From Gate to Gate

Improving the mental health and criminal justice care pathways for veterans and family members

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Community Innovations Enterprise

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Contents

Glossary of terms

A&E – Accident and Emergency

AFC – Armed Forces Covenant

AFCS - Armed Forces Compensation Scheme

ALB - Arms Length Bodies (a general term, used to cover types of organisations which operate at varying degrees of independence from government).

BWW – Big White Wall

CAMHS - Child and Adolescent Mental Health Services

CMP - Civilian Medical Practitioners (normally locum GPs working for the MOD)

Complex PTSD - Complex Post Traumatic Stress Disorder is a term used to describe the symptoms of long-term trauma.

CPN – Community Psychiatric Nurse

CRC - Community Rehabilitation Companies

CRHTT - Crisis Resolution and Home Treatment Team

DCMH – Departments of Community Mental Health

DH – Department of Health

FMB - Formal Medical Board

GP – General Practitioner

H4H – Help for Heroes

HEE – Health Education England

HSCIC – Health and Social Care Information Centre

IAPT - Increasing Access to Psychological Therapies

JSNA - Joint Strategic Needs Assessments

LGA – Local Government Association

MAPPA - Multi-Agency Public Protection Arrangements

MOD – Ministry of Defence

NHS – National Health Service

NICE – National Institute for Health and Care Excellence

NOMS – National Offender Management Service

PHE – Public Health England

PTSD – Post Traumatic Stress Disorder

QIPP – Quality, Innovation, Productivity, Prevention

RBL – Royal British Legion

Read codes – the system by which GPs record clinical data, named after the developer Dr James Read

ROHT - Regional Occupational Health Team

STP – Sustainability and Transformation Plan

TIS – Trauma, Injured and Sick

TrIM – Trauma Risk Management

VICS - Veterans in Custody Schemes

WIS – Wounded, Injured and Sick

WWTW – Walking With The Wounded

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National Offender Management Service
Nottinghamshire Healthcare NHS Trust
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Walking With The Wounded

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Introduction

1. It is becoming increasingly recognised by commissioners and service providers that veterans with complex mental and related health needs, including Post Traumatic Stress Disorder (PTSD) and dual diagnosis, require appropriate assessment and treatment. Without the correct support, this patient group is possibly at risk of offending, often more serious offences and there are consequential impacts on the whole family, including partners and children and for society in general.

2. The needs of these veterans and their family members extend along a continuum from inside the military gate while still serving, through transition and resettlement into civilian life, in the community and for some, up to and including contact with the criminal justice system, entry to prison and on leaving the prison gate. However, progression along this continuum should not and need not be inevitable. There are a number of key points along mental health and criminal justice care pathways where more effective, integrated and higher quality interventions should take place and there is a need to develop these further.

3. This report presents the findings from a programme of work, commissioned by NHS England that sought to identify the critical points of intervention in mental health and criminal justice care pathways and how these might be made more effective.

4. The work programme was led by Community Innovations Enterprise (CIE). NHS England valued CIE's experience in scenario planning and community engagement and the potential of CIE's methods to capture the lived experience of family members of veterans alongside a critical appraisal of the care pathways and key points for interventions.

5. The programme took place in two stages between February and June 2016:

   Stage one: Scenarios were developed using real case studies that formed the basis for two workshops with a range of expert stakeholders including clinicians, commissioners, managers and service planners from across the spectrum of health and criminal justice services. The case scenarios involved veterans who had experienced complex mental health problems including PTSD, which resulted in contact with both health services and the criminal justice system, either through arrest by police or being sentenced to a prison term.

   The first workshop explored the critical points along the care pathway in each case scenario and how this might have been made more effective. The second workshop identified the key implications for policy, commissioning and planning of services.

   Stage two: Family members and veterans were consulted on the key findings and conclusions from the case scenarios and implications for policy, commissioning and planning. Although some veterans took part, the primary focus was on the experience of family members as it was recognised that their needs are often overlooked. It was important to ensure that the views of families and their experiences of mental health and criminal justice care pathways could inform this report.

Background

6. There is increasing recognition of the needs of veterans with mental health problems and in the last few years there have been a number of high profile reports and research inquiries into veterans and offending. There is also increasing recognition that veterans who have offended often have complex mental health problems and that the current care pathways for mental health and criminal justice, although improving, do not always best serve the needs of this group. For example, with respect to the criminal justice pathways, Stephen Philips QC MP makes the point in his review that:

"A lack of national guidance to statutory agencies has previously hindered effective working with offenders who have served in the Armed Forces and led to piecemeal provision across England and Wales." (Philips, 2014. Page 1)

7. Philips also acknowledges that there are challenges in accurately identifying how many veterans are in contact with both the health and criminal justice systems, with consequent implications for preventing re-offending:

   "Policy makers have previously been hindered by the absence of robust data enabling the identification of pathways effective in preventing offending on the part of those who have served in the Armed Forces." (Philips, 2014. Page 1)

8. Although there have been improvements and some streamlining of Read codes in primary care for veterans, these continue to be the cause of some confusion for GPs in the NHS and CMPs (Civilian Medical Practitioners) working for the MOD. For example, there can be conflict between the codes that are in use on the Medical History on Release from HM Forces (FMED133) and GP Read codes.

9. Within the prison system, although prison data systems do have a question about veteran status, this is not routinely completed. Some veterans are also known to be reluctant to identify themselves in the prison system either due to fears of reprisal or due to stigma. However, estimates of numbers are thought to range between 3.5% and 7%, rising to as high as 13% amongst High Security and Category B prisoners[1].

10. There have been some high profile cases that have reached national press attention concerning veterans and violent offences, including murder where PTSD was thought to be a causal factor.

[1] Matching report between the Ministry of Defence's Defence Analytical Services and Advice (DASA) and the Ministry of Justice (2nd report) estimated 3.5%. Her Majesty's Inspectorate of Prisons (March 2014 – *'People in prison: Ex-service personnel'* reported 7% with the highest proportions of ex-Service personnel located in high security prisons and category B training prisons (each 13%)'.

One of these cases in particular raised concerns about the way in which veterans with Complex PTSD[2] are identified and how information is shared about risks and safeguarding in an appropriate and timely manner, prior to and after people are discharged from serving in the armed forces.

11. The Philips Review notes that complex mental health problems, including dual diagnosis can be contributing factors to why ex service personnel become offenders *'poor mental health and substance misuse often contribute to their offending, alongside other risk factors such as homelessness and unemployment'* (Page 1).

12. It is clear that there are increasing concerns about this cohort of offenders and that more could be done to improve the care pathways across both health and criminal justice sectors to better meet the needs of veterans and family members.

13. Accurate diagnosis of PTSD and attribution to having served in the armed forces can be further complicated by the late onset of symptoms and other related problems that may mask symptoms, such as alcohol or drug use and/or experiences of trauma prior to having served in the armed forces. These factors can make early identification of problems challenging.

14. The Five Year Forward View for Mental Health is a national strategy that covers care for all ages and was published in February 2016. The Five Year Forward View for Mental Health[3] states that:

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[2] Complex PTSD is a term used to describe severe psychological harm arising from prolonged, repeated trauma. Another name sometimes used to describe the cluster of symptoms referred to as Complex PTSD is Disorders of Extreme Stress Not Otherwise Specified (DESNOS)

[3] The Five Year Forward View for Mental Health. A report from the independent Mental Health Taskforce to the NHS in England February 2016 https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

"Only half of veterans of the armed forces experiencing mental health problems like Post Traumatic Stress Disorder seek help from the NHS and those that do are rarely referred to the right specialist care. NHS England is currently consulting on the future of mental health support for this group and it is essential that more is done to ensure their needs are identified early and they are supported to access specialist care swiftly." (Page 7)

15. This is not something that can be achieved by any sector acting alone; it will require an integrated approach involving the military and health and criminal justice agencies working together. The Mental Health Task Force recommended that:

"The Ministry of Justice, Home Office, Department of Health, NHS England and PHE should work together to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed." (Recommendation 24. Page 35)

16. This would enable a more effective care pathway that is focused on competent assessment and intervention including specialist treatment when necessary. In order to prevent mental health problems from becoming more complex, steps will needed to be taken at the earliest opportunity i.e. within the military gate.

17. There is scope for further mental health and criminal justice interventions along a continuum of care including at crisis points in the community, in primary and secondary care and up to and including entry to the criminal justice system. For those veterans who do enter the prison system, improvements in prison mental health in-reach services and on release through the prison gate will also be required. At all points along the care pathway the needs of family members should be considered and they should be included in care planning, as well as having an assessment of their own mental health needs with access to appropriate care, support and treatment.

The care pathway – learning from case scenarios

"A conversation about pathways means nothing if there is no final destination." (Family member)

18. Two scenario planning workshops took place in January and February 2016. A selection of scenarios was prepared for the workshops based on real cases. The aim of the workshops was to focus on the small, but significant number of cases that involved both mental health and criminal justice agencies. In the first workshop, participants were asked to explore the critical events that took place in each of the scenarios. In the second workshop participants addressed the policy implications that arose from the issues identified in the first workshop.

19. Although the scenarios were chosen for their contrasting nature, each shared some salient features. These features are not the common experience amongst military personnel and veterans but represent the key factors that are thought to be significant for those who do experience problems involving both mental health and criminal justice sectors:

- experience of trauma during combat and the lack of diagnosis on discharge to an approved treatment pathway of care;
- early discharge from the Ministry of Defence (MOD) on medical grounds, although this was not related to mental health in all cases;
- early and repeated concerns expressed by family members to professionals;
- disturbing and/or escalating extreme behaviours including harm to others and/or self; that can lead to
- a serious offence or risk of a serious offence being committed.

The critical events that impact on the care pathway were identified as follows:

Problem identification

20. In all the case scenarios, critical events that could have led to earlier and more accurate identification of mental health problems and associated risks were missed. This was thought to start within the military gate at/or immediately after a point of significant trauma and continuing to the point of premature medical discharge. Trauma and acute mental health crisis (often severe or at risk of becoming complex) was either not identified or, if it was identified, then key information was not shared or passed on to the relevant person. Various factors were thought to influence this:

21. ***Personal*** – individuals were often reluctant to acknowledge that they were experiencing mental health problems due to stigma and fears that it would impact on their career.

22. ***Culture and personnel*** – in some cases, the organisational culture and attitude of key personnel, including managers, welfare officers and medical staff, acted against identification of specific mental health problems associated with trauma, i.e. all personnel were seen as experiencing some degree of trauma and that this was normalised in the occupational experience, hence the failure to realise the need or urgency for a specialist assessment/intervention.

    This can be further compounded by lack of understanding about the impact of trauma and associated mental health problems alongside an attitude that people needed to act as if they were coping normally (whatever they may be experiencing).

23. ***Assessment*** – Mental Health assessments were compliant with NICE guidelines e.g. PHQ -9[4] and GAD (Generalised Anxiety Disorder Scale). However according to the NICE guideline (NICE, 2005 1.4.2) assessment of PTSD sufferers should be conducted by competent individuals and be comprehensive, including physical, psychological and social needs and include a risk assessment.

    Medical personnel, in particular GPs and Civilian Medical Practitioners (CMPs), are not normally trained to administer assessments of trauma that would identify PTSD and in particular, cases of Complex PTSD. Comorbid symptoms can also complicate the assessment, leading to inaccurate diagnosis of associated disorders such as depression, anxiety and psychosis. This is important, as diagnosis dictates referral for treatment and pathways of care. In addition, whilst physical needs are often being recognised, this is not necessarily so with regard to psychological injury and related health problems. There appears to be an unconscious bias with respect to physical problems being seen as more legitimate.

24. ***Risk assessment and information sharing*** – there is a need not only for an appropriate mental health assessment, but also a risk assessment when other indicators suggest a possible risk of harm to self or others. Even in instances when a risk assessment did take place, the information was not always shared with other appropriate professionals or services. This was a particular issue at the point of transition from armed services to primary care in the community.

25. ***Transition to civilian life***– as previously noted, the level of risk management and identification of problems related to mental health and trauma whilst serving may not be consistently or appropriately picked up by military doctors i.e. to the full extent of problems.

[4] The Patient Health Questionnaire (PHQ) is a diagnostic tool for mental health disorders used by health care professionals. PHQ-9 is the depression module, which scores each of the nine DSM-IV criteria as "0" (not at all) to "3" (nearly every day). It has been validated for use in primary care.

This can have a profound impact on transition to civilian life, as the problems remain unrecognised. For a number of cases medical discharge and onward referral can work well, but in the scenarios there was a lack of clarity about who needed to have the duty of care, especially amongst complex cases and those that present as a risk to self or others. For example, if a veteran does not register with a GP or there is a lack of information sharing when they do register, then he or she can easily fall through the safety net. In addition, the process for a medical discharge can be lengthy i.e. it can be many months before the official release date.

Military medical officers are also expected by the Departments for Community Mental Health (DCMH) to complete a short questionnaire on mental health issues i.e. anxiety depression, PTSD and alcohol with the client. However, the questionnaire is not necessarily sufficient or well received at that point in time to 'uncover' or satisfactorily address an identified issue.

26. ***Reservists*** - There are some additional factors that relate to reservists that are important to note in the context of scenario planning, e.g. they are more likely than deployed regulars to suffer from common mental health problems and PTSD[5]. This may be due to the fact that they return to a civilian environment where they are less able to share their experiences in an understanding environment. Problem identification for reservists can also be complicated by their reservist status and whether or not they have been deployed not being recorded or noted in primary care records:

"…while the status of a veteran may be recorded in a few primary care records those of family members and reservists are very seldom recorded." (Bashford et al, 2015. Page 8)

"They [stakeholders in the Call to Mind: Wales report] *reported however, that proactive work was needed to get a better handover of care from the military to the civilian GP, both for leavers and returning reservists, with access to military medical records highlighted as a particular problem."* (Collins et al, 2016)

[5] *"Reservists were found by the KCMHR Cohort study on Iraq to be twice as likely to have symptoms suggestive of common mental health problems (depression, stress, anxiety and so on) than fellow Reservists who had not been to Iraq, and six times as likely to have symptoms suggestive of PTSD.* (KCMHR, 2010)

Referral and entry into the care pathway

27. Referral and entry into an appropriate care pathway was variable and this was often because information about pathways was either, not clear, unreliable, or not sufficient enough to treat the most complex cases. This was the case for veterans, family members and GPs with the result that it was often thought to be luck if someone found the right service. This was summarised as:

- poor navigation of the care pathway by GPs and other primary health and social care staff;
- waiting times being too long;
- lack of effective treatment facilities in place or treatment and services not meeting presenting needs;
- lack of knowledge and awareness about appropriate care pathways amongst professionals in the criminal justice sector;
- insufficient integration of the care pathways, e.g. cases not being picked up and held at the initial point of entry;
- mental health problems not being identified and/or addressed as part of offending behaviour nor assessed as a cause of offending – although where Liaison and Diversion services are in place this is greatly improved.

28. Referral and entry into an appropriate care pathway is more problematic when the case is complicated and involves a range of behavioural and social factors, e.g. aggression and/or violence, including domestic violence, problems with debt and housing, alcohol and/or drug problems and family breakdown. Alcohol use in particular is known to be a significant factor that can impede access to services.

29. In these situations, an individual may fail to engage with care and this can go unnoticed until further crisis precipitates emergency or more coercive interventions, e.g. attendance at Accident and Emergency (A&E) or arrest by the police.

30. Poor information sharing and lack of ownership of a case can compound the care gap at this early stage.

Progression through the care pathway

31. Even when people were referred to or entered a care pathway, progression could be halted. This was due to a variety of reasons including:

- available community support for offenders being unable to address the needs of veterans, e.g. not recognising that someone is a veteran or failing to provide a culturally appropriate/veteran specific service;
- treatment interventions not being trauma specific or competent;
- missed opportunities within the court system, e.g. expert reports for those with trauma related offences as a result of their military experiences, including information and alternatives to custody were not presented to the court;
- inappropriate sentences or remand to prison ending up as being a service of last resort due to lack of a secure treatment pathway as an alternative to custody.

32. What is clear from the scenarios is that for those cases that are more complex, there are frequent interruptions in the care pathway, which usually results in referral to an array of services that are often inadequate and can result in clients falling between the gaps in service so that their condition declines further.

33. The case often falls back to primary care, but GPs may be ill equipped or unable to find alternative solutions other than prescription medication, which may in fact aggravate the problems, e.g. masking symptoms rather than addressing the root causes. The lack of appropriate treatment interventions and care can also result in an increase in blue light service interventions often following an incident of violence in the home.

34. There can also be perverse impacts, whereby if the person is known to be a veteran, this can escalate the nature of interventions often resulting in excessive police responses. This is a factor repeatedly raised by family members who can also become reluctant to seek help due to fears about reprisals by the police (see section below on families).

35. All of the above brings into question the appropriateness of mental health and criminal justice care pathways for veterans with complex mental health problems. For example, the current model of entry to a mental health care pathway is Increasing Access to Psychological Therapies (IAPT) services. IAPT was initially designed as a way to increase access to psychological therapies for common mental health problems, such as anxiety, depression and phobias. However, it is increasingly being used as the gateway to mental health services as part of a stepped model of care.

36. The issue for veterans with complex mental health and related problems, including PTSD, is that most IAPT services only provide a short term and limited range of therapies which may not be appropriate for complex trauma related problems. This can be compounded by the lack of a mental health diagnosis, which can result in higher level community mental health services refusing to own the case or dealing with the case under an inappropriate pathway. This creates a revolving door scenario whereby cases are repeatedly referred; there is a failure to engage and the case continues to fall back on primary and emergency services and the family with no resolution until the case comes to court and/or prison.

Police, Courts and Liaison and Diversion

37. The police are frequently first attenders for crisis intervention in the home and there may be multiple incidents before a case reaches the point of sentencing in a court.

38. One of the most successful areas of intervention in the care pathway is Liaison and Diversion services and there is increasing recognition by these services of the needs of veterans. Where Liaison and Diversion services are in place, the scenarios demonstrated that this could de-escalate problem behaviours, improve diagnostic recognition and enable an appropriate assessment to be put before the court.

39. Where Liaison and Diversion services are integrated with a veteran specific voluntary sector agency, this has the additional value of enabling engagement within an appropriate care pathway. However, for the more complex cases where a serious offence has occurred, there may be no alternative to a custodial sentence such as a secure treatment centre. Although there are some examples where a known problem, such as PTSD, has mitigated sentencing, there may still be no alternative to a custodial sentence.

40. While Liaison and Diversion services are clearly effective and valuable, they are primarily an assessment and sign posting service. In the absence of an appropriate community disposal option, including a secure treatment pathway with full supervision responsibility and appropriate treatment by qualified practitioners in the field of trauma who can undertake an evidence based assessment and manage risk, prison becomes the inevitable outcome.

Prison

41. Care pathways for veterans in prison can be even more problematic than in the community. Although many prisons now ask about veteran status at reception, this is not uniform and there is also a known reluctance on the part of veterans to be identified in prison as having served in the armed forces. Furthermore, there has been a reduction in veteran specific prison services, such as Veterans in Custody Schemes (VICS), whereby prison officers who have served in the armed forces are used to identify ex-service prisoners and link them to an armed forces service charity, which can best assist them following release from prison. Where VICS still exists, officers who elect to take on this role do so on a voluntary basis.

42. Prison health services also do not have the background and resources to manage veterans with complex mental health problems including PTSD, and even armed forces charities and veteran trauma services are often not able to provide in-reach into prisons in a consistent and effective manner.

Release from custody

43. The complex nature of some of these cases and the relative lack of appropriate care pathways and interventions in prison, raise particular questions about care pathways in and on release from prison. Through the prison gate, systems for offenders with drug problems have been successfully developed, but there are as yet no comparable services or treatment for veterans with complex mental health problems.

44. Offender management services on release may not be adequately prepared to care for veterans with complex needs and high risk concerns. Some of these cases may also result in raised thresholds for offender management in the community. The relative lack of appropriate assessment and intervention services in prison may also result in risks not being identified at the appropriate time.

Family experiences and perspectives on care

45. The scenario planning workshops with professionals did involve some valuable input from a family member. However, in recognition of the way in which family member experiences and perspectives on care are often not included in policy and service development, a further two workshops and some one to one interviews took place with veterans and family members. The workshops were attended by senior officials from NHS England and were facilitated on the basis of consultation that would enable family members in particular to share their lived experiences.

46. The following provides a narrative summary of the key issues that family members identified, after which some conclusions are drawn about how far the family experiences and perspectives match the findings from the professional examination of scenarios.

47. First and foremost, family members were not just speaking about a soldier or a veteran, but about their partner, someone who is a parent to their children or is their son or daughter. As such, their stories were understandably emotional and showed a deep level of love and care. At the same time, it was very clear that family members are under immense pressures themselves and they often felt alone in having to deal with the problems in the absence of specialist trauma treatment options.

Military culture – impact on families

48. For spouses in particular, they feel that they are left to cope on their own while their partner is serving and they report that there is little support or understanding for them from the military:

"The army expects us [wives] to be there so they can be deployed – it impacts on my wellbeing."

"Military life is abnormal – drinking, being away from home, trauma and death then back to being at home and expected to be normal."

“The impact on relationships is key, this is one of the early warning signs.”

“There is a huge pressure to be a soldier first and foremost and to then balance that out with being a husband and father... The traits of a good soldier are not necessarily those of a healthy husband and father.”

49. Partners in particular report having to deal with some major life stresses without much support:

“The difficulties and pressures I’ve faced as a parent from a military family were everything a single mother with no friends or family would face. I was isolated, depressed, lonely and alone. I had no one to talk to - to ask for help and I felt like I had to just carry on.”

“The effects are long term and I don't see an end. Things change from one week to another; some weeks feel better than others. As a soldier’s partner and full time parent I feel like I never get a break to rest and recover. I'm never getting a chance to be quite one hundred per cent me again.”

“A parent of a military family has all the pressures of parenting but also the unique challenges presented by military life. Mainly, the stress of frequent and/or prolonged separation, loss of identity once you become 'wife of' and the loss of support networks. In a family that moves a lot, losing the support networks is twice as hard.”

50. Alcohol and heavy drinking is regularly cited as an additional stress factor:

“My husband turned to drink - the army is an alcoholic society! He would be out drinking and getting drunk regularly.”

“There is also pressure to adhere to a lifestyle that doesn't always fit with parenting - the drinking culture, being encouraged to take time away from the family for socialising, for example.”

51. Military culture is thought to act against help seeking:

“If you’re not tough you can’t do the job, being in the military acts against talking openly.”

“They can’t stop and think in combat, so they partition it off, but when they come back they need to find ways round this, how to get past saying it’s ok.”

“Men wait until it’s too late to ask for help. They need to stay strong, there is not enough encouragement for them to seek help.”

“The expression he uses is – you have to have a heart like a swinging brick.”

“Men won’t talk, it all comes to a head when he says that’s it, I’m going and he just wants to be on his own.”

“I had to threaten to leave before he sought help.”

“My husband couldn't talk to anyone because no trust in people keeping things confidential and the worry that it could affect promotion.”

“There is an expectation that the partner of a service person should really just get on with it, generally.”

“Soldiers are just taught to ‘crack on’, when you sign up, you check your emotions at the door.”

52. Many spouses and family members described the military as having told the one serving to ‘man up’ and in some cases this was also said to family members:

“The family are told be tough too – where does it end if we are all being asked to bottle it up and stay strong?”

“There is a pressure on us, the wives, the mothers to keep it all going.”

“I have in the past had to seek medical help and use medication to get through the toughest times. I know this is pretty common amongst military spouses and firmly believe it is a direct effect of the life we lead. This is difficult enough but I feel the culture of being expected to keep the 'stiff upper lip' is equally as damaging.”

“The army don’t make things fair, they expect a lot from soldiers and they don't really care about the families as long as the job gets done, or they make it extremely hard for the solider to stay in his job and eventually choose.”

53. Spouses often report feeling isolated while their partner is serving:

“As soon as I got married my husband took a posting for training in a place where I knew nobody and had no family nearby…I was lonely and depressed. I got pregnant again and had a traumatic pregnancy, was in hospital twice because of severe sickness. Nobody from the regiment visited me and my husband was away working.”

“We were moved six hours away from everyone I knew, I had a new baby but he was away all the time.”

“The biggest problem is not having a support network. Your husband is away a lot and at short notice. The army thinks you always have friends or family around, and mostly we don't. The support that is offered is usually run by other wives and confidentiality isn't there. And when you move there is no thought given to how you'll manage until you get to know people.”

54. For many of the spouses, experiences during pregnancy could be problematic including post-natal depression and feeling a lack of support was a common occurrence with health services, the military and their partners who often poorly understood the needs:

“I had psychosis after the baby was born, the first two years of their life is a blur, I had a lot of tablets, Welfare didn’t get involved at all, I needed my husband at home, it only happened because his boss recognised this.”

“Pregnancy was very hard. There was no practical support with getting to appointments etc. I've had several miscarriages and difficult pregnancies and I had no confidence about how I would cope if there was an emergency - for myself or our existing children. I felt anxious and unsettled and very alone. I never felt like I could have my husband around if I needed him.”

55. Welfare and Personnel services in the military are not thought to work well:

“Need a formal way by which the chain of command or Welfare ask wives how things are.”

“The job comes first, family second, they just say if you don't like it you can leave.”

“The Army is just soldier focused, there is no recognition of the family.”

“Change the MOD/chain of command to listen to wives.”

“If he has to come back off duty because of my problems then I get stigmatised…”

“Army Welfare brought my husband home from deployment early because I was so ill and his regiment were told by the colonel at the time no one is to come back for baby related problems unless someone is dying...”

"He couldn't tell anyone about what I was experiencing and the way it affected our relationship. Unless you want a welfare case opened and your job put at risk you tell people very little unless it's vital."

56. However, many family members did not feel that welfare roles in particular were skilled or capable to deal with mental health and related issues:

"Welfare aren't trained for dealing with mental health problems, they don't have the experience, it would be good if someone listened but who will pick up on it?"

"Influence Personnel side, they can do general health but need to get into the personal side of things."

"They fall through the net with Welfare, chain of command don't look at the emotional side of things, but Welfare won't make a decision, we need something in the middle, something to protect the soldier from being put down, if you have problems you get automatically demoted."

"Welfare are not really there for you, they are there to keep the military going."

"Welfare is like old Personnel, they are military staff, may be in limbo towards retirement, they should look at who are in these roles and why they are there."

"They should review and professionalise Welfare, bring it up to date with modern day standards and treatment, do it in a positive way, probably need to rename it, call it something else, not Welfare."

"I think parents from military families should have a supportive welfare, maybe not use the position of welfare officer as a stepping-stone in a soldier's career…It should be trained professionals that the dependants can relate to where they know 100 per cent it won't be the regiment gossip the next day or effect their husband's job."

57. The system for welfare and support around mental health issues is also thought to lack standards and governance in comparison to general health:

"There aren't the same standards in the military, they do it for screening and vaccinations so why not mental health? Make it confidential with standards like it is in the community."

"Need it embedded as a standard policy, but with a distance from the chain of command system. Outside of that and with confidentiality, set it up in a way that people feel safe to use it."

"What is really needed are core functions that are about care, make it consistent across the military, should be able to get the same thing everywhere, not change all the time or be dependent on who is doing it."

"It's like rolling a dice what you get, it's not confidential, some sit there socialising at the Welfare office, the location can make it difficult, the office should be a safe place to go."

"What is happening is put on a public notice board, so if you are seeing a psychiatrist it says that, everyone knows…"

"I couldn't talk to anyone within the Army due to the lack of confidentiality within the Welfare Unit."

"They would rather we just leave and don't cause any trouble."

58. In particular, families thought that there should be a routine or mandatory assessment for serving personnel who have experienced trauma:

"Need an avenue where he is forced to be assessed for trauma, even if only three sessions with a CPN, wouldn't this save money and resources in the future?"

"There should be fixed assessments, ask the right questions before leaving – there is nothing."

"There needs to be follow up –the means of making this happen."

"De-compression is just going to Cyprus for three days to get drunk."

"TRiM gets skipped if they are needed to be deployed somewhere else, priorities take over, sometimes it doesn't happen until twelve months later."

Coping through transition to civilian life

59. Coping with the psychological transition to civilian life can be a struggle for veterans and family members:

"Inside he's still a soldier, he can't adjust to being a civilian."

"The resettlement training is not enough to prepare veterans for civilian life."

"When you are a soldier you are someone, maybe for the first time in your life – what defines you when you leave?"

60. Finding new housing is especially stressful:

"Huge stress because there is no flexibility with booking removal dates. Giving seven weeks' notice might work when you got a posting order and you know your address in advance before moving into civilian life but this is unrealistic with the current demand on the rental market."

"We had three months' notice to move out…all the stress of finding somewhere to live, the right place, the right area…"

"Medical discharge was difficult and no one gave us any information. Having to live separately got us in financial difficulties, which made it harder to find housing. No one visited from Welfare to see how he was or how the family is coping, we were not."

"I felt with the whole leaving military service very stressful as every time we felt like we were moving forward we went two steps back. A lot of the information that was given to us was very confusing and I felt like the council didn't have a clue what to do with us either."

61. Finding alternative employment can produce particular stresses including financial problems:

"I also felt that although my husband was entitled to apply for certain courses with the budget he had left over in the army, that there wasn't much help or emphasis on making sure he was going for the right path to lead him to a future job."

"After 20 years in the army it's a huge step to do something else, we need some kind of apprenticeship model rather than a few weeks training then straight into something completely different."

"You get three months support for resettlement, it's supposed to help but it doesn't. We lost everything, bankrupt, lost house, we were at the food bank the day he came home and said all the money had gone."

62. Finding employment can also be challenging for spouses:

"It is hard to get a job as an army wife, so much stigma and stereotypes…"

"I had 24 jobs on my CV but they don't amount to much."

"I cannot train because the childcare and costs of actual proper courses I want to do - not what's 'offered' to use up money pots - is really just out of my price range."

Finding the right help in the community

63. When back in the community after leaving the forces, despite the number of service charities apparently available, family members continue to find it a strain to find the right help and support:

"You just don't know who to go to for help…"

"There needs to be more signposting for this help."

64. Even when mental health services had been used, these were not viewed as having been effective:

"Got six weeks counselling, it's not enough, you can't build trust in that time."

"To get the guys involved is hard, it takes investment, needs outreach, they need peer support…"

"…suicidal…asked for medication but was just told to join the gym."

"All they offered at first was a phone call, you can't expect people to talk honestly over the phone about severe trauma…"

"They need to work with trauma, it needs to be specific."

"We need an appropriate range of services but get pigeon holed into what we have because it's the only thing there is."

"The psychiatrists say there are no beds, people are being moved all around the country, there is no respite care."

"There is no proper diagnosis, the doctor always says its anxiety or depression, just offers tablets and when he doesn't take them they just discharge him."

"We need a model like they have for WIS [Wounded, Injured and Sick] expert centres but for mental health."

"Health and social care need to be together, under one roof."

65. Family members report that aggressive and angry behaviour is often used as a reason for services not to engage and this indicates a lack of understanding of service-related trauma, including PTSD:

"He's classed as a nasty bastard, all the signs are there but no one picks up on it…"

"The majority of NHS don't understand the military mind set, the culture…there needs to be more tolerance of their anger issues."

"The CPN is scared when he comes round, he sits by the door."

"Services are too risk averse, support workers are being told it's too dangerous to be alone with them."

66. In particular, there is a view that services are not family friendly and do not take account of the importance of family members in identifying problems at an early stage:

"There needs to be a cultural shift in services to listen to the family more, involve them."

"No one is interested in us as a family."

"They didn't realise I was the carer…even I struggle with that term but I'm happy now to be the expert for the family, I used to be ashamed but now I am just angry."

"I wasn't taken seriously as a wife, now I will be taken seriously as a mother, I know what they are offering won't help."

"We need to be treated as a family unit, treat us as a complete unit; it's a spider's web."

"We need to be seen as individuals not just a problem who comes with the soldier."

"…he won't say anything if I'm not there, but they refuse to see us together, they just say it's confidential but he won't talk without me."

"You just get treated as the neurotic wife."

"They [husbands] won't make their own appointment and they won't talk on their own when they get there."

"They get an hour with someone but the family has to deal with the fall out, it opens doors and they can be worse afterwards but there is no support or education for the family and the kids on how to deal with it."

"They need to change things in hospital, I had to stay with him but they had no provision for me on the ward, they didn't feed me, I couldn't even use the loo, but without me there, if he freaked out they would have had to call security."

"They need to commission more for families, put rules in the book about what the family should get, how we should be treated."

"Not much support was available at all. When things got really bad between us we were offered Relate sessions but nothing really to help the whole family unit or us as parents."

67. Effective interventions at the point of crisis are thought to be particularly important and often lacking or are rarely followed up with appropriate intensive treatment to prevent the recurrence of problems:

"…his behaviour was putting the kids at risk, he called the police himself, the police recognised the risk, took him to A&E but the NHS did nothing, the only call we had after was from the Domestic Violence Unit, all the NHS says is that he needs to make an appointment."

"We need crisis services."

"You have to be at a crisis point before anyone wants to know."

"We need somewhere for them to go in crisis, I know it's coming four days before so why can't it be sorted out, some respite."

68. In particular, family members report experiencing rapid escalation in the level of interventions, including more coercive interventions by police and emergency services that were perceived as being unhelpful:

"The police were at the door and then it was 15 hours in A&E followed by a psychiatric admission but he was soon back out again with a CPN with whom he has no relationship."

"A veteran in crisis with PTSD is not just about a bed, mostly we are just told there is no care out of hours but you can't get an ambulance to A&E, they won't even come without the police, once it's happened you get flagged…"

69. Family members hold strong views about the lack of understanding regarding PTSD, in particular getting an accurate diagnosis and the requirement for significant retraining to include trauma and its link to PTSD:

"Doctors don't understand PTSD, they say go to A&E..."

"I knew he had PTSD but it took five years to get a diagnosis."

"There is no understanding about what PTSD is, no treatment…"

"There are always arguments about diagnosis."

"They don't understand PTSD, I am treated like a two year old, they just offer tablets, I'm scared they will just lock him up so I'm dealing with it myself."

"It is treated as a short term condition, they just want people off the books."

"It's all short term solutions for a long term condition."

"They need to treat the problem, the PTSD, give treatment and a solution for this."

70. Family members themselves also suffer with a variety of mental health problems and many found it difficult to find appropriate help; this was true in the military as much as in the community:

"It is making me ill."

"There is no care for us, we crack on until we crack."

"The family need respite, need time on our own and support or we become ill. The GP just says you're strong, carry on…"

"We can't show our emotions to them, it triggers things, so have to keep it all in."

"I've never had any support from the MOD. Never been offered counselling or therapy."

"Trying to support someone suffering from PTSD, panic attacks, anxiety and physical disabilities as well as three children but getting no support or help on how to do it by myself."

71. There is also stigma attached to mental health problems:

"People frown on you as if you have three heads, so you just hide it away more."

72. For many family respondents, the importance of family specific support from voluntary sector agencies, that are outside the military could not be over stated:

"If I'd had peer support sooner, it would have helped me."

"The Parents4Parents, Just Between Us group restored normality for me. If it hadn't been for that I don't know where I'd be now. We need something like Just Between Us - parents from military and civilian families getting together to support each other – in every camp, but not on MOD premises. The dynamic of having parents from military and civilian families together outside of the army culture is different, it makes them feel safer to open up and support each other."

"I believe that although spouses may go to coffee mornings and have friends the whole experience can be extremely isolating, so I think that a lot more emotional support should be offered, particularly the kind of one to one and group peer support that Parents4Parents provides."

"The MOD pays lip service to the idea that supported, happy families equal better soldiers but haven't genuinely delivered what is needed to underpin this idea. I don't think the MOD needs to be the source of this support. I believe they can outsource this to others with excellent outcomes."

Impact on children and mothers

73. Family members expressed serious concerns about the impact on their children:

"Parents shelter the kids, even if you are brought up in the army you don't necessarily know how it is."

"You could self-refer to the Children's Centre, they gave therapy, Welfare just said it was normal when my child was clearly suffering."

"My son was autistic but wasn't diagnosed until he was four, there was not help before then, I was left feeling to blame…"

"It's hard with moving all the time when you have kids with special needs, you have to keep starting the whole process of getting help from scratch."

"My daughter was self-harming, no one cared, the kids are getting secondary PTSD."

"Younger kids get support but there is nothing for teenagers."

“How can young people get help? They are not comfortable doing it at school, but they need to talk, they have problems with the military life, moving all the time…22 schools in 18 years.”

“I struggled to support the children emotionally and dealing with their subsequent difficult behaviour left me exhausted and drained which resulted in me becoming depressed as well.”

“My son is in his third school and he’s seven; he has expressed that he wants to go as soon as he turns eight, because he can’t bear to say goodbye to any more friends. That’s really sad.”

“As a parent I find myself so often having to wear multiple hats. My children need extra support in difficult times (around the time of a move or deployment, for example). Their behaviour and emotional health can be affected by military life and as the full time parent, it usually falls to me to work through this.”

“My children need extra support in difficult times (around the time of a move or deployment, for example). Their behaviour and emotional health can be affected by military life and as the full time parent, it usually falls to me to work through this. It can be very difficult and tiring and often means I don't have a lot of time to reflect or care for myself and my own needs. Obviously, in the long term this isn't sustainable or beneficial.”

Conclusions and Recommendations

74. NHS England has conducted a significant amount of engagement on mental health service needs with veterans, family members, service charities and staff working in these services. For example, NHS England commissions 12 mental health services for veterans, which were set up in 2010 following publication of Fighting Fit: a mental health plan for servicemen and veterans (Murrison, Dr A, MP. 2010*)*. With the contracting round for most of these services due in 2016/17, NHS England ran a programme of engagement from January 2016 to March 2016 to help inform future commissioning arrangements.

75. Throughout the engagement period, NHS England actively sought the views and experiences of veterans who have or have had a mental health illness, their families and carers, service charities, commissioners and providers offering treatment and support in this area. These findings, together with the feedback and findings in this report, confirm the view that there is a need to increase access to specialist care for veterans with complex mental health problems including PTSD and Complex PTSD and that this needs to be undertaken as part of an integrated mental health and justice care pathway approach.

76. NHS England, together with criminal justice partners, have been developing an integrated approach to health and criminal justice, e.g. street triage, Liaison and Diversion services and prison in-reach. In prisons, individual case management is increasingly being supported through effective clinical assessment on reception and throughout incarceration resulting in improved flow of communication across the prison estate and on release through use of SystmOne to support clinical care, including generating care summary records on discharge (which enables continuity of care and links with primary care in the community). This has been supported by co-designed health needs assessment tool-kits (developed by PHE in partnership with NHS England and NOMS).

77. In addition, work ‘through the gate’ led by probation services and Community Rehabilitation Companies (CRCs) and National Probation Service includes consideration of health and wider needs including accommodation, employment, training etc.

78. Work across organisations on developing integrated healthcare pathways including a focus on mental health and substance misuse will be further supported by new ‘pathfinder programmes’ including in Birmingham, Manchester and Essex.

79. A new Health & Justice Information Service (HJIS) will support the design and delivery of integrated care across custodial settings and the community, as well as providing better data and intelligence to support service design and delivery. Within these developments there has been some recognition of the needs of veterans, in particular by Liaison and Diversion services and the scenario planning showed these to have been very effective where they are in place. It is important that this work continues and there is more uniform coverage across the country of these services with more explicit recognition of the needs of veterans.

80. However, the evidence from the scenario planning and family consultation that has informed this report, also showed that there continues to be specific needs for the cohort of veterans that have complex mental health problems, including PTSD who are at risk of or are already in contact with the criminal justice system and that there should be more explicit recognition of the support needs of family members.

81. One of the strongest messages to come from the family consultation workshops and interviews, is that mental health problems start at an early point, often go unrecognised by professionals (in the military and in the community including primary care) and left without appropriate help and care these problems can get much worse.

82. If mental health problems are already acute in the serving personnel or veteran, then this has a profound impact on the whole family and yet the common experience of helping services, both within and outside the military gate is that they refuse to treat the family as a unit.

83. At the point of transition, family members find housing and employment amongst the biggest stresses. Inappropriate or ineffective help at this stage can produce immense stress in the family unit, including severe hardship for some. The help provided by the military is not thought to be sufficient and there are also views that help in the community can be inadequate with little or no understanding about the needs and experiences of military families. Support that is dedicated for family members, typically provided by the voluntary sector, is viewed as especially important.

84. For those with more complex problems, there are frequent care gaps along the pathway that can result in excessive use of blue light services and an escalation of problems towards more coercive criminal justice outcomes. Part of the problem is identifying an appropriate pathway for veterans with complex needs, including assessment/risk assessment and interventions for trauma related mental health problems.

85. Lack of continuity in the care pathway alongside lack of integrated governance, poor engagement and inappropriate interventions often leave primary care, emergency services and the family as the default position, placing the veteran at risk to self and others.

86. The care gaps and frequent interruptions to the care pathway for veterans with complex mental health problems who have, or are at risk of offending can lead to a rapid escalation in the severity of problems and likelihood of harm. For example, cases are most likely to be identified at the point of arrest and where Liaison and Diversion services are in place this can result in an effective intervention.

However, these services are not yet uniform across the country and even where they do exist, community options may not be available as an alternative to prison.

87. A custodial sentence often becomes the placement of last resort, but in prison there are continuing problems with identification, assessment and appropriate interventions. The lack of a care pathway in prison for veterans with complex mental health problems and the inability to deliver intensive treatment can have subsequent impacts on release.

88. Risks for the individual, the family and the wider community take place along a continuum from neglect, substance misuse and self-harm, through to aggression, assault and violence in the family home or community. Along this continuum, there are key points for intervention where care gaps become more salient:

- as a result of exposure to trauma and the failure to appropriately assess, diagnose and treat within the military gate;
- prior to and during transition to community from the armed services;
- registration with primary care;
- entry to a care pathway in the community;
- at the point of first dis-engagement with services;
- contact with blue lights services, including attendance at A&E;
- at the point of arrest;
- at Court;
- reception to prison;
- during a custodial sentence;
- on release from prison – at the gate;
- support and management in the community post release.

89. The following sections outline some of the constraints and/or barriers to providing an effective care pathway that were identified as part of the scenario planning workshops and family consultation with recommendations for action.

Assessment of trauma related conditions

90. The numbers of veterans with complex mental health problems who come into contact with both mental health and criminal justice systems are hard to quantify owing to poor identification of problems from the exposure to severe trauma. Problems with identification also mean that suitable assessments and interventions are not commenced at an earlier time, i.e. inside the military gate and subsequent information sharing on transition to the community may be poor.

91. There is a perceived skills and competency gap in the assessment of trauma related conditions. This gap is thought to exist inside the military gate and in the community. There is also increasing recognition in the biological and neurosciences and by the courts that trauma related conditions could have profound impacts on behaviour, including severe physical harm to self or others and serious offending.

92. The attribution of trauma related mental health conditions to having served in the armed forces, including reservists, is even more contentious, as symptoms may have a late onset and related behaviours may be due to early adult or childhood trauma that pre date serving in the armed forces. Reservists in particular are known to be more vulnerable to mental health problems, including PTSD and to have less support in the community.

93. While attribution of trauma related injury whilst serving in the armed forces is particularly pertinent to cases involving application for a War Disability Pension or payment under the Armed Forces Compensation Scheme (AFCS), it can also make an accurate diagnosis more problematic, which highlights the need for a competent and sensitive assessment.

94. Moving the care pathway and effective interventions up stream so that problems can be prevented or identified at an earlier point, is one of the key messages of the scenario planning and from family members.

95. This needs to extend to assessments and interventions inside the military gate whereby serving personnel exposed to significant and/or persistent trauma receive a timely, on going and effective assessment on return from a theatre of war by a competently trained professional with access to effective treatment. Discussion with the DCMH at an earlier point could help ensure that a more structured and detailed approach to identifying mental health issues is undertaken prior to the decision for release from the military. This should be considered in respect of both those who have come to the end of their service and those who are being considered for medical discharge.

96. In respect of this latter group, Medical Discharge can take considerable time (years in some cases) to organise, i.e. the length of time before someone is referred to the Regional Occupational Health Team (ROHT) for assessment and then for consideration and a decision by the Formal Medical Board (FMB) on medical discharge. This process could be improved with stricter governance for a more timely and effective process that takes adequate account of complex mental health problems including PTSD/Complex PTSD.

97. Stigma associated with mental health problems is also known to have a significant impact on the willingness and ability of veterans and family members to admit that they are experiencing mental health problems. Armed forces charities are working collaboratively to develop an anti-stigma campaign called Contact. Contact is a collaboration between a variety of statutory and non-statutory agencies including WWTW, H4H, Combat Stress, RBL, BWW, NHS England, MOD, amongst others. (See link for more information http://www.contactarmedforces.org.uk/)

Recommendation One: Assessment

NHS England and the MOD should work collaboratively with criminal justice partners to improve the assessment of trauma related conditions for serving personnel including reservists and veterans. In particular, there is a need to increase the competency and skills of medical staff including GPs and CMPs in trauma related mental health assessments.

Information sharing

98. There are impediments in the current system (including the lack of appropriate assessments) to information sharing that impacts on case identification and progress through the care pathway. Transition from serving in the armed forces to the community can be more problematic if it is not known where someone is resettling and whether or not they have registered with a GP in the community. However, this could be improved through further development of a shared electronic patient record between the military and NHS systems.

99. Veterans and family members could also be given more assistance to understand the importance of registering with a GP and providing consent to information sharing.

100. Greater sharing of information in the community between services, including the statutory and voluntary sectors and between community mental health services, blue light and emergency services and GPs, could also help strengthen the care pathway and improve governance.

101. There is also a need to ensure that work to improve information sharing continues between the MOD, the NHS and criminal justice partners to ensure that problems are recognised through transition to civilian life and can be picked up and addressed at an earlier point in primary and community care.

102. Although there have been significant improvements in data sharing and recording of veteran status there are some on going issues with respect to this that need to be addressed. For example, GPs and CMPs continue to express confusion about the number of Read codes for veteran and armed services status, including reservists.

Recommendation Two: Using and sharing data

NHS England and NHS Improvement should work with the MOD and criminal justice partners to ensure that appropriate and effective protocols and standards are in place for sharing of information about veterans and mental health problems across relevant agencies. Also, the Department of Health should ensure that HSCIC can provide timely and accurate reports on veteran status.

Crisis intervention

103. Evidence from the scenario planning and consultation with families shows that veterans with complex mental health problems struggle to obtain an appropriate service at the right time, i.e. at the point of first crisis. Ineffective and sometimes inappropriate use is made of emergency services, including A&E and veterans and family members often struggle to engage with mental health services outside of normal office hours. GPs also find it difficult to navigate the variety of service options, including the proliferation of military charities that are offering treatment.

104. Failure of first contact/crisis services to provide intensive home support at the earliest opportunity increases the likelihood of veterans who are in crisis, needing to be admitted to acute care. It will also be important for CRHTTs to work more effectively with blue light, emergency and criminal justice colleagues, especially A&E, the police and Liaison and Diversion services.

105. Also, when admission to an appropriate specialist inpatient facility is required, it will be important that CRHTTs are able to provide intensive home care support on discharge as needed. This may prove challenging as it is likely to require longer term engagement with service users.

106. The principle of providing care and treatment that is in the least restrictive setting and is appropriate to meet individual needs should also apply to veterans with acute mental health crisis.

107. This will help to ensure an approach that is based on care not custody and will strengthen the model being developed for Liaison and Diversion services as they continue to work with veterans. This should be considered further within the current governance and management arrangements for Liaison and Diversion services.

Recommendation Three: Crisis intervention

There is a need to ensure an effective response including assessment and interventions at points of crisis for veterans with complex mental health problems. NHS England and the LGA should work collaboratively with CCGs and criminal justice partners to ensure that local area crisis Concordat Action Plans take account of the needs of veterans with complex mental health problems.

Integrated mental health and criminal justice care pathways

108. Current care pathways for veterans with complex mental health problems are frequently interrupted and various factors influence this, including the willingness and ability of veterans themselves to engage with services and a relative lack of appropriate and sensitive interventions. However, key to this is an integrated approach to mental health and criminal justice care pathways.

109. Current care pathways for mental health and criminal justice are not sufficiently integrated for effective management of veterans with complex trauma related mental health conditions. There is also a need for integrated case management whereby ownership of the case resides with the most competent and pertinent service.

110. Increasing Access to Psychological Therapies (IAPT) is one of the main areas of mental health investment in recent years and it has helped 1,000s of people with common mental health problems receive evidence based therapeutic interventions. As the programme expands, it is increasingly expected to address the needs of those with psychosis, bipolar disorder and personality disorder.

111. The model for IAPT is increasingly becoming the gateway for entry to a mental health service care pathway, but this may not be sufficient or appropriate for veterans with complex needs who require a longer term case management approach that encompasses both mental health and criminal justice interventions.

112. In considering the needs of veterans, it is necessary to ensure that specific services are provided that are evidence based with treatment interventions for working with trauma, including PTSD/Complex PTSD and are subject to strict governance, validation and evaluation.

113. There is also a need to further integrate emergency and blue light services into the care pathway with effective information sharing protocols and a shared assessment, including risk assessments as part of an integrated mental health and criminal justice case management approach. This needs to go beyond sign posting to more specialist interventions, including crisis interventions and work with the whole family.

114. The severity of risks and potential harms associated with these more complex cases also raises adult safeguarding issues. Whilst an adult safeguarding approach could ensure closer monitoring, so that any interruptions or disengagement with the care pathway would be identified and communicated at an earlier point, this would not address the need for an effective treatment pathway.

115. However, if the care pathway and interventions were in place, alongside a strong and integrated case management approach, such as that undertaken for vulnerable adults, this may help prevent escalation of problem severity and crisis. This could provide a possible model for improved care co-ordination across different services in both mental health and criminal justice systems.

116. An integrated care pathway would need to have the following features:

- a single, competent case manager with admission rights to a relevant inpatient treatment service;

- a common assessment and care planning framework that is shared across both mental health and criminal justice systems and includes planning and interventions for crisis interventions;

- support and treatment for the whole family including children, as part of the same pathway, e.g. recognising the needs of family members, but also their vital role in supporting the veteran. This may also involve, when appropriate, improved coordination and integration with Child and Adolescent Mental Health Services (CAMHS);

- involvement of housing, debt management and employment support agencies;

- de-escalation interventions in criminal justice agencies that operate prior to court or imprisonment e.g. street triage, police, Liaison and Diversion and courts liaison;

- access to specialist therapeutic interventions for trauma.

117. While most of an integrated care pathway could be formed across existing mental health and criminal justice services, there may be a need for consideration of the development and commissioning for sub-regional specialist trauma related intervention services.

118. There is a need for some of these to be veteran specific, recognising the distinct differences in exposure to trauma. But there is also increasing recognition that other occupational groups are at risk of exposure to traumatic events that can result in mental health problems, e.g. police, fire services and paramedics. By building up the specialist services for trauma and veterans there is the potential for this to be extended to other occupational groups.

119. Some recent policy developments may also impact on the need for greater integration between health and criminal justice services; in particular, moves towards granting prison governors greater freedom to manage and commission services.

120. While this could bring benefits for prisoners, it will be important that governors are supported by national and local commissioners and service providers, with effective governance arrangements in ensuring an appropriately integrated service remains at the core of service delivery.

121. A specific guideline is needed, which should be targeted at regulators and inspection bodies and the commissioners and providers of mental health services. The guideline should address:

- the need for a competent and evidence based assessment for veterans who have complex mental health needs, including PTSD and Complex PTSD;

- workforce development and training for relevant professionals, e.g. GPs, CMPs and mental health practitioners on assessing trauma related mental health problems;

- the development of standards for specialist treatment for PTSD based on NICE guidance and updated to include care and treatment provided by voluntary sector agencies and military charities;

- achieving parity of esteem for veterans who are Wounded, Injured and Sick (WIS) and those who are Trauma, Injured and Sick (TIS);

- alignment in care pathways for complex mental health problems and alcohol and drug treatment services.

122. Evidence from the scenario planning, family consultation and elsewhere suggests that veterans with complex mental health problems, at the current time are more likely to enter the prison system following repeated episodes of harm and crisis. In order to break this cycle, and as part of its review of nationally commissioned specialist veteran mental health services, NHS England should consider the need for the development of sub-regional specialist trauma services as part of a secure care pathway.

123. An effective, integrated approach to early intervention and secure care, with competent and expert assessment and treatment interventions will help to prevent the harms associated with complex mental health problems and serious offending. This would also help reduce incidents of domestic assault and violence in the family home and ensure that early identification with an appropriate treatment response is in place.

Recommendation Four: Integrated mental health and criminal justice care pathways

There is a need to review the current service models for mental health and criminal justice interventions under a joint governance arrangement involving health, criminal justice and the MOD. This could be taken forward through an integrated action group, led by NHS England, that considers the findings from this report and seeks to develop pilot service developments, building on areas of best practice that can meet the identified needs for veterans with complex mental health problems who are at risk of offending.

Strategic leadership and governance

124. In order to ensure an effective response to the issues raised in this report, there is a need for coordinated, central strategic leadership and governance that encompasses mental health and criminal justice care pathways for veterans and family members. This can best be realised through the existing commissioning arrangements within NHS England for the Armed Forces and their Families, Health & Justice and Sexual Assault Services.

125. This could be strengthened at local levels through Sustainability and Transformation Plans (STPs). STPs are driving forward integrated approaches to health and social care. However, as indicated by Bashford et al, 2015 the relative absence of veterans and their family members from Joint Strategic Needs Assessments (JSNAs) means that the specific mental health needs of veterans may not be sufficiently addressed. A requirement to address this at local levels through STPs would bring benefits to the assessment and identification of mental health problems for veterans and their families.

Recommendation Five: Strategic leadership and governance

The strategic lead and governance for an integrated mental health and criminal justice system for veterans should sit within NHS England.

Parity of esteem for veterans who are Trauma, Injured and Sick

126. Achieving parity of esteem between physical and mental health problems is a national government objective and it is especially important for veterans who often experience both severe physical impairments as a result of serving in the armed forces and associated mental health problems.

127. Veterans are known to have a number of physical conditions that relate directly to their having served in the armed forces, including amputated limbs and neuro-physiological disorders. These conditions for veterans who are classified as Wounded, Injured and Sick (WIS) are increasingly well managed in the NHS with the provision of specialist centres and rising standards for prosthetics.

128. However, much less attention has been paid to psychological injury that may accompany physical ones and care pathways for physical and mental health care are usually quite distinct. An approach is needed that takes full recognition of veterans who are Trauma, Injured and Sick (TIS). This approach should include recognition that problems in accessing appropriate services and continuity of care can be further exacerbated when alcohol or drugs are involved.

129. The Call to Mind: A framework for action report on the mental and related health needs of veterans and family members suggested that there needed to be greater integration between mental and physical care pathways for veterans:

> *"The further development of appropriate and sensitive evidence based services for veterans and family members including reservists requires…greater integration in service responses for meeting both physical and mental health needs…"* (Bashford et al. 2015. *Call to Mind: A Framework for Action*. London: FiMT. Page 50)

130. Family members and veterans as part of the consultation for this report also thought that there needed to be greater attention paid to physical health care needs for veterans with mental health problems. There is a strong view amongst family members and other stakeholders that these go hand in hand and that physical health is directly affected by mental health and vice versa.

131. There is a well established treatment system for veterans who are WIS including specialist treatment centres. However, despite the existence of DCMH services, the development of specialist treatment for veterans who are TIS is less well developed. Achieving parity of esteem for these two patient groups will require:

- addressing the funding shortfall for specialist mental health treatment for veterans so that this is on a par with specialist physical health care provision by 2020/21;

- addressing the treatment gap (currently thought to be less than 50%) so that all veterans who require specialist mental health treatment can access this in a timely and effective manner, on a par with access and treatment standards for specialist physical treatment services;

- addressing stigma about mental health problems in the armed forces and amongst the veteran population, including amongst family members;

- strengthening financial incentives for primary and secondary care service providers to better identify and meet the mental health needs of veterans and family members e.g. through STPs

- developing population based funding pilots for secondary care services that focus on the specialist mental health needs for veterans and family members including CAMHS and secure care commissioning.

Recommendation Six: Parity of esteem for veterans who are TIS

In line with the previous recommendations there should be greater parity of esteem between veterans who are Wounded, Injured and Sick (WIS) and veterans who are Trauma, Injured and Sick (TIS)

Support for family members

Earlier interventions

132. The needs of family members are often overlooked; both from the perspective of their role as a key support for serving personnel and veterans, but also in terms of their own mental and related health needs. This is relevant from within the military gate and through transition to civilian life and beyond.

133. Family members, in particular spouses, are under some immense pressures and stresses that start when they enter military life and continue through resettlement into civilian life. Some of these stresses are related to the occupation and military culture and experiences e.g. having to move frequently, often feeling isolated from family and friends and living with someone whose job is very demanding, which comes with its own stresses, including exposure to extreme trauma.

134. However, there is also a strong sense amongst family members that many of these stresses could be alleviated with a stronger focus on professional occupational health services. In particular, there is a desire for professional welfare services that provide confidentiality and recognise the needs of families as being as valid as those of the serving personnel.

135. In particular, some strong views have been expressed by family members that more could be done by the military to ensure a more timely response through an appropriate and professional welfare service that can better meet the mental health needs of serving personnel and their families.

136. Family members in particular, would like to see improved responses and interventions, including assessments for trauma related mental health problems. In the case of complex mental health problems, including Complex PTSD, families often find help to be the least effective. This includes:

- lack of accurate assessments and diagnosis;
- poor understanding about behaviours, including fears about safety that result in poor engagement by services;
- escalation of blue light services and police interventions;
- inappropriate referrals to A&E and/or psychiatric assessment units with the person often returned to the family home with little or no adequate follow-up;
- lack of crisis interventions and respite care that places additional burdens on the family;
- retreat from services with family members concluding that it is more harmful to engage services i.e. for fear of arrest and/or prison.
- fear of isolated intervention from Social Services and/or Domestic Violence services, including removal of children from the home.

137. The evidence from family members consistently supports the need for voluntary sector support agencies, often provided on a peer support basis that is not part of the military system or part of statutory service provision. Although, it is important to recognise that improved partnership working with the voluntary sector including family support agencies should form part of an integrated care pathway.

138. There may also be a need to ensure appropriate access to and continuity of care with respect to CAMHS for children and young people who are known to regularly move location as a result of being in a military family unit. This could be considered as part of the development of the access standard for CAMHS including revised information sharing protocols that cross health and the military systems.

Recommendation Seven: Earlier intervention and support for family members

There is a need to improve the welfare response and services for families within the military gate. This should include ensuring an appropriate and professional service that recognises the mental health needs of family members.

Social support – employment and housing

139. Being unable to find and/or sustain meaningful employment is one of the factors that family members and veterans identify as being a significant cause of stress and anxiety that can aggravate or initiate more complex mental health problems. Employment is also recognised as a key life moment that can impact on the prevention of mental health problems.

140. The scenario planning and consultation with family members has shown that employment, post armed services, can be problematic for many veterans and family members. This can, in some instances produce hardship and result in the loss of self-esteem and confidence. As part of an approach to a more fully integrated care pathway, health services need to recognise the importance of employment and work more collaboratively with employment agencies, including the armed forces charities that work in this area to support veterans and their families in employment.

141. The Department of Health, the Department of Communities and Local Government, NHS England, HM Treasury and other agencies are working together with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and exploring the case for using NHS land to make more supported housing available for this group. One of the biggest stresses for veterans and family members leaving the armed forces is housing, and it is especially important that this is considered within local Crisis Care Concordat Plans and local Mental Health Prevention Plans.

Recommendation Eight: Employment and housing support for veterans during transition to civilian life

NHS England, PHE and the LGA in collaboration with the MOD should explore the development of service pathways, alongside social sector partners to promote greater access and support into employment and/or housing for veterans during transition to civilian life.

Perinatal care and support

142. There is consistent feedback from the partners of armed forces personnel or veterans that they experience problems accessing appropriate perinatal mental health care. There is a need to address this within the national programme for increasing access to this care.

143. Work has been taking place to ensure that female serving personnel are able to access appropriate care during pregnancy and after birth and this needs to include access to support and treatment for post-natal depression.

144. The consultation with family members also revealed that problems after giving birth, including depression and feeling isolated, can be a severe problem for some military spouses. Increased access to evidence-based specialist mental health care during the perinatal period should include the needs of serving forces women and military spouses.

Recommendation Nine: Perinatal mental health care

NHS England should include women who are partners of armed forces personnel or veterans in access targets and reinvestment plans for perinatal mental health care.

Involvement and participation of family members

145. NHS England's programme of work on involvement and participation of service users and carers has already brought considerable benefits to the commissioning, planning and delivery of services and this includes the involvement and participation of veterans and family members. This commitment to continued and sustainable involvement and participation must continue and be strengthened at local levels amongst commissioners from health and social care and in the criminal justice system. It is especially important that family members, including children, young people and parents, are included and that their voices are raised alongside those of service users as equal experts by experience.

146. Although family members welcomed being involved in the consultation, some also expressed anger and frustration at being continually consulted and asking for help with little or no effective response, as they see it, from commissioners and service providers, both in the military and in the community. In particular, family members feel that:

- help and interventions need to be moved up stream to an earlier point in the problem cycle as part an effective prevention and early intervention strategy;

- family members, especially spouses and parents, need to be formally involved in decisions and planning about care;

- care pathways and interventions need to be longer term, taking account of the severity of problems and providing effective therapeutic treatments delivered under strict governance arrangements;

- there needs to be greater continuity of care between the MOD, the NHS, criminal justice and social care, including the voluntary sector where this provides effective and appropriate support as part of a regulated, governed and integrated approach.

Recommendation Ten: Participation and involvement of service users, families and carers

NHS England should continue to engage veterans and family members including carers and children and young people in order to ensure that their voices and the lived experience of those who need and use services continues to be at the heart of service commissioning, planning and delivery.

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