity building approach could form the bedrock of development for improving commissioning and service responses for veterans and family members.

Conclusion

The three building blocks are interdependent and are proposed as key mechanisms for creating a sustainable and lasting framework for action that will improve the assessment of the mental and related health needs of veterans and their family members and inform the commissioning and delivery of services to meet those needs.

1. Introduction

This report sets out the findings from the review of veterans and family members' mental and related health needs assessments in England¹. The review was designed to support NHS England in building on its track record of success in meeting the health needs of armed forces personnel and veterans through the single operating framework for commissioning. In addition, the project seeks to support wider NHS partners such as Public Health England, Clinical Commissioning Groups (CCGs) and Local Authorities to better meet the mental and related health needs of veterans and their families.

Forces in Mind Trust in collaboration with NHS England sought to build on these achievements by commissioning a review of the extent to which the mental and related health needs of veterans and family members are being assessed. This was viewed as a priority for ensuring that services to meet these needs are commissioned appropriately and delivered effectively.

1.1 Background

It is important to state at the outset that the picture of veterans as all suffering from severe mental illness and behaviour problems is over-exaggerated:

“There is a pervading myth that serving and ex-Service personnel are ‘mad, bad and sad’ i.e. that most suffer mental health problems, that many veterans end up in prison or sleeping rough on the streets, and that many are suicidal...rates of mental health problems amongst service personnel and recent veterans appear to be broadly similar to the UK population as a whole²”.

Nevertheless, since 2008 when the Ministry of Defence (MOD) and the NHS funded the first veterans' mental health pilot services there has been an increasing concern about and focus on veterans' mental and related health needs. This was given further emphasis and priority with the Murrison Report, *Fighting Fit* (2010) and the revised Armed Forces Covenant in 2011. The Armed Forces Covenant states:

*“Veterans receive their healthcare from the NHS, and should receive priority treatment where it **relates to a condition which results from their service** in the armed forces, **subject to clinical need**. Those injured in service, whether physically or mentally, should be cared for in a way, which reflects the nation's moral obligation to them, whilst respecting the individual's wishes. For those with concerns about their mental health, where symptoms may not present for some time after leaving service, they should be **able to access services with health professionals who have an understanding of armed forces culture**.”* (The Armed Forces Covenant, MOD, 2011)

¹ For the purposes of this review a veteran has been identified as someone who has spent one day or more in the armed forces including reservists. The review has also taken into consideration the health needs of family members including children and carers of veterans.

² RBL, 2014. *A UK Household Survey of the ex-Service Community 2014*. London: Royal British Legion. Page iv.

The importance of ensuring that the mental and related health needs of veterans and their families are appropriately assessed and thus able to be considered in terms of commissioning priorities is emphasised by a number of recent legislative and national policy drivers. For example:

- Armed Forces Act 2011: Includes an annual duty to report progress against the Armed Forces Covenant to Parliament including health;
- Securing excellence in commissioning for the armed forces and their families (26 March 2013);
- NHS England Mandate from the Department of Health (DH) requires that NHS England deliver the health actions of the Armed Forces Covenant;
- Health & Social Care Act 2012 includes duty of NHS England to commission services on behalf of the armed forces;
- NHS Mental Health Strategy 2011 (No Health Without Mental Health) includes specific provision for veterans.

There are also a number of recent changes and some expected over the next few years, which will impact on the health needs of the armed forces, these include:

- the withdrawal of armed forces personnel from Afghanistan;
- rebasing of service personnel returning from British Forces in Germany;
- plans for the increased use of reservists;
- changes in the use of armed services e.g. use for humanitarian aid;
- unforeseen/future operations at significant scale where combat and operational needs may impact on health including increased routine training for contingency operations that could result in a range of health needs that would not be the same as for a normal civilian population.

The Health and Social Care Act 2012 confirmed the NHS commitment to supporting better health outcomes for veterans including mental health and related problems. The commissioning of most health services for armed forces i.e. those who are registered in MOD GP practices as serving personnel, mobilised reservists and some families is the responsibility of NHS England.

NHS England has continued to develop its national strategy and operating framework for armed services including veterans since *Securing excellence in commissioning for the armed forces and their families* (2013) and the more recent *Armed Forces and their Families Commissioning Intentions 2015/16* (March 2014). CCGs retain the responsibility for veterans, most families and non-mobilised reservists.

The tangible enhancements of provision achieved by the NHS, MOD and the Department of Health with respect to the recommendations made in the Murrison Report was recognised by Lord Ashcroft in the Veterans' Transition Review:

“The MOD and Department of Health have worked with the NHS in England and with Service charities to implement the recommendations, resulting in a tangible enhancement of provision, improved access and an increase in awareness of the potential for and nature of veteran mental health problems amongst healthcare providers and the ex-military community”. (Lord Ashcroft 2014. *The Veterans' Transition Review*. London MOD).

1.2 Methods

The review has been conducted through a twin process of desktop analysis and focused consultation with key stakeholders. The desktop analysis consisted of a review of Joint Strategic Needs Assessments (JSNAs) across England. In addition, a number of related health needs assessments and relevant documentation including published literature and national surveys were considered. The following criteria were used for inclusion of evidence to be reviewed:

- includes data on at least one of the following: health need, service utilisation and/or stakeholder views concerning veterans and their families and/or serving armed forces personnel;
- is from within the last four years;
- can be attributed to a legitimate source e.g. named author and/or organisation(s).

The focused consultation involved key individuals from commissioning and provider statutory services and armed services charities including lead clinicians, managers and other staff members with particular expertise of meeting veterans' health needs. Interviews were conducted on a confidential basis by telephone and face-to-face. A small number of focus groups and interviews were held with veterans and their families. In total 71 respondents were included in the focused consultation:

- 23 individuals from statutory health services e.g. veterans' mental health services, CCGs, NHS Trusts and Universities;
- 20 individuals from the armed forces charities;
- 28 veterans and family members.

The purpose of this exercise was not to repeat the kind of consultation that is used as part of individual health needs assessments, but rather to ensure that the stakeholders could help to identify key gaps in commissioning and assessment of needs for veterans' mental and related health needs through an appropriate process of engagement.

1.3 Consultation and feedback on the report and the framework for action

The report and the framework for action were shared with key stakeholders at an event on the 2nd July 2015. Participants represented a wide range of interests including commissioners, service providers, armed forces charities, universities, local authorities and veterans and family members.

The aims were to:

- provide an early opportunity for stakeholders to understand the context to the review and the main findings;
- have an opportunity to discuss how to best to take forward the emerging priority areas;
- provide an opportunity for stakeholders to meet the review team and to network.

The event was opened by Ray Lock, CE of the Forces in Mind Trust and participants had the opportunity to hear first hand from one of the report's authors, Dr Jon Bashford in addition to key note presentations by Professor Lord Patel of Bradford OBE and Kate Davies OBE and Amanda Fisk from NHS England. Participants also had the opportunity to discuss each of the building blocks in the framework for action in a series of breakout groups.

Participants broadly welcomed the report and there was strong support for the approach proposed in the framework for action. The comments and feedback have been incorporated into the framework and NHS England and Public Health England are using the feedback to inform their ongoing work programmes.

2. Assessment of mental and related health needs

The National Institute for Health and Clinical Excellence (NICE) defines a Health Needs Assessment (HNA) as:

“A systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities³”

This includes three key processes:

- **The epidemiological needs assessment** – e.g. robust data on clinical need and manifestation including current and historical patterns of service utilisation;
- **The corporate needs assessment** – e.g. the inclusion of stakeholder views including service providers and clinicians, Non Governmental Organisations (NGOs) in particular those with a specific remit for armed services personnel and their families;
- **The comparative needs assessment** – e.g. comparing the available evidence base and existing services and need against current healthcare standards and priorities.

Each of the three processes is considered to be important for a comprehensive and robust health needs assessment. There are examples of specific Health Needs Assessments for veterans, however Lord Ashcroft’s Veterans’ Transition Review highlighted that there are significant shortfalls in the quality and completeness of these assessments:

“In reviewing a cross-section of these health needs assessments we noted that the reports all highlight significant limitations created by an absence of reliable quantitative national data about the veteran population and an inability to accurately estimate the size of the local veteran population”. (The Veterans’ Transition Review. Lord Ashcroft KCMG PC. February 2014)

More significantly, it was not known to what degree veterans’ health needs were being accounted for in Joint Strategic Needs Assessments across England. This is important in the current health and social care commissioning landscape because JSNAs are key to determining the priorities and strategy for local area health and social care commissioning.

³ Health needs assessment: A Practical Guide (2005) NICE

2.1 Joint Strategic Needs Assessments

The NHS and upper-tier local authorities have had a statutory duty to produce an annual Joint Strategic Needs Assessment since 2007. Under the Health and Social Care Act 2012, JSNAs became a statutory requirement to underpin local area Joint Health and Wellbeing Strategies (JHWSs). Their purpose is to provide analysis of the health needs of populations, to inform and guide commissioning of health, wellbeing and social care services within local authority areas.

JSNAs are also intended to be the means by which local leaders work together to understand and agree the needs of all local people, with the Joint Health and Wellbeing Strategy setting the priorities for collective action. For example, guidance from the Department of Health states:

“This strengthened role of JSNAs and Joint Health and Wellbeing Strategies will enable local Councillors, GPs and Directors of Public Health, Adult and Children’s services to work with their communities in leading a more effective and responsive local health and care system. They will sit at the heart of local commissioning decisions, underpinning improved health, social care and public health outcomes for the whole community.” (Joint Strategic Needs Assessment and joint health and wellbeing strategies explained – commissioning for populations. 2011. DH. Page 7)

Taken together these are the pillars of local decision making, focusing leaders on the priorities for action and providing the evidence base for decisions about local services.

The process for conducting a JSNA aims to provide a comprehensive picture of current and future health needs for adults and children, based on a wide range of quantitative and qualitative data, including patient, service user and community views. Guidance produced by the NHS Confederation states:

“The ‘product’ of a JSNA is intended to improve health and wellbeing outcomes and help address persistent health inequalities. Clinical Commissioning Groups, the Local Authority and the NHS Commissioning Board will need to consider the JSNA and the health and wellbeing strategy when commissioning services, because the JSNA should guide decisions around where to invest or reduce spending⁴”.

Local Authorities and CCGs have equal and joint duties to prepare JSNAs. Statutory guidance from the Department of Health (DH) states that:

“Local areas are free to undertake JSNAs in a way best suited to their local circumstances – there is no template or format that must be used and no mandatory data set to be included⁵”.

⁴ NHS Confederation, 2011. *The joint strategic needs assessment: A vital tool to guide commissioning*. London: NHS Confederation.

⁵ DH, 2013. *Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies*. London: DH.

However, despite there not being a mandatory data set requirement the statutory guidance does go on to state that:

“JSNAs can also be informed by more detailed local needs assessments such as at a district or ward level; looking at specific groups (such as those likely to have poor health outcomes); or on wider issues that affect health such as employment, crime, community safety, transport, planning or housing...” (DH, 2013. Page 6)

The JSNAs are intended to look at current and future health and social care needs and to ensure parity of esteem between physical and mental health:

“JSNAs must assess current and future health and social care needs within the health and wellbeing board area and it is important to cover the whole population, and ensure that mental health receives equal priority to physical health.” (DH, 2013. Page 7)

The types of data that should be included in a JSNA are:

- demographics of the area i.e. needs of people of all ages of the life course including how needs vary for people at different ages;
- how needs may be harder to meet for those in disadvantaged areas or vulnerable groups who experience inequalities;
- wider social, environmental and economic factors that impact on health and wellbeing i.e. access to green space, the impact of climate change, air quality, housing, community safety, transport, economic circumstances, employment; and
- health and social care information that the local community needs i.e. how they access it and what support they may need to understand it. (DH, 2013. Page 8)

There is also recognition that where data is not readily available for a particular group it is important to seek information and local area intelligence from other sources such as charities and voluntary sector organisations:

“Health and Wellbeing Boards may find that there is a lack of evidence about some issues, and some seldom heard and vulnerable groups, which could be indicative of unmet needs and deprivation. Local partners such as voluntary sector organisations or local Healthwatch may be able to help where such evidence is lacking as they are well placed to collect both quantitative and qualitative evidence and have good specialist knowledge of the community. They can also help boards to directly engage with some of these seldom heard and vulnerable groups.” (DH, 2013. Page 8)

The Royal British Legion issued guidance for its members on participating in JSNAs in recognition that this is an essential component of having the needs of veterans identified and addressed in local area commissioning plans:

“As local authorities will now be leading the JSNA and influence many other bodies’ commissioning services on a local level, it is imperative that the county Legion branches engage in this process so that the charity sector and more specifically, the armed forces and veterans population, is taken into account when important commissioning decisions are made for health and social care services⁶”.

2.2 Coverage of veterans’ health needs in JSNAs

There are wide variations in the coverage of veterans’ health needs in JSNAs across England. For example, at regional levels the inclusion of veterans in JSNAs varies from 0% in the West Midlands to 78% in the North East:

Table 1: Geographical variations of JSNAs and inclusion of veterans’ health needs

Region	No. Authorities conducting JSNAs	No. JSNAs reviewed	No. Referencing veterans	Percentage
Eastern (4 County; 7 Unitary)	11	11	8	73%
East Midlands (4 County; 4 Unitary)	9	9	0 (NB: There is an East Midlands HNA on veterans and some related documents on specific veteran health needs)	0%
West Midlands (4 County; 3 Unitary; 7 Metropolitan)	14	14	0	0%
Yorkshire & Humber (County 1; Unitary 8; Metropolitan 8)	17	17	7 (NB: One only refers to homelessness)	41%
South East (County 7; Unitary 11)	18	18	14	78%
South West (County 4; Unitary 12)	16	16	10	62.5%
London (32 London Borough Councils)	32	32	4 (NB: One only refers to housing needs)	12.5%
North West (County 2; Unitary 6; Metropolitan 16)	24	24	10	41.5%
North East (Unitary 4; Metropolitan 5)	9	9	7 (NB: One refers to plan to undertake HNA for veterans)	78%
TOTAL	150	150	60	40%

As can be seen from the above table fewer than half (40%) of JSNAs across England include a reference to the health needs of veterans. There are also variations in the way that the JSNAs address the health needs of veterans e.g. the majority of those that do address veterans (82%) have only the word ‘veteran’ somewhere in the assessment as either a vulnerable group or one whose specific health needs should be addressed. Amongst the 18% that do have more detailed information only a handful cover the full range of health needs including mental health needs.

⁶ RBL, 2010. *Public Policy Unit – Briefing: Joint Strategic Needs Assessments*. London: Royal British Legion.

The significant gaps in coverage of veterans' health needs in the JSNAs for England have implications for local area commissioning and whether veterans' health needs will be adequately addressed in Health and Wellbeing Strategies. This may have an impact on local authorities meeting their statutory duties for public health in line with the Health and Social Care Act 2012. These include a duty to take steps for improving the health of the people in their area, and responsibility for providing a range of public health services previously provided by the NHS. It is also possible that if not included in JSNAs then CCG commissioning plans may be affected if they are unable to more fully address this population's health needs.

One of the central challenges for the JSNAs that seek to address the health needs of veterans is the relative lack of local area intelligence and data. There are two aspects to this challenge: firstly, the challenge in identifying accurately the number of veterans that reside in an area; and secondly, access to data on service utilisation amongst veterans who have approached or used primary or secondary mental health and other health services, including the armed forces charities.

2.2.1 Identifying the veteran population through national household surveys

The most recent Royal British Legion (RBL) Household Survey (2014) estimates that there are between 6.1 and 6.2 million members of the ex-Service community living in the UK including 2.8 million veterans:

“In total, Compass Partnership estimates that there are between 6.1 million and 6.2 million members of the ex-Service community living in the UK. Of these, around 2.8 million are veterans, 2.1 million are dependent adults (including spouses and widows) and 1 million are dependent children. The remaining 190,000-290,000 represents the estimated size of the ‘hidden’ ex-Service community e.g. those residing in communal establishments such as care homes”. (RBL Household Survey, 2014. Page vii).

The RBL Household Survey, 2014 estimates that 82% of the adult ex-Service community lives in England:

Table 2: UK geographical distribution of adult ex-Service community in year 2014

Area	Percentage of adult ex-Service community	% of UK population	Penetration of adult ex-Service community
England	82%	83%	9%
Scotland	9%	9%	10%
Wales	7%	5%	12%
Northern Ireland	2%	3%	7%

(RBL, 2014. Page 15)

While the RBL Household Survey data is very useful and gives a strong indication of the numbers of veterans likely to reside in the different regions across England there are some limitations to using this data.

For example, the data combines the number of veterans with spouses and adult family members and in terms of health needs it may be important to distinguish these groups more clearly. The data is also based on the Household Survey, which only covers those living in private residential accommodation, and therefore excludes veterans who may be living in residential care establishments or other forms of supported housing.

Most of the JSNAs make use of the RBL Household Survey data to determine their local area veteran population. However, these JSNAs were undertaken prior to the publication of the most recent survey. More recent analysis undertaken by Compass Partnership and the Royal British Legion on behalf of NHS England shows that there are significant variations in the estimates of penetration of the ex-Service community between 2005 and 2015. In addition the average age of veterans has increased and the areas that have seen the greatest falls in number of veterans are those with lower life expectancy.

These changes in the data mean that some of the JSNAs that have relied on the 2005 RBL Household Survey may have over estimated the number of veterans living in their area and also not taken full account of changes related to age and life expectancy.

Some of the JSNAs have also used other proxy measures for estimating the number of veterans living in their local area such as the ONS [Office of National Statistics) Population Trend Series data that used the 2007 Adult Psychiatric Morbidity Survey (APMS). The APMS was a household survey of 7,461 private residents and it included questions about previous military service. Use of this data in the Kent and Medway veterans' 'ex-military' Health Needs Assessment, 2011 produced an estimate of community dwelling veterans of 9.1% of the 16 plus aged population:

“When extrapolated out to the mid-2007 estimate of the English population, this gave an estimate of 3,771,534 community-dwelling veterans (95% confidence interval: 2,986,315 – 4,910,205), constituting 9.1% of the 16 and over English population. That the 95% confidence interval spans a range of nearly 2 million is a reflection of the uncertainties associated with extrapolating out from a relatively small sample. Since the original survey only included individuals in private dwellings, a further estimate was made of the number of veterans living in communal establishments: this was 33,198”. (Veterans' 'ex-military') Health Needs Assessment for Kent and Medway. October 2011. Page 16)

It is important to note the wide confidence interval in the above estimates i.e. from 2.9 million veterans to 4.9 million veterans based on extrapolation to the 2007 mid year ONS population estimates. However, the lower end of this figure does more closely approximate that of the 2014 RBL Household Survey i.e. that there are 2.8 million veterans in the UK.

Nevertheless, the relatively small sample sizes involved and these wide confidence intervals make extrapolating this data further to local authority area populations problematic.

2.2.2 War Pension Scheme and Armed Forces Compensation Scheme data

Attempts have also been made in JSNAs to use data from the War Pensions Scheme (WPS) and the Armed Forces and Reserve Forces Compensation Scheme (AFCS) as proxy measures for the number of veterans living in local areas. The UK's War Pensions Scheme applies to ex-Service personnel whose injuries, wounds and illnesses arose before 6 April 2005. The scheme includes War Disablement Pensioners and War Widowers. The AFCS provides compensation for any injury, illness or death, which is caused by service on or after 6 April 2005.

However, this is not a suitable proxy measure for determining the total numbers of veterans that may reside in area, as not all will be in receipt of a War Pension or AFCS payment. Also, this data uses the postal address of recipients at the time of the claim and do not therefore reflect subsequent re-location and moves that may have taken place.

2.2.3 GP and primary care registration data

The most useful health data for numbers of veterans residing in an area would be that contained in GP registration lists. GP Practices themselves can identify veterans registered with their practice using Read codes⁷. The specific Read code recommended by the Department of Health and the Royal College of Physicians for patients with a military background is Xa8Da. However, there are a variety of other possible codes:

- ◆ 13q3 - Served in the armed forces
- ◆ 13JR – Left military service
- ◆ 13Ji – Military veteran
- ◆ 13JY – History relating to military service
- ◆ 091 – Occupation domain – armed forces
- ◆ 06E – Occupation domain – Officer armed forces

What is clear from the JSNAs is that attempts to obtain adequate data from GP registration systems have found that it is inconsistent:

“Use of Primary Care data is therefore limited by:

- ◆ *The willingness of veterans to identify themselves as such when first registering with a GP;*
- ◆ *Awareness of the existence of relevant Read codes by GPs and other primary care staff.*

Given these caveats, data from primary care is likely to under-estimate the size of the local veteran population.” (Southampton JSNA. 2012. Section 1.4 Page 11)

⁷ Read Codes are a coded thesaurus of clinical terms and they provide the standard vocabulary by which clinicians can record patient findings and procedures in health and social care IT systems across primary and secondary care.

These problems have also been found in recent research into military veterans and GPs:

“This study has shown that there was considerable uncertainty regarding whether GPs had seen a veteran recently and only 7.9% stated that they used the Read Code⁸”.

Simpson and Leach concluded that:

- GPs are not aware of how many veterans are in their practice population;
- few GPs use the unique identifying code for veterans (Read Code);
- the Royal College of GPs has tried to raise the awareness of veterans’ issues, but few GPs surveyed were aware of the educational resources available.

This inconsistency in GP registration data represents one of the most significant challenges to conducting a robust local area health needs assessment for veterans:

“Get them flagged in clinical records at the outset – it takes lot of education and awareness raising to achieve this.” (Consultation respondent, Statutory Service)

“All GPs should be required to record veteran status on registration.” (Consultation respondent, Statutory Service)

However, some improvements are being made since many of the JSNAs were undertaken. For example, the latest data from NHS England now shows the numbers of recently discharged veterans registering with NHS GP practices. It therefore provides a more accurate number of active recently discharged (i.e. younger) patients, but will exclude those that have not settled or registered with GPs.

A comparison of this more recent data on GP registrations with the RBL data shows some close correlations but there are also some significant regional variations with the AFCS data:

⁸ Simpson Robin, G and Leach, J. 2014. The General Practitioner and the military veteran. J R Army Med Corps 2014; 0:1–3. doi:10.1136/jramc-2013-000243.

Table 3: Comparative Figures for veteran Distribution (NHS England June 2015)

	England population %	RBL Household 2014 Adult ex-Service community %	AF Compensation (AFCS and WP) %	GP Registration %
Greater London	16%	4%	4%	4%
South East	17%	15%	19%	19%
South West	10%	15%	19%	19%
East of England	11%	12%	9%	8%
East Midlands	8%	10%	9%	12%
West Midlands	11%	11%	8%	9%
Yorkshire & Humber	10%	14%	10%	10%
North East	5%	7%	8%	7%
North West	13%	12%	14%	12%

NB: Green highlight indicates areas of over representation compared to other measures and red highlight indicates areas of under representation.

As can be seen from the above table the more recent GP registration data is broadly in line with RBL survey data with the exception of the East of England where it is below the estimated number of veterans in the RBL survey data.

2.2.4 Secondary and community services utilisation data

One of the key sources of evidence for the epidemiological part of the health needs assessment process should be the inclusion of service utilisation. This is more a measure of demand rather than health need but taken together with the other sources of evidence can provide an estimation of likely capacity and whether or not services are able to appropriately meet health needs.

This is complicated for veterans’ mental health needs as many mental health services do not record or report on service utilisation by veterans. In fact service utilisation data are rarely used in the health needs assessments for veterans:

“We know needs from individual cases but we don’t have cohort knowledge.”
(Consultation respondent, statutory service)

Where this data has been included this tends to be due to an existing veterans’ specific mental health service. Though even where such services exist it does not follow that their service utilisation data has been used to inform the JSNA:

“There are obstacles in sharing service data, problems about ownership and use.” (Consultation respondent, statutory service)

The other most significant data omissions in the JSNAs concern Secondary Users Services (SUS) data and the Community Information Data Set (CIDS) especially with respect to mental health services. These were both identified as priority areas for development with respect to armed forces personnel in 2013⁹:

“This will include tracking all acute and outpatient care through the Secondary Users Service (SUS) data set and build upon the use of the NHS number, the accuracy and use of which is being improved for armed forces personnel. In terms of the community information data set (CIDS), the dataset has been available from April 2011 to start local collection; it should be possible to develop a proxy of the current position... All providers MUST be fully compliant with this standard by April 2014. So long as datasets are capturing the NHS number and registered GP Practice code, this should be sufficient to provide relevant commissioning data.” (NHS Commissioning Board. 2013. *Securing excellence in commissioning for the armed forces and their families*. March 2013. Page 20).

These improvements for armed service personnel should start to have a knock on effect of improving the recognition of veterans in similar data sets for secondary care services. Hospital managers in Wales, for example have already started to routinely record veteran status on hospital admission forms:

“Wales have started to use a template for hospitals that includes Veteran status for all referrals.” (Consultation respondent, Statutory Service)

2.3 Prevalence of mental and related health problems

Another challenge for JSNAs is to accurately identify the prevalence of mental health and related problems amongst veterans. For the reasons outlined in the previous section there is very little local area data that could inform this assessment and so the JSNAs tend to use proxy data from the most commonly cited national research and surveys.

One of the largest studies of mental health problems' prevalence in the military is the longitudinal study conducted by the King's Centre for Military Health Research (KCMHR). This is also one of the most commonly cited pieces of evidence in the JSNAs for determining estimates of mental health prevalence amongst veterans.

The following table shows the three most commonly cited mental health problem disorders with estimates of prevalence compared to the general population from the KCMHR cohort study. This is the most commonly referenced evidence on prevalence in the JSNAs.

⁹ Securing excellence is primarily concerned with serving personnel and this work is ongoing for the serving population.

Table 4: Comparison of Mental Health Problem Prevalence in Military and General Populations

Mental Health Problem	Military (Serving populations) %	General population %
Probable PTSD	4%	3%
Common mental disorder	20%	20%

Source: KCMHR cohort study, 2010

While the KCMHR data is one of the most commonly cited sources of evidence by which local data has been extrapolated in the JSNAs to inform health needs assessments for veterans there are limitations to the use of this data:

- the veteran population differs from the serving population by age, military experience and lifestyle;
- the KCMHR study covers individuals who served in Iraq or Afghanistan either as regulars or reservists;
- the follow up period for the study is relatively short and does not address long term prevalence of mental health problems that may arise amongst veterans.

The recent RBL Household survey suggests that the prevalence for mental health problems amongst veterans in particular depression has increased:

“The prevalence of reported mental illness within the ex-Service community has increased since 2005, with the proportion reporting depression doubling to 6%. Since mental illness is more common among those aged 35-64, this increase is not related to the ageing population. The incidence of reported mental health problems is higher than average for veterans who served in Northern Ireland and in post 1990s peacekeeping operations: one in ten of each group reports suffering from depression”. (RBL, 2014. Page 40)

It is also recognised in the JSNAs that serving in the armed forces has positive impacts on health:

“Service in Her Majesty’s Forces is generally associated with good mental and physical health. Whilst serving, the requirement for physical fitness and regular medical checks probably have a positive impact on the health of an individual who otherwise might have had a poor diet, limited exercise, and been at risk of unemployment and criminality”. (Veterans’ ‘ex-military’) Health Needs Assessment for Kent and Medway. October 2011. Page 7)

However, it is not certain how long lasting these positive impacts are post-service with the implication being that many younger veterans (i.e. post-national conscription which tended to recruit from a much wider pool of applicants) soon lose these benefits and revert to the socio-economic disadvantages and impacts of early years deprivation.

2.3.1 Post Traumatic Stress Disorder (PTSD)

The prevalence of PTSD amongst veterans is challenging to estimate due to the limitations of some studies e.g. lack of clinical diagnostic testing. However, particular factors identified by the KCMHR study that were thought to impact on development of PTSD include:

- reported PTSD was associated with deployment of any kind;
- there was a higher reported incidence of PTSD amongst deployed reservists than deployed regulars;
- higher reported incidence of PTSD amongst those who had experience of combat roles.

Although the prevalence of PTSD may be lower than previously thought the JSNAs recognise that the specific needs of this group need to be recognised:

“Whilst rates of PTSD may be similar amongst veterans and the general population, this does not rule out the possibility that they have specific needs”. (Health Needs Assessment of The armed forces Community (the armed forces, their families and veterans). Surrey 2013. Page 48).

2.3.2 Alcohol and drug use

The KCMHR study shows significantly higher rates of alcohol misuse amongst serving military personnel compared to the general population:

Table 5: Comparison of Alcohol Misuse prevalence in Military and General Populations

Mental Health Problem	Military (Serving populations) %	General population %
Alcohol misuse	13%	6%

Source: KCMHR cohort study, 2010

The RBL Survey found that 1% of veterans had a self reported alcohol problem, however, these figures differed significantly by age for example amongst those aged 16 – 54 years old 4% are described as having a high level problem and 23% as having a problem:

“Alcohol problems are strongly age-related. Of those aged 16-54, 23% have a problem (equivalent to around 160,000 veterans), with 4% having a high level problem. Only one in twenty of those aged 65 or over has any level of alcohol problem.” (RBL 2014. Page 42)

These differences are also noted as being reflected in time since discharge:

“These age differences are also reflected in differences by time since military discharge, with a big difference between those discharged less than 40 years ago (18%), and those discharged 40 years ago or more (3%).” (RBL 2014. Page 42)

Amongst stakeholders in the review there is a common perception that alcohol problems amongst veterans are under reported and less recognised:

“70% of cases we see have an alcohol problem at some point, it mainly comes up when they are in crisis and so drink more at these points, like most men.” (Consultation respondent, statutory service)

“Alcohol is a massive area that needs attention.” (Consultation respondent, armed forces charity)

Drug use is an area that has received less attention though there are reports from service providers that this is a problem for some veterans:

“Drug problems definitely exist, I’ve seen it clinically but it doesn’t feature in the research. It is not as big a problem as alcohol but it shouldn’t be overlooked.” (Consultation respondent, statutory service)

“Most have taken some illegal drugs in addition to alcohol. Mostly stimulants.” (Consultation respondent, armed forces charity)

2.3.3 Physical conditions

The RBL Household Survey identified significant numbers of the adult ex-Service community living with a variety of related health conditions:

Table 6: RBL Survey related health conditions

Conditions	% of Adult Ex-Service community
Multiple conditions	30%
Any musculoskeletal	28%
Any sensory (e.g. hearing loss, sight loss, speech impediment)	17%
Other progressive illness (e.g. MS, symptomatic HIV, Parkinson’s)	2%

(RBL, 2014 Page 86. Figure 6iv)

These physical conditions are thought by stakeholders to give rise to related mental health problems notably adapting to physical disabilities and living with chronic pain:

“There is a strong component of mental health issues related to living with the loss of limbs.” (Consultation respondent, armed forces charity)

“Chronic pain is a big issue, back injuries, knee injuries, pain associated with musculoskeletal disorders.” (Consultation respondent, statutory service)

However, it is not possible to determine exact or robust prevalence rates for mental health problems that are directly attributable to related physical conditions.

2.3.4 Involvement with the criminal justice system

Very few of the JSNAs include data on the number of veterans in the criminal justice system. Estimates from the Her Majesty's Inspectorate of Prisons based on their prisoner surveys for 2013/14 suggest that 6% of the prison population are veterans¹⁰.

Provisional data with small numbers from NHS England suggests some key variances in manifestations of clinical need for Liaison and Diversion (L&D) Services for veterans compared to the general population.

This data suggests that veterans are more likely to present to L&D services with adjustment disorders/reaction, depressive illness and anxiety, phobia, panic disorder, Obsessive Compulsive Disorder (OCD) and PTSD and less likely with schizophrenia and personality disorder.

There are also some differences in presenting problems at L&D Services for veterans with additional problems. This data suggests that more veterans than the general population present at L&D services with associated alcohol misuse problems and suicide risk but lower issues of communication and learning difficulties.

However, some caution must be exercised in assessing the data as it represents a relatively small sample (221 service users) covering a nine-month period up to December 31st 2014. With this caveat in mind the data does suggest that veterans present to L&D services with more complex needs and this would be worth further investigation.

¹⁰ Ex-Service Personnel Supplementary Paper: Veteran data from HM Inspectorate of Prisons' inspection surveys HMIP. 2014

3. Care Pathways and manifestations of clinical need

While there are clearly some methodological challenges in accurately identifying prevalence levels of mental and related health needs amongst veterans and their families, there are some known factors that impact on the manifestations of clinical need and subsequent impacts on access to, experience of and outcomes from the care pathways. These have important implications for the assessment of health needs and designing appropriate services to meet those needs, from prevention and early identification through to tertiary care services. For example, there is a consistent view amongst stakeholders that the existing care pathways for mental health services do not suit veterans and that this can result in people failing to access services or falling out of the care pathway:

“Sometimes people are referred to services but they don't fit the access criteria for either a community mental health team or primary care, they may have personality issues, not coping, problems with adaptation.” (Consultation respondent, statutory service)

“It's trial and error to find a good thing.” (Consultation respondent, veteran and family members)

3.1 Prevention and early identification

Though improvements are being made many stakeholders are concerned that the care pathway needs to be commenced at an earlier stage as part of the transition from serving in the armed forces to entering civilian life:

“The transition needs to be smoother, it should be same as if someone just moving areas across the NHS.” (Consultation respondent, statutory service)

“You are tossed out into the great big world and have to deal with it yourself, it's stressful when you come out after they paid all your bills and now you have to learn how to budget, it places a lot of stress on veterans.”
(Consultation respondent, veteran and family members)

“People only think about it when they become unwell, it needs to be part of their planning before they leave the Forces.” (Consultation respondent, statutory service)

“There is no support at transition even with housing.” (Consultation respondent, veteran and family members)

“Someone came round to the house twice after I left but they were no help, I didn't know them, just said I was fine.” (Consultation respondent, veteran and family members)

Despite improvements in transition management and the work of Personnel Recovery Units this is partly viewed as a management issue within the armed forces:

“If you have superb management then you are less likely to fall ill, a good manager will see that problems exist and do something about it, like any other company manager, it's an occupational health issue.” (Consultation respondent, armed forces charity)

However, it is also viewed as something that requires greater collaboration between the MOD and the NHS:

“There are increased stresses on families during transition, risk assessments should be shared, it is patchy, there needs to be more communication between MOD and NHS.” (Consultation respondent, armed forces charity)

“They need to have better links for getting your medical records from Service into general health care.” (Consultation respondent, veteran and family members)

“There needs to be more link up between DCMH [Departments of Community Mental Health] teams and the NHS.” (Consultation respondent, statutory service)

“If someone has been having therapy in a DCMH then it needs to be better linked to community for continuity of care when they leave the DCMH but it can be difficult as the DCMH covers such a wide geography.” (Consultation respondent, statutory service)

Understanding and awareness amongst GPs is viewed as one of the key barriers to prevention and early identification:

“The GP couldn't understand what I was trying to explain, my emotional state, physical health, I was also drinking too much, I was just given pills, no referral.” (Consultation respondent, veteran and family members)

“There are problems getting GPs to understand the issues and feel confident in this area, it's easy to do badly and much harder to do well, GPs have very little understanding about veterans and they need help.” (Consultation respondent, statutory service)

This should also include other key health care professionals e.g. community midwives, health visitors, healthy child programme leads and GP practice nurses and healthcare assistants.

Differences in help seeking behaviour are noted by stakeholders according to gender:

“Males are slower to admit that they have a problem.” (Consultation respondent, armed forces charity)

“There are big differences between men and women, females are seen less but they can be more vulnerable, they are expected to hold the family together and yet they may not be used to this having been on deployment so they don't ask for help.” (Consultation respondent, statutory service)

Early service leavers are seen as being particularly vulnerable:

“Early service leavers often have bigger problems but we tend to pick them up much later when things have already reached crisis.” (Consultation respondent, armed forces charity)

“Those with less than four years service are known to have particular problems, we need to be more responsive to this group.” (Consultation respondent, Statutory Service)

“Early service leavers don't see themselves as veterans, they may only be 19 years old and tend to have more risky behaviours, more drug and alcohol use, housing problems, debt, a lot of problems.” (Consultation respondent, armed forces charity)

Reservists are also thought to be more reluctant to seek help for mental health problems:

“Reservists tend to be more distrustful about giving information, they are concerned who it will be shared with, if it will be shared with employer or armed forces.” (Consultation respondent, statutory service)

3.1.1 Prioritisation of clinical need and the Armed Forces Covenant

There is a view amongst stakeholders that the commitments made under the Armed Forces Covenant regarding prioritisation of clinical needs are poorly understood and inconsistently applied in healthcare:

“The NHS needs to be clear that it should be based on medical need, the Military Covenant is not always understood, NHS priorities and clinical need are better known among medics”. (Consultation respondent, armed forces charity)

“The Covenant is interpreted differently in different places.” (Consultation respondent, armed forces charity)

Some respondents feel that the attempt to prioritise veterans' health needs has been taken out of proportion and is not something veterans are necessarily seeking from the NHS:

“Things have got out of proportion, we need some perspective back.” (Consultation respondent, armed forces charity)

“A good veteran would want the emergency case to go first, yes recognise that they have served but give them respect, treat them like a human being.” (Consultation respondent, armed forces charity)

Problems most often occur when there is doubt about whether or not a condition can be attributed to having served in the armed forces:

“GPs don’t understand the prioritisation for veterans, they shouldn’t have to argue it out with the GP.” (Consultation respondent, statutory service)

This is often related to the late onset of presenting problems:

“We had a complex case of late onset PTSD and IAPT refused to see the person because they said it wasn’t service related, we need to be able to unpick the issues and guide people down the right pathway.” (Consultation respondent, statutory service)

The delayed onset of problems and the dominant focus on PTSD amongst veterans are clearly complicating factors in the prevention and early identification of mental and related health needs. For most stakeholders the most important thing is to focus on presenting health needs rather than the attribution of these needs to having served in the armed forces:

“The bottom line is that people need to get the right treatment, in the right place, at the right time, by the right people.” (Consultation respondent, armed forces charity)

3.2 Responding to complex needs

It is a common stakeholder view that veterans rarely present with a clear single mental health problem:

“It’s never just a mental health issue, alcohol, debt, employment someone needs to be addressing these needs while the person has therapy for mental health problems.” (Consultation respondent, armed forces charity)

“If there is any trauma the IAPT reject the case, if they are too angry or too drunk IAPT won’t see them, and they won’t own the referral it just goes back to GP or nowhere.” (Consultation respondent, statutory service)

Veterans commonly report having to try various services and that they are reluctant to keep retelling their story in new assessments:

“Assessment steps are important but they can be overly complex and put people off, it creates barriers if too many hurdles to get in a service, leads to drop out.” (Consultation respondent, statutory service)

“People get fed up with having to keep tell their story to different clinicians.” (Consultation respondent, statutory service)

Veterans are thought to have a very low tolerance for waiting times:

“If told they have to wait 18 weeks they just bail and not engage,” (Consultation respondent, armed forces charity)

“Waiting times for IAPT can be up to three months, it is too long people just don’t turn up.” (Consultation respondent, statutory service)

Some veterans who used IAPT did not feel that the limited number of sessions was sufficient:

“Eight sessions are not enough, you need time to build trust, people don't know what you have experienced.” (Consultation respondent, veteran and family members)

The Increasing Access to Psychological Therapies programme provides one of the key pathways for veterans with mental health problems. Although IAPT is not intended to provide a pathway for more complex problems, as indicated above, interim (and as yet incomplete) national data for 2013/14 supplied by the Health and Social Care Information Centre (HSCIC) shows that veterans experience a broadly similar pathway to non-veterans. This also mirrors areas of greater density in the veteran population.

Table 7: Comparison between the non-veteran and veteran populations of the percentages of people entering treatment completing that course of treatment, by region.

	Region	Total entering treatment	Completed course	Percentage completing
Non-veteran	National*	696,847	357,889	51.4%
	North of England	210,900	113,055	53.6%
	Midlands and East of England	183,820	89,855	48.9%
	London	98,355	49,025	49.8%
	South of England	176,370	92,450	52.4%
Veteran	National*	12,270	6,454	52.6%
	North of England	3,340	2,025	60.6%
	Midlands and East of England	3,645	1,845	50.6%
	London	540	275	50.9%
	South of England	4,195	1,980	47.2%

*Note that the national value includes the value from the National Commissioning Hub, meaning regional figures may not total to the national figure.

The above table shows that there is very little difference on both national and regional levels.

In the South of England region the veteran percentage is lower by 5.2% than the non-veteran population, suggesting that those who are veterans are more likely to leave treatment before the course has been completed in this region, however the reasons for this are unknown.

With respect to outcomes i.e. those having a clinical condition on completion of the course, in the North of England region 6.8% of veterans are more likely to have indications of a clinical condition after treatment, however once again the reasons for this are unknown.

Table 8: Comparison between the veteran and non-veteran populations of the percentage of those entering treatment whose assessments indicate they have a clinical condition, by region

	Region	Total entering treatment	Those with indications of a clinical condition	Percentage
Non-veteran	National*	696,847	314,223	45.1%
	North of England	210,900	99,950	47.4%
	Midlands and East of England	183,820	79,105	43.0%
	London	98,355	42,365	43.0%
	South of England	176,370	81,275	46.0%
Veteran	National*	12,270	5,681	46.3%
	North of England	3,340	1,815	54.3%
	Midlands and East of England	3,645	1,640	45.0%
	London	540	250	46.3%
	South of England	4,195	1,700	40.5%

NHS England will have more accurate and complete data for 2014/15 but while acknowledging the limitations in the current data the early indications are that care pathway progressions for veteran and non-veterans are broadly similar:

“...the care pathways remain more or less the same for the veteran and non-veteran populations, higher levels of progression tend to be seen in areas where there is a much higher presence of veterans in the population such as the South West and Yorkshire and Humberside regions, and the lack of progression demonstrated in London tallies with the below average proportion of veterans located in London”. (2013-14 IAPT Data: Analysis of veterans Marker. NHS England).

3.2.1 Alcohol and drug use

One of the most commonly cited areas of presenting health need that is underdeveloped is alcohol use:

“All the mental health programmes need to have an effective alcohol pathway built in.” (Consultation respondent, armed forces charity)

“The big gap is in alcohol services, there needs to be a pathway for alcohol.” (Consultation respondent, statutory service)

Veterans who tried to access mainstream alcohol services report that these services were poor at recognising issues for veterans:

“In six months they never asked me if I was a veteran.” (Consultation respondent, veteran and family members)

“They didn’t have anything specific for veterans.” (Consultation respondent, veteran and family members)

There is also a view that veterans experience particular difficulties in participating in mainstream alcohol treatment programmes owing to fears about talking openly about their experiences with civilians:

“Veterans were struggling to share more openly in group therapy, they said that they felt too vulnerable and also that it was in some way disloyal to those still serving if civilians in the group see them as being weak.” (Consultation respondent, armed forces charity)

“I felt judged, not safe or secure, I felt blamed.” (Consultation respondent, veteran and family members)

Drug use is also recognised as a problem that may be less prevalent than alcohol but can be overlooked:

“There is no support for drug use, if you are still in the Forces you get kicked out straight away, they are much less tolerant of drugs, the attitude is you are dead to us now. In the US they have NA and AA on the bases.” (Consultation respondent, veteran and family members)

“Drug problems definitely exist, I’ve seen it clinically but it doesn’t feature in the research. It is not as big a problem as alcohol but it shouldn’t be overlooked.” (Consultation respondent, statutory service)

3.3 Cultural understanding and sensitivity

Military culture and subsequent impacts on help seeking behaviours are thought by many stakeholders to be a key factor influencing the manifestation of clinical needs and help seeking behaviours:

“The military culture is mostly male, this impacts on attitudes to treatment, less inclined to respond to soft approaches, it is more transactional, consumerist, they go in and want the problem addressed there and then, they expect to get a specific response and don’t cope well with ambiguity or delays.” (Consultation respondent, statutory service)

“A lot of veterans have a stiff upper lip attitude, but they can still be very fragile inside, this needs understanding.” (Consultation respondent, statutory service)

For some veterans behavioural issues such as anger and frustration can complicate the presentation of clinical needs resulting in some veterans being barred from services or left feeling that they are not being understood:

“The default setting is anger, some have been banned from services or GP for being angry.” (Consultation respondent, armed forces charity)

“They need to understand our reactive impulses to work with us.”
(Consultation respondent, veteran and family members)

Lack of understanding about military culture and being sensitive to this can also result in veterans falling out of the care pathway:

“Mainstream services don’t understand the military culture.” (Consultation respondent, statutory service)

“You need to understand the military mindset, without this people won’t engage.” (Consultation respondent, armed forces charity)

Veterans identify lack of cultural understanding and sensitivity and having to mix with civilians as a barrier to engaging effectively with therapies:

“It doesn’t work mixing with civilians in therapy, they don’t have the understanding about veterans.” (Consultation respondent, veteran and family members)

“You need to have military experience to have understanding of veterans’ health needs.” (Consultation respondent, veteran and family members)

3.3.1 Specialist veterans’ services versus generic services

There are mixed views about how much the pathway should be targeted at specialist veterans’ services versus improving access to generic mainstream services:

“It’s not what veterans come with it’s the context that matters not the speciality, there are some things like prosthetics, high end hearing aids that need to be specialist but not all things do.” (Consultation respondent, statutory service)

“What most veterans say they want is to be treated by other veterans.” (Consultation respondent, statutory service)

“It is about making a better fit, culturally sensitive services rather than specialist services.” (Consultation respondent, statutory service)

3.3.2 The role of armed forces charities

There is recognition that armed forces charities have an important role to play in signposting and enhancing engagement amongst veterans with the care pathway:

“The charities bring additional benefits for engagement with veterans, our branding brings credibility and mainstream services could benefit from this in creating improved access.” (Consultation respondent, armed forces charity)

“Working with a good military charity gives credibility to the NHS service and helps the charity work better with us, it all helps the veterans engage better.” (Consultation respondent, statutory service)

However, the multiplicity of armed forces charities and confusion about care pathways are viewed as creating additional problems:

“A lot of the charities are only signposting but if this doesn’t result in people accessing and staying in treatment then it’s a waste of money.” (Consultation respondent, armed forces charity)

“There needs to be a national coordinator to bring all the charities together – bang heads.” (Consultation respondent, veteran and family members)

There are also some concerns that the proliferation of armed forces charities has created confusion and that some are providing treatments that lack an effective evidence base:

“Part of the challenge is looking at the whole wide range of provision dropping out of the voluntary sector, it tends to be unregulated and we don’t have a handle on organisations that tend to be offering services for example, unregulated psychological therapies.” (Consultation respondent, statutory service)

“There are too many charities, you don’t where which ones to go to.” (Consultation respondent, veteran and family members)

“The charities need to design services on the evidence and not interests.” (Consultation respondent, armed forces charity)

There is a view that there needs to be an accreditation system for the armed forces charities that would enable veterans and service providers to distinguish which ones were more appropriate and effective:

“We need collective responsibility and a statement or principles that the charities can all sign up to.” (Consultation respondent, armed forces charity)

“There needs to be a kite marking system for the charities but one with teeth, not a CQC role but something like that, something that sets agreed standards.” (Consultation respondent, armed forces charity)

3.4 Parity of Esteem – integration of health and social care

There is a view amongst stakeholders that mental health services need to be able to work more effectively with a broad range of problems for veterans including integration of health and social care needs:

“It works well when you don’t just look at mental health in isolation but include wrap around services, helping people with housing, social care, employment as well as mental health”. (Consultation respondent, statutory service)

“The whole pathway is problematic, there shouldn’t be services in silos, we need more integration not just with mental health but broader welfare.” (Consultation respondent, statutory service)

Employment is viewed as one of the main gaps in service responses:

“There needs to be more focus on getting people back into work, the impact of unemployment can be profound for mental health.” (Consultation respondent, statutory service)

“Care plans need to include employment as part of the pathway to recovery.” (Consultation respondent, armed forces charity)

This potentially presents a unique opportunity to wrap services around the individual person rather than treating people in silo services, which do not have insight into the individual's holistic needs.

3.4.1 Physical and mental health needs

Veterans report experiencing particular difficulties in having both mental and physical health needs addressed:

"I have complex physical problems and was told these will just get better when my PTSD is treated." (Consultation respondent, veteran and family members)

"Once you say you have a mental health problem they won't treat anything else." (Consultation respondent, veteran and family members)

This is a gap in service responses that is also recognised amongst other stakeholders:

"People don't physically improve if their mental health doesn't improve, the two are linked." (Consultation respondent, statutory service)

"A lot have both physical and mental health problems, but is hard to get this recognised or dealt with together," (Consultation respondent, armed forces charity)

There is a need to ensure that care pathways are not developed in isolation and that there is increased recognition amongst clinicians and commissioners of the need to provide integrated care for mental and related physical conditions.

Stakeholders suggested that there could be greater consideration about where the pathways and commissioning practices between physical health, including musculoskeletal conditions and mental health, could be linked and how the pathways and commissioning systems could be brought together to achieve better outcomes.

3.5 Families and carers

One of the largest care gaps perceived by stakeholders is for families and carers:

"Families are the biggest gap. It's a problem because you can do as much psychological treatment with veterans as you like but if going out to same dysfunctional family system there is a likelihood of relapse". (Consultation respondent, armed forces charity)

"The families don't know where to get help, they are often isolated with the problems." (Consultation respondent, armed forces charity)

“We don’t listen enough to the family, we expect the veterans to come forward and be the ones asking for help.” (Consultation respondent, armed forces charity)

“Work with families and carers is a big gap.” (Consultation respondent, statutory service)

Veterans and family members responding to the consultation held very strong views about the neglect of family needs:

“Families go through a lot, they need to be involved more.” (Consultation respondent, veteran and family members)

“We should have been able to do therapy as a couple, they wouldn’t allow it. I felt as if they were blaming me as his partner, it felt like they were trying to split us up.” (Consultation respondent, veteran and family members)

“You can feel isolated and hard done by ... don’t anyone in mental health system understand the effect he’s having on people he’s chosen to live with? ... It takes you to the end of your tether - and I’ve only been eight years with it. Very tiring, very draining. ... as a carer for this Combat PTSD – we are in an unrecognised community which I hope will be recognised in the near future.” (Consultation respondent, veteran and family members)

“My marriage went down the pan when I came out. I wasn’t coping well – was verbally aggressive. I normally keep things bottled up and get to point where I explode. I was not talking, a shadow of former self, used to be outgoing now keep myself locked away.” (Consultation respondent, veteran and family members)

This is seen as something that needs to be addressed as part of the transition out of the armed forces:

“Divorce can leave a lot of problems, a serving soldier has the right to social housing but a divorced spouse does not, it has a big impact on health.” (Consultation respondent, armed forces charity)

“Spouses are less prepared if their partner is discharged early, it can be a shock and housing can be a big issue.” (Consultation respondent, armed forces charity)

“Housing can a big source of stress, while serving there are disability adaptations to the house but can’t always get these in the community.” (Consultation respondent, armed forces charity)

There is also a view that the needs of parents, especially mothers, can be over looked:

“Parents are often forgotten but they can be the ones dealing with sons who are single so they come home to the parents.” (Consultation respondent, armed forces charity)

“Parents of veterans find it very difficult, they see the changes in their child when he or she comes home, changes in mental health, drinking problems but they don’t have the same rights as partners, they can’t always get help for their children or themselves.” (Consultation respondent, armed forces charity)

Recognising and addressing the needs of children of veterans including mental health needs and safeguarding is also viewed as an area that needs more attention:

“Children’s needs are often over looked, recognising what they are going through.” (Consultation respondent, armed forces charity)

“There are safeguarding issues for children that are not being picked up.” (Consultation respondent, statutory service)

“Children often have needs that go unrecognised resulting from frequent moves, continuity of education, psycho-social problems associated with these.” (Consultation respondent, statutory service)

“When moving to a different authority area things get lost, education statements, it all impacts on families.” (Consultation respondent, armed forces charity)

“Children are often overlooked, we expect a lot of the children, living with a parent who is dealing with trauma, who do the children talk to?” (Consultation respondent, armed forces charity)

Particular concerns are expressed about access to Child and Adolescent Mental Health Services (CAMHS):

“Access to CAMHS varies a lot, it is not always clear who is doing what and how to access CAMHS.” (Consultation respondent, armed forces charity)

“CAMHS responses for children of veterans are poorly developed, there needs to be greater awareness about this area.” (Consultation respondent, statutory service)

4. Summary

The review has highlighted some significant gaps in the extent to which the mental and related health needs of veterans and family members are included in JSNAs. For example, fewer than half (40%) of JSNAs across England include a reference to the health needs of veterans and most of these have only the word 'veteran' somewhere in the assessment. Amongst those that do have more detailed information only a handful address mental health needs. There are also serious limitations in the availability of relevant and accurate data that further restricts the utility of these assessments. Some of these limitations include:

- inconsistencies in the identification of veterans, and especially their family members in GP registration data;
- challenges in extrapolating national data to local authority area populations e.g. use of older national survey data that may have overestimated the number of veterans living in local areas and also not taken full account of recent changes related to age and life expectancy;
- lack of or incomplete data on veteran and family members access and use of mental health services.

The JSNAs are also limited with respect to the NICE guidance on conducting health needs assessments. For example, the primary focus is on the epidemiological aspect of the assessment using national proxy data from household surveys. There is very little evidence of corporate assessment e.g. the views of key stakeholders including armed forces charities and veterans and family members are often excluded and there is very little assessment of differential service access, experience and outcomes compared to national standards and guidance.

These significant gaps in JSNAs are likely to have critical implications for local area commissioning and whether veterans' mental and related health needs will be adequately addressed in Health and Wellbeing Strategies. This may also have an impact on local authorities meeting their statutory duties for public health in line with the Health and Social Care Act 2012.

While there are clearly some methodological challenges in accurately identifying prevalence levels of mental and related health needs amongst veterans and their families, there are some known factors that impact on the manifestations of clinical need and subsequent impacts on access to, experience of and outcomes from the care pathways. These have important implications for the assessment of health needs and designing appropriate services to meet those needs, from prevention and early identification through to tertiary care services.

There is a consistent view amongst stakeholders that, despite some improvements the existing care pathways for mental health services do not suit veterans and that this can result in people failing to access services or falling out of the care pathway.

For example:

- lack of understanding and sensitivity about military culture amongst GPs and other key health care professionals;
- poor understanding and inconsistency about commitments made under the Armed Forces Covenant regarding prioritisation of clinical needs;
- the need to strengthen prevention activities and engagement in earlier interventions within care pathways, particularly in primary care;
- restrictive access criteria to services that exclude people with more complex problems e.g. it is a common stakeholder view that veterans rarely present with a clear single mental health problem;
- the need for alcohol problems to be included as part of an integrated care pathway for mental health;
- the wide range of service options across the statutory and charitable sectors that can be confusing to navigate and result in uncertainties about which services are providing evidence based treatments;
- poor or under developed integration of armed forces charities with lack of recognition of their vital role in supporting engagement and providing wrap around support services as part of an integrated care pathway;
- the need to ensure that care pathways are not developed in isolation and that there is increased recognition amongst clinicians and commissioners of the need to provide integrated care for mental and related physical conditions;
- concerns that mental health services need to be able to work more effectively with a broad range of problems for veterans including integration of health and social care needs e.g. employment support is viewed as one of the main gaps in service responses;
- one of the largest care gaps perceived by stakeholders is for families and carers including recognising and addressing the needs of children of veterans. Particular concerns are expressed about access to Child and Adolescent Mental Health Services (CAMHS).

Improving the care pathways for veterans and family members is not something that can be done by any single agency. Commissioners, service providers, armed forces charities and veterans and family members need to work collaboratively on co-designing an effective framework for action on assessment of health needs and improving the care pathway.

5. A framework for action

The following framework for action is proposed in order to address the gaps that have been identified in JSNAs and to ensure that commissioning and service provision for veterans and family members is effective and appropriate. The framework consists of three building blocks:

- 1. Targeted and intelligent use of data and information** – veterans and their family members need to be routinely identified and included in health and social care data collection as part of a targeted and intelligent approach to assessment of their mental and related health needs.
- 2. Appropriate and sensitive evidence based services** – responding to the needs of veterans and their family members requires services that are sensitive to their identity and culture and provide evidence based interventions as part of an appropriate care pathway.
- 3. Involvement and participation of veterans and family members** – assessing and responding to the mental and related health needs of veterans and their family members should be done with their active involvement and participation.

The three building blocks are interdependent and are proposed as key mechanisms for creating a sustainable and lasting framework for action that will improve the assessment of the mental and related health needs of veterans and their family members and inform the commissioning and delivery of services to meet those needs.

5.1 Targeted and intelligent use of data and information

The variations in coverage of veterans' mental and related health needs in JSNAs across England may mean that national guidance on how to effectively ensure these needs are addressed is required. This could take the form of a practical resource with specific advice on how to address the methodological issues identified in this report such as making appropriate use of data and ensuring that veterans and family members are engaged in the assessment.

Public Health England would welcome the opportunity to take a leadership role, along with key partners e.g. the Local Government Association (LGA), in the development of a resource to support local activity to address the needs of veterans' and their families. For example, PHE exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services.

PHE's responsibilities include protecting the public's health from infectious diseases and other hazards to health; improving the public's health and wellbeing and reducing health inequalities; improving population health through supporting sustainable health and care services; and providing professional, scientific and delivery expertise to partners. The resource would need to address the following areas:

Primary and secondary care data collection of veterans and family members

Although there have been some clear advances in data collection by GPs of veteran status amongst their patient lists this is not yet uniform across regions and CCGs. Also, there is a need to improve recognition of family members and ensuring that primary care data and Read codes are able to reflect the status of family members of veterans. Encouraging and supporting families to come forward and identify themselves as family members of veterans when registering and engaging with primary care services could further enhance this. There is also a need to streamline the number of Read codes in use in order to provide greater consistency.

Secondary care services data collection and analysis for veterans and family members could be improved through a national template for data collection that supports greater transparency in data sharing. This would need to apply to the range of services e.g. veteran specific mental health services in the statutory and charitable sectors in addition to generic community and hospital mental health services. This could also be used to support the development of common case management systems and case examples.

Veteran status has already been included in national data sets for Liaison and Diversion Services and IAPT. This approach could be replicated in other areas of national mental health data collection for example the inclusion of veteran status in the National Drug Treatment Monitoring System (NDTMS). Family member status should also be included in these systems.

Additional support measures to enable improved targeting of resources and service developments in areas of greatest need or where there are adverse differential experiences and outcomes could include:

- a national data sharing compact that encompasses statutory services and armed forces charities;
- model templates for the standardisation of recording of veteran and family members status across primary, secondary and tertiary care services;
- development of Patient Reported Outcome Measures (PROMs) for veterans and family members.

These measures would also support services in meeting their responsibilities for safeguarding children and young people¹¹. Safeguarding should be woven into the delivery of all child health services, and all children should be subject to checks for safeguarding issues.

¹¹ The Government have defined the term “safeguarding children” as: “The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully.” Further background on safeguarding requirements can be found via: <https://www.gov.uk/childrens-services/safeguarding-children>

Training and awareness of GPs and primary care staff

Despite the existence of some very good training and awareness tools for GPs on understanding and recognising veterans, many GPs appear to be unaware of these resources or reluctant to make use of them. It is also unclear to what extent these resources are accessible for other primary care staff members e.g. practice managers and reception staff who may be responsible for recording the veteran status of patients.

It may be necessary to re-launch the e-learning resource developed by the Royal College of Physicians with a view to making this available to other primary and community health care professionals e.g. health visitors, community midwives, healthy child programme leads, children's services leads etc. This could be linked with training and awareness on mental health.

Adopting a population based approach to health inequalities for veterans and family members

The Armed Forces Covenant has provided an important vehicle by which individual veterans' health needs have been recognised and where appropriate given priority. However, this has not translated into a population-based approach for health needs that can address health inequalities amongst veterans and their families. Stakeholders suggest that part of the problem is the apparent disjunction between the Armed Forces Covenant and the NHS. There is a perceived lack of coherence between local authorities, CCGs and Health and Wellbeing Boards on taking responsibility for implementation of the Armed Forces Covenant's commitments on health.

The Armed Forces Covenant may also have created some confusion with respect to health care as the question of prioritisation for veterans' health needs is often poorly understood in the correct context of attribution of health conditions to serving in the armed forces and assessment of clinical need. Stakeholders also suggest that the politicisation of these issues has not been helpful either for commissioners of health care or for veterans themselves. Rather than focusing on veterans, as a distinct population group with specific health needs, clinicians have been distracted by questions about whether or not health conditions can be attributed to having served in the armed forces.

A more helpful approach may be to consider the health needs of veterans from the perspective of the NHS Constitution with recognition that veterans and their families have a distinct culture and experiences that directly influence their health needs. The comparator is with other groups and communities that are known to experience health inequalities and differential access, experience and outcomes from services e.g. Black and minority ethnic communities.

This is not to suggest that the Armed Forces Covenant commitments are ignored but rather that it may be more fruitful for commissioners to consider the health needs of veterans from the perspective of health inequalities. The Armed Forces Covenant commitments will remain important for individuals where there is a clear association with a condition arising from having served in the armed forces.

Some of the suggestions above for improving JSNAs will support more targeted and intelligent use of data and information. This could be further assisted by an integrated national mapping exercise that brings together data on service access, use and outcomes with data on GP registrations and related data on veteran populations. The mapping exercise could provide a baseline population based assessment that can be used to determine regional and local area priorities for service locations.

5.2 Appropriate and sensitive evidence based services

One of the most significant factors influencing veterans and their family members' access, experience and outcomes from services is the degree to which these are perceived to be appropriate and sensitive to military culture. Veterans and family members in particular often report that they feel stigmatised and alienated from mainstream service provision and that they experience difficulties engaging fully with services as a veteran or family member of a veteran.

Integration and collaboration

There are a number of specialist veterans' mental health services some of which have been developed locally through the initiative of individual NHS Trusts, armed forces charities or CCGs, and some through NHS England's specialist commissioning role. These services should continue to form an important part of the care pathway but they will never be able to meet the full levels of need or demand. More needs to be done to bridge the gap between specialist and generic services. It is important that there are improvements in generic statutory mental health services at local area levels including greater integration and collaboration with the armed forces charities.

There are examples of successful local area service models that incorporate a hub and spoke framework to improve access, experience and outcomes for veterans and family members. A variety of factors are thought to influence the success of these models including:

- a lead clinician with dedicated time and responsibilities for veterans;
- champions within departmental service areas across Trusts – often though not exclusively these are clinicians and managers who are themselves veterans;
- specific veteran and family member service user forums;
- partnership agreements with local armed forces charities where these form part of an integrated pathway;
- training and awareness programmes;
- formal recognition of the service development with local commissioners either through contracting and procurement or CQUINs (Commissioning for Quality and Innovation).

Although it is unlikely that one service model would be appropriate for all areas, the above factors are in keeping with NHS England's securing excellence model and the Murrison Report's recommendations. What is clear is that there is a need for greater integration, collaboration and sharing of good practice.

Improving the care pathway

Effective care pathways are key to ensuring good outcomes from services. The further development of appropriate and sensitive evidence based services for veterans and family members including reservists requires the following improvements in care pathways:

- less restrictive access criteria that can enable services to better respond to complex needs;
- clear referral routes for alcohol services as part of an integrated care pathway;
- recognition of the needs of family members including children and parents of veterans that takes account of the wider determinants of health such as access to employment, and adequate housing;
- greater integration in service responses for meeting both physical and mental health needs;
- clarity on liaison and partnership working between statutory services and the armed forces charities.

Making these improvements to the care pathway will require a range of stakeholders to work together at national and local area levels. This could be undertaken as part of a national care pathway development programme encompassing primary prevention and early identification through to tertiary care. This will also require greater use of informed sign posting support to help veterans and family members navigate the care pathways and service options. Co-locating or embedding healthcare staff within community or charity based services can help overcome some of these challenges. It can also improve both navigation and access for clients with multiple needs, who are accessing several services while at the same time supporting local pathway redesign to improve service integration.

This may require the use of pilot programmes through a system of focused implementation sites. These developments could be further supported through the use of seed funding, possibly through a Tariff Plus model, as a way to kick-start the national development programme. This would fit well with the securing excellence model already developed by NHS England.

Sharing good practice

There is potentially an untapped resource of clinicians who are veterans or family members of veterans working in the NHS and who may be willing to act as champions and lead advisors within a structured learning programme. For example, learning collaboratives could be developed for GPs and primary care staff members alongside those working in Mental Health NHS Trusts.

Some of the areas for sharing good practice could include:

- parity of esteem between physical and mental health care e.g. learning from work on musculoskeletal disorders amongst armed forces personnel;
- extending learning on PTSD and stress related trauma to other personnel e.g. police, fire service, A&E nurses;
- learning from developments of integrated care pathways for alcohol and drug use;
- family work including sharing learning from broader areas of child health and wellbeing such as immunisations and screening or dental health with improvements in CAMHs access and delivery.

Establishment of effective learning collaboratives will only be sustainable if they are adequately resourced including senior leadership support and administration. However, this could provide a very cost effective method for enhancing the development of appropriate and sensitive evidence based services.

5.3 Involvement and participation of veterans and family members

Effective involvement and participation of veterans and their family members is essential for improving data collection and the successful development of appropriate and sensitive evidence based services. NHS England has been recognised for its commitment to the involvement of veterans and family members in commissioning and this has already formed a key component of NHS England's Veterans' Mental Health Networks.

However, there is a need to further strengthen the involvement of veterans and family members in local area service developments to ensure that there is a strong service user voice.

To be effective this requires a structured and supported programme building upon the existing networks but seeking to underpin these with a more comprehensive development of local area veterans and family members' networks. This will also require senior leadership support by commissioners and service providers to ensure service user champion roles are adequately supported and recognised.

Activities that these networks could be involved in include:

- **Raising awareness** – there is a need to raise awareness of the specific needs of veterans and family members including reservists both within the ex-Service community itself and amongst service providers and commissioners. When this is undertaken directly by veterans and family members in a supported way it can greatly enhance credibility and validity of the core messages.
- **Reducing stigma** – amongst veterans and family members there is stigma about mental health problems and about services. Overcoming this can be challenging and it is essential that veterans and family members are directly involved.
- **Assessing and articulating needs** – veterans and family members have a vital role to play in the ongoing assessment and articulation of needs. Their active involvement also helps ensure that changing needs are picked up at an earlier point and that potential service gaps are avoided.
- **Co-designing commissioning and service provision** – appropriate and sensitive evidence based services are more likely to be developed with the full and active participation of veterans and family members.

In order to ensure meaningful and active involvement a structured programme of support would need to include capacity building for network participants through training and education e.g. information and knowledge about policy and legislative drivers and understanding about standards and frameworks for commissioning and service provision. Language is also key e.g. the need to ensure that information is shared in a way that is easy to understand by lay people. This approach would ensure that participants are equipped with the knowledge, skills and experience to undertake and sustain a programme of lasting change.

In addition, the networks will need to be adequately resourced with appropriate facilitation and recognition for practical expenses e.g. travel, catering and room hire. Facilitators could be drawn from a wide variety of sources including lead clinicians, armed forces charities and from amongst veterans and family members themselves. This would also help ensure that the aims of involvement and participation are clearly articulated and understood with clearly defined outcomes from the process.

An adequately resourced and facilitated programme of involvement and participation that takes a capacity building approach could form the bedrock of development for improving commissioning and service responses for veterans and family members.

5.4 Conclusion

The framework for action contains three interdependent building blocks that seek to address the key gaps and priority areas for development identified in the review. The first, targeted and intelligent use of data and information is intended to enhance the assessment of mental and related health needs for veterans and family members. In particular, the proposed actions will enable the effective inclusion of these needs in JSNAs so that CCGs and local authority commissioning plans can take account of them.

This will also support the development of appropriate and sensitive evidence based services for veterans and family members who have mental and related health needs. This will be achieved through greater integration and collaboration between commissioners, service providers and armed forces charities to improve care pathways and ensure the sharing of good practice.

The inclusion and participation of veterans and family members in decision making and planning for the above actions will ensure that intelligence and data is accurate and informed and that service developments and care pathway improvements are supported by those who are intended to be the principal beneficiaries.

Although the assessment of need and commissioning are the key focus of this review the framework for action will require collaboration and partnership working across the full range of stakeholders including statutory commissioners and service providers, armed forces charities and veterans and their family members. The next stage is for the findings from this review and the framework for action to be considered by these stakeholders with a view to reaching consensus and agreement on the way forward.

Glossary

A&E	Accident and Emergency
AFCS	Armed Forces and Reserve Forces Compensation Scheme
APMS	Adult Psychiatric Morbidity Survey
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning group
CEO	Chief Executive Officer
CIDS	Community Information Data Set
CQUIN	Commissioning for Quality and Innovation
DCMH	Departments of Community Mental Health
DH	Department of Health
GP	General Practitioner
HMIP	Her Majesty's Inspectorate of Prisons
HNA	Health Needs Assessment
IAPT	Increasing Access to Psychological therapies
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
KCMHR	King's Centre for Military Health Research
L&D	Liaison and Diversion
LGA	Local Government Association
MOD	Ministry of Defence
NDTMS	National Drug Treatment Monitoring System
NGO	Non Governmental Organisation
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OCD	Obsessive Compulsive Disorder
ONS	Office of National Statistics
PTSD	Post Traumatic Stress Disorder
PHE	Public Health England
PROM	Patient Reported Outcome Measures
RBL	Royal British Legion
SUS	Secondary Users Services
WPS	War Pensions Scheme