

National Assembly for Wales
Health, Wellbeing and Local
Government Committee

Post-traumatic stress disorder
treatment for services veterans

February 2011



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Health, Wellbeing and Local Government Committee

The Health, Wellbeing and Local Government Committee is appointed by the National Assembly for Wales to consider and report on issues affecting health, local government and public service delivery in Wales. In particular, as set out in Standing Order 12, the Committee may examine the expenditure, administration and policy of the Welsh government and associated public bodies.

Powers

The Committee was established on 26 June 2007 as one of the Assembly's scrutiny committees. Its powers are set out in the National Assembly for Wales' Standing Orders, particularly SO 12. These are available at www.assemblywales.org

Current Committee membership

<i>Committee Member</i>	<i>Party</i>	<i>Constituency or Region</i>
Jonathan Morgan (Chair)	Welsh Conservative Party	Cardiff North
Lorraine Barrett	Labour	Cardiff South and Penarth
Veronica German	Welsh Liberal Democrats	South Wales East
Irene James	Labour	Islwyn
Ann Jones	Labour	Vale of Clwyd
Helen Mary Jones	Plaid Cymru	Llanelli
Dai Lloyd	Plaid Cymru	South Wales West
Val Lloyd	Labour	Swansea East
Nick Ramsay	Welsh Conservative Party	Monmouth

The following Members were also members of the Committee during this inquiry:

Darren Millar	Welsh Conservative Party	Clwyd West
Andrew R.T. Davies	Welsh Conservative Party	South Wales Central'

Contents

Chair’s Foreword	5
The Committee’s Recommendations	7
1. Introduction	10
Terms of reference	10
Methods	10
2. Background	12
3. Prevalence of PTSD	15
Transition to Civilian Life	16
Veterans in the Criminal Justice System.....	17
Minister’s View.....	18
Committee’s View	18
4. Identification of Post-traumatic Stress Disorder	20
Barriers to Effective Identification of PTSD in Veterans	20
Training for Healthcare Staff.....	21
Information Sharing	22
Screening	24
Arrangements for Raising Awareness	24
Minister’s View.....	25
Committee’s View	26
5. Treatment and Support Services	29
Adequacy and Suitability of Treatment and Support Services	29
Treatment Provided by the Independent Sector	30
Veteran-led and/or Veteran-specific Service.....	31
Residential Treatment.....	34
Holistic Approach	35
Priority for Veterans.....	38
All-Wales Veterans’ Mental Health Service.....	38
Support for Families and Carers of Veterans with PTSD.....	39

Approach Taken in America	39
Minister's View	41
Committee's View	43
6. Funding Arrangements.....	47
Partnership Arrangements	48
Minister's View.....	48
Committee's View	49
Annex A - Witnesses.....	50
Annex B - Written evidence	52
Annex C - Consultation Responses	53
Annex D - Supplementary Evidence	54

Chair's Foreword

The men and women who serve in our armed forces put their lives on the line every day of their active duty. Many return home with visible scars of battle; many return with scars of battle that cannot be seen and are therefore difficult to treat. During the First World War, this was referred to as 'shell shock'; during the Second World War, it was known as 'war neurosis'; since the 1980s and the Falklands War, it has been referred to as post-traumatic stress disorder.

PTSD is the psychological response to an event of an intensely traumatic nature. It can arguably be called a 'normal' reaction to an abnormal and extreme event. In this inquiry, we have focused on post-traumatic stress disorder in veterans of the armed forces, but anyone can suffer from it, for example, as the result of a car crash or an assault. Members of the armed services, the police, fire fighters and ambulance workers are among those more likely to have such experiences.

As a Committee, we heard that the symptoms of PTSD can take many years to manifest, and that even then, the sufferers may not be aware that the problems they experience on 'civvie street' - from substance misuse and crime, to family breakdown and homelessness - are the result of PTSD.

This Committee report identifies problems with the identification of PTSD in veterans, a lack of data, and inadequate and inappropriate services for veterans with PTSD. If accepted, we believe that the recommendations contained in our Committee report will help to improve treatment services for these brave men and women who have given so much for their country, and who deserve the best treatment and support we can give them.

I thank my predecessor, Darren Millar AM, for all of his work on this inquiry and, on behalf of the Health, Wellbeing and Local Government Committee, I would like to express my gratitude to all those who have

contributed to this inquiry. I would also like to thank the Members of the Committee for their work in producing this report, and I commend it to the Minister for Health and Social Services and to the National Assembly.

Chair, Health, Wellbeing and Local Government Committee
February 2011

The Committee's Recommendations

Recommendation 1. The Committee recommends that the improved data collection on the incidence of PTSD (and other conditions) that will be facilitated by the new Mental Health and Wellbeing Service for Veterans should be used to inform the distribution of funding for treatment and support services across Wales. (Page 18)

Recommendation 2. The Committee recommends that the Welsh Government ensures that prisoners in Welsh prisons who are veterans suffering from PTSD receive the full benefits of the new specialist veterans mental health service and that, in particular, those Health Boards with prisons in their areas receive sufficient resources to provide an adequate service. The Committee asks that the Welsh Government liaises with the National Offender Management Service for Wales and the Department for Health in England to ensure that Welsh prisoners held in privately contracted prisons in Wales and those held in English institutions also benefit from the new specialist veterans mental health services. (Page 19)

Recommendation 3. The Committee recommends that the Welsh Government works with the Royal British Legion and other services charities to disseminate information and raise awareness of PTSD and the services available to treat it. Any such information should also seek to reduce the stigma associated with mental health problems. (Page 27)

Recommendation 4. The Committee recommends that the Welsh Government liaises with the UK Government around the implementation of recommendations in the Murrison report regarding the provision of follow-up screening for regulars and reserves 12 months after leaving service, and of an online mental wellbeing website. If these facilities are not to be made available across the UK, provision in Wales should be considered. (Page 27)

Recommendation 5. The Committee recommends that service in the armed forces be flagged up in veterans' medical records, with an opt-out for those who request it. (Page 27)

Recommendation 6. The Committee recommends that the Welsh Government liaises closely with the Ministry of Defence and monitors

the effectiveness of the transfer of medical history from the armed services to GP practices to ensure that GPs treating veterans are fully aware of their medical histories. (Page 27)

Recommendation 7. The Committee recommends that the Welsh Government takes steps to raise awareness amongst GP practices of the symptoms of the PTSD and the vulnerability of veterans to it. (Page 28)

Recommendation 8. The Committee recommends that primary care staff receive training in the symptoms and treatment of PTSD, including in the military context, as part of Continuing Professional Development. (Page 28)

Recommendation 9. The Committee recommends that the Welsh Government provides more funding/support for veterans groups to develop information and support networks for veterans and for them to link in with the new veterans' mental health services in Health Boards. (Page 44)

Recommendation 10. The Committee recommends that the Welsh Government ensures that the new carers' strategies encompass the needs of veterans' carers when making regulations to enact the Carers Strategies (Wales) Measure (2010). (Page 44)

Recommendation 11. The Committee recommends that, given the prevalence of substance misuse amongst veterans, and incidence of this and PTSD co-occurring, that the Welsh Government makes a particular priority of ensuring that veterans with PTSD also have timely access to substance misuse treatment. (Page 45)

Recommendation 12. The Committee recommends that the Welsh Government addresses the need for increased capacity in the NHS to provide specialist therapeutic treatments for veterans suffering from PTSD, including the use of 'talking therapies', and commissions a pilot project of specialist therapy services to assess the extent and durability of the benefits for veterans with PTSD. (Page 45)

Recommendation 13. The Committee recommends that the NHS keeps under review the evidence for the effectiveness of alternative treatments for PTSD with the aim of ensuring that veterans suffering from PTSD have access to the best possible treatments for the

condition, whether provided directly by the NHS, or by the independent sector on behalf of the NHS. (Page 45)

Recommendation 14. The Committee recommends that the NHS explores ways to increase the number of nurse-led self-help veterans groups in the community. (Page 45)

Recommendation 15. The Committee recommends that the Welsh Government reviews the training of NHS staff to ensure that they are fully aware of the priority treatment scheme for veterans and that the scheme is made available to all veterans. (Page 45)

Recommendation 16. The Committee recommends that specific provision be made for veterans suffering from complex PTSD, particularly those who are at risk of committing, or who have already committed crimes. (Page 45)

Recommendation 17. The Committee welcomes the new steering group as a contribution to improving the co-ordination of services for veterans with PTSD and recommends that the opportunities created by the establishment of the new Mental Health and Wellbeing Service for Veterans for better use of resources are fully exploited. (Page 45)

Recommendation 18. The Committee recommends that the Welsh Government raises with the UK Government the issue of the difficulties that can be experienced by veterans suffering with PTSD in the process of applying for benefits. (Page 46)

Recommendation 19. The Committee recommends that the Welsh Government keeps under review the level of funding provided to the veterans' mental health project to ensure it is able to meet demand. The Committee supports the Government's efforts to press the Ministry of Defence for a contribution. (Page 49)

1. Introduction

1. The Committee agreed to conduct an inquiry into post-traumatic stress disorder treatment for Services Veterans

Terms of reference

2. The Committee agreed the terms of reference for the inquiry on 8 July 2010. They were:

To consider the adequacy and suitability of services in Wales for veterans of the armed services, including the Territorial Army, suffering from post-traumatic stress disorder (PTSD), and in particular:

- the arrangements for raising awareness of PTSD and for signposting treatment and support services for veterans, their families and carers;
- the identification of veterans suffering from PTSD and the collection of data on the prevalence of the condition and the need for services to address it;
- the adequacy and suitability of treatment and support services for veterans suffering from PTSD and their geographical spread across Wales, including NHS provision in primary and secondary care and specialist provision for ex-services personnel in the NHS and the third sector;
- the adequacy and suitability of treatment and support services to address additional needs of veterans with PTSD such as depression and alcohol and drug misuse; and
- the funding arrangements for services providing care and treatment to veterans with PTSD including partnership arrangements with, for example, the Ministry of Defence and the voluntary sector.

Methods

3. The inquiry was held between 22 September 2010 and 3 November 2010, and a call for evidence was issued on 23 July 2010. Thirteen submissions were received, which can be found at Annex C.

4. Fourteen sets of witnesses were invited to give oral evidence during four Committee meetings. A list of meeting dates, details of the witnesses who appeared, written papers provided to the Committee, and links to transcripts are provided at Annexes A and B.

5. Agendas, papers and transcripts for each meeting are available in full on the Committee's pages on the National Assembly for Wales' website, which can be found at <http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlg-home/bus-committees-third-hwlg-agendas.htm>

2. Background

6. Post-traumatic stress disorder (PTSD) is a psychological response to an event of an intensely traumatic nature that triggers mental distress. It may be recognised only after a period of time has elapsed since the traumatic experience and is often manifest in individuals that have been discharged from the armed forces. It also often occurs alongside other disorders, such as depression and drug and alcohol abuse.

7. Services for the treatment of PTSD amongst services veterans have been the subject of discussion in Wales¹ and the rest of the UK for a number of years, and concern has been expressed about the adequacy of the steps taken by the Government to respond to the needs of the growing numbers of veterans experiencing PTSD and of the suitability of NHS services, in particular.

8. Although information on serving military personnel is available, data on the number of veterans suffering from PTSD is limited and there is no clear indication of the scale of the need for services. Combat Stress, a charity that provides mental health care and support to ex-service personnel, states² that across the UK the number of veterans seeking its help has risen by 72 per cent since 2005.

9. Many veterans endure the symptoms for a considerable time before seeking help and, in some cases, there is a delay before symptoms become apparent. According to Combat Stress, it takes, on average, more than 14 years from service discharge for individuals to make first contact with the charity.³

10. The House of Commons Defence Select Committee noted in its 2008 report on Medical Care for the Armed Forces that identifying veterans with mental health needs and directing them towards the appropriate treatment is a 'major challenge'. The report stated:

“We are concerned that the identification and treatment of veterans with mental health needs relies as much on good intentions and good luck as on robust tracking and detailed

¹ See National Assembly for Wales Plenary debates: 20 January 2010, p106; 10 February 2010, p98; 16 January 2010, p130

² See Combat Stress website: <http://www.combatstress.org.uk/index.php>

³ See Combat Stress website, FAQs: http://www.combatstress.org.uk/pages/ptsd_faq.html

understanding of their problems. If the NHS does not have a reliable way of identifying those who have been in the Armed Forces, then it already has one hand behind its back when it comes to providing appropriate clinical care. We repeat our belief that there must be a robust system for tracking veterans in the NHS, and this should feed into enhanced facilities for addressing their specific needs.”⁴

11. In 2008, the Welsh Government, in partnership with the Ministry of Defence, launched the Community Veterans Mental Health Service, a two-year pilot scheme in Cardiff to provide care and treatment for veterans, one of six such projects across the UK. Following an evaluation, the project was rolled out across Wales from spring 2010.⁵

12. The Minister for Health and Social Services has also commissioned a Veterans’ Needs Assessment Project to provide data on veterans’ health in Wales⁶

13. NHS services provide treatment for people with PTSD using guidelines produced by the National Institute for Health and Clinical Excellence,⁷ but there is some doubt about the appropriateness of mental health services provided by or contracted to the NHS in meeting the needs of veterans, particularly those with complex PTSD. In a recent BBC interview,⁸ Dr Dafydd Alun Jones, a psychiatrist who treats war veterans with PTSD, expressed concern about the adequacy of services for those with the most severe symptoms. The UK Trauma Group also argues that the NICE guidelines,

“do not provide adequate guidance in relation to the assessment and treatment of Complex PTSD.”⁹

14. In its 2008 report, the House of Commons Defence Committee highlighted evidence from the Chief Executive of Combat Stress who

⁴ House of Commons Defence Committee, ‘Medical Care for the Armed Forces’, 5 February 2008, HC327, Seventh Report of Session 2007-08

⁵ Welsh Government press release, 8 March 2010, ‘Veterans mental health service extended across Wales’

⁶ National Assembly for Wales Plenary Debate, 20 January 2010, p114

⁷ National Institute for Health and Clinical Excellence, (2005) Clinical guidelines CG26, Post-traumatic stress disorder (PTSD): ‘The management of PTSD in adults and children in primary and secondary care’

⁸ BBC Wales, 22 June 2010 ‘Rhondda veterans say Wales lacks full trauma care’ <http://www.bbc.co.uk/news/10350387>

⁹ The UK Trauma Group is a managed clinical network of UK Traumatic Stress Services.

questioned the appropriateness of NHS PTSD services for some veterans with PTSD, given that they are not specific to services personnel and attempt to accommodate veterans alongside members of the general public.¹⁰

15. Contributors¹¹ to debates in the National Assembly for Wales have also suggested that a lack of specialist staff and resources in the NHS is hampering the implementation of the NICE guidelines, which recommend trauma-focused psychological treatment before medication.

¹⁰ House of Commons Defence Committee, 'Medical Care for the Armed Forces', 5 February 2008, HC327, Seventh Report of Session 2007-08, paragraph 106

¹¹ National Assembly for Wales Plenary Debate, 10 February 2010, p112

3. Prevalence of PTSD

16. Post-traumatic Stress Disorder (PTSD) has become increasingly recognised as an important psychiatric disorder over the last few years. Increased media coverage, and work by the pilot Veterans Service and various organisations involved in the support of veterans have contributed to this.

17. As a number of witnesses pointed out, the increasing engagement of the UK armed forces in international conflicts is likely to result in increased prevalence of PTSD in the future. There is therefore a need for better intelligence, particularly given that local funding for the new hub and spoke specialist service is neither based on populations of veterans nor on the prevalence of PTSD in Health Board areas.

18. There is a lack of data on the prevalence of PTSD in veterans. Comprehensive data collection is hampered by the fact that, in many cases, the symptoms of PTSD take a number of years to appear.

19. A snapshot was provided by Neil Kitchiner from the Cardiff and Vale Community Veterans Mental Health Service pilot project who stated that just over half of the 200 patients seen by the project had a primary diagnosis of PTSD, alongside a range of other conditions.

“As a rough guess I would say that about 52 per cent were diagnosed with a primary diagnosis of chronic post-traumatic stress disorder with co-morbid problems such as depression, anxiety disorders, or problems with alcohol or drugs, and lots of social problems in relation to housing, relationships, unemployment and so on.”¹²

20. Some witnesses believed the problem is under-reported but this is not the view of all agencies: the Royal British Legion suggested that the condition is not as widespread as is sometimes claimed. In written evidence, the RBL stated:

“There is a common misconception that the majority of Service personnel and veterans experience PTSD and that any mental health disorder is necessarily caused by a traumatic experience during Service.

¹² Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

“The crux of mental health problems experienced by service personnel and veterans are common mental health disorders such as depression and anxiety.”¹³

Transition to Civilian Life

21. The Committee heard that there is an issue with forces personnel being unprepared for life after they have left the forces, which leads to many problems. Kevin Richards of Healing the Wounds, who is also a former combat medic said:

“There is no transition on leaving the armed forces to become a civilian. It is at this stage that problems start to occur because you learn to become a soldier, you serve as a soldier, and then you just turn 180 degrees and you are a civvy, and that does not work...They have been removed from the military environment where almost everything is taken care of for them, including employment, training, housing, clothing and medical requirements...and some of them just do not know what to do. They cannot cope with it.”¹⁴

22. The Committee heard that, on leaving the armed forces, some personnel are offered resettlement support, but that those who have not served over six years are not. Some of those personnel will be leaving the forces within six years due to suffering from PTSD or other mental health problems. Interestingly, Professor Bisson, Professor of Research and Development at Cardiff University Medical School, told the Committee that research shows that those who have served in the armed forces for less than four years are at more risk of developing mental health problems than those who have served for longer.

23. The Committee also heard that the therapies used in the resettlement courses are not always effective. Ian Pitchford of Talking2Minds said:

“a lot of the therapies that you see and a lot of the courses that you go on, for those lucky enough to get some kind of resettlement support, are a ‘do to’ process rather than a ‘do with’... A ‘do with’ process encourages people to be able to

¹³ Health, Wellbeing and Local Government Committee 20.10.10, written evidence, HWLG(3)-16-10-p3

¹⁴ Health, Wellbeing and Local Government Committee 6.10.10, oral evidence

develop strategies to go on to be able to deal with whatever happens in life.”¹⁵

24. Chris O’Neill of Forces for Good told the Committee that establishing veteran points of contact would help veterans with the transition into civilian life. He said veterans’ day centres would be helpful, as they would provide a place where,

“ex-service personnel can mix among each other and everything that they need is within that building. The community is there, the bond is still there and they are making the transition, but there are professionals there or the first point of contact is a veteran.”¹⁶

25. The Committee heard that more resource needs to be put into preparing veterans for civilian life. Professor Bisson of Cardiff University School of Medicine told Committee that the NHS was not sufficiently resourced to provide this service,

“I would argue that more resource should be made available in the NHS for us in the NHS to deal with that. Another model would be for the MOD to take responsibility for doing some work with veterans as well. You could argue for either model, but more resource and effort needs to be put in.”¹⁷

Veterans in the Criminal Justice System

26. The Committee heard about the number of veterans in the prison population, some of whom also experience PTSD. John Davies of Hafal said:

“The first point of contact for many people will be either general practitioners or, sadly, criminal justice services.”¹⁸

Some of the evidence suggests that timely support and treatment for veterans suffering from PTSD and other mental health difficulties helps with resettlement and reduces the incidence of crime.

27. The Committee heard evidence from Dr. Dafydd Alun Jones about Ty Gwyn, a residential project which supported veterans with chronic

¹⁵ Health, Wellbeing and Local Government Committee 6.10.10, oral evidence

¹⁶ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

¹⁷ Health, Wellbeing and Local Government Committee 20.10.10, oral evidence

¹⁸ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

PTSD and provided holistic treatment, helping to prevent some from going to prison. The project closed in 2005 and Dr Jones told the Committee that there is a need for specialist services to meet the needs of this group of veterans, possibly through the provision of a 6-bed residential unit.

Minister's View

28. In her written submission, the Minister told Committee that work on the identification of the mental health needs of veterans in Wales is under way to support the findings of the Community Veterans Mental Health Service pilot. She also told Committee that she has commissioned a Veterans' Health Needs Assessment Research project, which will report shortly. Public Health Wales are also looking at research to predict the increase in future demand on specialist health services over the next five years arising from former armed service personnel and to predict the specialist service requirement necessary to meet this additional demand.

29. The Minister told the Committee that the new specialist veterans' mental health service will be available to prisoners in the three public sector Welsh prisons but that prisons run by the private sector have different arrangements, although all Welsh prisons have access to the Welsh Government's Prison In-Reach mental health scheme.

Committee's View

30. The Committee feels that there is a need for better intelligence on the prevalence of PTSD in veterans, particularly as local funding for the new hub and spoke specialist service is neither based on populations of veterans nor on the prevalence of PTSD in Health Board areas.

31. The Committee feels that veterans' mental health services need to make strong links with prison mental health services and that there needs to be a focus on providing training and awareness raising around veterans' mental health needs, given the limited resources available.

Recommendations

Recommendation 1: The Committee recommends that the improved data collection on the incidence of PTSD (and other conditions) that will be facilitated by the new Mental Health and

Wellbeing Service for Veterans should be used to inform the distribution of funding for treatment and support services across Wales.

Recommendation 2: The Committee recommends that the Welsh Government ensures that prisoners in Welsh prisons who are veterans suffering from PTSD receive the full benefits of the new specialist veterans mental health service and that, in particular, those Health Boards with prisons in their areas receive sufficient resources to provide an adequate service. The Committee recommends that the Welsh Government liaises with the National Offender Management Service for Wales and the Department for Health in England to ensure that Welsh prisoners held in privately contracted prisons in Wales and those held in English institutions also benefit from the new specialist veterans mental health services.

4. Identification of Post-traumatic Stress Disorder

Barriers to Effective Identification of PTSD in Veterans

32. Witnesses identified a number of barriers to the effective identification of PTSD in veterans. There was universal acknowledgement that PTSD is one of a range of co-occurring mental health problems that may be experienced by veterans. Dr Andrew Dearden of the BMA told Committee that this can make the identification of PTSD more difficult:

“The slight difficulty is that PTSD is not the only psychiatric disorder that you see in veterans. In 60 to 70 per cent of cases, PTSD does not occur alone, so it is often co-morbid with depression or substance misuse, which can complicate the picture or even dominate the picture so that the PTSD is missed.”¹⁹

33. The Committee heard that the symptoms of PTSD can take a long time to emerge, and that this problem is exacerbated by the fact that many sufferers also have co-occurring mental health problems, including substance misuse. Ian Hulatt of the Royal College of Nursing said:

“It may be many years before an individual presents with PTSD. People talk sometimes about 12 years maybe being an average period of time before someone is diagnosed or formally receives services. So, there is a lengthy trajectory of emotional and psychological difficulties, difficulties within social contexts, issues related to familial difficulties, domestic issues and, in some cases, unfortunately, crime as well...So, the numbers known might be small, but that does not mean that there is not a large number of people waiting to be formally diagnosed, assessed or receive services.”²⁰

34. Dr Hughes, Pathways said:

“There has been successively more interest from the media and within the military in the last seven or eight years since Iraq and now Afghanistan. So troops leaving now should have a

¹⁹ Health, Wellbeing and Local Government Committee 3.11.10, oral evidence

²⁰ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

better understanding of what can happen, but very often the individual deteriorates over a period of time and is not aware of what is going on, unless someone looks objectively at him and says, 'Something has happened to you'. For example, he may have broken up with his girlfriend or his wife and is drinking heavily and has lost his job. So, unless somebody is focusing on that, they will not pick up on the fact that these are the signs of his life disintegrating."²¹

35. The Committee also heard that there is a stigma around mental health issues within the armed forces. One veteran who gave evidence to the Committee said that he had been told to 'pull his socks up'. Simon Weston OBE told Committee:

"The big problem is that it has become a stigma for the guys. The guys would not present before, because there was nobody to present to. Then, after 1987, they would not present because it was a stigma and it would ruin your career."²²

Training for Healthcare Staff

36. Chris Jones, a veteran and member of the Rhondda Veterans Support Group, said:

"The Rhondda Veterans Support Group has found that GPs have no understanding of veterans who have PTSD. They treat it as depression or anxiety."²³

37. Professor Bisson said that, in primary care, PTSD in veterans may not be identified due to the limited time that GPs have with patients and GPs' varied knowledge base. He told Committee that the rates of identification could be improved if healthcare professionals asked the right questions. He said:

"we advocate the NICE guidelines, which state that when you have individuals who present with a particular type of symptom - perhaps irritability, anxiety or depression - one of your standard questions should be about whether the individual has

²¹ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

²² Health, Wellbeing and Local Government Committee 6.10.10, oral evidence

²³ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

ever been involved in a traumatic event, such as being a veteran, a road traffic accident or sexual assault.”²⁴

38. He told Committee that work is required to enhance that knowledge base and to raise awareness of post-traumatic stress disorder, given that it has only been a recognised disorder since the early 1990s in the UK. He suggested that training on PTSD should be part of the overall training package for primary care practitioners.

39. Dr Dearden told Committee that the GP is well placed to detect a pattern in patients because they will see a patient over a period of time, perhaps presenting with slightly different problems each time. However, he also acknowledged:

“There is always the question of keeping up with something that is newly described... For me, for example, anything that has been described in the last 20 years, I will not have learned about as a student. There is a constant professional need, not just to keep up with new diagnoses but also with new treatments, which is a real struggle, on occasion... what we need to do is make available the training and then make available the opportunity to be trained.”²⁵

Information Sharing

40. The Committee heard that individuals are deregistered from GP practices when joining the armed forces or when leaving the country for more than three months. This caused some concern for witnesses in terms of the lack of continuity in primary care services that could result. The British Medical Association told the committee that de-registration is a requirement of the General Medical Services contract to prevent GPs receiving payment for patients they no longer treat.

41. The Committee also heard that the arrangements for transferring information on service and medical history from the armed services are poor. Evidence from the BMA in particular highlighted the gaps in medical notes often facing GPs treating veterans, and other witnesses stressed the importance of making GPs aware of an individual’s service history in order to ensure they ask the right questions of them during consultation, as information on where an individual has been deployed

²⁴ Health, Wellbeing and Local Government Committee 20.10.10, oral evidence

²⁵ Health, Wellbeing and Local Government Committee 3.11.10, oral evidence

and the medical records from his or her time in the armed services are vital for correct diagnosis. Dr Dearden told Committee,

“in 17 years, I have never had a copy of the medical records from a defence organisation for any patient of mine. They are considered confidential. So, if I write, I very rarely get a full response with copies of everything...There is a real communication thing there.”²⁶

42. Dr Dearden told Committee that PTSD is fairly straightforward to diagnose and emphasised the difference that such information would make to effective identification of PTSD:

“If someone comes to me with, ‘I am getting flashbacks’, if I can read in someone’s notes that they have been in Afghanistan and Iraq, and that they were in Northern Ireland 20 years ago, I could give a diagnosis in the first five minutes, and not three or four weeks later.”²⁷

43. A suggestion from witnesses that attaching a note to medical records to flag up armed service was widely endorsed by others. Ian Hulatt of the RCN said:

“I know the idea of marking records and tagging and labelling may sound unpleasant, but practically could we not know that that individual has served so that if someone comes in with alcohol issues or depression, it makes sense that that is a consequence of what they have experienced elsewhere in the theatre of war?”²⁸

44. Dr Dearden of the BMA, said:

“From my point of view the answer is absolutely ‘yes’. It is a very important part of not just their mental health but possibly even their physical health. They could have come up against injuries, diseases, infections or other things...They may simply not wish that to be part of their record, and we have to balance

²⁶ Health, Wellbeing and Local Government Committee 3.11.10, oral evidence

²⁷ Health, Wellbeing and Local Government Committee 3.11.10, oral evidence

²⁸ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

their good versus their desires. It would be much better, in any clinical situation, for people to know that.”²⁹

Screening

45. Professor Bisson of Cardiff University Medical School and the Royal British Legion commended the report by Dr Andrew Murrison MP, ‘Fighting Fit’, which recommends that regulars and reserves undergo pre-discharge screening and follow-up screening for mental health problems twelve months after they leave the armed forces. The Royal British Legion agreed with this:

“Dr Murrison has also made an interesting proposal...which will allow a follow-up 12 months post-discharge. We think that that allows enough time for someone to make adjustments to civilian life, such as settling back into work and home life. If problems are still occurring, they should perhaps seek treatment at that point and be signposted to the appropriate veterans’ service.”³⁰

Arrangements for Raising Awareness

46. Professor Bisson told Committee that research shows that if an individual has had traumatic experiences during childhood, he or she will be more vulnerable to being adversely affected by traumatic events in the military and that,

“when you look at individuals recruited to the military, you will see in their backgrounds that they are more likely to have experienced adversity during childhood than some others.”³¹

47. Dr Andrew Dearden of the BMA told Committee that, in terms of signposting, two things were important: the availability of a service, and awareness of that service. In his paper to Committee, Professor Bisson stated that the effectiveness of signposting varies at present. He states that, in the Cardiff and Vale and Cwm Taf areas, the presence of the pilot Veterans Service has raised awareness of PTSD and has improved signposting, as has the long-established Traumatic Stress Service at Cardiff and Vale University Health Board.

²⁹ Health, Wellbeing and Local Government Committee 3.11.10, oral evidence

³⁰ Health, Wellbeing and Local Government Committee 20.10.10, oral evidence

³¹ Health, Wellbeing and Local Government Committee 20.10.10, oral evidence

48. Services personnel appear to be poorly prepared for return to civilian life and those with no existing diagnosis of PTSD may have little awareness of it. Given that there is sometimes a considerable delay before the appearance of symptoms, ongoing support and information provision may be required.

49. Witnesses pointed out that families and carers of veterans with PTSD also need information and support, as it is often they who spot the first signs that someone is suffering with mental health issues, from a change in personality or behaviour. The Committee heard that early detection, which can often be the result of those signs being picked up, is key to that individual's treatment. Lisa Bainbridge of the Royal British Legion stated that, in this way, a helpline that was also open to the families of veterans would be valuable.

50. The work done in the voluntary sector on veterans' welfare issues was commended by witnesses. The Royal British Legion told the committee about its extensive welfare services delivered through community-based caseworkers working with families of veterans.

51. Witnesses welcomed the introduction of veterans champions in local health boards. Professor Bisson told the Committee that the veterans champions would also allow better liaison between veterans, who have sometimes reported negative experiences with primary and secondary NHS care. The Royal British Legion said:

“champions can be very useful to bring agencies to the table, and, as a voluntary sector organisation, we can sometimes have difficulty expressing the importance of these things. So, having that leadership will be important.”³²

Minister's View

52. The Minister told Committee that, in terms of raising awareness of PTSD and the services available to treat it, Local Health Boards will be responsible for creating and maintaining local networks of key stakeholders, which will raise awareness of the treatment services available amongst veterans, staff in primary and secondary care. The Minister told Committee that her department has been working with the Royal College of General Practitioners, the Royal British Legion and Combat Stress to advise GPs about the needs of veterans.

³² Health, Wellbeing and Local Government Committee 20.10.10, oral evidence

53. The Minister told Committee that she concurred with the view that the effective flow of information from the Ministry of Defence to GPs is vital:

“You have made the case, really, for the proper transfer of records, so that GPs can see the full records to take a holistic approach to what might be wrong with an individual, whether it is a shrapnel wound, mental health issues or anything else.”³³

She told Committee that the Government is working with the armed forces, the MOD, the local health board veterans champions, and the Department of Health to ensure that problems experienced with information sharing in this area in the past are now being addressed.

54. The Government’s Senior Medical Officer accepted that the idea of including a note on an individual’s medical records to say that they had served in the armed forces was worth considering, and agreed to discuss the idea with colleagues in the primary care sector.

Committee’s View

55. The UK developments are, in part, a response to the recommendations in a report, ‘Fighting Fit’,³⁴ by Dr Andrew Murrison. Other recommendations in the report include follow-up screening for regulars and reserves 12 months after leaving service and the provision of an online mental wellbeing website. The Committee feels that these recommendations could make a valuable contribution to the health and welfare of veterans.

56. Given the mixed evidence received on the effectiveness of GP practices in diagnosing PTSD, the Committee believes that the Welsh Government needs to take steps to raise awareness of the symptoms of PTSD.

57. The Committee feels that it is vital that GPs are aware of an individual’s service history in order to ensure they ask the right questions of them during consultation, and that, therefore, the Welsh

³³ Health, Wellbeing and Local Government Committee 3.11.10, oral evidence

³⁴

www.mod.uk/DefenceInternet/AboutDefence/CorporatePublications/PolicyStrategyandPlanning/FightingFitAMentalHealthPlanForServicemenAndVeterans.htm

Government should monitor the effectiveness of the transfer of medical history from armed forces to GP practices.

58. The Committee also believes that including a note on a veteran's medical record that they have served in the armed forces would be useful in enabling healthcare professionals to diagnose PTSD. However, concern was expressed that some veterans may not wish to be identified as such, so the Committee believes that it would also be important to allow veterans to opt out of this arrangement.

59. The Committee feels that there is a need for better information and awareness-raising for veterans and families. The Committee accepts that the new Mental Health and Wellbeing Service for Veterans should help, as should the veterans' champions in LHBs, but that the evidence strongly suggests a role for the voluntary sector.

Recommendations

Recommendation 3: The Committee recommends that the Welsh Government works with the Royal British Legion and other services charities to disseminate information and raise awareness of PTSD and the services available to treat it. Any such information should also seek to reduce the stigma associated with mental health problems.

Recommendation 4: The Committee recommends that the Welsh Government liaises with the UK Government around the implementation of recommendations in the Murrison report regarding the provision of follow-up screening for regulars and reserves 12 months after leaving service, and of an online mental wellbeing website. If these facilities are not to be made available across the UK, provision in Wales should be considered.

Recommendation 5: The Committee recommends that service in the armed forces be flagged up in veterans' medical records, with an opt-out for those who request it.

Recommendation 6: The Committee recommends that the Welsh Government liaises closely with the Ministry of Defence and monitors the effectiveness of the transfer of medical history from the armed services to GP practices to ensure that GPs treating veterans are fully aware of their medical histories.

Recommendation 7: The Committee recommends that the Welsh Government takes steps to raise awareness amongst GP practices of the symptoms of the PTSD and the vulnerability of veterans to it.

Recommendation 8: The Committee recommends that primary care staff receive training in the symptoms and treatment of PTSD, including in the military context, as part of Continuing Professional Development.

5. Treatment and Support Services

Adequacy and Suitability of Treatment and Support Services

60. The Committee heard evidence, from veterans' groups in particular, of a lack of effective treatment services for those suffering from PTSD. Chris Jones, a member of the Rhondda Veterans Support Group said:

“I have been diagnosed with chronic PTSD...my GP has treated me, and my consultant has treated me. When I saw the consultant, he said, ‘Keep on taking the tablets and I will see you in three months’. The support is not there.”³⁵

61. The Rhondda Veterans Support Group was established by a psychiatric nurse, who is also a veteran, in his own time. Mr Jones told the Committee that he found the support of, and rapport between, the group's members to be beneficial to him. The Mental Health Foundation has provided the Committee with written evidence pointing to a 2003 research study showing a clear association between talking about experiences and lower distress levels.³⁶

62. Although primary care services may be able to offer short-term interventions such as counselling and CBT, the evidence suggests that more specialist services are needed to treat PTSD. Neil Kitchener, the mental health therapist who has run a two-year pilot project looking at increasing veterans' access to mental health services, said:

“Our understanding from our two years is that there is a lack of clinical psychologists, particularly in Cwn Taf Local Health Board, and those who are there are not always particularly skilled in trauma-focused therapies and they are not always happy to take on veterans.”³⁷

63. Professor Bisson of the Cardiff University School of Medicine told the Committee that patients may face long waits for specialist treatment. He told the Committee that, currently, patients are waiting

³⁵ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

³⁶ Greenberg, Neil, Gould, Matthew, Langston, Vicky and Brayne, Mark(2009) 'Journalists' and media professionals' attitudes to PTSD and help-seeking: A descriptive study', *Journal of Mental Health*, 18: p6, 543 — 548

³⁷ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

more than a year for complex trauma therapy in Cardiff and the Vale, for example. Some witnesses worried about the lack of specialist therapeutic skills in the NHS in Wales, particularly for ‘talking therapies’, which are recommended for the treatment of PTSD.

64. The Committee heard from Dr Andrew Dearden of the British Medical Council that some of the problems stem from a widening gap between primary and secondary psychiatry care. He told Committee that, as the workload has increased, secondary psychiatric care has tended to focus on the severe end of mental health problems, leaving a gap in treatment for those problems that are just above a GP’s skill level. The Committee heard that voluntary organisations have tried to fill this gap but that they are not interconnected with primary or secondary care services, meaning that communication between the sectors can be poor.

Treatment Provided by the Independent Sector

65. Some independent sector providers favour specific therapeutic interventions for the treatment of PTSD that may not be available to NHS patients. For example, Talking2Minds presented evidence of the results achieved through their neurolinguistic programming therapy.

66. Some witnesses, especially the Talking2Minds witnesses, suggested that the NHS is constrained by National Institute for Health and Clinical Excellence guidance in terms of the interventions it provides. Bob Paxman told Committee that NICE would need 15 years’ worth of empirical data to approve the therapy used by Talking2Minds, and that they only have five or six years’ worth. Simon Weston OBE, Talking2Minds patron, said:

“When does it stop being alternative, given that it works?”³⁸

67. Other witnesses, however, felt that the guidance is effective and emphasised the importance of robust evidence for the effectiveness of treatments. Professor Jonathan Bisson, Director of Research and Development at Cardiff University School of Medicine, said:

“I think that it is very important that veterans are treated using evidence-based and effective treatments...From practice, I think

³⁸ Health, Wellbeing and Local Government Committee 6.10.10, oral evidence

that, if we follow what is available to us under the NICE guidance, we have a very good range of treatments that we can help veterans with.”³⁹

68. John Davies of Hafal told the Committee that, in Hafal’s experience, many veterans are not open to the idea of therapy and are unwilling to consider themselves as suffering from mental health problems. He said that many would consider therapy to be a ‘cop out’, and not something that ‘strong men’ would require. He argued that a one-size-fits-all approach is not appropriate, especially in the case of veterans:

“Cognitive behaviour therapy is mooted now as the way forward, but it does not work for some people...It is about matching skills and matching the right therapist to you...CBT is not for everybody.”⁴⁰

Veteran-led and/or Veteran-specific Service

69. Many witnesses believed that such specialist services are best provided specifically for veterans. Chris O’Neill of Forces for Good made the case for PTSD services for veterans to be separate from general PTSD services,

“do not ask me to come to hospital and attend an appointment when I will get the paranoid phobias and everything else that goes with sitting and waiting and becoming impatient. It is not because I am stubborn, but because in a lot of cases that is the effect that it has on you along the way.”⁴¹

70. Dr Dafydd Alun Jones, a consultant psychiatrist, who has worked for many years with veterans, in particular those who get into trouble and enter the criminal justice system said that veterans,

“do not respond well in ordinary psychiatric units. If you put one of these men in an ordinary mixed unit of depressed little old ladies and people with all sorts of other problems, they know that they are not the same and the other patients are afraid of them.”⁴²

³⁹ Health, Wellbeing and Local Government Committee 20.10.10, oral evidence

⁴⁰ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

⁴¹ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

⁴² Health, Wellbeing and Local Government Committee 20.10.10, oral evidence

71. Nicolas Cowan, a veteran and Talking2Minds service user, stated that he felt that the service should be veteran-specific service. He said:

“We have all had therapy from people who have never been in the services and when you say to them, “I did this, and I did that”, they will look at you in shock and say, “Oh, that is really bad”. You are thinking...”there is no point in saying it to me, I really do know that.”⁴³

72. Neil Loughborough, also a veteran and Talking2Minds service user, said that having to explain military terminology to a therapist inhibited the flow of a therapy session and could even be counter-productive in leaving the veteran feeling worse than he or she did before the session.

73. Lisa Bainbridge of the Royal British Legion stated her view that badging a mental health service as being specifically for veterans would assist in removing the stigma of suffering from mental health problems for veterans, because it would be accepted that this is an issue that affects veterans and that it would therefore be perceived as being,

“okay to have the condition.”⁴⁴

74. Veterans’ groups in particular were clear about the value of veterans supporting veterans and about the greater success such groups have in helping PTSD sufferers seek treatment. Chris Jones of the Rhondda Veterans Support Group, which is a (veteran) nurse-led group, told the Committee about the benefits of such peer support,

“civilians do not understand the forces’ attitude.. We meet once a week...I have to admit that it is good. We have a good rapport.”⁴⁵

Paul Estebanez said:

“The camaraderie among ex-military personnel is renowned, so there is a lot of support that way.”⁴⁶

⁴³ Health, Wellbeing and Local Government Committee 6.10.10, oral evidence

⁴⁴ Health, Wellbeing and Local Government Committee 20.10.10, oral evidence

⁴⁵ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

⁴⁶ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

75. Others felt that an understanding by clinicians of the military context was the key factor. Professor Bisson said:

“Veterans say that they prefer to relate to ex-military personnel rather than civilians. Interestingly, my experience is that, if the civilians are well versed in military culture and know and understand the needs of veterans, once veterans engage with them it can work very well.”⁴⁷

76. Chris O’Neill of Forces for Good, who is also a veteran, said that his support service operates on the principle that a veteran will talk to a veteran. However, he also said of the posts to be created in the hub and spoke model in Cardiff and the Vale:

“Create those posts and by all means make them qualified professionals. It would assist if they were veterans - they do not have to be, but they should be placed alongside veterans.”⁴⁸

77. Ian Pitchford of Talking2Minds said that the important point is that the therapist understands the language of a veteran,

“as a therapist, I think that we can comfortably work across the spectrum, but, for our clients, it is important that the person whom they are working with has some connection with the forces...It is about not having to continually explain the language.”⁴⁹

78. Neil Kitchener, the therapist who led the Community Veterans Mental Health Service pilot, corroborated this point:

“I heard the veterans speak earlier about veterans wanting to speak to veterans. That is an interesting concept, and one that I do not entirely agree with, having seen 200 veterans...In our research, when we ask veterans whether they would prefer that we had been a veteran, they usually say, ‘Not really. As long as you know what you are doing in your particular field, that is great, as long as you are willing to learn about our culture.’”⁵⁰

79. The Royal British Legion said:

⁴⁷ Health, Wellbeing and Local Government Committee 20.10.10, oral evidence

⁴⁸ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

⁴⁹ Health, Wellbeing and Local Government Committee 6.10.10, oral evidence

⁵⁰ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

“One main issue with seeking treatment, particularly for mental health conditions, is not that there is a need for veteran-specific services, but that there is a need for them to be labelled as being for veterans and a need for there to be pathways to them through veteran-specific organisations. That would have a real impact on the issues around access and awareness.”⁵¹

Residential Treatment

80. Some specialist services have been provided by the independent sector, particularly in North Wales, but these have sometimes lacked secure funding. Such services often use an intensive, in-patient model, which can provide peer support for veterans. Dr Dafydd Alun Jones in particular made a strong case for a residential programme for veterans with complex PTSD. We also received written evidence from the wife of an ex-serviceman suffering with PTSD who said she and her family had found the residential service provided at Ty Gwyn, before its closure, to be valuable:

“it was a place where I knew my husband was safe while being treated for his PTSD, and above all I myself and my family could have a break from the stress and anxiety we were all under.”⁵²

81. Chris O’Neill of Forces for Good stated that, as different people will require different therapies, residential therapy will be the appropriate option for some, but there is no residential provision in Wales.

82. The emphasis in NHS-provided services is on a community-based model of treatment, i.e. non-residential provision. On the question of whether a residential service is required in Wales, Neil Kitchiner, who led the Mental Health Service for Veterans Pilot, said:

“We have gone for an out-patient community model because we feel that that is how to integrate veterans back into civilian life because it is closer to the home. There is no evidence that there is a need for residential in-patient units as far as I am aware.”⁵³

⁵¹ Health, Wellbeing and Local Government Committee 20.10.10, oral evidence

⁵² Consultation response, HWLG(3)PTSD008 Susan Riggs

⁵³ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

83. Dr Steven Hughes of Pathways said:

“I do not think that there is published evidence, but certainly the model that works for us is taking an individual in for assessment in order to plan a course of therapy...We are dealing with ex-servicemen, so they are used to arduous activity...we take them out and get them physically tired and we build the man back together”⁵⁴

84. Dr Hughes also talked about the benefits of group therapy in a residential unit, as networks can be formed, meaning that the veterans can continue to support each other in the community, having left the unit.

85. Professor Bisson indicated that some find residential treatment helpful. However, he also stated that this should be looked at as part of a range of approaches that can be taken, depending on the patient, and emphasised that the main objective is for the veteran to be able to function within, and integrate with, the community. He also pointed out:

“We should be trying to deliver our treatments in the most cost-effective manner...delivering community-based treatments that are as effective as residential treatments would be a more cost-effective way of delivering them.”⁵⁵

Holistic Approach

Much of the evidence received by the Committee emphasised the importance of addressing the needs of veterans holistically. Most veterans with PTSD also experience other difficulties including other mental health problems such as depression and anxiety, and substance misuse problems, especially alcohol dependence. Many also need help with wider resettlement issues such as housing, employment and debt problems. Chris Jones of the Rhondda Veterans Group told Committee that veterans suffering from PTSD can be asked to undergo repeated assessments for benefits and, in written evidence, the Mental Health Foundation stated:

“it is important for people to be supported holistically, as difficulties over other health problems..., benefits claims or

⁵⁴ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

⁵⁵ Health, Wellbeing and Local Government Committee 20.10.10, oral evidence

uncertainty about housing can significantly worsen the impact of the disorder and make it harder to recover.”⁵⁶

Lisa Bainbridge from the Royal British Legion advocated the greater involvement of the voluntary sector to help veterans and their families with the stresses of everyday life, which would allow the veteran to concentrate on getting well.

86. The Royal British Legion strongly advocated a holistic service that did not only deal with PTSD but also with the other types of mental health conditions that veterans suffer from. Lisa Bainbridge stated in Committee:

“We are in danger of PTSD becoming a generic term for veteran mental health issues, and we would be doing ourselves a disservice if that were to happen...I would like to see a veterans’ mental health service that is perhaps augmented with alcohol-related services, which would be really beneficial to this group of people.”⁵⁷

87. Witnesses suggested that individuals with a military background may be less likely to seek help for mental health problems and that this may influence coping strategies, leading, for example, to a high risk of alcohol abuse. The committee received a considerable amount of evidence about the shortcomings of substance misuse services for veterans and co-ordination between them and other services. There were frequent references in the evidence to the difficulties facing veterans who need treatment both for PTSD and for substance misuse problems. Such difficulties include having to access two separate services (with separate waiting lists), and the possibility that services will not address one problem before the other has been addressed. Ian Hulatt of the RCN told Committee that this approach is unhelpful,

“for the individual receiving that experience, it is very rejecting and can compound the feelings of alienations, isolation and, frankly, despair and feeling that you are pretty much rejected by the society that you served at great personal cost.”⁵⁸

Dr Stephen Davies of the BMA stated:

⁵⁶ Written evidence, HWLG(3)PTSD002 Mental Health Foundation

⁵⁷ Health, Wellbeing and Local Government Committee 20.10.10, oral evidence

⁵⁸ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

“The way in which treatment for substance misuse is organised and funded in Wales does not make for an integrated service that communicates well.”⁵⁹

88. Written evidence received from CAIS, the drug and alcohol agency in north Wales, stated that,

“practitioners will provide evidence demonstrating that alcohol misuse amongst serving and former services personnel dwarfs problems with PTSD.”⁶⁰

Neil Kitchener, who led the Mental Health Service for Veterans Pilot, said that it would be helpful to have a veteran-specific detoxification service in Wales. Dr Clarke-Walker, a consultant psychiatrist, also called for a service that treated substance misuse along with PTSD, but felt that it should be open to anyone who has experienced trauma, not just veterans:

“I think that the soldiers must be treated, but I also feel that paramedics, ambulance people, people in the forces, and doctors have to see truly gruesome things, and so it should be open to all people who experience trauma.”⁶¹

89. The new Mental Health and Wellbeing Service for Veterans has a national steering group of stakeholders which includes statutory, voluntary and government agencies amongst its membership. Professor Bisson stressed the importance of co-ordinating the efforts of all organisations involved in the support and treatment of veterans with PTSD to reduce duplication and ensure that the limited funding available is used to maximum effect.

90. Professor Bisson also told Committee that the addiction service now provides priority treatment service for veterans. However, although that is a mandated national priority within the NHS, he told Committee that there is variation with regard to the way in which it is delivered.

⁵⁹ Health, Wellbeing and Local Government Committee 3.11.10, oral evidence

⁶⁰ Written evidence, HWLG(3)PTSD011 CAIS

⁶¹ Health, Wellbeing and Local Government Committee 6.10.10, oral evidence

Priority for Veterans

91. Veterans are entitled to priority NHS treatment for service-related illnesses⁶² where a doctor identifies a need for it in medical notes. However, evidence suggests that the scheme is not as effective as it might be and that practitioners are not always aware of it, leading to instances of veterans' requests for priority being declined by clinicians.

92. The Committee heard evidence that the symptoms of PTSD can often take many years to emerge and that, therefore, the GP must make a judgement as to whether the mental health problems experienced by a veteran are service-related. Ensuring that veterans' medical histories and service records are available to GPs would contribute to the effectiveness of the scheme.

All-Wales Veterans' Mental Health Service

93. The announcement of the new Mental Health and Wellbeing Service for Veterans based on a 'hub and spoke' model with provision in six health board areas was widely welcomed by witnesses. Professor Bisson explained that the idea behind it is that, as Cardiff has more experience and more expertise in some of these areas than other parts of Wales, this can be disseminated across Wales so that people have access to the same level of service, no matter which part of Wales they live in. However, concerns were raised about the capacity of the NHS in Wales to fully implement the new service.

94. The British Medical Association also welcomed the new model, but had reservations about the fact that, as 50 per cent of the therapists' time will be devoted to providing short-term therapeutic interventions, there will be limited capacity for providing more specialist interventions. They also expressed concern about the potential for duplication in areas where short-term psychological therapies are already being provided.

95. Neil Kitchener expressed frustration with the time being taken to appoint the staff required to run the new service, saying that this was mostly due to the reorganisation of the senior structure within the health board.

⁶² See Welsh Health Circular WHC (2008) 051, [http://www.wales.nhs.uk/documents/WHC\(2008\)051%20full.pdf](http://www.wales.nhs.uk/documents/WHC(2008)051%20full.pdf)

Support for Families and Carers of Veterans with PTSD

96. Witnesses pointed out that families and carers of veterans with PTSD also need information and support, as they often help to ensure that veterans seek treatment. Mr Cowan, a veteran and treatment service user, told Committee,

“it is about ensuring that people are screened correctly and debriefed properly when they come back from the theatre, and ensuring that the whole family unit is supported because once the family breaks down, there will be more of a problem for that person who is suffering. It is not just about the mental health side, although it is very important, because the family can suffer from the mental health side as well, and there needs to be that support on both sides. There needs to be a better and more well-thought-out system than presently exists”⁶³

97. The Royal British Legion echoed Mr Cowan’s words:

“The inclusion of families is a trick that is being missed quite often. Families—particularly spouses—are normally the ones who will first approach a welfare organisation and to encourage husbands and wives to seek treatment if it is impacting on family life, particularly if they see someone acting differently. Many service spouses talk about a change in personality when their spouses come back from deployment. They behave differently, drink more and are more isolated, so they pick up those early signs, which are very important for early detection and treatment, as you mentioned earlier.”⁶⁴

Approach Taken in America

98. Several witnesses referred to good practice in America. There are a variety of research centres, preventative measures and treatment programmes available to veterans of the United States military. In evidence to the House of Commons Defence Select Committee, Major General Robin Short, former Director-General of British Army Medical Services, said:

“The US has made good progress in de-stigmatising PTSD, and now included psychological maintenance as an integral part of

⁶³ Health, Wellbeing and Local Government Committee 6.10.10, oral evidence

⁶⁴ Health, Wellbeing and Local Government Committee 20.10.10, oral evidence

post-deployment activity. By contrast, the MoD lacked a coherent policy towards the detection and treatment of PTSD.”⁶⁵

99. In written evidence, the Royal British Legion suggested that a mental health strategy for veterans should demonstrate the following:

“Understanding the characteristics of those who are vulnerable in the Armed Forces and in the veteran community. New and innovative strategies for early detection and treatment for those who may need clinical interventions, particularly within the Armed Forces. Implementing strategies aimed at reducing the stigma associated with mental health, educational programmes on the health effects of excessive alcohol use and myth busting relating to the prevalence of PTSD. Understanding the points and stages at which different vulnerable groups are the most vulnerable. Implementing prevention, intervention and support strategies that are tailored at the right time, in the right place, for the right people.”⁶⁶

100. Neil Kitchener referred to the two-year mental health pilot for veterans of the armed services and said:

“The pilot benefited from forming strong links with the Royal British Legion, the Serving Personnel and Veterans Agency, and Combat Stress welfare officers who flagged up the service when they had contact with veterans in the course of their daily duties. This resulted in a steady flow of referrals to this service, averaging two per week.”⁶⁷

He said that the pilot was advertised via a dedicated web site and was supported by posters and leaflets. He went on:

“The veterans pilot liaised and referred many of it is veterans for social support/intervention via the Royal British Legion (RBL) and the Serving Personnel and Veterans Agency where a physical or psychological injury has been obtained whilst

⁶⁵ Defence Committee, Seventh report: Medical Care for the Armed Forces, 5 February 2008, HOC 327, 2006-07

⁶⁶ Health, Wellbeing and Local Government Committee 20.10.10, written evidence, HWLG(3)16-10-p3

⁶⁷ Health, Wellbeing and Local Government Committee 22.9.10, written evidence, HWLG(3)-14-10 p6

serving in the armed forces leading to many of our veterans accessing compensation or war pensions e.g. for PTSD.”⁶⁸

Minister’s View

101. The Minister agreed that the needs of veterans should be considered in the round, and that their health and wellbeing should be considered alongside their social care and housing needs.

102. The Minister told the Committee about the draft care pathways for veterans that have been developed with the MoD, which aim to address all physical and mental health treatment needs as services personnel leave the armed forces. There is evidence that such an approach is needed; several witnesses lamented the poor liaison between the armed forces and community-based civilian services.

103. One witness had suggested that the funding streams for mental health services and substance misuse services should be combined, but the Minister stated that she has no plans to do this. She stated that Welsh Government guidance is clear on the need for co-ordinated services, that substance misuse services have received considerable investment in recent years and that veterans are entitled to priority treatment in substance misuse services, as with other health services. However, the Minister also stated in her written evidence that closer integration is needed between mental health and substance misuse services.

104. The Minister indicated that the ‘Welsh NHS Annual Operating Framework for 2010-11’⁶⁹ requires local health boards to take account of the needs of veterans when planning services.

105. The UK Government announced some changes to the mental health services provided to services personnel and veterans in October 2010, which included the provision of a 24-hour helpline across the UK. In her evidence to the Committee, the Minister for Health and Social Services told the Committee that Wales has its own Community Advice and Listening Line, which will complement the service.

106. The Committee heard that the Welsh Government has worked with the Ministry of Defence to ensure that there is a care pathway for

⁶⁸ Health, Wellbeing and Local Government Committee 22.9.10, written evidence, HWLG(3)-14-10 p6

⁶⁹ NHS Wales, [Annual Operating Framework 2010-11](#), AOF 11, p44

any personnel leaving the armed services needing mental health or physical treatment.

107. The Minister commended the work done between the voluntary sector and the statutory sector, but told Committee that there is a 'mixed pattern' across Wales. The Minister also said that it is her intention that the steering group of the new Mental Health and Wellbeing Service for Veterans will undertake work in this area and that she hoped,

“that we can do far more work with the voluntary sector as times goes on, and that is definitely the instruction to local health boards.”⁷⁰

108. When asked whether she would support service level agreements being established between LHBs and the voluntary sector to provide service for veterans, the Minister told Committee that there are already many service level agreements in place between local health boards and the voluntary sector, and that, therefore, there are no barriers to setting SLAs for veterans' services. However, the Minister also said:

“The NHS is bound to look at treatments that are clinically effective and are proven, because the public would not want us to invest in treatments that are not clinically proven.”⁷¹

109. The Welsh Government's Senior Medical Officer, Dr Sarah Watkins, indicated that the NHS provides an additional service for those suffering with complex PTSD:

“Generic services are able to provide to a certain level and then, for people who have more specific, specialist needs, there is this additional service. You can seek support and advice - whether you are a GP or a consultant psychiatrist - to support them, or if you need specific, complex interventions, they can be provided by that service.”⁷²

Dr Watkins also confirmed that this service is available to people in prison.

⁷⁰ Health, Wellbeing and Local Government Committee 3.11.10, oral evidence

⁷¹ Health, Wellbeing and Local Government Committee 3.11.10, oral evidence

⁷² Health, Wellbeing and Local Government Committee 3.11.10, oral evidence

110. On support for families, Dr Sarah Watkins, told Committee that mental health services are expected to take into account the needs of families and carers of any patient and acknowledged that this is a particular issue in the case of patients who are veterans. She told the Committee that, under the new Mental Health and Wellbeing Service for Veterans, a patient will undergo a holistic assessment, and that the family would be included in that.

111. When asked about specific therapeutic interventions for the treatment of PTSD that may not be available to NHS patients, the Minister said that the NHS will only provide treatments that have been proven to be clinically effective.

Committee's View

112. The Committee feels that the voluntary sector has a strong role to play as veterans groups in particular were clear about the value of veterans supporting veterans and about the greater success such groups have in helping PTSD sufferers seek treatment. As such, the Committee feels that the Welsh Government should provide veterans groups with more funding and support so that they can link in with the new veterans mental health services in Local Health Boards.

113. The Committee recognises the important role that veterans themselves can play in assisting other veterans suffering from PTSD and acknowledge that veterans can feel more comfortable talking to a fellow veteran.

114. In the light of the evidence received, the Committee acknowledges that treating PTSD in isolation from other problems, such as substance misuse, is unlikely to be fully effective. Therefore, the Committee believes that the Welsh Government should make it a priority to ensure that veterans with PTSD also have timely access to substance misuse treatment.

115. Given that we heard that patients are facing long waits for specialist treatment in the NHS, we feel that capacity needs to be increased, especially with regard to talking therapies, which are recommended for the treatment of PTSD. The demand on the service is only likely to increase, given the ongoing campaigns in which the armed services are engaged, which makes the need to increase capacity all the more pressing.

116. We accept that the establishment of the new Mental Health and Wellbeing Service for Veterans is a positive step forward, as is the development of veterans' champions in local health boards, but the evidence strongly suggests a role for the voluntary sector. Therefore, we would like to see greater inclusion of the voluntary sector in patients' care pathways.

117. A group of Committee Members visited the Talking2Minds centre in Wigan, to observe the therapy used there. The evidence that we received in Committee from service users was echoed by the service users at the centre. We feel that veterans suffering from PTSD should have access to a variety of treatments for the condition.

118. We accept that there is a prioritisation scheme for veterans in the NHS for the treatment of service-related illness and/or injury, but evidence suggests that practitioners are not universally aware of the scheme. Indeed, the Welsh Government's Senior Medical Officer stated that she could not be sure that every GP in Wales knows about it. We would therefore encourage the Minister to take steps to ensure that NHS staff are fully aware of the priority treatment scheme.

119. The Committee would like to see specific provision for veterans suffering from complex PTSD, particularly those who are at risk of committing, or who have already committed crimes.

Recommendations

Recommendation 9: The Committee recommends that the Welsh Government provides more funding/support for veterans groups to develop information and support networks for veterans and for them to link in with the new veterans' mental health services in Health Boards.

Recommendation 10: The Committee recommends that the Welsh Government ensures that the new carers' strategies encompass the needs of veterans' carers when making regulations to enact the Carers Strategies (Wales) Measure (2010).

Recommendation 11: The Committee recommends that, given the prevalence of substance misuse amongst veterans, and incidence of this and PTSD co-occurring, that the Welsh Government makes a particular priority of ensuring that veterans with PTSD also have timely access to substance misuse treatment.

Recommendation 12: The Committee recommends that the Welsh Government addresses the need for increased capacity in the NHS to provide specialist therapeutic treatments for veterans suffering from PTSD, including the use of ‘talking therapies’, and commissions a pilot project of specialist therapy services to assess the extent and durability of the benefits for veterans with PTSD.

Recommendation 13: The Committee recommends that the NHS keeps under review the evidence for the effectiveness of alternative treatments for PTSD with the aim of ensuring that veterans suffering from PTSD have access to the best possible treatments for the condition, whether provided directly by the NHS, or by the independent sector on behalf of the NHS.

Recommendation 14: The Committee recommends that the NHS explores ways to increase the number of nurse-led self-help veterans groups in the community.

Recommendation 15: The Committee recommends that the Welsh Government reviews the training of NHS staff to ensure that they are fully aware of the priority treatment scheme for veterans and that the scheme is made available to all veterans.

Recommendation 16: The Committee recommends that specific provision be made for veterans suffering from complex PTSD, particularly those who are at risk of committing, or who have already committed crimes.

Recommendation 17: The Committee welcomes the new steering group as a contribution to improving the co-ordination of services for veterans with PTSD and recommends that the opportunities created by the establishment of the new Mental Health and Wellbeing Service for Veterans for better use of resources are fully exploited.

Recommendation 18: The Committee recommends that the Welsh Government raises with the UK Government the issue of the difficulties that can be experienced by veterans suffering with PTSD in the process of applying for benefits.

6. Funding Arrangements

120. The Minister has provided funding of approximately £500,000 per annum for the new specialist veterans mental health service. There is some concern around the adequacy of this sum to meet demand. Professor Bisson, Director of Research and Development at Cardiff University School of Medicine, told Committee that that sum, spread over Wales, will not go far. However, Dr Andrew Dearden of the British Medical Association welcomed the funding, saying:

“We are in a difficult financial situation, which is why the funding is so important - and all credit to the Assembly for doing that - but as Stephen said, rather than duplicating, we need to look at what we have, look at what we need, and then try to fill the gaps and reabsorb and redistribute...So, it can be done.”⁷³

121. The Ministry of Defence funds work by Combat Stress, including in Wales, and it has also announced the provision of a helpline for veterans, which will be available in Wales. Nevertheless, some witnesses felt that the Ministry of Defence has a moral obligation to take more responsibility for the support and rehabilitation of veterans with PTSD. Professor Bisson said:

“My understanding of the agreements in our country is that, once an individual leaves the military, the responsibility lies with the national health service. If that is the case, I would argue that more resource should be made available in the NHS...to deal with that. Another model would be for the MOD to take responsibility for doing some work with veterans.”⁷⁴

122. The Committee noted that the funding for the all-Wales service is based on the general population and does not take account of the fact that personnel are recruited in higher numbers from some areas of Wales than others. Neil Kitchener told Committee that there is a lack of evidence to say where veterans are located, and how many of those have mental health problems requiring treatment.

⁷³ Health, Wellbeing and Local Government Committee 3.11.10, oral evidence

⁷⁴ Health, Wellbeing and Local Government Committee 20.10.10, oral evidence

Partnership Arrangements

123. The Committee heard evidence from John Davies of Hafal that there is not good interaction between veterans' organisations and statutory bodies. He said:

“The voluntary sector generally has either been looked at as ‘the great unwashed’ or as an area in which there is no expertise. However, the expertise is in the voluntary sector, which is working with people directly and the investment should be at ground level.”⁷⁵

124. Chris O’Neill of Forces for Good gave the Committee an example of the work done on the ground by Pathways, based in Bangor. He said:

“Without Pathways in Bangor I would have some guys in serious trouble.”⁷⁶

However, this work is done ‘On a wing and a prayer’,⁷⁷ as Pathways are not funded for this work.

125. Dr Steven Hughes of Pathways told committee that the health service in Wales will not fund referrals to Pathways, even with a recommendation from a consultant psychiatrist. The lack of funding for the services provided by Pathways was also discussed in a National Assembly for Wales Plenary debate.⁷⁸

126. Professor Bisson stressed the importance of co-ordinating the efforts of all organisations involved in the support and treatment of veterans with PTSD, to reduce duplication and ensure that the limited funding available is used to maximum effect.

Minister’s View

127. The Minister told Committee that she expects the NHS to be able to deal with the treatment of veterans suffering from PTSD, and that the establishment of the new All-Wales Veterans Mental Health Service will enable the NHS to do that,

“the clinical needs of veterans with PTSD have to be met by the NHS in Wales as part of its core commitment, and it should be

⁷⁵ Health, Wellbeing and Local Government Committee 22.9.10, oral evidence

⁷⁶ Ibid.

⁷⁷ Ibid.

⁷⁸ National Assembly for Wales, Plenary Debate, 20 January 2010, p116

undertaking that role...we are doing all the right things to deliver the service.”⁷⁹

128. On the question of targeting funding at areas where high numbers are recruited by the armed services, the Minister said that the new veterans’ champions in local health boards will be able to provide more information on the numbers of veterans using their services. She said that she would be happy to look at the situation in the light of information gathered from the LHB veterans’ champions.

129. The Minister stated in evidence that she had requested funding from the Ministry of Defence for the new Mental Health and Wellbeing Service for Veterans but that this had been declined:

“I have written in very strong terms to ask it to reconsider its position, but it did not agree.”⁸⁰

Committee’s View

130. We feel that the issue of funding the veterans’ mental health service according to the population of an LHB area instead of on the basis of the numbers of personnel recruited from certain areas should be revisited. We welcome the establishment of the veterans’ champions in LHBs and support the Minister’s view that they could be a useful resource in helping to identify the numbers of veterans in the different areas of Wales.

131. We accept that the Minister has sought funding from the MoD for the Mental Health and Wellbeing Service for Veterans and that, so far, this has not been forthcoming. We feel that the Minister should keep the level of funding and demand for the service under review and fully support and endorse her efforts to press for a contribution from the MoD.

Recommendation

Recommendation 19: The Committee recommends that the Welsh Government keeps under review the level of funding provided to the veterans’ mental health project to ensure it is able to meet demand. The Committee supports the Government’s efforts to press the Ministry of Defence for a contribution.

⁷⁹ Health, Wellbeing and Local Government Committee 3.11.10, oral evidence

⁸⁰ Health, Wellbeing and Local Government Committee 3.11.10, oral evidence

Annex A - Witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. Transcripts of all oral evidence sessions can be viewed in full at:

<http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlg-home/bus-committees-third-hwlg-agendas.htm>

Wednesday 22 September 2010	
Ian Hulatt	Mental Health Adviser, Royal College of Nursing
Lisa Turnbull	Policy and Public Affairs Adviser, Royal College of Nursing
John Davies	Practice Leader at Hafal
Paul Cleary	Staff Volunteer at Hafal
Chris Jones	Rhondda Veterans Support Group
Paul Estebanez	Rhondda Veterans Support Group
Chris O'Neill	Forces for Good
Neil Kitchiner	Community Veterans Mental Health Therapist
Dr Steven Hughes	Pathways
Wednesday 6 October 2010	
Kevin Richards	Managing Director of Golden Grove Mansion Appeal, Healing the Wounds
Carol Richards	Golden Grove Mansion Appeal, Healing the Wounds
Dr Alastair Clarke-Walker	Consultant Psychiatrist
Robert Paxman	Chief Executive Officer and Founder of Talking2Minds
Ian Pitchford	Trainer and Therapy Provider at Talking2Minds
Neil Loughborough	Service User at Talking2Minds
Nicolas Cowan	Service User at Talking2Minds
Simon Weston OBE	Patron of Talking2Minds
Wednesday 20 October 2010	

Professor Jonathan Bisson	Director of Research and Development, Cardiff University School of Medicine & Cardiff and Vale University Health Board
Dr Dafydd Alun Jones	Consultant Psychiatrist
Lisa Bainbridge	Head of Public Policy, the Royal British Legion
Wednesday 3 November 2010	
Dr Andrew Dearden	British Medical Association
Dr Stephen Davies	British Medical Association
Edwina Hart AM	Minister for Health and Social Services
Dr Sarah Watkins	Senior Medical Officer and Head Of Mental Health & Vulnerable Groups, Welsh Assembly Government

Annex B - Written evidence

The following people and organisations provided written evidence to the Committee in support of oral evidence. All written evidence can be viewed in full at:

<http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlg-home/business-hwlg-inquiries/hwlg3-ptsd2/ptsd-papers-transcripts.htm>

Name	Organisation	Reference
Tina Donnelly	Royal College of Nursing	HWLG(3)-14-10 : Paper 2
John Davies	Hafal	HWLG(3)-14-10 : Paper 3
Chris Jones Paul Estebanez	Rhondda Veterans Support Group	HWLG(3)-14-10 : Paper 4
Chris O'Neill	Forces for Good	HWLG(3)-14-10 : Paper 5
Neil Kitchiner	Community Veterans Mental Health Therapist	HWLG(3)-14-10 : Paper 6
Dr Steven Hughes	Pathways	HWLG(3)-14-10 : Paper 7
Kevin Richards	Healing the Wounds	HWLG(3)-15-10 : Paper 1
Dr Alastair Clarke-Walker	Consultant Psychiatrist	HWLG(3)-15-10 : Paper 2
Robert Paxman	Talking2Minds	HWLG(3)-15-10 : Paper 3
Professor Jonathan Bisson	Cardiff University School of Medicine & Cardiff and Vale University Health Board	HWLG(3)-16-10 : Paper 1
Dr Dafydd Alun Jones	Consultant Psychiatrist	HWLG(3)-16-10 : Paper 2
Lisa Bainbridge Marie-Louise Sharpe	Royal British Legion	HWLG(3)-16-10 : Paper 3
Dr Andrew Dearden Dr Stephen Davies	British Medical Association	HWLG(3)-17-10 : Paper 1
Edwina Hart AM	Minister for Health and Social Services	HWLG(3)-17-10 : Paper 3
June Milligan	Armed Forces Advocate, Welsh Assembly Government	HWLG(3)-17-10 : Paper 4

Annex C - Consultation Responses

The following people and organisations provided written evidence to the Committee as part of its public consultation. All consultation responses can be viewed in full at:

<http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlg-home/business-hwlg-inquiries/hwlg3-ptsd2/ptsd-consultation-responses.htm>

Name	Reference
Mental Health Foundation	HWLG(3)-PTSD001
Cardiff and Vale Mental Health Development Project	HWLG(3)-PTSD002
Betsi Cadwaladr University Health Board	HWLG(3)-PTSD003
Rhondda Veterans Support Group	HWLG(3)-PTSD004
CAIS Drug and Alcohol Agency	HWLG(3)-PTSD005
Aly Renwick, author of <i>Hidden Wounds</i>	HWLG(3)-PTSD006
Mental Health Foundation	HWLG(3)-PTSD007
Susan Riggs	HWLG(3)-PTSD008

Annex D – Supplementary Evidence

The following people and organisations provided supplementary. All supplementary evidence can be viewed in full at:

Name	Organisation	Description
Chris O’Neill	Forces for Good	Arrangements for services veterans in Scotland
Dr Alastair Clarke-Walker	Consultant Psychiatrist	Journal Article Abstract
Dr Alastair Clarke-Walker	Consultant Psychiatrist	Journal Article Abstract
Sue Mellerick	Department for Work and Pensions	Letter
Minister for Health and Social Services	Welsh Assembly Government	Letter
Dr Andrew Dearden	British Medical Association	Letter