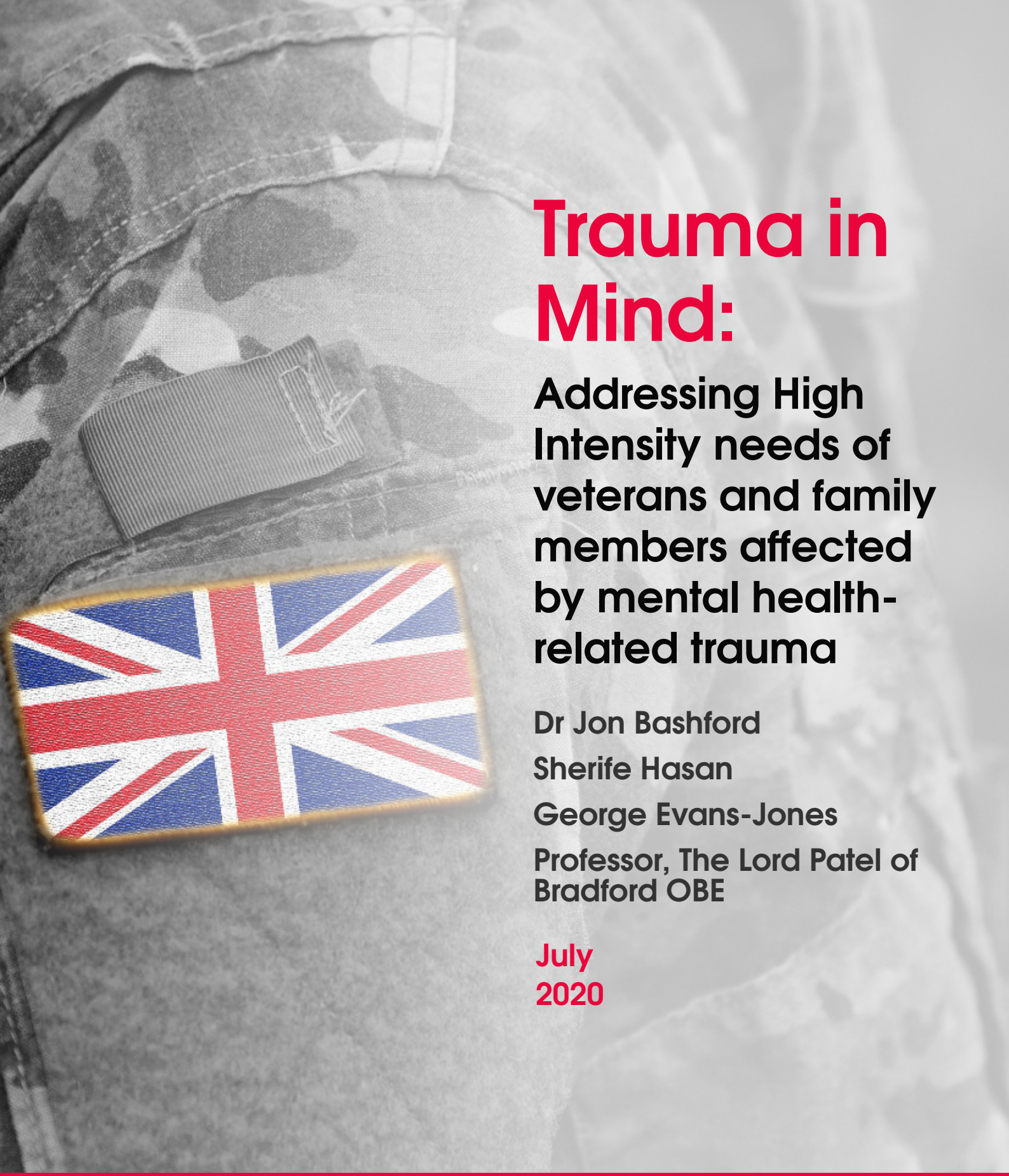

Trauma in Mind:

Addressing High Intensity needs of veterans and family members affected by mental health-related trauma

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NHS Solent NHS Trust

BREAKING BARRIERS INNOVATIONS

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Foreword

I have spent most of my working life seeking to promote the protection and safety of the most vulnerable people in our society, especially those who have significant mental health problems. It has always been my view that the quality of our mental health services and their effectiveness depends on our ability to identify and understand the lived experiences of the people who need these services and provide dedicated, targeted services, whether that is about their age, sex, sexual orientation, gender identity, religion, being disabled or ethnicity. But as this needs assessment makes clear, we also have to provide services that meet the specific needs of those who belong to a particular occupational group, in this case having served in the armed forces.

For veterans and their family members, nothing could be more important than ensuring that, if and when, they experience significant mental health needs they receive the best, most timely and appropriate care that is possible. That must hold true in all circumstances, as set out by the nation's commitment under the Armed Forces Covenant. However, when it comes to our understanding about trauma related mental health problems, we must clearly have a more concerted effort and determination to ensure that we can fully address and meet these particular health and social care needs for veterans and their family members.

Trauma is not easy to comprehend. It creates substantial disruption to relationships and our ability to be ourselves. Trauma isolates people and separates us from what we know and trust. It severs our ties to the world, too often with tragic and permanent results. This needs assessment, which came about through the foresight and commitment of Solent NHS Trust and NHS England and NHS Improvement, sets out with remarkable clarity the specific needs and challenges that trauma related mental health problems create. The evidence on which the assessment is based, consists of lived experience accounts from 101 veterans and family members, the views of 25 professional stakeholders and a review of the most

relevant national and international research. The outcome is a clear articulation of the kind of service model that is required to treat and support this particular cohort, who are characterised by a level of complexity and high intensity needs.

Our response to this must be swift and coherent. It requires focus and attention from national and local commissioners of health and social care services, local authorities and NHS Trusts, the armed forces charities and veterans and family members themselves. Only in partnership, with each other can we hope to do what must be done. To that end this report requires us to keep trauma in mind and to ensure that no veteran or their family members lack timely, effective and appropriate access to services that can meet these most complex and challenging needs. This is even more important now as a result of the Covid 19 pandemic, especially the trauma of working at the front line. What this report shows for veterans will be of use to address the long-term impacts for the workforce dealing with Covid 19.

Professor, The Lord Patel of Bradford OBE

Executive Summary

Introduction

Our understanding of trauma and the profound and lasting ways in which it can affect people's lives is increasing, and there is growing awareness of the requirement to make services more responsive to the specific needs that traumatic experiences can create. These needs can be immediate, arising at the point of the trauma or they can manifest years later in unforeseen ways that can make the experience hard to comprehend for the individual, those close to them and amongst the professionals and services they turn to for help.

The unpredictability and seeming dislocation between cause and effect that is often associated with the experience of trauma can complicate and challenge our ability to respond effectively. And it is this challenge that is coming to the fore in the Armed Forces Covenant and our commitment to ensuring that those who serve in the armed forces, whether Regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of services. For the majority of people who serve on the armed forces, the experience benefits their mental health and wellbeing and most veterans transition to civilian life successfully. But for some, mental health problems and the experience of trauma can be significant and greatly impairs their ability to thrive after leaving the armed forces. For this significant group we must ensure that their needs are met.

NHS England and NHS Improvement has been at the forefront of driving service developments to meet these needs, in particular Transition, Intervention and Liaison Services (TILS) and Complex Treatment Services (CTS). But what is being recognised is that despite the tremendous improvements these services have made in the identification and

treatment of mental health related problems amongst veterans and their family members, there are some who require a much higher intensity service response.

What is revealed by the needs assessment, in particular the lived experience of trauma that has informed this report, is that we need a more nuanced and comprehensive understanding of the full range of needs that can arise from the experience of trauma and the many emotional and social impacts that follow, not only for veterans but most importantly for the family.

Alongside TILS and CTS NHS England and NHS Improvement are developing High Intensity Services (HIS), and we need to ensure that these vital services come together as part of an integrated care pathway that can meet the biological, psychological and social impacts of trauma related mental health problems. In this way, we will not only meet the commitment of the Armed Forces Covenant we will go beyond it: so that every veteran or family member who requires help receives it, in the right way, at the right time, every time.

That is the aspiration of this report and while it is primarily focused on meeting the high intensity needs that arise from trauma related mental health problems, it also seeks to address the underlying causes of these needs. Because prevention must always be our first goal, and we can only achieve it by increasing our understanding and awareness, especially from the first-hand knowledge and lived experience of those who are the intended beneficiaries, the veterans and family members themselves.

Methods

A mixture of qualitative and quantitative research methods has been used including:

- a review of the evidence from national and international literature;
- 101 participants in semi-structured interviews and focus groups with veterans and family members and other members of the Armed Forces Community for example, reservists (71 veterans, 25 family members and 5 reservists). This is a rare sample, recruited largely by word of mouth, everyone who participated was in some way affected by trauma, whether directly themselves or through someone they knew;
- 25 interviews with professional stakeholders including managers and frontline practitioners and clinicians from NHS providers, criminal justice agencies and armed forces charities; general voluntary and community sector providers and commissioners locally in the Solent area and nationally.

Trauma and high intensity needs

For the purpose of the needs assessment we deliberately took a broad approach to the definition of trauma related mental health problems. This is mainly because we wanted to explore the issues from the lived experience of veterans and family members rather than pre-determined diagnostic categories. But also, because we were looking at high intensity needs, which by their nature involve a complex interplay of problems, which cross various health and social care needs.

There is no single accepted definition of trauma related mental health problems that require a high intensity level of service response. The usefulness and applicability of trauma related diagnostic terms such as Post Traumatic Stress Disorder (PTSD) have been subject to much debate, for example the extent to which distress can be medicalised, the significance of guilt, shame and complex emotional problems and what factors support resilience during and after trauma. Also, many people who are purported to suffer from PTSD actually lack a formal diagnosis which is confirmed by the lived experience of veterans responding to this needs assessment.

The subjective experience of trauma related mental health problems is highly individualistic and isolating, with veterans and family members reporting that they often perceive themselves to be the only person with these problems. That said, there are some common experiences of trauma amongst participants including:

- Feelings of hyper anxiety and fear, especially in crowded environments (66.2%)
- Poor sleep patterns with frequent nightmares (59%)
- Rapidly fluctuating moods including guilt, remorse and depression (56%)
- Feelings of powerlessness and an inability to cope (58%)
- Feelings of overwhelming anger and rage (39.5%)
- Self-harm and attempted suicide (35%)

Alongside the psychological impacts, people describe significant social and interpersonal issues:

- Relationship problems and breakdown (62%)
- Loss of employment (49%)
- Financial problems (45%)
- Homelessness (22%)
- Offending (12.6%)
- Problematic use of alcohol (45%) and/or drugs (15%)
- Experience of discrimination and prejudice (15.5%)

The sample is biased because the recruitment sought people who wanted to talk about trauma related mental health problems amongst veterans, so these figures cannot be used to extrapolate population estimates. But the lived experiences of this sample do provide important insights into the profound ways in which trauma disrupts and debilitates people, often leaving them with irreparable relationship breakdowns, loss of employment, financial problems, homelessness and intense feelings of despair. Some have harmed other people, often those close to them and others have harmed themselves, a number knew other veterans who had succeeded in committing suicide.

That is why we need high intensity services, so that we can provide stability and security in a way that a less intense service could not do, and in so doing give people back control over their lives and prevent the worse harms from ever happening. But to better understand what a high intensity service must provide, we have to first consider some of the harms and risks in more depth, in particular:

Self-harm and suicide - Research on self-harm amongst veterans in the UK is rare, but some studies suggest that is increasing. The increase is pertinent to this assessment of high intensity needs because, some of the known factors that predict suicide are prominent amongst the lived experience of the veterans who participated. For example, habitual poor coping, serious financial problems, severe anxiety, panic attacks, a depressed mood, a diagnosis of major affective disorder, recent loss of an interpersonal relationship, recent abuse of alcohol or illicit substances coupled with feelings of hopelessness, helplessness and worthlessness. We also know from the evidence that younger veterans and early service leavers are most at risk.

Violence and offending - Those who have served in the armed forces have a lower lifetime rate of criminal convictions than those who have not. However, this is not true for violent convictions, which are increased. Self-reported violence increases after deployment and is associated with pre-service adversity, alcohol misuse and PTSD. Combat personnel are twice as likely to report violence on return from deployment as those less exposed to combat.

Social impacts including employment, housing and debt - For veterans with complex needs, especially those experiencing trauma related mental health problems, it is hard to find and sustain employment. As a consequence, financial problems can accumulate, and some lose their home and either end up sofa surfing or homeless. There is clearly a need for the social harms associated with trauma related mental health problems to be addressed alongside the psychological harms and risks. From a lived experience perspective, they are inseparable. People feel less able to engage with helping services if their social situation is unstable, but they also need psychological help to create and sustain that stability.

Family experiences - For veterans and family members trauma related mental health problems are not just experienced by the individual, but by the whole family. For those with significant problems the strains can cause relationships and family breakdown, which leaves people more vulnerable. Family members often do not understand the nature of the problems that a veteran may be experiencing, nor the timescales involved in recovery, which can be longer than some people can put up with.

Some of the main concerns for families are the degree to which they can also experience trauma, in the form of secondary stress disorders. Families are often at the frontline in care and supporting recovery, but their support needs are consistently viewed by participants as being unmet by services.

Inclusion and diversity - Trauma disproportionately affects marginalised population groups, for example research has shown that traumatic and other stressful events tend to be more frequent in individuals of low socio-economic status, ethnic minorities, and younger age groups. Gay, Lesbian and Transgender participants to the needs assessment report a high degree of occupational trauma related to their treatment under the ban on homosexuality. They also report feeling less confident to access some sources of veterans support due to fears about discrimination and prejudice.

Understanding trauma

The traditional approach to trauma and especially PTSD and Complex PTSD amongst veterans is very heavily medicalised, with the primary focus on various clusters of trauma associated psychiatric symptoms. This has been important for the identification of problems and vulnerable populations, such as veterans, and in the development and delivery of appropriate treatments. However, the approach is contested, for example:

- The efficacy of the diagnostic frameworks for PTSD and Complex PTSD have been challenged, including questions about what constitutes a traumatic event and differing rates of detection and prevalence across global population cohorts that might be expected to be similar.

- There are a range of linked diagnostic frameworks that can result in confusion about the primary diagnosis and the overlapping nature of some symptoms.
- It is not always clear what treatment options are best, for example if used too soon after the traumatic event some psychological interventions and counselling may actually be harmful. Also, the use of medication is not thought to be best as an early intervention, but it is commonly used.

Treatment models

Trauma-focused psychotherapies such as prolonged exposure and cognitive processing therapy are the current predominant evidence-based interventions in civilian and military PTSD, but do not always translate well to veteran populations. For example, between one third and half of veterans receiving these interventions do not demonstrate clinically meaningful symptom improvement. This could be due to a variety of factors including context specificity for example, rape trauma and military trauma are very different things, but most PTSD treatments do not differentiate between types of traumatic events.

However, some of the primary problems with the current medical model of trauma related mental health problems, and the one most often raised by veterans and family members is the failure to address social harms. The evidence in the needs assessment suggests that a biopsychosocial model of trauma would be more appropriate for recognising and addressing the range of needs, including when people have more complex problems that require high levels of intensity in service responses.

A biopsychosocial model of trauma would be aware of early risks and harms and potential points of intervention. But this requires more thought about the role and contribution of emergency and urgent care services, the role of primary care and the potential for first contact and triage services including NHS 111 and the military charitable services that may have earlier engagement with people. There is tremendous scope for armed forces charities to be part of an integrated service model with statutory services, providing essential wrap around support for individual veterans and their families.

This suggests that there is a need for a new service paradigm that can better identify

people with more complex needs, at an earlier point and without the multiple referrals to different providers along separate and often siloed care pathways.

From the literature and feedback from veterans, family members and professional stakeholders, best practices in delivering high intensity services for trauma, related mental health needs involve:

Engaging people in treatment

While it is clear from the needs assessment that there is a requirement for dedicated veterans services that can meet higher intensity needs, these cannot be situated in isolation. In order to be effective such services need to sit on a bedrock of awareness and education about trauma and its impacts, so that the wider health and care workforce and veterans and family members themselves are enabled to become trauma informed. This requires a whole system approach that can:

- promote awareness about trauma and being trauma informed
- increase public awareness and reduce stigma;
- raise awareness amongst primary care services, and
- enable trauma informed emergency and urgent care responses.

There is scope to build on the existing models such as the Veterans Trauma Network and The Veterans Covenant Healthcare Alliance to ensure parity of esteem between the approach to physical trauma and mental trauma.

Sustaining people in treatment

Raising awareness, creating a trauma informed and veteran aware workforce and strengthening the capacity of emergency and urgent care services, including the armed forces charities as partners are all essential means by which engagement with services for higher intensity needs for veterans must be founded. But having engaged veterans, it is equally important that they are adequately supported to remain engaged. This will only be achieved through:

- Low or invisible access thresholds, by which there is no wrong door and a consistent point of contact

- Effective case management and care coordination that holds on to the case for the time that is required by the person, rather than the treatment modality
- Access to residential or inpatient care where required, which maintains appropriate aftercare.

The role and contribution of families and partners in supporting veterans cannot be underestimated and as frontline care givers and people who are often the first point of contact, family members and those close to veterans must be supported and worked with to ensure that their needs are met and that they can continue in their vital role of sustaining people in treatment and enabling recovery.

Conclusions

For those veterans who do experience complex trauma related problems that encompass physical, psychological and social harms there is a need for higher intensity services that can fully address and meet these needs. In particular, there is a need for a new model of veterans' service delivery that can:

- Encompass a broad definition of trauma related mental health problems that is not limited by strict diagnostic criteria for PTSD and Complex PTSD.
- Recognise that there is no single way in which trauma related mental health problems manifest and that the symptoms and ways in which people experience trauma related problems can be fluid, inconsistent and not always obviously associated with a specific traumatic event.
- Engage with veterans and family members at the earliest point in their experience of problems including mental health and/or social crisis.
- Ensure that there is no wrong door by which individuals can access help and support as part of a consistent point of contact.

- Effective case management and care coordination that can facilitate speedy and appropriate transfer between levels of service intensity, without having to sign post or redirect people to separate services.
- Work with and support for family members as an integral part of recovery and resilience, while also being able to provide support and treatment for the secondary traumatic stress that family members may be experiencing.
- Provide an inclusive environment and therapeutic milieu that instils trust and confidence for veterans and family members who share a protected characteristic and/or are vulnerable as a result of discrimination and marginalisation.
- Prevent the most serious harms e.g. self-harm, suicide and harm to others through effective case management and coordination that includes risk assessment, triage and integrated care pathways.
- Address the links between physical health, especially pain and mental health and wellbeing.

The above can be achieved by development of veteran's specific services that are fully embedded within a regional service model that involves the following:

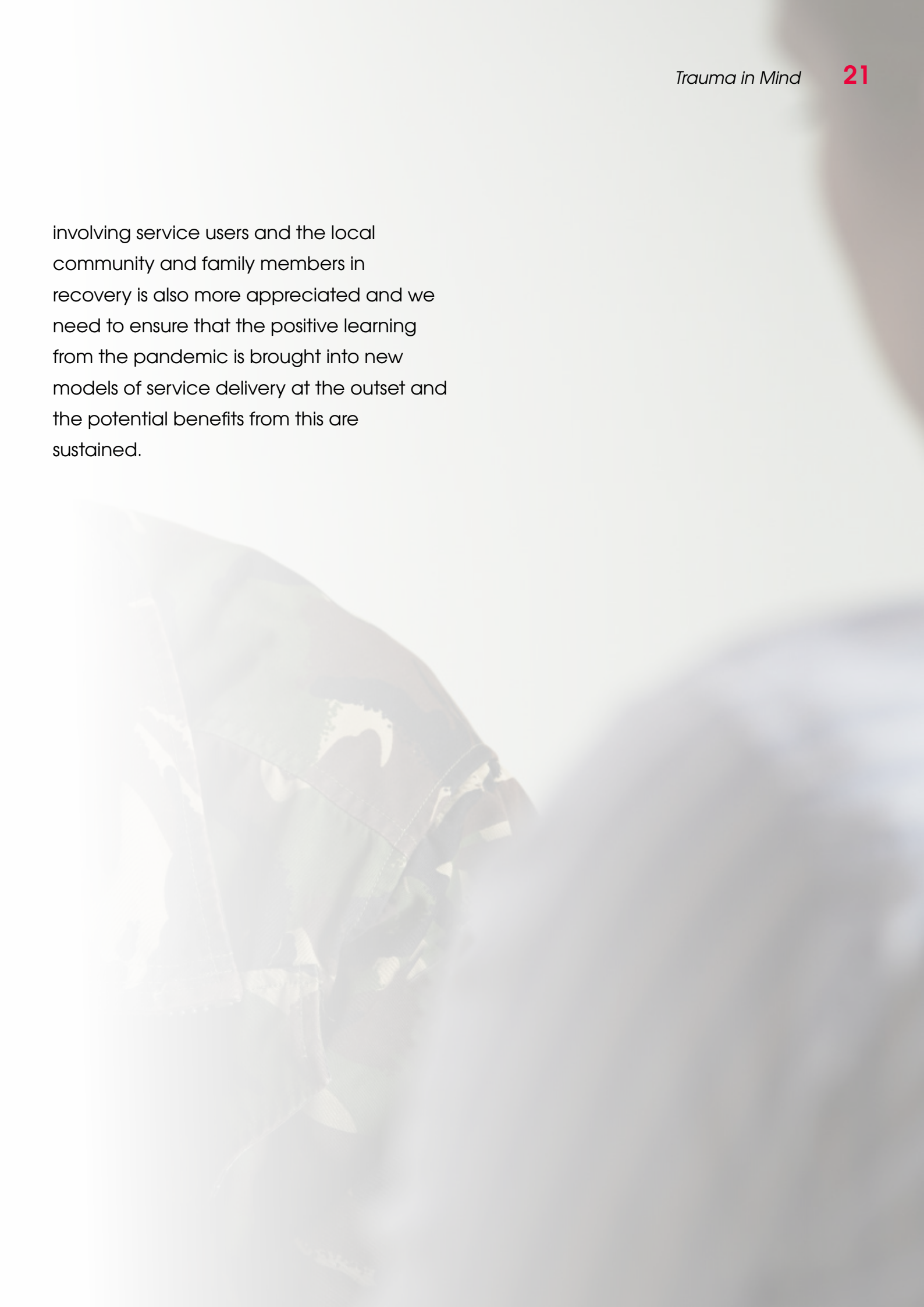
- Building on the success of TILS, CTS and the expertise and experience of the armed forces charitable sector by ensuring that the overall balance of provision can meet the full range of needs, including those that require a higher intensity level of service response.
- A model of integrated care pathways that involves the defining features of trauma related mental health needs.
- Low or invisible thresholds - being able to move seamlessly between levels and types of care and or intensity, at a pace that the service user feels comfortable with as part of a robust care coordination process.
- Peer support – initiating and sustaining engagement through veteran peer support networks.
- Collaboration - different professionals working together, offering different types of help at the same time, but with a consistent point of contact.

- A biopsychosocial model of trauma that seeks to promote healthy development rather than focusing solely on pathology i.e. being concerned with the resources of the family and community including peers, rather than on the individual and how these wider family and community strengths can be harnessed to aid recovery.
- Being clinically led, with improved involvement of people with experience of using (or caring for others using) services at the centre of the approach.
- Integrated leadership which, spans regional specialist veterans commissioning alongside local integrated care partnerships and systems.
- Enabling people to be cared for closer to home including being in hospital when and for as long as clinically needed and improving people's experience and outcomes from services.
- Being underpinned by effective governance frameworks, with relevant risk sharing agreements and accountability for the decisions made and the quality of care provided.
- Achieving all of the above will not be done in the short term. It requires significant leadership focus, central government support and resources and the will and commitment of national, regional and local NHS and social care commissioners and providers, including the armed forces charities.

It is essential that the current pathways and pathfinders and for veterans and family members are brought together, as part of a fully co-ordinated and comprehensive system of care and treatment. This is how our commitment to the Armed Services Covenant can be realised for those with complex and higher intensity needs, and how we will ensure that for those who served this country, we fully honour the debt we owe and provide the highest quality service response to the full range of needs, as and when they need it.

The experience of the Covid-19 pandemic has brought the urgency of trauma related mental health needs into sharp focus. NHS England and NHS Improvement, alongside the Military Alliance, have maintained the focus on the development of high intensity services and responding to pandemic as a priority. The necessity and value of

involving service users and the local community and family members in recovery is also more appreciated and we need to ensure that the positive learning from the pandemic is brought into new models of service delivery at the outset and the potential benefits from this are sustained.



1. Introduction

While the majority of those who serve in the armed forces do so without developing mental health problems and most transition into civilian life successfully and without harm, there are some who experience significant mental health problems. Amongst this group are veterans who have severe, complex presentations of PTSD, often combined with substance use and other mental and social problems. For those who require long-term and intensive mental health care there is thought to be a current gap in statutory provision, for example it has been reported that this area is under resourced and there is a lack of respite care (House of Commons, 2019). In particular, there is a perceived need for a higher intensity level of service that can meet more complex needs, possibly through a tier four type of inpatient or residential provision.

The concept of a Veterans' High Intensity Mental Health Service (HIS) has been introduced by NHS England and NHS Improvement as part of its ongoing commitment to the development of specific veterans and family members services. HIS pathfinders are being developed by NHS England and NHS Improvement for both inpatient and community-based crisis response services. An important element of service delivery will be to monitor and evaluate patient outcomes with learning and insight from the pathfinders informing the development of future veterans' mental health services from 2022.

Although the HIS procurement pre-dates completion of this needs assessment, many of the issues that have been identified will be relevant to the ongoing roll out of the pathfinders and subsequent consideration of further development for the provision of dedicated services for veterans and family members.

This report sets out the findings from an assessment of needs of trauma related mental health problems for veterans and family members, in particular those with

more significant and complex problems that require a high intensity level of service response. The assessment was conducted between September and December 2019 and was commissioned by Solent NHS Trust and NHS England and NHS Improvement. The specific questions that it seeks to address are:

- What are the different ways in which veterans and their families are affected by trauma-related mental health problems and how these impact on other mental health and related substance use problems?
- What are the existing service provision and pathway gaps in meeting these needs and the needs of families?
- What are the most effective service responses for meeting trauma-related mental health problems, such as therapeutic interventions and aftercare support including barriers to help seeking?
- How to address the secondary traumatic stress and mental health problems experienced by family members, in particular spouses, parents and grandparents?
- How could a regional/sub-regional model for service development designed to meet high intensity trauma-related mental health needs be scaled up nationally?

1.1 Trauma and High Intensity Needs

There is no single accepted definition of trauma related mental health problems that require a high intensity level of service response. Trauma related mental health problems are commonly understood to mean Post Traumatic Stress Disorder (PTSD), which is a discreet term used to describe psychiatric conditions as defined by a specific set of symptoms that are identified by either the Diagnostic Statistical Manual V (DSM V, American Psychiatric Association, 2013) and/or the International Classification of Diseases 11 (ICD 10 – WHO, 2018).

However, the usefulness and applicability of the term PTSD has been subject to much debate, for example there are limits to the extent to which distress can be medicalised, and there is value in focusing on resilience during and after traumas (Stein et al., 2007). Also, many people who are purported to suffer from PTSD actually lack a formal diagnosis (Grasso et al., 2009), which is confirmed by the lived experience of veterans responding to this needs assessment:

"I was in and out of many mental health services after leaving the forces, but It was years later before I was diagnosed with PTSD." (Veteran)

It is thought that the context, severity and complexity of PTSD amongst veterans may require different treatments or models of care from those offered to the general population, but these are, as yet, not fully understood (US Department of Veterans Affairs National Center for PTSD, 2016). For example:

- There are no clear definitions of what constitutes a traumatic event, and indeed, what impact an individual's vulnerability factors have both pre the traumatic event and after (Greenburg et al., 2015).
- There are questions about the ways in which combat related PTSD is understood and whether this compares to concepts of civilian related trauma, for example exposure to interpersonal violence, natural disasters and accidents. The research tends to focus more on commonalities of symptoms across different populations of trauma survivors, rather than the particular consequences of specific trauma events (Yehuda, 2014).

- The differences between (single incident) PTSD and complex trauma has significant treatment implications and patients with more complex trauma related problems may react adversely to current, standard PTSD treatments (Courtois, et al. 2013).
- Recommendations on the duration of treatment varies from 32 weeks to 24 months (House of Commons Defence Committee, 2019).

There are a range of UK services for veterans with PTSD, but the evidence for effectiveness of available treatments in the research literature is limited. For example, there is some evidence to support some present treatments and systems of care delivery, but there are no studies on the cost-effectiveness of care delivery methods (Dalton, et al. 2018).

The National Institute for Health and Care Excellence (NICE) has not yet developed recommendations specifically for Complex PTSD. They caution that the existing guidelines for PTSD were not developed for this kind of diagnosis and that the evidence was limited on interventions for people who have complex PTSD. But NICE suggested that trauma-focused therapies could also benefit this group. Based on their clinical experience, the committee recommended modifications that may be needed to trauma-focused therapies to facilitate engagement for those with complex PTSD or other additional needs (NICE, 2018).

For these reasons, the needs assessment takes a broad approach to describing trauma related mental health problems that includes PTSD but also the wide range of associated mental health and social problems that often accompany trauma related mental health problems, for example depression and anxiety, affective disorders, relationship problems and breakdown, somatic disturbances and problematic substance use. The complex interplay of problems, which often occur simultaneously, are further explored through the lived experience accounts of veterans and family members.

1.2 Methods

The needs assessment uses a mixture of qualitative and quantitative research methods involving desktop research, including a literature review and demographic analysis, fieldwork involving semi-structured interviews and focus groups with veterans and family members and other members of the Armed Forces Community for example, reservists.

Interviews have also taken place with 25 professional stakeholders including managers and frontline practitioners and clinicians from NHS providers, criminal justice agencies and armed forces charities; general voluntary and community sector providers and commissioners locally in the Solent area and nationally.

The sample of Armed forces Community members were recruited using a snowballing technique through a variety of methods including distribution of flyers, social media posts and by word of mouth. In total 101 people participated including 71 veterans, 25 family members and 5 reservists.

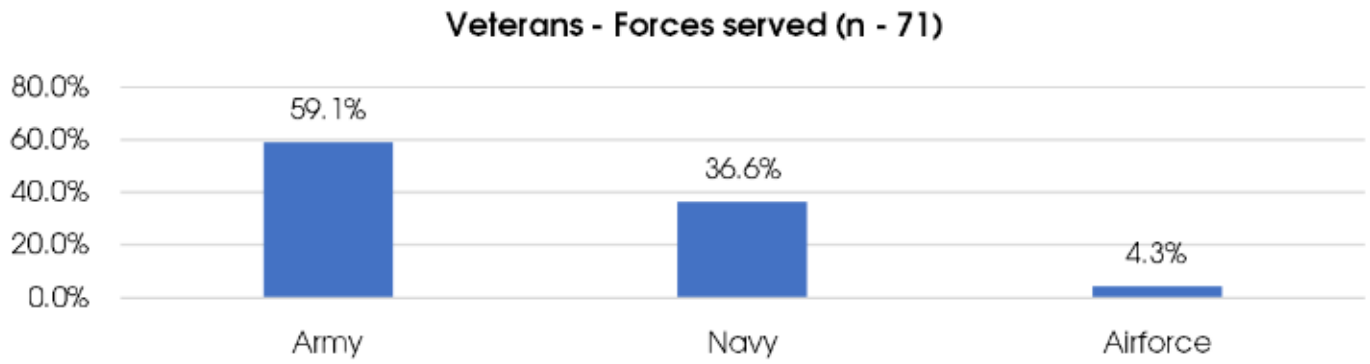
Transcripts of interviews, which were all conducted confidentially have been analysed using constant comparative methods to determine common issues and themes. Combined with evidence from the literature, these have been used to frame the content of the report. Where individuals are quoted this is done anonymously by the category of interview, for example Veteran, Family member of Professional stakeholder. The use of quotations is to demonstrate that there was consensus on the issue or theme and if only one person raised something, but it is thought to be worth including this is indicated.

1.2.1 Demographics of the lived experience sample

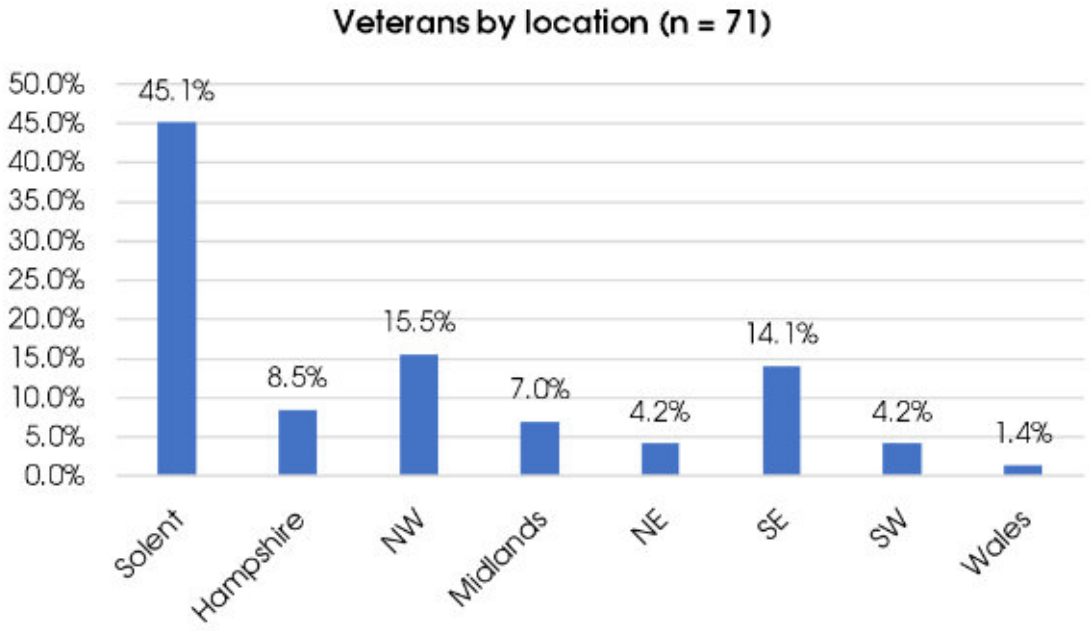
A breakdown of the veterans and family participants sample is as follows:

Veterans (n = 71)

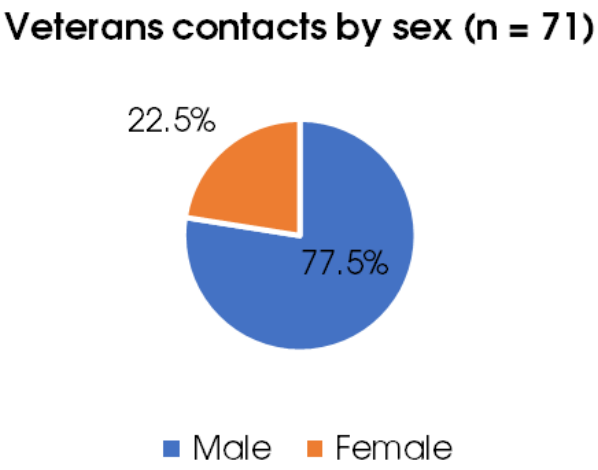
The majority of veterans served in the Army (59%):



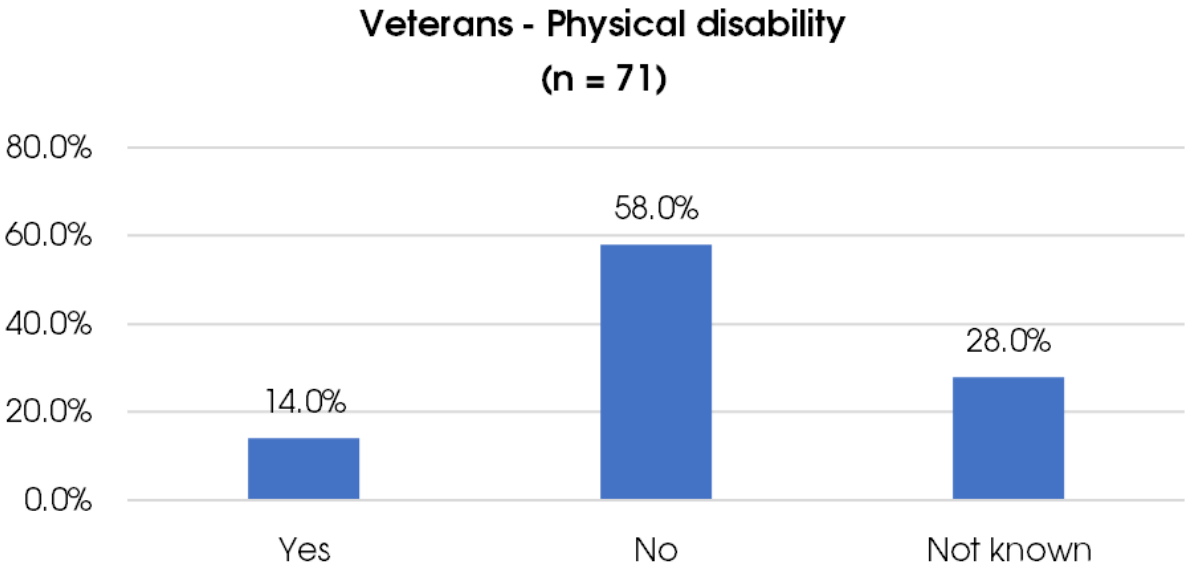
The majority of veterans were located in the South East (67.7%) followed by the North West (15.5%) and the Midlands (7%):



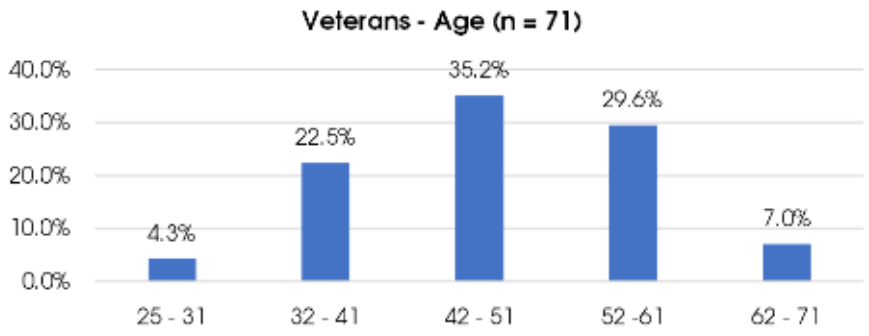
Amongst veterans there were 55 males and 16 females:



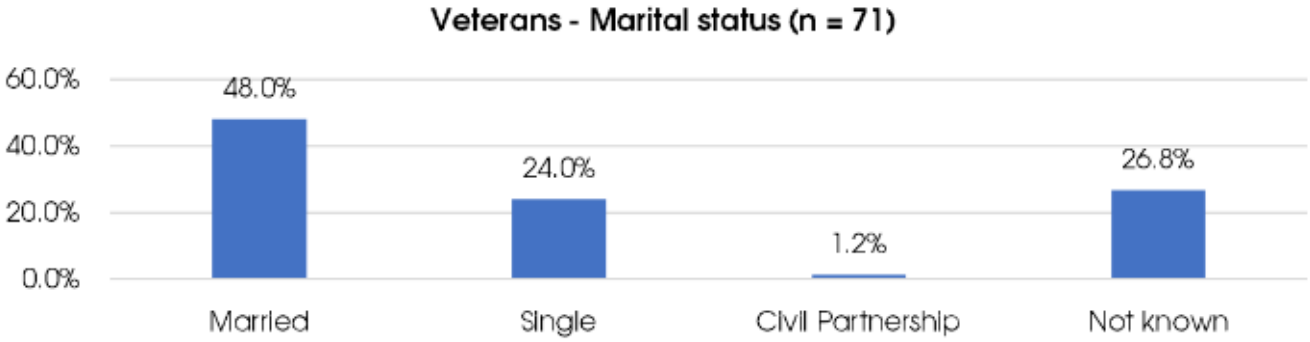
14% of veterans had a physical disability



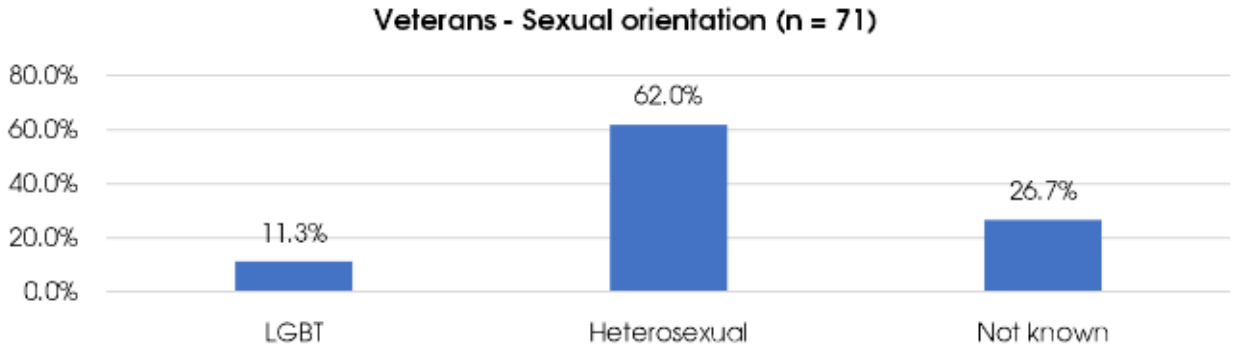
The majority (35%) were aged between 42 and 51 years:



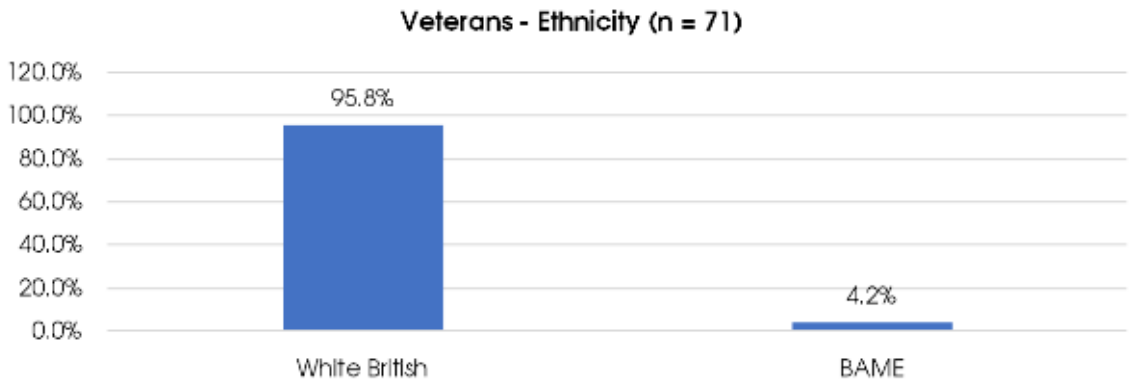
Just under half of veterans were married (47.9%):



Sexual orientation was not known for all participants and the numbers of veterans identifying as Lesbian, Gay, Bisexual or Trans was low (8) but this does mean that at least 11% of the sample were LGBT:

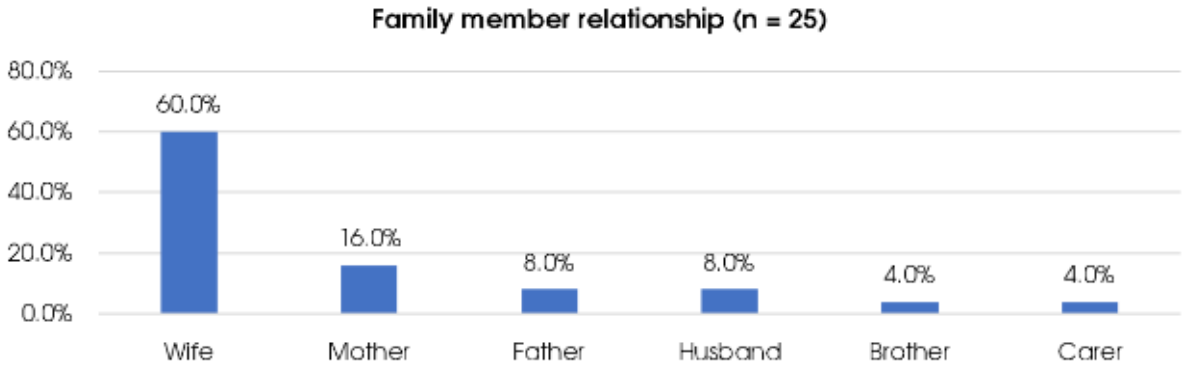


The number of Black, Asian and Minority Ethnic (BAME) veterans was low (4%):



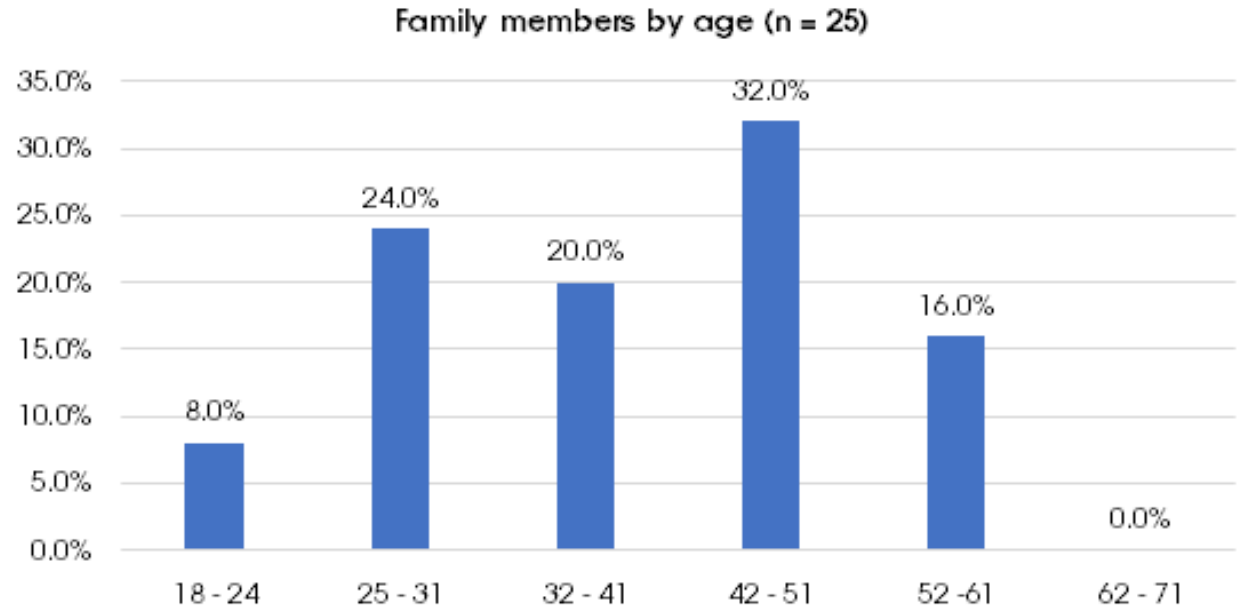
Family members (N = 25)

The majority of family members were spouses (68%), one person identified as a carer:

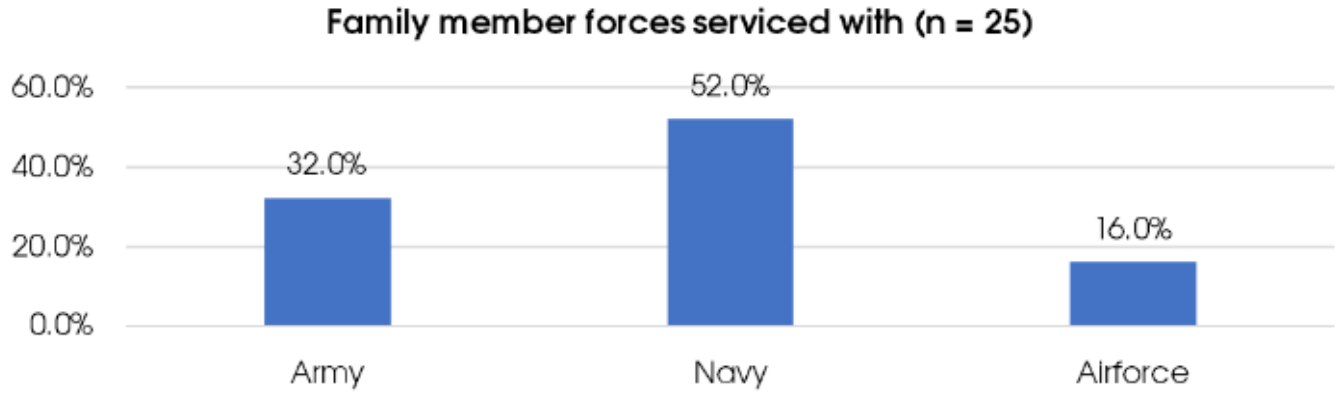


Amongst family members the majority were female (80%):

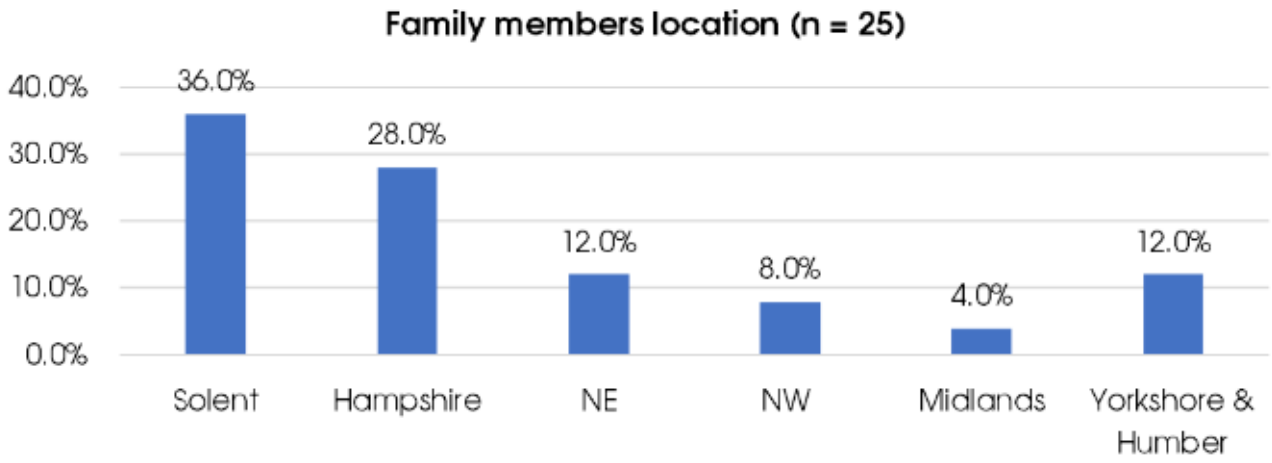
Nearly a third were aged between 42 and 51 years:



One family member identified as Lesbian and the rest as heterosexual. The majority were White British (92%). Amongst the forces that their family served with, over half were with the navy (52%):



The majority resided in the South East (64%):



1.2.2 Professional stakeholders

A total of 25 professional stakeholder interviews took place.

- 7 with Clinicians and managers in NHS Trust providers
- 7 with managers and officers in armed forces charities
- 3 with commissioners
- 3 with managers from general voluntary and community service providers
- 5 with practitioners from criminal justice agencies

1.2.3 The literature review

A literature review has been undertaken from a wide range of national and international sources including searches of standard data bases for peer reviewed journals, professional associations, commissioning reports and also 'grey literature', for example locally produced surveys and reports.

The literature review has been largely restricted to evidence from the last five years, though where a particular article or report has not been repeated and remains significant this has been included.

1.2.4 Consent, confidentiality, data protection and ethics

Participants were informed about the aims and objectives of the project so that they were able to give informed consent to participate. Consent could be withdrawn at any time. All appropriate steps were taken to ensure the confidentiality of participants including use of anonymous interview transcripts. While some demographic data were recorded, no personally identifiable data was requested or recorded. All data was collected and stored in accordance with data protection rules and GDPR policy.

Various ethical considerations were considered at length and the needs assessment was assessed and confirmed by Solent NHS Trust's clinical audit and service evaluation committee. Owing to the potential for participants to be vulnerable and/or experiencing trauma a rapid assessment and treatment protocol was established with the appropriate psychological services. No participants were identified who needed to make use of this protocol.

2. Trauma and High Intensity Needs

Trauma is by its nature intense, so much so that it can be sealed off from conscious awareness only to manifest years later in unpredictable and debilitating ways. So unpredictable that to the one suffering, their problems can seem unrelated to the original trauma. So, debilitating it can cut people off from everyone that they know and trust, even to the point of self-harm and suicide. People who have experienced trauma often talk about the acute sense of loneliness it produces, often leaving people feeling that they are isolated and the only one to be experiencing these problems:

"No one is affected in same way."
(Veteran)

But there are patterns of behaviour, common feelings that people experience, such as hyper anxiety and vigilance. People describe very acute feelings of anxiety, often persistent and associated with particular environments such as supermarkets and on public transport:

"I was always on the watch for something, vigilant all the time…I would easily become nervous, I avoided any crowds of people."
(Veteran)

Amongst veterans responding to this needs assessment 47 (66.2%) described experiencing this at some time. And alongside the anxiety, people describe a fear that their lives were in immediate danger from an external, unnamed source. The cognitive dissonance associated with this only made the anxiety and fear worse:

"I knew I was safe in my head, I was at home, there was only me and my family there, but I couldn't stop the feeling that something was going to happen, the more I tried to calm down, to tell myself it was ok, the worse I got."
(Veteran)

For many veterans and family members, night-time is often described as the worse time, with people saying they would often wake up from nightmares, sometimes even in a different part of the bedroom or the house, not knowing how they got there:

"Sometimes I would find him downstairs, shaking all over, like he was still asleep but didn't know where he was."
(Family member)

Poor sleep patterns with frequent nightmares were cited by 42 veterans (59%).

Part of the problem people experience in identifying that something is wrong is that they can feel fine one day and then deeply depressed the next:

"One day I could be fine, then I would just sink into darkness, a deep depression."
(Veteran)

Rapidly fluctuating moods including guilt, remorse and depression were mentioned by 39 veterans (56%) and the unpredictability of this was a problem for many family members:

"The mood changes were the worst thing, I didn't know from day to the next what it would be like, it made no sense…"
(Family member)

All of the above helps to conflate feelings of powerlessness and an inability to cope:

"It felt like I had no control, like things were just happening to me and I had no way to do anything about it."
(Veteran)

"It's overwhelming, even simple things, you just don't feel able to cope."

(Veteran)

41 veterans (58%) described experiencing this at some time.

And what is most concerning, is that 28 veterans (39.5%) described feeling out of control and unable to influence or change what is happening:

"It's like your life is spinning out of control and there is nothing you can do."
(Veteran)

32 veterans describe problematic use of alcohol (45%) and 11 (15%) talk about using drugs (15%).

These are all intense needs: hyper anxiety and vigilance, fear and night time terrors, unpredictable mood swings, guilt, remorse and depression, powerlessness and loss of control. They are also profoundly disruptive and debilitating, often leaving people with irreparable relationship breakdowns, loss of employment, financial problems, homelessness and despair.

Some harm other people, often those close to them and others harm themselves, some succeed in committing suicide. That is why we need high intensity services, so that we can we provide stability and security in a way that a less intense service could not do, so that we can give people back control over their lives and prevent the worse harms from ever happening. But to better understand what a high intensity service must provide, we have to first consider some of these harms and risks in more depth, in particular:

- Self-harm and suicide
- Violence and offending
- Social impacts including employment, housing and debt
- Family experiences
- Occupational trauma and systemic impacts on different groups2.1 Self-harm and suicide

2.1 Self-harm and suicide

Research in the UK suggests that the rate of suicide in the armed forces is below that of the general population and that there are no clear links between suicide risk and self-harm, which is thought to be mainly impulsive and not associated with deployment (KCMHR, 2018). The KCMHR study also found that length of service was a significant factor, with longer-serving personnel seeming to have greater resilience.

Few studies have examined the risk of suicide for people after they have service. One such study aimed to investigate the rate, timing, and risk factors for suicide in all those who had left the UK Armed Forces from 1996 to 2005 (Kumar et al., 2009). The study identified 233,803 individuals who had left the Armed Forces and 224 of these had died by suicide.

The study found that:

- although the overall rate of suicide was not greater than that in the general population, the risk of suicide in men aged 24 years and younger who had left the Armed Forces was approximately two to three times higher than the risk for the same age groups in the general and serving populations;
- the risk of suicide for men aged 30–49 years was lower than that in the general population. The risk was persistent but may have been at its highest in the first two years following discharge;
- the risk of suicide was greatest in males, those who had served in the Army, those with a short length of service, and those of lower rank;
- the rate of contact with specialist mental health was lowest in the age groups at greatest risk of suicide (14% for those aged under 20 years, 20% for those aged 20–24 years).

The study concluded that the heightened risk of suicide for younger service leavers may be more related to pre-service vulnerabilities rather than factors related to service experiences or discharge. The authors call for preventive strategies that include practical and psychological preparation for discharge and encouraging appropriate help-seeking behaviour once individuals have left the services.

Other studies have also identified the increased risk of suicide amongst younger veterans (aged 16 -24), in particular, young men from the Army aged under 20 and those leaving service early who appear to be at greater risk of self-harm and suicide. The study suggested that links to pre-enlistment vulnerabilities and risks associated with early childhood adversity were the most likely reasons (Pinder, et al 2012).

This UK research contrasts with the USA where estimates of suicide rates among veterans are higher. For example, 35.1 deaths per 100 000, which is almost triple that of civilians and equates to approximately 22 Veteran deaths by suicide per day (Kemp & Bossarte, 2012).

In the USA under the Trump administration, the Veterans Affairs (VA) Secretary has made veteran suicide the top clinical priority in the VA. Though it has been argued that this should not be at the expense of other focused programmes such as addressing homelessness, which is a known risk factor for suicide (Tsal, 2018).

Data from 1,533 U.S. veterans drawn from wave 3 (July–August 2015) of the National Health and Resilience in Veterans Study, a nationally representative study of all U.S. veterans, revealed high rates of suicidal ideation and self-harm amongst veterans who had been homeless:

- Any suicidal ideation in past 2 weeks – 19.8% compared to 7.4% amongst veterans who had not been homeless
- Any suicide attempt in past 2 years – 6.9% compared to 1.2% amongst veterans who had not been homeless
- Any lifetime suicidal ideation or attempt – 44.6% compared to 17% amongst veterans who had not been homeless (Tsal et al., 2016)

There are no comprehensive figures for veteran suicides in the UK as coroners are not required to record whether the deceased had been a veteran and the Ministry of Justice has no plans to require coroners to record the deceased's occupational history given the potential difficulties of accurately identifying this information (House of Commons Defence Committee, 2018). However, this is an issue that is gaining prominence in public concerns and amongst veteran's campaign groups:

"Military charities say they are not coping with the increased demand for mental health support. Campaigners estimate that last year, at least 58 veterans took their own lives."
(BBC News, 16th February, 2019: https://www.bbc.co.uk/news/av/uk-47246487/is-there-a-suicide-crisis-for-british-veterans)

"Veteran suicides have become an 'epidemic of our time' the former head of the army has warned… General Lord Richard Dannatt, the ex-Chief of the General Staff said he pushed hard for it in the House of Lords, adding: "The coroners' service ought to record people with a service background who have taken their own lives."
(The Telegraph 28th November, 2019 https://www.telegraph.co.uk/news/2019/11/28/veteran-suicides-epidemic-time-former-head-army-has-warned/)

Lord Danatt's interview with the Telegraph followed a visit to Forgotten Veterans UK (FVUK), which is one of the veteran's charities that have contributed to this needs assessment. FVUK, which is staffed entirely by volunteers, has helped hundreds of suicidal veterans since being set up two years ago:

"FVUK is a life saver, I made several attempts to kill myself before coming here. The buddy system has made a real difference, I don't feel so alone. There is nothing where I live, I travel quite a long way to come here, there are no veteran services where I live."
(Veteran)

It is beyond the scope of this assessment to establish a causal link between trauma related mental health problems and self-harm or suicide, but despite the above evidence, it is clear from the lived experience accounts that this is a reality of experience for many people.

Amongst veteran respondents, a quarter (24%) knew someone who had killed themselves in the last two years and over one third described having self-harmed (34%) at some point in the last few years:

"I thought about killing myself and I know others, other veterans who have, I think a lot of us have thought about it."
(Veteran)

For some, this is clearly part of a long-standing problem with mental health that pre-dates their service in the forces:

"I had mental health problems over many years, from before I was in the army...I tried to kill myself more than once, I've been in mental hospitals…"
(Veteran)

Research on self-harm amongst veterans in the UK is rare, but some studies suggest that is increasing. For example, one study found that lifetime self-harm amongst a UK armed forces cohort increased significantly ($p < .001$) from 1.8% among serving personnel and 3.8% among veterans in 2004/06 to 1.9% and 4.5% in 2007/09 and to 4.2% and 6.6% in 2014/16 (Jones et al., 2019). The study concludes that:

- veterans were consistently significantly more likely to report lifetime self-harm than serving personnel;
- significant determinants of lifetime self-harm included current mental disorder symptoms, stigmatization, poor social support, suicidal ideation, and seeking help from formal medical sources;
- suicide prevention should focus on ameliorating mental disorder by encouraging engagement with health care, reducing negative views of mental illness, and fostering social support.

The suggested increase in rates of self-harm amongst veterans is pertinent to this assessment of high intensity needs arising from trauma related mental health problems. Because, some of the known factors that predict suicide are related to habitual poor coping, followed by serious financial problems (Chool et al., 2017), both of which are problems that are strongly associated with veterans experiencing trauma related problems.

Other strongly associate factors that predict suicide include severe anxiety, panic attacks, a depressed mood, a diagnosis of major affective disorder, recent loss of an interpersonal relationship, recent abuse of alcohol or illicit substances coupled with feelings of hopelessness, helplessness, worthlessness, global or partial insomnia, anhedonia, inability to maintain a job, and the recent onset of impulsive behaviour (Hall et al., 1999).

There is also some evidence that self-harm conveys an enduring heightened risk of completed suicide and all-cause premature death (Carr et al., 2017). Negative attitudes to mental ill health, and perceived practical barriers to care were all significantly associated with self-harm. It is also important to note that social support provided a significant protective factor, acting as a buffer against both lifetime self-harm and suicide attempts. (Chool et al., 2017).

2.2 Violence and offending

For some participants to the needs assessment the experience of overwhelming anger and rage can manifest in violence:

"I would just become uncontrollably angry; I would lash out at anyone in the way."
(Veteran)

"I was convicted for GBH, I don't even remember what happened, I just couldn't stop it…"
(Veteran)

Family members describe being afraid at the outburst of anger and the impact on their children:

"He had such rage, so angry at me, the kids…it just came from nowhere…"
(Family member)

Evidence on violent behaviour in personnel returning from deployment to Iraq shows a strong association with pre-enlistment antisocial behaviour (MacManus, et al. 2012).

In addition, having a combat role in deployed personnel appeared to be a risk factor for violent behaviour, as was self-reported aggressive behaviours, increased exposure to traumatic events, post-deployment alcohol misuse and symptoms of post-traumatic stress disorder (MacManus, et al. 2013).

Incidents of violence appear to increase following deployment but are also thought to be more associated with adversity prior to serving and are higher amongst those using alcohol problematically and for those with self-reported PTSD. (KCMHR, 2018).

A USA study that grouped Iraq and Afghanistan War veterans by level of PTSD symptomatology and compared them on self-report measures of trait anger, hostility, and aggression, found that veterans who screened positive for PTSD reported significantly greater anger and hostility than those in the subthreshold-PTSD and non-PTSD groups. The study suggested that providers should screen for anger and aggression among veterans who exhibit symptoms of PTSD and incorporate relevant anger treatments into early intervention strategies (Jakupcak, et al. 2007).

In the adult male prison population, veterans constitute the largest occupation group, approximately 4% of the current prison population (HMPPS, 2019). But external estimates have reported that the proportion of veterans in the prison population range from 3.5% and 17% (MacManus and Wood, 2017 and Short et al., 2018).

It is also reported that their offending profile differs, for example they are more likely to be convicted for a sexual offence or violence against the person than the general population and less likely to be convicted for acquisitive crime (KCMHR, 2018). A recent survey by the MOD found that veterans in the UK criminal justice system are:

- more likely to be male, white and older on average than those who had not served in the armed forces;
- more likely to have qualifications, and the experience of secure employment;
- have similar practical needs, like accommodation and finance issues compared to those who have not served in the armed forces, but they report lower needs for issues like drug addiction;
- more likely to be recorded as having experienced (often multiple and co-existing) mental health issues, harmful or hazardous drinking, and physical health problems;
- more likely to have offences that are associated with higher levels of interpersonal violence, motoring offences, anxiety disorders and hazardous drinking patterns
- more likely to experience anxieties over identity, stigma and loss of a sense of belonging often resulting in experiences of social isolation and disconnection/ adaptation disorders in civilian life, (these are more common than the overused PTSD explanation of behaviour).

(HMPPS, 2019)

The literature and evidence from this needs assessment suggest that being able to work with trauma and higher intensity needs is essential for addressing the underlying risk factors and presenting problems for those veterans that are involved with the criminal justice system. furthermore, these needs are unlikely to be adequately identified and addressed without a dedicated veterans criminal justice pathway that is trauma informed.

NHS England and NHS Improvement have been leading on development of a veteran's criminal justice pathfinder, ReGroup, that is providing a whole criminal justice and health pathway service for veterans and family members. The pathfinder is for veterans who are at risk of entering the criminal justice process, at the point of arrest and or conviction and sentencing through to a period of imprisonment and on release.

Emergent findings from the evaluation of this pathfinder suggest that a dedicated criminal justice pathway for veterans is essential to meet the level of complexity involved. Given the complexity of needs for those in the criminal justice system, it is important that trauma is addressed effectively and that any future development of veterans criminal justice services is integrated alongside the development of high intensity services with shared care coordination and ease of access.

2.3 Social impacts including employment, debt and housing

While a variety of social harms and risks follow from mental health problems, they can also precipitate problems. For example, trauma related mental health crisis is rarely solely a medical issue, it is usually precipitated by or accompanied with an acute social crisis. Social problems build up over time and it is the combination of factors that results in crisis including loss employment, increasing financial problems and losing stable accommodation, often accompanied by drug and alcohol problems and problems with offending:

"I was in a mess when I left the Army, not coping well, drinking too much, getting in to trouble with police, fighting, I went out looking for a fight…lost friends, lost my job, my family got fed up, I ended up homeless, I'm still staying on a friends sofa."
(Veteran)

Participants to the needs assessment described a variety of social problems including:

- Loss of employment - 35 veterans (49%) described experiencing this at some time.
- Financial problems - 32 veterans (45%) described experiencing this at some time.
- Homelessness - 15 veterans (22%) described experiencing this at some time.

For veterans with complex needs, especially those experiencing trauma related mental health problems, it is hard to find and sustain employment. As a consequence, financial problems can accumulate, and some lose their home and either end up sofa surfing or homeless:

"He couldn't keep a job, he was missing too many days off sick, but he couldn't cope with it, not the way he was then, it was too much for him."
Family member)

While often being the result of complex needs and trauma, these problems can also be the cause:

"Things were fine at first, I was working, had a good job, but when I lost it, that's when things got much worse…"
(Veteran)

People appear to go through cycles of social decline whereby their psychological health impairs their ability to function, and as they lose social supports such as employment, they face practical problems related to debt and housing and mental health deteriorates further. But the loss of these social supports can have a profound impact on the experience of trauma related symptoms, for example increased feelings of detachment, low self-esteem and hyper anxiety states:

"I thought my problems were like anyone else, I knew others who lost their job, had money problems, but I didn't realise it was all making my PTSD worse, I was becoming more isolated, I didn't trust anyone, anxious all the time…"
(Veteran)

For some, it is easier to see their problems through the lens of employment and financial needs rather than face up to the psychological needs and the impact these are having on their social functioning:

"Some come seeking help with employment, they think if they can get a job that everything will be alright, but it's clear they haven't dealt with their mental health problems and that these won't just go away if they get a job, working could even make them worse."
(Professional stakeholder)

There is clearly a need for the social harms associated with trauma related mental health problems to be addressed alongside the psychological harms and risks. From a lived experience perspective, they are inseparable. People feel less able to engage with helping services if their social situation is unstable, but they also need psychological help to create and sustain that stability. These problems often start during transition from the services.

2.3.1 Problems coping with transition

While the majority of veterans manage the transition to civilian life without problems, for those who do experience problems, the transition itself is identified as a significant factor for mental health:

"When I left I had very little idea what help was available, there was no information, my GP didn't know anything, I just knew about RBL, SAFFA, but that was low level help, practical, it was important but I need help with my mental health."
(Veteran)

Experiencing problems with transition can itself be seen as causing trauma:

"It can be the transition that actually causes problems, veterans are not recognised, their skills aren't recognised, they aren't taken seriously and treated as an individual, military culture is also de-humanising and veterans are seen in a certain way so they can act that way, societal integration is a big problem."
(Professional stakeholder)

"All his problems started when he left the Navy, he never really found his feet and as he struggled more, he became more ill."
(Family member)

This creates a significant challenge to the way in which we conceive trauma with respect to veterans, i.e. as being combat related. But there are some clear problems with respect to transition that are increasingly recognised as traumatic experiences, such as:

- loss of employment – especially when this results in significant financial pressures that may lead to relationship problems and loss of stable accommodation;
- relationship breakdown – either due to interpersonal problems or additional stressors created as a result of poor adaption to civilian life;
- loss of esteem and social role – which can add to feelings of isolation and dissociation

For an occupational group that are used to high esteem factors, strong peer support and occupational stability, the loss of these factors can indeed constitute traumatic experiences.

2.4 Family experiences

For veterans and family members trauma related mental health problems are not something that are just experienced by the individual, but by the whole family:

"Trauma doesn't happen to a single person it is a family problem."
(Family member)

"It affects everyone around you."
(Veteran)

Often this involves family conflict and breakdown:

"It all took its toll, eventually she just had enough, and we split up."
(Veteran)

"We don't speak much anymore and when we do it ends up in us just shouting at each other."
(Family member)

For those with significant problems the strains can cause relationships and family breakdown, which leaves people more vulnerable:

"People get in these states when they don't have anyone else, if you have lost family or friends, it can fall apart quickly, it's only my family and friends that keeps me sane."
(Veteran)

Family members often do not understand the nature of the problems that a veteran may be experiencing, nor the timescales involved in recovery, which can be longer than some people can put up with:

"It is hard for families to understand the process of recovery, the timescale involved. If you have a reasonable relationship then you expect there to be some insight, but as time goes on, over the longer term, tolerance and resilience wears thin and things break down."
(Veteran)

Some of the main concerns for families is about the degree to which they can also experience trauma, in the form of secondary stress disorders:

"Trauma passes on to families. Wives, parents, they have their own problems as a result of being in close contact with someone who is going though it themselves."
(Veteran)

It is important to recognise parents and not just focus on partners:

"I have moved back in with my mother and she is my main support, but she gets no help, I know she worries a lot about me, she is old now and has her own physical health problems."
(Veteran)

Although the problems are taking place in the home and it is the family feeling the impact, there are very few services directed at helping the family:

"… most services do not have sophisticated enough data to capture family needs adequately, to identify people who need family or relationship support, so they can know what the issues and problems are."
(Professional stakeholder)

The needs of family members are consistently viewed as being unmet by services:

"There is nothing for family members."
(Veteran)

"It was hard getting some treatment for him, but when it came to me, as his wife, there was nothing."
(Family member)

Family members, most commonly spouses, are the first ones to recognise the problems and the ones that push for help, often acting as the prime referral agent. But once someone is in contact with a service, the family member can feel left out:

"If it wasn't for me he wouldn't have got help, but once he did they treated me like I was nothing to do with him, if I phoned up to ask if he was doing ok, they just said that they couldn't speak to me about it."
(Family member)

"You are told that you can't come with your partner, they only want to see a person on their own – we should both have gone in together."
(Family member)

Some armed forces charities are also thought to be lacking in a strong family focus:

"The armed forces charities are behind the curve on family work and importance of this, when supporting an individual with complex needs, it is important to recognise that the family have complex needs too."
(Professional stakeholder)

As noted previously, family or relationship breakdown is often a precipitating factor for crisis, but there is very little evidence of people being offered couples or family therapy:

"We wanted to be seen as a couple, but they said they couldn't do that, all they offered was Relate."
(Veteran)

"Families can feel excluded, they should be in with us, in treatment with us…"
(Veteran)

Qualitative research on the experiences of partners living with veterans who have trauma related problems is limited. But one study suggests that the subjective experience of partners is significant in particular, understanding about whether the trauma related problems were due to being unwell or bad behaviour. For example, some female partners are thought to subdue their own emotional and behavioural responses, while negotiating multiple roles, and also struggling with transition to civilian life (Doncaster, et al. 2018).

Understanding the role of family members and partners as carers is important for recovery of the individual with trauma but also to protect and support the primary care giver. For example, primary carers of veterans with PTSD experience poorer physical and mental health and report related problems with finances and employment (Griffin, et al. 2017)

A better understanding of protective factors is required to ensure that burden of care does not exceed the caregiver's health and financial capacity, or undermine the care, well-being, and recovery of the service members or veterans (Moy, et al, 2018).

2.4.1 Children of parents with PTSD

Children of parents with PTSD are known to experience problems that are related to the symptomology of the parent. A review in 2013 found that parents with elevated levels of trauma may pass on psychological vulnerabilities to their children, which can impact on childhood development and cause acute distress (Leen-Feldner, et al. 2013). Parenting behaviours can also become more negative, including lack of engagement with children and displays of anger or violence, which are also associated with children experiencing problems (Fitzgerald, et al. 2017).

A study from Australia on the impact of the Vietnam war, found significant long-lasting impacts on children. Up to 40 years after the war higher rates of depression, self-harm and suicide in adulthood were reported (Forrest, et al. 2018).

Parental PTSD has also been associated with PTSD in children alongside other problems including substance use, depression, anxiety and suicidal ideation (O'Toole, et al. 2018).

The associations between combat exposure for women in the armed forces and subsequent impacts on family functioning and relationships has been shown to be negative, suggesting that family and relationship focused therapies may be important post deployment (Creech et al, 2016).

2.5 Occupational trauma and systemic impacts on different groups

Trauma disproportionately affects marginalised population groups, for example research has shown that traumatic and other stressful events tend to be more frequent in individuals of low socio-economic status, racial and ethnic minorities, and younger age groups. (Bowen, et al. 2016; Becker-Blease, 2017). For many individuals, especially those in marginalised communities, feeling unsafe and threatened is a direct response to their experience of society and its institutions and this can be as real for veterans as with other occupational groups.

The intersection between discrimination, occupation and trauma is evidenced in the research. For example, the relationship between trauma and marginalisation points to the fact that trauma is not only an individual phenomenon, but also a systemic one. Systemic trauma refers to:

"The contextual features of environments and institutions that give rise to trauma, maintain it, and impact posttraumatic responses"
(Goldsmith, Martin & Smith, 2014).

Systemic trauma is a broad concept that includes both abstract structures, such as societies, cultures and families, and more concrete institutions, such as employers, hospitals and schools. However, systems of any type can give rise to and perpetuate trauma in the form of, for example, racism, sexism and poverty. By recognising this relationship between environmental and occupational factors and psychological wellbeing, the field of systemic trauma challenges traditional conceptualisations of trauma (Wilton, et al, 2019).

The importance of recognising and being able to work with systemic trauma and its impacts on people is evidenced in this needs assessment from consideration of: Lesbian, Gay, Bisexual and Transgender individuals, ethnicity, sex and age.

2.5.1 Lesbian, Gay, Bisexual and Transgender individuals

LGBT veterans are known to generally experience added barriers to seeking health care, which has been attributed to fear of discrimination and previously negative healthcare experiences (McNair & Bush, 2016; Shipherd, Green, & Abramovitz, 2010). Fears about stigma and how they will be treated from veteran specific support services can be influenced by this general poor experience of healthcare and perceived or real discrimination:

"As LGBT veterans, I suspect that the issues about access to healthcare are the same as for other LGBT people. Many LGBT people still have fears about stigma and how they will be treated. For example, health professionals make assumptions people, that we are all straight and we don't question that, don't correct them, and we don't offer to tell the GP that we are LGBT, is it relevant to health need?"
(Veteran)

LGBT Veterans can also feel alienated from the general veteran/military community, for example perceptions that some of the existing military charities and systems of support are not LGBTQ friendly:

"The media make us think of veterans of white males in combat gear, the squaddie, front line soldiers experiencing combat stress. The focus is always on the extreme end, suicides, homelessness, and yes, these people do need veteran specific services but generally these are not attractive to LGBT people."
(Veteran)

"I tend to avoid the military support system, charities, breakfast clubs…I just assume that they are mainly run by straight, older men who are the same as when I experienced abuse in the military for being a Lesbian."
(Veteran)

For those experiencing trauma in addition to fears about being discriminated against, it can be doubly hard to seek help and trust that services will be responsive:

"If you have trauma then it is made worse by being unable to be yourself, if you were gay or trans then too much remained hidden, you couldn't talk openly about it and had to educate the people who are supposed to be there to help."
(Veteran)

Transgender

Whilst people who are transgender in the military share many similar experiences with respect to discrimination and prejudice, there are some additional factors that can add to mental health needs that may arise as a result of trauma. For example, for some trans people the very nature of being trans is sometimes regarded as a mental health problem and trans individuals fear losing their employment as a result of this, which can prevent them from seeking help or feeling safe to come out as being trans:

"… there is also a real fear of being classed as having a mental health problem if trans – even today and people fear they could lose their job, all that is before you start to deal with other people and their attitudes and prejudice, it is other people who make the problems, being trans is not a mental health problem."
(Veteran)

For trans veterans there can be additional fears and stress in dealing with medical professionals in civilian life, especially as a result of low levels of understanding about what it means to be trans and the particular health needs people may have:

"Where you leave the forces there are no signposts or help, you are left to your own devices and community services, which not only don't know you are a veteran but know nothing about gender identity."
(Veteran)

2.5.2 The legacy of the ban on LGBT serving personnel

The Ministry of Defence maintained a total ban on the service of LGBT Personnel from the mid 1950's until 2000. The impact upon the lives of LGBT serving personnel was significant, with some people not only losing their employment, accommodation and friends but often being outed after having been arrested, investigated and in some cases medically inspected.

For older LGBT Veterans who served under the ban, there remain deep feelings of hurt and anger and in some cases, post traumatic stress as a result of the way that they were treated:

"Looking back, at the time it was PTSD, but I had no recognition of that then. I didn't seek any help… I was on anti-depressants for a time, I had a strong sense of failure, I was discounting my own experience, comparing it to others who were worse off, the attitude was of needing to pull my socks up… it all stopped me seeking help."
(Veteran)

The last person to be placed in military detention was in 1996. Thereafter it was agreed by Service Chiefs that the process would be administrative rather than criminal. But the law remained in place until 2000, after having been challenged at the European Court by Stonewall and a group of people in the forces who had experienced discrimination.

In celebration of the 20-year anniversary of the lifting of the ban a book was published, Fighting with Pride (Jones, 2019) which chronicles the experiences of a selection of Lesbian, Gay, Bisexual and Transgender servicemen and women who served in the Armed Forces since the Second World War.

Their stories are profoundly moving testaments to their loyalty, their courage on the battlefield, and their unswerving sense of right and wrong. Some of the people included in Fighting with Pride have shared their experiences as part of this health needs assessment:

"In some cases, writing these personal accounts has involved telephone interviews and transcription because their own attempts to write them were on tear-soaked paper It's been cathartic for all. One contributor told me last week that the ashes of his service career had been replaced by a book through which he had reminded himself that he had much to be proud of."
(Veteran)

The employment situation has certainly improved for current serving personnel, but it is important to recognise the legacy impacts for older LGBT veterans, and the ongoing trauma that they experience. This is particularly important for access and inclusion to services and support, as many are reluctant to approach helping services and agencies that they perceive to be part of their historical and systemic experience of discrimination.

Overcoming all of these barriers and negative perceptions about potential sources of support, will be challenging and require specific messaging and communications that speak to LGBT Veterans. For example, reaching out to people through general LGBT charities and groups, being inclusive in messaging and promotion of services and having positive LGBT policies. In particular, there is a need to actively reach out to LGBT veterans:

"LGBT veterans will need to be high up on the list to be found."
(Veteran)

2.5.3 Ethnic diversity and veterans

Most of the literature on trauma and ethnicity amongst military personnel and veterans is from the USA and other countries such as Israel and Australia. These studies suggest that ethnic minorities are at higher risk for developing PTSD than their White counterparts after experiencing a traumatic event and are less likely to receive evidence-based treatment for their symptoms. They may also be more likely to terminate treatment early.

One study of veterans with PTSD returning from Iraq and Afghanistan found that Asian/Pacific Islander (A/PI) women, Latino/Hispanic men, and Black men were more likely to be diagnosed with PTSD than other racial/ ethnic groups (Koo, et al. 2016). Another USA study (Roberts et al., 2011) found that the lifetime prevalence of PTSD was highest among Black veterans (8.7%), intermediate among Hispanics and Whites (7.0% and 7.4%) and lowest among Asians (4.0%).

These differences also translated into variations in trauma risk by type of event. For example, combat exposure trauma was higher for Asian men and women, Black men and Hispanic women compared to their white counterparts. However, the risk of experiencing PTSD was higher among Black individuals and lower amongst Asians. Also, fewer than half of ethnic minorities with PTSD sought treatment. The study concluded that PTSD amongst USA ethnic minority veterans is usually untreated and that there are large disparities in treatment, which indicate a need for investment in accessible and culturally sensitive treatment options (Lester, et al. 2010).

The UK has a very different ethnic makeup compared to the USA and other countries, for example although 2% of veterans are from Black and Minority Ethnic groups (BAME) this includes Gurkhas from Nepal, who were serving in the British Army (NHS Midlands and Lancashire, 2019).

Ethnic groups such as Ghurkhas are also reported to be isolated, as they may be living away from their families and have poor command of English. Cultural factors may be helping to mask recognition of trauma related mental health problems including additional stigma about mental health. The biggest problem is thought to be overcoming cultural barriers so that the issues can be more openly discussed:

"It is very challenging in the Ghurkha community to break down cultural barriers, it really does take a community approach."
(Professional stakeholder)

Amongst respondents to this health needs assessment, 4.2% of veterans and family members were BAME including Ghurkhas and Black Caribbean, Black African and Asian British. The numbers are very small, so it is difficult to draw any firm conclusions about specific themes that are pertinent on the basis of ethnicity. However, many of the issues that are known to impact on non-veteran BAME individuals accessing mental health services are likely to be relevant. For example:

- differences in socioeconomic status;
- the degree of acculturation to dominant occupational and societal norms;
- perceived discrimination
- stigma about mental health and perceptions about mental health services

In the research it has also been reported that measurement bias in how ethnicity is accounted for may contribute to the differential findings across ethnic groups, including the ways in which trauma is understood and recognised and subsequent manifestation of PTSD symptoms (Trepasso-Grullon, 2012).

Covid-19 has brought some of these concerns to the fore with respect to the differential impacts on mortality from the pandemic amongst BAME communities. These differences in experience and impact also need to be better understood with respect to trauma and the mental health of BAME veterans.

2.5.4 Differences between women and men

Veterans in the UK are more likely to be male (89%) compared to non-veterans -47% (MOD, 2019a) and in this needs assessment 22.5% (16 individuals) were female. As with ethnicity, the numbers are too small to draw any firm conclusions but there is evidence in the literature that men and women experience trauma differently including prevalence, frequency and nature of the traumatic event. There are important implications of these differences for treatment and access to services.

There are differences in the types of trauma that men and women are exposed to. For example, men are more likely to experience combat trauma, accidents, natural disasters and disasters caused by humans, while women experience more incidents of sexual abuse. Experience of attempted or completed sexual assault amongst women is significant, approximately one of six women, and this is associated with higher rates of PTSD (Greenberg, 2018).

Sexual trauma whilst serving in the armed forces was also associated with at least one other non-military trauma including sexual abuse as adult civilians (77.0%) and as children (52.6%). The same study also found an association with chronic pain and recommended that treatment should include integration of physical and mental care
(Kelly, et al. 2011).

Female veterans with PTSD experienced significantly higher levels of hostility, by a factor of 1.5 (Butterfield, et al. 2000). There is also evidence that women experience different first responses to trauma than men, for example women are more likely to seek social support, which suggests that while personal relationships can be a cause of trauma, they are also a potential source of protection, but this depends of being capable of reaching out for support (Olff, 2017).

Self-harm, eating disorders and emotionally unstable personality disorder are reported to be more common among women than men, and these problems are also associated with experiences of violence and abuse (DHSC, 2018).

There is increasing awareness of the risk and prevalence of sexual abuse in occupational settings and how women in particular are subject to pressures and cultural factors that make them less likely to report sexual abuse. Military sexual trauma (MST) refers to sexual harassment and assault experienced by individuals in the armed forces and while research is limited, it is strongly associated with trauma (Williams and Bernstein, 2011). Sexual trauma amongst women is also associated with poorer health behaviour and veterans with a history of sexual assault are

associated with increased substance abuse, risky sexual behaviours and an increased need for preventive health care (Lang et al., 2003).

The support that women experience during conflicts and as veterans may also differ and this has implications for the experience and resilience to trauma, for example social the degree of support that women experience while deployed has been shown to play a buffering role against negative mental health consequences of stress and trauma (Vogt et al., 2011).

Understanding the differential experiences of trauma, types of traumatic event and resilience factors are important considerations for service responses for female veterans at risk of trauma related mental health problems.

2.5.5 Age of veterans

It is often assumed that the problems of ageing for veterans are much the same as for the general older population, and some studies have concluded that PTSD in the elderly must be considered within the context of normal aging. But there are increasing concerns and greater awareness that the experiences of older veterans are changing. For example, there are greater numbers who were deployed in more recent conflicts that are associated with higher rates of trauma such as Afghanistan and Iraq. Strong claims about an interaction between PTSD and aging are difficult to make due to sample heterogeneity, but it is clear that PTSD in this age group presents unique aspects not seen in younger cohorts (Lapp, et al. 2011).

There are also some important demographic variations, for example veterans are less likely to be single (10%) and more likely to be widowed (16%) compared to non-veterans (10%) older veterans also tend to self-report slightly higher rates of poorer health (NHS Midlands and Lancashire, 2019).

As the veteran population ages, problems with co-morbid mental and chronic physical health problems are likely to increase, with subsequent implications for services.

Younger veterans are also known to be at higher risk of self-harm and suicide and are less likely to self-identify as veterans. This means that for younger veterans, there is a need to consider the ways in which they are encouraged to seek help, including messaging and promotion of veteran specific services.

3. Prevalence and Diagnostic Frameworks

The classification of trauma as a mental health problem is a relatively new phenomena, for example the term PTSD was first added to the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) nosologic classification scheme in 1980. Though undoubtedly, the experience of psychological trauma has always been part of the human condition and accounts of trauma can be found in much of the world's earliest literature (Friedman, 2019).

For military personnel, trauma was recognised as a significant problem during World War I, when it was called 'shell shock' but it was not until the activism of Vietnam veterans in the USA in the 1960s and 70s that PTSD was given credence as a diagnostic condition related to combat exposure.

Tensions continue to exist in the literature about the relative value of differing terms and diagnostic thresholds. The 11th revision to the World Health Organization's International Classification of Diseases (ICD-11) proposed two distinct sibling conditions:

- Post-Traumatic Stress Disorder (PTSD) and
- Complex PTSD (CPTSD).

3.1 Post Traumatic Stress Disorder

The ICD-11 (WHO, 2018) defines Post-traumatic stress disorder (PTSD) as a disorder that may develop following exposure to an extremely threatening or horrific event or series of events. It is characterised by all of the following:

1) re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares. These are typically accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations;

2) avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event or events; and

3) persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. The symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

More recently there is much greater focus on the emotional impact of trauma, in particular guilt, remorse and the associated complexity of emotional reactions.

The revised ICD-11 classification is simpler than that in the Diagnostic and Statistical Manual (DSM), the latest version of which, DSM-5 includes four clusters of symptoms and one dissociative subset:

- Re-experiencing - spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress.
- Avoidance - distressing memories, thoughts, feelings or external reminders of the event.
- Negative cognitions and mood - myriad feelings, from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event.
- Arousal - aggressive, reckless or self-destructive behaviour, sleep disturbances, hyper-vigilance or related problems.

(APA, 2013)

The dissociative subset refers to the experience of PTSD with prominent dissociative symptoms (either experiences of feeling detached from one's own mind or body, or experiences in which the world seems unreal, dreamlike or distorted). Dissociation is a mental process with disruption or lack of connection between aspects of a person's functioning which usually work together. These include thoughts, feelings and sensations which are separated or disconnected from present experience, and awareness.

Dissociation can be healthy e.g. daydreaming or being absorbed in an activity. It can also become problematic and challenging. People can dissociate in the face of a terrifying event or a series of traumatic events that threaten to overwhelm them. While at first protective, trauma-related dissociation can cause ongoing problems. This can happen if the trauma has not been resolved. Degrees of dissociation occur with all types of trauma (Howell & Itzkowitz, 2016).

There has been some debate about use of the term `disorder' particularly in relation to military personnel experiencing trauma.

Some view the overtly pathological and medical connotations of the term `disorder' to be a factor that may deter military personnel from seeking help, due to associated stigma of mental illness. The counter argument is that access to appropriate medical help and treatment may suffer if the term were de-medicalised and that it is the culture of the military that needs to change.

Amongst professional stakeholders and veterans there are some tensions about the utility of a diagnosis of PTSD:

"People always think about PTSD but nothing more nuanced, people can be experiencing trauma related problems without having a strict diagnosis of PTSD."
(Professional stakeholder)

"PTSD at the moment is simply an umbrella word for failed mental health. For veterans, a number of things pile on top of each other, drugs and alcohol are involved and very quickly people just can't cope, it's not all about PTSD."
(Veteran)

The focus on the emotional complexity of trauma and associated feelings of remorse, guilt and what has been termed `moral injury' are receiving greater focus in trauma therapies and responses.

3.1.1 Moral injury

The concept of moral injury is closely associated with serving in the military and with PTSD. It refers to psychological distress that results from actions, or the lack of them, which violate someone's moral or ethical code (Litz, et al. 2009). Although it is not classified as a mental illness, moral injury can result in intense feelings of shame, guilt, or disgust that may be pathological in nature and manifestation. The personal and psychological difficulties that result include depression, PTSD, and even suicidal ideation (Williamson, et al. 2018).

Being able to identify specific emotional mechanisms, such as moral injury, and the role these play in trauma is essential for the development of appropriate and sensitive responses and enhancing treatment effectiveness (L'opez-Castro et al., 2019)

3.2 Complex PTSD

Recognition of the complexity in presentations of trauma has led to the introduction of Complex PTSD as a diagnostic category in ICD-II. While complex trauma survivors are also more likely to experience PTSD, part of the reason for the change in the classifications was because the symptoms of PTSD do not cover the variety and breadth of the adverse impacts. For example, Complex PTSD can cause challenges in many areas of functioning including within the person, with friendships, intimate relationships, family and in the workplace. Complex PTSD is proposed to have the following six symptoms.

- Intrusions including regular suicidal feelings.
- Avoidance including feeling like nobody can understand what happened to them and avoiding friendships and relationships or finding them very difficult.
- Hyperarousal – sense of threat including feeling very hostile or distrustful towards the world.

- Emotional dysregulation - severe ongoing problems in controlling emotions and often experiencing dissociative symptoms such as depersonalisation or derealisation.
- Negative self-concept - ongoing sense of being worthless and defeated, as well as extreme feelings of shame and guilt and constant feelings of emptiness or hopelessness.
- Disturbance in relationships - ongoing difficulties in forming and sustaining relationships and connection

Three are common to PTSD: avoidance, arousal and negative self-concept (APA, 2013).

Complex PTSD is associated with trauma that is more prolonged, repetitive and harder to avoid or escape from. It is also more strongly associated with repeated childhood sexual or physical abuse, prolonged domestic violence, genocide, slavery and torture.

The more often people were traumatised as a child and the more different types of childhood trauma they experienced, the more likely they are to develop Complex PTSD (Karatzias et al., 2018).

3.3 Co-morbidity and differential diagnosis

People with complex trauma can also exhibit many other mental health problems and may be diagnosed with multiple coexisting conditions such as substance misuse, eating disorders, self-harming behaviours and suicidality (Cutajar et al. 2010). These can also include mood and anxiety disorders and psychosis such as schizophrenia, bipolar disorder and dissociative disorders (Dorahy et al. 2016; Shevlin et al., 2007; Schäfer and Fisher, 2011).

Changes in diagnostic criteria add to the challenge of understanding differential diagnosis, for example, Complex PTSD is in part, a reformulation of a previous diagnostic category, that of Enduring personality change after catastrophic experience (EPCACE. ICD-10 diagnosis F62.0). Some commentators regret the loss of EPCACE as a diagnostic classification, believing that it better captured the lived experience of some trauma survivors than the more restricted symptom classification that has been attributed to Complex PTSD (Tenaka et al., 2018).

It is thought that EPCACE as a diagnosis captures neglected subpopulations of traumatised individuals whose presentations cannot be fully explained by PTSSD, namely, the enduring change in trauma victims' sense of identity and community belonging. This is particularly pertinent to the lived experience of veterans:

"Nothing seems the same, I don't know who I am anymore."
(Veteran)

"The biggest impact is not feeling like you belong anywhere anymore, I just feel distant from everyone, my wife, the kids, friends…"
(Veteran)

What is common amongst lived experience accounts of trauma is the sense of enduring personality change. But this is not clearly associated with having served in the armed forces. For some, it is about early childhood experiences of trauma, while for others it is actually about their experience of transition from the forces.

This may be associated with another area of potential differential diagnosis, that of adjustment disorder, which is also part of the new classification of Disorders Specifically Associated with Stress.

Adjustment disorder is described as a maladaptive reaction to a stressful event including ongoing psychosocial difficulties or a combination of stressful life situations.

While adjustment disorder usually emerges within a month of the stressor and tends to resolve in six months, it can have much longer duration if the stressor persists.

The reaction to the stressor is characterised by:

- symptoms of preoccupation like excessive worry, recurrent and distressing thoughts about the stressor or constant rumination about its implications;
- failure to adapt, i.e., the symptoms interfere with everyday functioning, like difficulties concentrating or sleep disturbance resulting in performance problems;
- loss of interest in work, social life, caring for others and leisure activities;
- impairment in social or occupational functioning for example, restriction of social networks, family conflict, absenteeism etc.

Some of the symptoms of Complex PTSD are very similar to those of borderline personality disorder (BPD), and not all professionals are aware of Complex PTSD.

As a result, some people are given a diagnosis of BPD or another personality disorder when Complex PTSD fits their experiences more closely. It is also possible to experience both Complex PTSD and BPD at the same time. BPD does not require a traumatic stressor for diagnosis, but it characterised by similar symptoms, for example fear of abandonment, shifting self-image or self-concept, shifting idealisation and devaluation in relationships, and frequent impulsive and suicidal behaviours (Cloitre et al., 2014).

Differential symptom experiences have been noted amongst PTSD sub-populations. For example, women were more likely than men to report feeling emotionally distant and easily startled, whereas men were more likely than women to report having a lack of a plan for the future, unwanted memories, unpleasant dreams, and a short temper (Qiwei et al., 2014).

In one treatment outcome study, which included diagnostic assessments of veterans at pre-treatment, posttreatment, and three follow-up times, the research team identified several challenges in the differential diagnosis of PTSD. The reasons were because of high levels of comorbidity, where symptoms were shared with or resembled other mental health problems such as:

- agoraphobia which also involved avoidance and hypervigilance
- psychosis involving hallucinations that appeared like flashbacks
- depression that included withdrawal and a negative self-concept

The study concludes that clinicians in mental health settings should be aware that those suffering from PTSD might present with symptoms that initially point to diagnoses other than PTSD and that mistaken diagnoses in the PTSD population can have a detrimental clinical impact (Schillaci et al., 2009).

The implications are that for people with some highly complex and acute mental disorders, the risks of misattributing symptoms to PTSD could impact on treatment and the likely benefit of

treatment. This could also be the case for those with both PTSD and co-existing mental disorders.

3.3.1 Mild Traumatic Brain Injury

Trauma is known to affect both mental and physical health and this can be especially challenging when trying to differentiate potential brain injury from psychological and emotional effects of trauma. One potentially complex or long-lasting condition that current and former servicemen and women may have developed as a result of service is mild traumatic brain injury (MTBI). Mild Traumatic brain injury has been described as the 'signature injury' of the conflicts in Iraq and Afghanistan, although there are currently differing views about the extent and long-term effects on mental health (House of Commons Defence Committee, 2019).

Mild Traumatic Brain Injury and psychological trauma share some similar symptoms, and, there is a risk that brain injuries in serving personnel may be misdiagnosed as PTSD.

For example, the most common symptoms of traumatic brain injury include headache, confusion, dizziness and difficulties with concentration and attention. As a result, this could make treatment and recovery more difficult. Research suggests that repetitive exposure to mTBI can result in long-term degradation of brain nerve cells and result in conditions such as dementia (KCMHR, 2018).

In one study an overall mTBI prevalence of 15% was found in a large survey of US combat infantry personnel deployed to Iraq (Hoge et al., 2008), whilst the prevalence in injured personnel returning from Iraq or Afghanistan who had been exposed to a blast was 40% (Okie, 2005). However, research by King's College London found only small rates of mTBI cases (3.2%) in UK Forces deployed in Afghanistan during 2011 with little evidence to show that mTBI had anything but limited lasting mental health effects (KCMHR, 2018)

The primary treatment with PTSD is cognitive behaviour therapy, and it was reported that this does not necessarily work with people who have sustained mild traumatic brain injuries. Correctly identifying mTBI can be problematic, for example the National Centre for Trauma reported that there were only two specialist scanners in the UK at Aston and Nottingham Universities, which may be able to identify cases of mTBI. This is an area the requires more attention and research and is a factor that needs to form part of further development of high intensity services for veterans.

3.3.2 Chronic physical health conditions

There is considerable overlap between psychological trauma and long-term physical problems, including pain management. Evidence has linked traumatic experiences, trauma-related disorders and mental disorders generally with chronic physical health conditions. Conditions such as cardiovascular disease (CVD), diabetes, gastrointestinal disease, fibromyalgia, chronic fatigue syndrome, musculoskeletal disorders and other diseases have been associated with trauma (Boscarino, 2004). There are also suggested differences between men and women for example, for men with a history of trauma there are raised incidences of arthritis and diabetes and in women digestive diseases and cancer (Norman, et al. 2006).

Possible explanations include lifestyle changes linked to the consequences of exposure or neuro-chemical changes in the brain arising from PTSD (Kemeny, 2005). Physical health may be also be impaired due to injury whilst serving in the Armed Forces including physical disability which requires specialist services for rehabilitation and prosthetic services. Some of the physical conditions that are associated with trauma include:

- Musculoskeletal: There are higher prevalence levels for musculoskeletal injury in relation to military activity and injury (NHS Midlands and Lancashire, 2019).
- Hearing loss: Hearing loss and hearing related problems is commonly experienced. Data in 2017, states that 1.8% of serving personnel had a hearing impairment of which less than 1% had poor hearing (MOD, 2018).

- Eye sight loss: Only 3% of veterans with eye sight loss were injured in service. Most of veterans are over the age of 75 (87%) had lost their sight due to age-related conditions such as macular degeneration, diabetes or glaucoma.
- It is estimated that currently there are 59,000 Armed Forces and National Service veterans battling severe sight loss (NHS Midlands and Lancashire, 2019).
- Cancer: Research indicates that for smoking related cancers there is slightly higher prevalence in military veterans compared to the general population. There is evidence that serving military personnel are more likely to smoke and smoke more heavily than non-veterans (Bergman et al., 206).

The Veterans Trauma Network provides specialist care to veterans with service-specific traumatic injuries. Veterans benefit from a personalised care plan implemented by top military and civilian trauma experts. The needs of veterans' families and carers are also taken into consideration.

Although primarily established to address physical trauma, there are cases where care covers both physical and mental health and it is important to recognise the need for joint working on both physical and mental trauma to ensure parity of esteem. The network operates 10 centres in eight major cities: Plymouth, Oxford, London (three centres), Birmingham, Nottingham, Liverpool, Leeds and Middlesbrough.

3.3.3 Substance use

Heavy alcohol consumption has been long recognised as an issue in the mental health of Service personnel and recent research demonstrates that excessive alcohol use among serving personnel continues to be an issue (Forces in Mind Trust, 2013). Drug use is thought to be less common in the UK armed forces, compared to the USA where 21% were reported to have a diagnosis of drug use alongside mental illness. For those with severe mental illness, bipolar disorder and schizophrenia, the rates of comorbidity with substance use were higher still (Petrakis, et al. 2011). Amongst treatment seeking populations high rates of trauma exposure have been found for those with a substance problem (Campbell, 2010).

Alcohol and drug use were cited amongst participants to this needs assessment as one of their coping mechanisms, which was often described as self-medicating to ease or numb the pain of trauma. Problematic alcohol use was more frequent than drug use:

"If you are drinking too much, then you only think about that, can't think straight, the alcohol takes over and you don't know what you are doing, you are just thinking about getting the next drink. I think a lot of veterans' drink to cover up trauma, you keep it hidden, but alcohol only makes it worse."
(Veteran)

However, the evidence is not clear whether alcohol or drug use put people at increased risk of trauma or is a consequence (Campbell, 2010). Nevertheless, substance use is known to commence or increase following exposure to trauma. For example, in the first 2 months after September 11, 2001, more than a quarter of New Yorker residents who smoked cigarettes, drank alcohol, or used marijuana (about 265,000 people) increased their consumption. The increases continued 6 months after the attacks (Vlahov, et al. 2004).

Alcohol and drug use can also have profound impacts on treatment, for example cessation of use can precipitate trauma symptoms. Challenging emotional problems, depression and anxiety can also occur once people stop use alcohol or drugs and these need to be accounted for in therapeutic approaches and treatment.

Amongst armed forces personnel in the UK, those who misused alcohol were the least likely to seek help (KCMHR, 2018).

3.3.3 PTSD and psychosis

Various studies have reported an association between PTSD and psychosis with many of the symptoms either co-occurring or overlapping and the severity of the trauma has been associated with both psychosis and levels of distress and social impairment (Ayub et al., 2015).

The overlap between symptoms of psychosis and PTSD has called into question the traditional diagnostic boundaries for these conditions and there are implications from this for treatment in the short and long term. For example, extreme symptoms of PTSD can approximate psychosis, underlying psychotic illness may be undiagnosed or masked by presentations assumed to be PTSD (ÓConghaile and DeLisi, 2015).

For veterans with a family history of anxiety disorders there is an increased risk of psychotic symptoms and for those with both psychotic symptoms and PTSD there is a higher rate of suicide attempts and more incidents of hospitalisation compared to veterans without psychotic symptoms. The increased suicidality in the group experiencing psychosis and PTSD is thought to be due to the additional burden of the comorbid symptoms and also additional strains that this places on family and social support (ÓConghaile et al., 2018).

3.4 Prevalence

The complexities in establishing reliable rates of prevalence for mental health problems amongst veterans, and in particular those that are trauma related are well recorded (House of Commons, 2018). Also, the vast majority of service personnel leave the Armed Forces with no ill-effects and have a positive experience from their time in service. In fact, the support and sense of community offered by the military environment might have improved the mental health in some, or at least delayed the onset of pre-existing conditions. However, the focus on mental health has increased over recent years and it has been suggested that at least 10% of veterans who served over the last 20 years may present with mental health conditions that need treatment (Help for Heroes and KCMHR, 2015).

It was estimated that in 2016 there were approximately 2.5 million veterans residing in Great Britain, and this is projected to decrease year-on-year to 1.6 million by 2028 MOD, 2019b). Understanding the prevalence rates for trauma and PTSD amongst veterans is challenging and the evidence is conflicting across groups serving in different combat zones and timescales. Considerable differences have been identified in the rates of PTSD, dependent on the role troops had in their last deployment before leaving service.

It was estimated that in 2016 there were approximately 2.5 million veterans residing in Great Britain, and this is projected to decrease year-on-year to 1.6 million by 2028 MOD, 2019b). Understanding the prevalence rates for trauma and PTSD amongst veterans is challenging and the evidence is conflicting across groups serving in different combat zones and timescales. Considerable differences have been identified in the rates of PTSD, dependent on the role troops had in their last deployment before leaving service.

- The rate of PTSD amongst UK veterans serving in in Afghanistan and Iraq was 4% in 2004/06 and 2007/09 but had risen to 6% in 2014/16. This compares to a rate of 4.4% within the civilian population.
- For regulars who are still serving, the overall prevalence of PTSD is 4.8% and is statistically higher in ex-regular veterans at 7.4%. In addition, it was reported that among ex-service regulars who had not deployed, the rate of PTSD was 5.0% and for those who had deployed the rate of PTSD was 9.4%.
- For those veterans whose last deployment had been in a combat role the rate of PTSD was 17% compared to 6% among veterans whose last deployment was in a service support role.
- Health problems and associated difficulties were also found to persist for longer amongst deployed reserves compared those not deployed, by as much as five years. Deployed reserves had higher rates of common mental disorders and alcohol problems (KCMHR, 2018).

A USA study found that between 0.6% and 13% of military veterans who have been exposed to trauma may suffer from Complex PTSD (Wolf, et al. 2015). There is more limited data on Complex PTSD in the UK. The House of Commons Defence Committee (2018) concluded that the mental health problems are across serving personnel and veterans.

While there is little consensus over prevalence rates, PTSD is one of the most widely used diagnoses amongst psychiatrists and psychologists worldwide. For example:

- PTSD ranks 14th amongst psychiatrists in their day-to-day clinical practice (Reed et.al., 2011).
- It is the eighth most frequently used diagnosis amongst clinical psychologists using ICD-10 and among psychologists who use the DSM-IV, PTSD ranks third, following only generalized anxiety disorder and major depressive disorder (Evans et al., 2013).

Complex trauma has far more extensive and debilitating impacts than PTSD alone and international preliminary findings suggest that Complex PTSD is common in clinical and general population samples although there may be variations across countries in prevalence rates (Courtois & Ford, 2013).

Further cross-cultural work is required to explore differences in PTSD and Complex PTSD across different countries with regard to prevalence, incidence, and predictors of PTSD and Complex PTSD (Karatzias, et al. 2017).

4. Help Seeking

One of the more common ways in which differing levels of needs are estimated in populations is through help seeking and subsequent service demand. But many secondary mental health services do not record patient activity by the number of veterans, and there are known problems in identifying veterans in some mental health services.

The development of TILS and CT services is helping to provide more robust estimates of need based on service use, and the current evidence suggests that the levels of demand are rising and that there are more cases with higher intensity needs. However, one problem with using service demand to estimate needs is that many veterans are isolated and do not easily approach services or seek help and that estimates of need and prevalence based on service use alone do not adequately take account of this.

Some professional stakeholders have also highlighted the fact that there are already high levels of trauma related problems in general mental health populations using services, and that the absence of high intensity services to meet these needs impacts on estimates of prevalence:

"80% of current mental health service users have some form of trauma but there is not enough specialist level of service for this level of need."
(Professional stakeholder)

This includes a lack of sophistication in considering co-morbidity and the impact of social factors on estimating the prevalence of high intensity needs:

"There is a high level of trauma across the spectrum of needs in mental health service users, also a lot of inter-generational trauma, substance use, deprivation factors, domestic violence, offending. The patterns repeat and it is very difficult to estimate the numbers of people with these more complex issues."
(Professional stakeholder)

It has been suggested that some veterans believe that their emotional problems are not sufficiently serious to warrant support, that they wish to deal with the problems themselves or question the quality of mental health services. Mental health-related stigmatisation has been cited as one of the main barriers to engaging with services and appears to be particularly problematic for those who have not accessed mental healthcare before. However, for those who did seek help, mental health specialists were rated as the most helpful source of support. The same pattern of help-seeking and reluctance to seek care has been found in the US and Canadian militaries and the Australian Defence Force (KCMHR, 2018).

But for those with higher intensity needs, too often recognition of that need comes too late, with the consequence that problems build up and become much worse than they might if help were sought sooner:

"People only really seek help when it's too late, you don't realise soon enough, how bad things have become, it builds up, problems mount up and then you only get help when things explode. If people understood sooner what was happening, then they could get help sooner."
(Veteran)

Amongst respondents to the needs assessment, lack of awareness about trauma related mental health problems and stigma associated with help seeking are amongst the defining features of this cohort of veterans. Despite the severe nature of the symptoms described and, what might to the professional eye, be an obvious trauma related phenomenon, to those experiencing these problems there is a distinct lack of awareness about it being mental health related:

"I didn't realise that what I was experiencing was trauma related – waking nightmares, feeling hyper anxious, sweats…I thought it was physical."
(Veteran)

There are also strong feelings of being isolated and a lack of belief that anyone could understand or help:

"The biggest impact is being isolated…you feel cut off, different, as if no one could understand what you are going through, it feels like you are going mad, thoughts are fractured."
(Veteran)

The sense of isolation and difference as a result of trauma is further complicated by a culture or mindset of not talking about problems:

"People keep a lot hidden, even from friends."
(Veteran)

This is thought to be a particular feature of military life:

"The trouble is that in the army you keep things to yourselves, you are a tight unit of friends and very close, problems come when you leave the forces, you are more alone, and it bubbles away…"
(Veteran)

This cultural aspect for veterans cannot be underestimated; the sense of letting others down and appearing weak, holds many people back from facing up to the reality of their problems:

"I couldn't face the reality of it, I felt weak, like I was letting everyone down, how could this be me? I just couldn't admit I had a problem…"
(Veteran)

This has a huge impact on help seeking; firstly, because people don't recognise that they need help and secondly, because if they do, it would mean admitting to a perceived weakness that they cannot face. These twin barriers of recognition and stigma leave people less likely to access help at earlier points, with the consequence that their needs are unmet and risk becoming more intense and complex.

4.1 Emergency and urgent care

There is no hard data on the number of veterans presenting to emergency and urgent care services with trauma related mental health problems. But there is a perceived service gap in recognising veterans who present to emergency services and providing an appropriate and sustained response to ensure access to care and treatment:

"We need a better way to pick people up in crisis and respond to veterans in emergency care situations, failing to do this right is actually causing more problems down the line."
(Professional stakeholder)

It is a commonly reported experience for people to have attended A&E in an acute crisis, only to be discharged rapidly with either tablets or a referral to a community mental health service, which they rarely follow up:

"I wasn't in A&E long, I think they just wanted to get rid of me, they gave me some information about the mental health service, but I didn't contact them."
(Veteran)

4.2 Mainstream mental health services

Veterans' experiences of mainstream mental health services vary. Some veterans report a positive experience that met their needs:

"The access and assessment team from the mental health service were good, I had a good case worker, regular visits."
(Veteran)

But others felt there was a lack of empathy for them as a veteran and poor understanding about trauma related mental health problems:

"I didn't feel that my key worker understood me, as a veteran and what that meant to me and my problems."
(Veteran)

"The service is fine for people with depression or anxiety, but when it comes to trauma or PTSD they didn't understand it."
(Veteran)

If someone is identified as a veteran, it can seem like they are being viewed negatively, as one veteran working for a charity said:

"The hospital said, 'We have one of yours, don't know what to do with him.' It feels like you are an immigrant. Not part of this culture…"
(Veteran)

Being able to establish a relationship of trust with key workers is seen as essential:

"Trust is a big issue for veterans, it doesn't come easily, especially with civilians."
(Veteran)

This is strongly associated with the individual worker:

"My key worker changed and there were problems, I didn't feel engaged, there was no proper hand over, I made an official complaint and the worker has been changed, the new one is better, more sympathetic, I feel more trust now."
(Veteran)

"It depends a lot on the worker, they don't need to be a veteran, but they do need to understand, have empathy."
(Veteran)

Feeling empowered and able to have control over the process of treatment is seen as important:

"You feel frightened, seeing a mental health service, so it's important to feel involved, that you can influence what happens, make your own decisions."
(Veteran)

But it when it comes to the offer of therapeutic treatments and remaining engaged with the service this can seem limited:

"I had six sessions with IAPT (Increasing Access to Psychological Therapies) but it was a group format given from a stage, there was no choice about it, and it didn't help."
(Veteran)

4.3 NHS mental health services for veterans

Mental health service provision for veterans in England has dramatically improved in recent years as a result of NHS England and NHS Improvement's concentrated focus on meeting needs from a lived experience viewpoint (NHS England, 2016a). This focus, alongside other dedicated needs assessments and reports (MOD, 2015; Bashford et al., 2015; Bashford et al., 2016 and Bashford et al., 2017) has supported the development of a range of

dedicated veterans mental health services. These include:

Mental Health Transition, Intervention and Liaison Service (TILS)

This is a dedicated local-community-based service for veterans and those transitioning out of the armed forces with a discharge date. The service provides a range of treatment, from recognising the early signs of mental health problems and providing access to early support, to therapeutic treatment for complex mental health difficulties and psychological trauma.

Where appropriate, help is also provided for other needs that may affect mental health and wellbeing – for example, with housing, finances, employment, social support and reducing alcohol consumption.

Mental Health Complex Treatment Service (CTS)

This is an enhanced local-community-based service for ex-service personnel who have military-related complex mental health problems that haven't improved with earlier care and treatment.

The service provides intensive care and treatment including, but not limited to, support for drug and alcohol misuse, physical health, employment, housing, relationships and finances, as well as occupational and trauma-focused therapies.

Veterans who had experience of using these services, very clearly valued them:

"TILS really helped; it was an excellent service."
(Veteran)

"We need this in the NHS, there should be more of these services."
(Veteran)

However, nearly half (45%) of veterans responding to the needs assessment had not used either TILS or CTS. Given the expressed levels of needs amongst this cohort, this suggests a potentially high level of unmet needs, especially high intensity needs that are trauma related. This strongly supports the need for additional veteran's high intensity support services.

While the development of these dedicated veterans' services has been a significant improvement in the NHS responses to meeting the mental health needs of veterans, there is general recognition that more needs to be done. For example, prior to TILS and CTS it was

reported that only 23% of UK veterans suffering symptoms of PTSD went on to access support services and while this has increased to over half, that still leaves many individuals who require help.

4.4 Armed Forces Charities

The value of small, armed forces charities and informal networks of low-level support, run by veterans for veterans, are viewed as very beneficial and important to have as part of the overall service model for high intensity needs:

"There are a lot of small, local good initiatives and projects like breakfast clubs, cafes and drop-ins, services where individuals have the right the right passion and commitment to make things happen. They are local and understand the local veteran's community and what services there are, close working with these is key, it needs to be a partnership model."
(Veteran)

"First Light cafes in run down areas are very good example of local services that are meeting needs, this is where care co-ordinators can add value, but it all needs to be lined up, knowing what is there and how to help people to access and use this level of local support."
(Veteran)

Whether residential or community services, there is a strong view that there should be a fully integrated model between the NHS and armed forces charities:

"It needs to be done with the military charities, not just NHS on its own. If NHS picks up treatment, then charities can pick up the social support needs."
(Veteran)

"It should be a joint approach with NHS and charities working together."
(Veteran)

"The NHS should align its services more with charities."
(Veteran)

There also needs to be recognition that armed forces charities, especially smaller one's struggle with finances and are often dependent on charitable donations or short-term grants. Veterans and family members would like to see greater sharing of funding by the NHS with these charities:

"The NHS could do more to share services, do things together with the military charities but they need funding, charities, the small ones, struggle to keep going and the NHS doesn't appreciate this, they want charities to do all the support but won't pay them for it."
(Veteran)

In particular, the armed forces charities should be included fully in new collaborative service delivery models:

"We need to have the armed forces charities embedded in the model, but it will take time to get this right and know what the right approach for a local collaborative is."
(Professional stakeholder)

NHS England and NHS Improvement has pioneered collaborative work with armed forces charities in many different areas and there are good examples of this working in practice to improve access, experience and outcomes for veterans and family members. This good practice and experience needs to inform the development of high intensity services and ensure that trauma informed services and treatment models make full use of the potential of the armed forces charitable sector.

5. Engaging People in Treatment

Having considered the specific range of high intensity needs, how these are classified, assessed and understood and the different ways in which people seek help from services, it is now necessary to consider how to effectively engage people in treatment.

Veterans' experiences of engaging with treatment are often marked by a perception that they might be treated for a mental health problem such as depression or anxiety, but without any awareness that this might be trauma related:

"…they treated me for depression, but no one spoke to me about trauma..."
(Veteran)

For some veterans the lack of recognition that they had a problem goes back to the time when they were serving and immediately after leaving:

"In service I didn't get any help, looking back I had real problems, but I wouldn't admit to it, only to friends, and when I left, I felt even more isolated. I didn't know where to go for help, didn't know what was wrong with me."
(Veteran)

Sometimes, it is the individual choosing not to engage with mental health services and even for those veterans who described having significant trauma related problems, it is often many years later that they say they found appropriate help:

"Help was there, but I didn't use it until years after."
(Veteran)

So, while there are those for whom symptoms related to traumatic experience(s) do not appear until sometime later, there are also people for whom the problems were evident, but for various reasons they did not recognise the need or did not feel safe to approach helping services. These need to form the twin aims of engaging and sustaining people in treatment: promoting awareness of trauma related mental health needs and establishing trust.

5.1 Promoting awareness and being trauma informed

While it is clear from the needs assessment that there is a requirement for services that can meet higher intensity needs, these cannot be situated in isolation. In order to be effective such services need to sit on a bedrock of awareness and education about trauma and its impacts, so that the wider health and care workforce and veterans and family members themselves are enabled to become trauma informed.

This needs to commence within the military establishment and continue through the point of transition to civilian life. The military establishment is becoming better at recognising the impact of trauma and fulfilling its duties as an employer for the mental health and wellbeing of the armed forces and their families. But there is more to do, because too many veterans still talk about being afraid to be open about their mental health, in particular, trauma, as they think that it will threaten their status and employment.

Of course, as we know from civilian occupations such as the police and emergency services, the opposite should be true. Enabling the workforce to talk openly about mental health, acknowledging trauma as an occupational hazard and providing appropriate help and support sustains people in employment and keeps people healthy.

But for veterans, as with the rest of the civilian population at risk of experiencing trauma, we need three things:

- Increase public awareness and reduce stigma
- Raise awareness amongst primary care services
- Enable a trauma informed emergency and urgent care response

This could build on existing initiatives such as Veterans Covenant Healthcare Alliance (VCHA), which a group of more than 40 providers aiming to improve the healthcare veterans receive from the NHS. The VCHA works closely with NHS England and NHS Improvement, service charities and the Ministry of Defence to showcase high quality veterans' healthcare and support NHS trusts to learn from each other by sharing what works. This includes committing to the Armed Forces Covenant, raising awareness among staff of veterans' healthcare needs, and establishing clear links with service charities and local support providers. 49 trusts have already demonstrated they are delivering these standards and have been accredited as 'Veteran Aware.' *

5.2 Increasing public awareness and reducing stigma

Unwillingness to use mental health services is a general problem across society and is not specific to the UK Armed Forces. However, there are already good examples of effective ways to do this and a foundation of work on which to build. For example, levels of stigma in the UK military have been declining since 2008 and recent service leavers are seeking help more rapidly than ever before. In fact, research has suggested that help-seeking has increased amongst both serving personnel and veterans. KCMHR reported that nearly one third (31%) of those with recent mental health problems had accessed a mental health specialist and 47% had consulted a GP or Medical Officer. Only 7% had not sought any help at all (KCMHR, 2018).

There is a need to continue to build on this success, but with a particular focus on trauma, especially about the impact of trauma on veterans and family members and positive messages about the fact that there is help and problems can be overcome. Campaigns work, but rather than presenting veterans as mad, bad or

* https://gettingitrightfirsttime.co.uk/veterans/

sad, the focus should be on promoting resilience and recovery.

5.3 Raising awareness for primary care staff

A great deal has been done to improve general awareness about veterans in primary care and many GPs are signing up to become 'veteran friendly' under a new national scheme to improve medical care and treatment for former members of the armed services that has been backed by NHS England and NHS Improvement and the Royal College of GPs. However, this is not necessarily translating into awareness and understanding about trauma related mental health needs.

This is especially important, because some veterans who have experienced traumatic stress, may present to their GP initially with physical symptoms. Thus, primary care may be the first and only door through which these individuals seek assistance for trauma-related symptoms.

It is no longer enough to be veteran friendly; GPs and the wider primary care workforce must become trauma informed.

Many veteran respondents to the health needs assessment described their GP as helpful and understanding, but for those with more complex mental health problems and trauma their experience is less positive. Even if the GP is perceived to be sympathetic, the most common response is tablets:

"I talk to my GP a lot, but he just gives tablets, it doesn't help enough."
(Veteran)

So, while it is important that more GPs become veteran-friendly, it is equally important that they can identify and respond to more complex mental health needs, in particular, GPs need to be trauma aware.

What appears to be happening is that veterans present at their GP feeling anxious and receive medication for anxiety, or they are depressed and have anti-depressants but what is lacking is awareness of underlying causes and related issues, which may be trauma. The service gap is in a trauma aware response that can identify behaviours within a context of risk assessment for veterans and identifying trauma related mental health problems.

5.4 Enabling a trauma informed emergency and urgent care response

Emergency and urgent care services provide an important route for veterans to receive help in crisis. However, veterans and family members report that emergency services have low awareness of veterans and are relatively poor at identifying trauma related mental health problems. There are three ways in which this can be improved:

- Utilise 111 services through trauma informed assessments, triage and intervention.
- Improve the level of expertise and understanding about trauma within psychiatric liaison services.
- Develop closer partnership with the armed forces charities that are already working proactively with veterans in acute mental health crisis.

5.4.1 Utilising 111 services through trauma informed assessments, triage and intervention

There is increasing use of NHS 111 as a central point for 24/7 crisis support. This could be improved through being trauma and veteran aware. For example, some NHS 111 services have dedicated mental health professionals who are trained in trauma and are increasingly being used to provide triage and emergency assessment for veterans.

In order to work this will require locally or regionally developed shared protocols so that the NHS 111 service is brought into the mainstream offer for dedicated veterans mental health services and in particular, as part of the offer for high intensity services.

5.4.2 Liaison psychiatry

Liaison psychiatry is the specialty of psychiatry that deals with the link between people's physical and mental health, hence it is often focused on emergency departments. But there is a need to ensure that these services, which are increasingly multi-disciplinary are trauma informed and veteran aware. The advantages are evidenced by NICE, which states in its guidelines that It is important to identify the trigger associated risks and options for ongoing care and respond to the crisis according to the individual's need and circumstances, including for trauma.

This includes recognition of social vulnerability that may have a mental health problem, including trauma as a component or root cause of mental health problems (NICE, 2016).

5.4.3 Partnership with the armed forces charities

Many of the armed forces charities are at the frontline of addressing the emergency and urgent care needs of veterans in distress, as a result of trauma including those who are at risk of self-harm or suicide.

For some social media is an increasing factor in identifying and reaching veterans at risk. For example, services such as All Call Signs, which is a peer-to-peer Internet chat service for veterans is viewed as successfully reaching veterans in acute crisis. Other veterans' charities such as Forgotten Veterans UK (FVUK) are also using social media to identify people at risk and in crisis:

"We knew from his media posts that he was in real crisis and we managed to make contact and get him to A&E."
(Veteran)

However, there is no published data on the numbers of veterans using these services, nor the reasons for, or types of crisis that people face. This is partly the nature of charities, which often lack the funding and resources for such analysis. But where they are brought into partnership with statutory services, as part of an integrated emergency response, this can be achieved.

Peer to peer veteran services, run by volunteers need good working relationships with the statutory emergency and urgent care services in order for both to be effective. This is not always

straightforward, but where these charities are supported to take an advocacy role, veterans are more likely to receive the service response that they need:

"We knew that he needed to be admitted, but the A&E doctor was reluctant to do it, it was only because we pushed them that eventually they did admit him."
(Veteran)

6. Sustaining Engagement

Raising awareness, creating a trauma informed and veteran aware workforce and strengthening the capacity of emergency and urgent care services, including the armed forces charities as partners are all essential means by which engagement with services for higher intensity needs must be founded. But having engaged veterans, it is equally important that they are adequately supported to remain engaged. This will only be achieved through:

- Low or invisible access thresholds, by which there is no wrong door
- Holding on to the case for the time that is required by the person, rather than the treatment modality
- Access to residential or inpatient care where required, which maintains appropriate aftercare.

6.1 No wrong door

The lived experience of veterans and the literature supports the view that we need take a more nuanced account of high intensity needs and the different ways in which trauma related mental health problems manifest in people, and the type of service response this requires. In particular, one-size fits all approaches are likely to be less effective and there is a need for more tailored responses (Murphy et al., 2019).

One option is to attempt a multi-variate service response that seeks to be all things to all people. But a more effective alternative is to have an integrated range of services, appropriate to the level of intensity of needs, but with no wrong door. That is to say, however someone approaches or enters the service they will be accepted, assessed and provided with the right response.

This is a very challenging suggestion, as it requires having very low or invisible

thresholds for access, which is the opposite of traditional approaches to higher tier services. It is also vital that this part of providing a consistent point of contact to ensure the experience of the user is that they have not ever entered a wrong door.

6.1.1 Learning from tiered, specialist services

In the NHS, it is more usual for services that are designed to meet higher levels of complexity to have their own access criteria, which is often restrictive and tightly formulated. However, tiered approaches of this nature have not always proved to be as effective as intended.

For example, tiered four Child and Adolescent Mental Health Services (CAMHS) have been known to create unexpected challenges, such as:

- creating a mismatch between regional, supra-regional and national provision arising from sporadic demand from local commissioners;
- a lack of strategic commissioning meant that standards were difficult to achieve
- isolation and geographical spread produced poor integration with tier three CAMHS;
- a lack of systematic and robust information about Tier 4 services precluded year on year comparisons of activity and cost, so even need based on demand or use could not be accurately calculated;
- ad hoc development produced inequality in access and patchy provision of inpatient services across the country;
- relying solely on the benchmark of beds per population gave an incomplete picture of current and potential future capacity to meet the needs of children and adolescents requiring comprehensive Tier 4 services.

(McDougall et al., 2008)

Concerns have also been raised that overly stringent access criteria for CAMHS Tier Four services, for example severe symptoms lasting more than three months has resulted in poorer access, which is compounded by increasing waiting times for community-based services in lower tiers. These problems are also thought to be adding to the burden of adult mental health (Varma, 2019)

Although NICE have produced guidelines for depression (NICE, 2009), there are no formal blueprints for the organisation and delivery of tiered services. The two common methods are stepped or stratified models.

Stepped care systems

In a stepped model, the system is self-correcting, in that although most patients are assigned to low-intensity interventions initially, those failing to benefit are 'stepped up' to higher intensity treatment (Haaga, 2000; Sobell and Sobell, 2000). The advantages of this approach are to increase the proportion of patients who might benefit from low intensity interventions. However, it may also delay access to appropriate care for some patients.

Evidence suggests that that the principal driver of patient flow through stepped care systems is the allocation to initial treatments. However, the rate of stepping up was low, no matter how the patients were assessed or how many were allocated directly to high-intensity treatment. The chart below illustrates the variations across sites in the proportion of patients referred directly to high-intensity treatment:

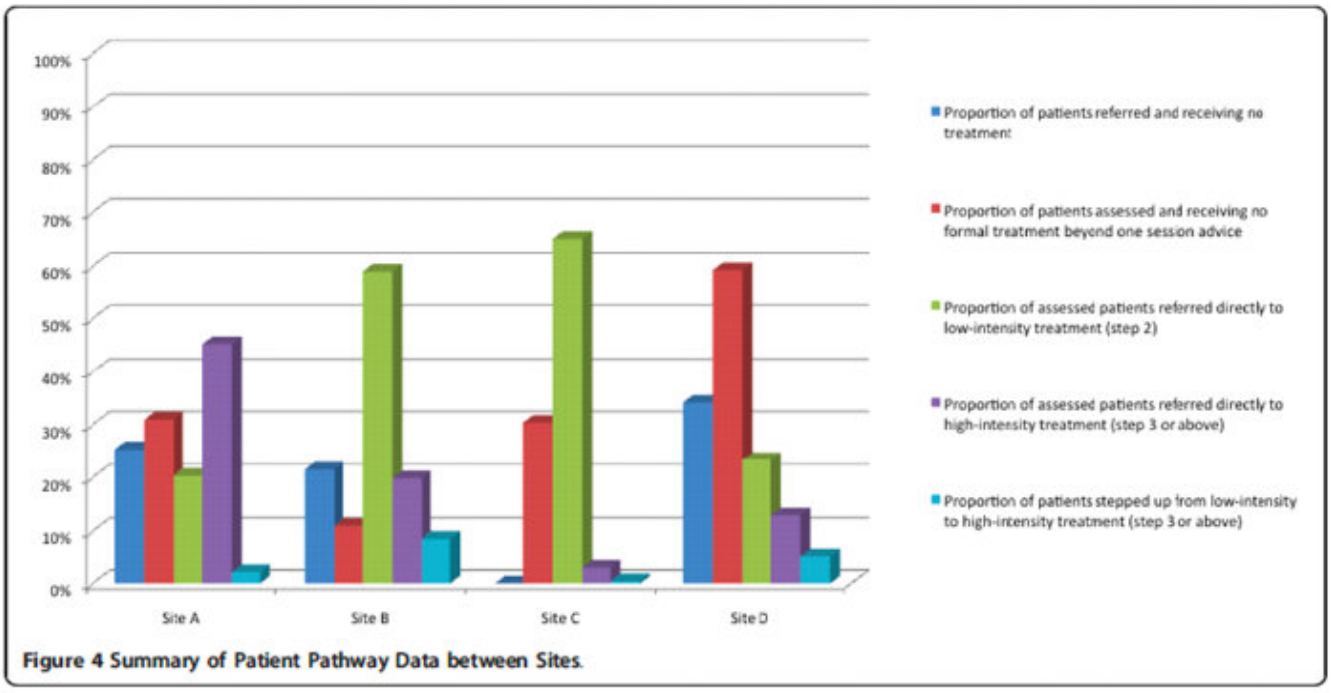


Figure 4 Summary of Patient Pathway Data between Sites.

The conclusion is that it is important to resource all available steps sufficiently to allow patients to be stepped up from low- to high-intensity treatment and to prevent situations arising where patients might be inappropriately 'held' at a low-intensity step (Richards et al., 2012).

Stratified care systems

A stratified care system is one that assigns patients to specific targeted interventions based on the presenting problem characteristics and/or apparent severity of symptoms (Richards 2010). This approach attempts to ensure more timely delivery of interventions that are thought to be more appropriate to the level of intensity. However, in order to be effective, it requires greater knowledge about which patients are more likely to benefit from specific interventions, which, while improving, is not allays straightforward with respect to trauma.

It is likely that a combination of 'stepping' and 'stratification' is necessary, and this could be incorporated into the principle of no wrong door. It is also important to consider the ways in which the care system is viewed by service users who, may interpret lower intensity interventions as second rate. An alternative term to tiered care may be required such as matched care (Williams and Martinez, 2008) and this will also need to be understood in the context of the Armed Forces Covenant.

6.1.2 Implications arising from the Armed Forces Covenant

The Armed Forces Covenant sets out the moral obligation and commitment of the nation and the government to its armed forces so that no one who has served or has a family member who served in the armed forces should be disadvantaged in accessing services compared to the civilian population. It establishes how the armed forces community should expect to be treated including priority access to NHS care such as hospital, primary or community care, for conditions that are service-related, subject to clinical need.

Veterans who have a complex and lifelong health condition, may also be eligible for the Integrated Personalised Commissioning for Veterans (IPC4V) programme. This is to ensure that they have more choice and control over how care is planned and delivered. This may include receiving a personal budget to pay for some of the care and support that is needed, for example additional support in the community and being able to access a range of help, such as emotional and practical support from people who have similar health conditions or disabilities. The IPC4V programme is part of NHS England and NHS Improvement's transformation programme and work is ongoing with Clinical Commissioning Groups and other stakeholders to increase the uptake.

The Covenant commitments are very important, but it is not always understood, either amongst veterans or amongst professionals (Bashford et al., 2017; Rand Europe, 2019). In the context of trauma related mental health problems experienced by veterans, two aspects in particular can prove problematic: the concept of priority treatment according to clinical need and that the condition must be related to having served in the armed forces.

As noted previously in this needs assessment, determining priority for trauma related mental health problems can be challenging, given the issues related to limitations in diagnostic frameworks, stigma and lack of trust preventing people coming forward to seek help and main stream health services not being trauma informed.

The late onset of problems, up to many years after having serviced in some cases, and the complexity inherent in trauma, for example related complex co-morbidities and social problems can also make it difficult to determine that the condition(s) is related to serving in the armed forces.

There may be a need to revisit the Covenant commitments for healthcare with respect to trauma related mental health problems so that the principle of fair treatment and no disadvantaged can be sustained.

6.2 Holding the case

One of the more contentious areas in the research literature concerns the numbers of people dropping out of treatment. For example, while there is a good evidence base for effectiveness of some psychotherapeutic interventions for trauma, such as EMDR compared to non-trauma focused interventions, there is also evidence to suggest relatively high dropout rates. For example, the Cochrane review of Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults found evidence of greater drop-out in active treatment groups. However, although drop-out rates were high in many of the studies, the reasons for attrition were generally poorly reported (Bisson et al.,2013).

Moreover, even when patients do improve, symptoms often remain high: Mean PTSD scores in trials of military-related PTSD have tended to remain at or above diagnostic thresholds following evidence-based interventions and approximately two-thirds of patients retain their PTSD diagnosis after treatment. Veterans that do not respond to one or two evidence-based interventions can receive labels such as "difficult to treat," "treatment refractory," "or non-responders" (Vermetten, et al. 2018).

Amongst the reasons cited by veteran respondents to the needs assessment for dropping out of contact with treatment services were:

- sign posting - for example having to be assessed by one service prior to referral to a more specialist one, regardless of the intensity of needs. This also involves further waiting times which can be problematic for some veterans;
- lack of sufficient follow-up – while veterans value information about other sources of support and help, they felt that being sign posted was insufficient in itself and that there should be a more pro-active process of ensuring they do actually take up these alternative offers of help and support;
- location – for some veterans' travel distances to attend appointments can be problematic.

6.2.1 Sign posting

Many veterans and family members expressed concerns about the amount of services that only offer sign posting. Their view is that what is needed is life-long case management, holding onto people for longer, rather than continually re-referring people round the system:

"For some people it's is a lifelong problem and they need a service that stays with them. It's very important to have trust and it takes time to build this so you shouldn't have to change workers all the time."
(Veteran)

While people recognise that there may be a need for people to access different parts of the system at different times and be able to step and down from intense levels of service and support, continuity of care and adequate follow-up is viewed as essential:

"There should be end to end care co-ordination, something that stays with people, don't let them go and then make them have to re refer back in."
(Veteran)

6.2.2 Ensuring sufficient follow-up

Limiting follow-up to a few appointments is thought to be problematic, as people may re-enter crisis and those with more complex needs are likely to require more substantial follow-up:

"There should be more than 3 or 4 follow-up appointments, it needs to be long term, regular."
(Veteran)

This something that family members and carers regard as important:

"As a carer, I feel that the most important thing is that there is little follow-up in the community, a weekly appointment is not enough."
(Family member)

Some form of pro-active outreach is considered important to help address this:

"There should be someone who chases people that don't attend appointments, making them keep in touch."
(Family member)

"Services are not good enough at reaching out to people."
(Veteran)

6.2.3 Care closer to home

The location of services for trauma related mental health problems is clearly paramount to sustaining engagement. But this is not simply a matter of geography, it is more fundamentally about integration of the service offer across different levels of intensity and specialisation.

Travel is an issue for people, especially if they have to spend a lot of time and money travelling for single, community-based appointments. However, whatever the geographical spread of the service, people think that travel can be overcome if the model is right.

For example, meeting the principle from the NHS Long Term Plan of providing services as close to home as possible requires having the right level of connections and a clear approach to a model of provision that ensures consistency and fidelity to a single model of provision:

"Travel and distance is an obstacle to be overcome. There is a need to build relationships locally, ensure that across the area there is fidelity to a model."
(Professional stakeholder)

For veterans the key component is local integration of the service offer:

"It is very important for people who live a long way away to have things locally, different levels of support including one-to-one, a day centre, inpatients but all acting together, not separate services by different providers, we don't want to keep repeating the same assessment, it should be one contact for all levels."
(Veteran)

These issues are equally important when considering the provision of residential or outpatient care for high intensity treatment.

6.3 A residential model with appropriate aftercare

Feedback from veterans and family members to this needs assessment provides for support for the development of a high intensity model of care for veterans, but it is not something that people think can be done as a one size fits all and that there should be a strong focus on spreading learning and best practice:

"There is a need for specialist trauma services but you can't run them as the same for everyone, there needs to be recognition that people are different, they come with different experiences, identities and we don't all fit in one service fits all models."
(Veteran)

"Yes, there definitely needs to be a high intensity service that is a centre of excellence. Even if there is just one, the learning from it can be spread out to other regions."
(Veteran)

There is a clear view amongst respondents that there should be centres of excellence for trauma and veterans, but this should not be on a basis of one service for the country, but spread out to ensure there is an appropriate level of connection with local services and with community engagement:

"For those who are really, really, seriously unwell there is a need for an inpatient service, but one centre of excellence to serve the whole country is dangerous as people need to be connected to their home area, and local services. Even if you had several centres, it is the role of the entire community to help people, not just a few specialist centres."
(Veteran)

Even if the service involved a residential element, there is a view that this should be relatively short term, to ensure that service users are not cut off from their home community and sources of support:

"If it was residential then it would need to be short term, which is difficult because the longer people stay, the more likely they are to be isolated from their community."
(Veteran)

"Meeting high intensity needs does require a specialist unit to work, but the model needs to be one that really thinks about continual plug-in to the rest of the system, residential but not keeping people for long periods, more of a dynamic rehabilitation model."
(Professional stakeholder)

There is strong support for learning from models elsewhere in the world, such as the USA:

"We should learn from examples in other countries, the VA in the States is a good example. The VA is run by people with military experience and they have the unique understanding of veterans that is needed. They have specialist treatment centres in the States, and they are saving lives."
(Veteran)

The need to address multiple problems, especially substance use is viewed as essential:

"A residential unit would need to include detoxification and substance use treatment alongside trauma including dependency on prescribed meds, pain killers, opiates etc."
(Professional Stakeholder)

Some veterans expressed concern that any treatment centre should not be done on the basis of existing NHS services, but should be less clinical in focus:

"We need some sort of super hospital but if it's clinical, too NHS then people won't go there."
(Veteran)

In particular, people thought that there should be an explicitly veteran aware and friendly environment:

"The environment needs to be right or it could make people uneasy. Have doctors and nurses with combat/field experience, be veteran savvy and aware."
(Veteran)

6.5 Promoting trust and strengthening control

Trauma can leave people feeling unsafe in everyday situations and the associated psychological and social problems can result in people feeling disempowered and alienated. Promoting trust and strengthening control is important to understanding the impact of trauma and creating help and support that can meet people's needs. From a psychosocial perspective this involves not only recognising the individual personality traits that might make people appear distrustful and increase their feelings of powerless, but also the social context behind which these feelings can be aggravated and reinforced.

For example, for some veterans there can be a lasting affect from military culture of distrusting civilians and a lack of understanding about the ways in which civilian health services operate. This is particularly important for those with more complex needs who may already have a prolonged experience of feeling let down or misunderstood by NHS services.

Trust cannot be assumed by virtue of medical authority or clinical expertise, it must be earned and demonstrated in practice. One of the ways to achieve this is by strengthening the degree to which people feel they have control over the process of help seeking and treatment. This might be as simple as enabling people to choose the time of an appointment, and subsequently keeping to it.

Or it could also be about involving people more in decision making about the choice of interventions and the mode of delivery.

Promoting trust and strengthening control are also achieved through consistency and steadfastness. For example, not continually assessing people and then sign-posting them to other services, which is one of the areas that veterans and family members complain about the most.

6.6.1 Peer support

Veterans and family members very clearly value peer support as a key means of promoting and sustaining trust, whether this is through social media, breakfast clubs, friendship networks or as an aspect of formal service delivery. Being able to identify with a peer, especially at points of crisis and high intensity needs increases the likelihood of help seeking and sustains engagement with services. The psychosocial benefits of peer support are clear including:

- Forming trusting relationships – sometimes after a period of having felt the loss of peer military relationships, peer support can inspire hope, destigmatise mental illness, and provide robust relational support.
- Feeling less isolated – trauma isolates people and establishing relationships with others who have experienced the same thing can help overcome this.
- Initiating contact with helping services - making first contact with helping services is greatly enhanced when there is a peer to peer contact.
- Sustaining engagement – Peer to peer relationships are effective in sustaining people to remain engaged with services and can help identify problems when people have disengaged.

6.6.2 Placing family first

Understanding that trauma is situated within the social context in which the individual lives involves recognising the problems within a family context from the outset. The term `family' is loosely used to mean the full range of people that someone regards as their family, which may include partners, children, parents, grandparents, friends or carers. It is important to recognise the variety of contexts and cultures in which people identify their families and to enable the individual to determine this.

A person's family is very often their main support and can also often be the first line of referral to helping services, as family members may be the first ones to know something is wrong and actively encourage people to seek help. In cases of trauma, family members can also be profoundly affected including experiencing secondary stress disorders of their own. Embedding family work in the service model is viewed as essential to sustaining engagement and something that is gap in current services:

"The gaps in support and service responses are even bigger for family members than for serving members/veterans."
(Professional stakeholder)

Family work also needs to attend to the needs of children, in particular being risk aware and considering the mental health impacts on children if they are living in a home that may be scary and very disruptive:

"It has a big impact on kids because they don't know what is wrong, they worry a lot, feel the tension in the home. When you are arguing a lot, it is hard for the kids, they become afraid about what will happen."
(Veteran)

A safeguarding approach is recommended for more severe cases where the behaviour in the home may be threatening and possibly dangerous:

"There are potential safeguarding issues, if services are aware a person is a veteran, they should be trauma aware also. We need to think more about potential risk areas, if trauma is not being managed and if the person is in close proximity to a child, we are recording it, but not thinking what it means."
(Professional stakeholder)

But there are also views that services should tread carefully with respect to children and not promote problems as being about them having an illness:

"Kids need something for them, to help them understand. But it should be informal, an education approach, don't make it about them being ill."
(Family member)

As with veterans, people think that there should be peer led support, from other military family members with experience:

"Something run by other military family members, peer support, someone at the end of the phone."
(Family member)

Education and awareness raising is thought to be as important as therapeutic support:

"Families lack understanding about trauma and PTSD how it impacts on behaviour, how to support people. Families need an education approach alongside therapies."
(Professional stakeholder)

Family first approaches are embedded in other service areas, such as with substance use and this is thought to be a model that could be used for trauma and mental health:

"Family members are key, take the model of addiction for this, in addictions it is often the same therapist doing joint family work. There may some mileage in veterans and family members being co-located for some of the service journey."
(Professional stakeholder)

A family first approach recognises that people may be using or needing a variety of services at the same time and that is important to provide a means of bringing care packages together under one umbrella. This goes beyond care co-ordination, as all the services need to be taking a family first approach and working to common principles and outcomes. Some of the challenges in this approach that need to be addressed include:

- Service and agency silos – an effective family first approach to trauma requires steps to overcome organisational sovereignty through a collaborative model of service delivery that breaks down the silos and promotes cross agency co-operation.
- Information sharing and consent – traditional service approaches to client confidentiality, while important, can also be a barrier to collaboration and information sharing. Information sharing protocols need to be established and agreed alongside a realistic process for obtaining service user consent that is a) informed and b) promotes personal control.

- Professional boundaries – in addition to organisational sovereignty, professional boundaries and overly protective practices can inhibit collaboration. Cross professional forums and networks are needed to establish a comprehensive, trauma informed network of practitioners.
- Specialism – complex conditions and areas of high intensity needs can sometimes be considered as specialist areas in their own right. This can be challenging in the context of a family first approach which seeks to promote greater cohesion of service responses across a range of needs. The risk is that an entirely new area of specialism is created that actually contradicts the need for collaboration and integration.
- Strategic leadership and understanding – practitioners at the ground level of practice are very good at building alliances and co-operating but this can be adversely affected when strategic leadership systems are not in accord with changing operational dynamics and responding to new areas of need. A family first approach to trauma cannot simply be a matter of professional practice, it needs to be part of a more dynamic shift in strategic priorities and responses to what is an increasingly challenging area.

6.6.3 Addressing social needs

Integrating social needs into the approach to trauma and service delivery is thought to be more than adding on a new layer of service, it must be embedded in the whole approach:

"There should be a stronger professional, social support focus, all services need to up their game on this, not as an add on, it needs to be a core commitment."
(Veteran)

In particular, the approach should enable people to stabilise their lives either before or while entering psychological treatment and therapy:

"People will need short stabilisation periods, followed by a course of treatment that includes relationships, housing, step down support."
(Veteran)

This should include attention to employment, housing debt and accommodation, but also making people safe:

"Therapy won't work until you address the social instability, having a settled home, sorting finances, all the things that make people feel safe …"
(Professional stakeholder)

There is a perception that the complex interplay between the medical aspects of trauma related mental health problems and the social impacts are not viewed as a whole. This can result in siloed approaches to care pathways and multiple referrals:

"I was referred to four different agencies and none of them spoke to each other."
(Veteran)

From a therapeutic perspective there is a view amongst some professionals and veterans that people need to be socially stable in order to benefit from therapeutic treatment. But it can also be a chicken and egg question:

"How do you know what to do first? People need to be stable to benefit from treatment, but they need treatment to become stable."
(Professional stakeholder)

The inability to address multiple, complex medical and social problems together may in part explain the relatively high drop rates from treatment. Addressing social crisis should possibly be as important as meeting therapeutic needs.

This does not mean that individually tailored treatments and interventions are not required, but rather that these should not be undertaken in isolation from socially supporting interventions.

This would include support to find employment or improve education and skills, financial advice and support to find appropriate accommodation.

The sequencing of a combination of psychological and social interventions may need to be considered, for example a person may need a period of stabilisation before embarking on a course of treatment. But these should not be viewed from a hierarchy or tiered service perspective but as an integrated programme.

6.6.4 Inclusion and diversity

As explored in previous sections there is a need for the service model to adequately address inclusion and diversity:

"There is a need to consider specific needs of different groups, BAME, LGBT, migrants and asylum seekers… they have different sets of needs, it is crucial to fully understand and respond to their particular experiences and context."
(Professional stakeholder)

For LGBT veterans there is a view that outreach will be needed, as LGBT veterans may be more isolated and less likely to approach services due to past experiences:

"Services need to reach out to LGBT veterans; you can't expect them to just come in."
(Veteran)

Women veterans are also perceived to be a group who may require specific, different approaches. For example, being child friendly in access times and appointments:

"We need services that women feel comfortable to use, with family support, help with kids."
(Veteran)

Group therapy, if it is predominately male may also be an issue that requires further thought:

"It's very different for a woman, we are not always comfortable with going in a therapy group when there may be no other women. If they have kids then women feel nervous about seeking help for mental health problem, afraid how they will be judged as a parent, will kids be taken away."
(Veteran)

Given the higher rates of trauma exposure and PTSD in some ethnic minorities, it is important to consider disorder presentation, identification, and treatment from a culturally informed standpoint in order to best address PTSD in the most at-risk patients (Dixon, et al. 2017). This includes identifying the barriers to accessing evidence-based care for ethnic minorities including negative perceptions of therapy, and beliefs that treatment will exacerbate the traumatic experience (Valentine, et al. 2016).

Differential risk factors by age, in particular the increased risk of self-harm and suicide amongst younger veterans and those with shorter service histories means that age should be a consideration in service development and targeted interventions.

7. Conclusions

The majority of veterans lead healthy, well adapted civilian lives free from trauma and mental health problems. But this does not detract from the fact that there are a minority, who may be increasing in numbers, who experience significant problems which are increasingly recognised as being trauma related.

For this group, including their family members and carers, awareness about the extent of their problems and needs is increasing and there are more services than ever before that provide treatment, help and support. Much of this improvement is due to the concerted efforts of NHS England and NHS Improvement and a number of leading veterans' charities, who have pro-actively engaged with veterans and family members to identify their needs and provide a range of services to address these.

However, for those veterans who do experience complex trauma related problems that encompass physical, psychological and social harms there is a need for higher intensity services that can fully address and meet these needs. In particular, there is a need for a new model of veterans' service delivery that can:

- Encompass a broad definition of trauma related mental health problems that is not limited by strict diagnostic criteria for PTSD and Complex PTSD.
- Recognise that there is no single way in which trauma related mental health problems manifest and that the symptoms and ways in which people experience trauma related problems can be fluid, inconsistent and not always obviously associated with a specific traumatic event.
- Engage with and support veterans and family members at the earliest point in their experience of problems including mental health and/or social crisis.

- Ensure that there is no wrong door by which individuals can access help and support through effective case management and a consistent point of contact.
- Facilitate speedy and appropriate transfer between levels of service intensity, without having to sign post or redirect people to separate services.
- Work with family members and support them as an integral part of recovery and resilience, while also being able to provide support and treatment for the secondary traumatic stress that family members may be experiencing.
- Provide an inclusive environment and therapeutic milieu that instils trust and confidence for veterans and family members who share a protected characteristic and/or are vulnerable as a result of discrimination and marginalisation.
- Prevent the most serious harms e.g. self-harm, suicide and harm to others through effective care management and coordination including risk assessment, triage and integrated care pathways.

The above can be achieved by development of veteran specific services that are fully embedded within a regional service model that involves the following:

- Building on the success of TILS and CTS by ensuring that the overall balance of provision can meet the full range of needs, including those that require a higher intensity level of service response. This should not take place as an isolated development but needs to be part of a fully embedded NHS system, not just with TILS and CTS but also associated partners such as military charities.

- A model of integrated care pathways that involves the defining features of trauma related mental health needs including:
  - Co-morbidity of trauma with other mental health problems ranging from depression and anxiety to psychosis and personality disorder.
  - Acute mental health crisis involving attempts at self-harm and suicide.
  - Symptoms that are sometimes masked or complicated by co-occurring mental health and substance use problems.
  - Social disruption and decline including loss of employment, debt and housing problems
  - Problems with interpersonal relationships including loss of partners and friends and family breakdown.
  - Offending, which is often associated with anger and violence and domestic violence.
  - Pre-enlistment vulnerabilities including childhood neglect and abuse.
- Low or invisible thresholds - being able to move seamlessly between levels and types of care and or intensity, at a pace that the service user feels comfortable with.
- Peer support – initiating and sustaining engagement through veteran peer support networks.
- Collaboration - different professionals working together, offering different types of help at the same time.
- A biopsychosocial model of trauma that seeks to promote healthy development rather than focusing solely on pathology i.e. beings concerned with the resources of the family and community including peers, rather than on the individual and how these wider family and community strengths can be harnessed to aid recovery.
- Being clinically led, with improved involvement of people with experience of using (or caring for others using) services at the centre of the approach for example, people's lived experience should inform the design, delivery and evaluation of services to enable greater local co-production between

people with professional experience and those with lived experience.

- Integrated leadership which, spans regional specialist veterans commissioning alongside local integrated care partnerships and systems
- Enabling people to be cared for closer to home including being in hospital when and for as long as clinically needed and improving people's experience and outcomes from services. They will build community and step-down services and links to other settings to achieve this, investing in services needed locally;
- Being underpinned by effective governance frameworks, with relevant risk sharing agreements with accountability to NHS England for the decisions made and the quality of care provided. In particular, the frameworks should be part of a collaborative mental health trauma care network approach that includes a fundamental requirement for co-design and co-production that can demonstrate a vision and clinical model that has been created with veterans and family members with lived experience. These collaborative networks should articulate how the voice of lived experience will be heard and acted on through their quality assurance frameworks.

Achieving all of the above will not be done in the short term. It requires significant leadership focus, central government support and resources and the will and commitment of national, regional and local NHS and social care commissioners and providers, including the armed forces charities.

But it is possible, and the consequences of failing to do this effectively in the short to medium term threaten the foundations of the Armed Forces Covenant, and most importantly the lives and wellbeing of those to whom the nation owes a considerable debt.

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