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Collaborating for Military Mental Health

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ROYAL COLLEGE OF PSYCHIATRISTS

VETERANS
QUALITY NETWORK FOR VETERANS MENTAL HEALTH SERVICES

Issue 02, July 2022

This Issue

WELCOME

Welcome to our 2nd Issue of the Quality Network for Veterans Mental Health Services newsletter! We are pleased to be sharing another fantastic range of articles with our members. The newsletter covers topics such as designing a recovery college, providing accessible interventions and creating effective patient perspective treatment. Within the newsletter, you will also find some updates from the Quality Network.

As the United Kingdom is slowly emerging out of the pandemic, veteran's mental health services are facing their own set of unique challenges. With budget squeezes and waiting lists, services are showing remarkable resilience and commitment towards providing exceptional support to veterans. This was reflected in all the positive feedback we received from the veterans we have been speaking to during our reviews.

We have now come to the end of our second cycle of reviews. Our member services from the pilot year, recently completed their accreditation reviews. We were delighted to see that services implemented significant improvements from the developmental reviews as well as champion and share areas of good practice across the network.

We have also seen an increase in members joining our network and completing their developmental reviews. We understand the time constrains our members are facing and are particularly grateful for all the meaningful engagement shown throughout the process. Thank you for all your hard work and we are looking forward to working with you in our next cycle of peer reviews, which are due to take place between September 2022 and June 2023.

Finally, we would like to thank all the contributors to our second issue of the newsletter and we hope you all enjoy reading it!

Melina Charalambous, QNVMHS Project Officer

Help For Heroes Recovery College

Debbie Boundy, *Recovery College Development Manager, Hidden Wounds Service*

The Help for Heroes Recovery College is unique; the first to be designed specifically for wounded veterans and their loved ones. The Recovery College delivers courses that provide education and practical help to progress the recovery journey of both the veteran and close family members. The courses are designed to encourage autonomy and help those we support find purpose and live a healthy and secure life.

Our courses are co-produced by recovery staff, together with veterans and family members (Peers) who have lived experience of the subject matter and the recovery process. Our team of 6 Peers are instrumental in both course production and course delivery, providing the benefit of their lived experience to ensure that courses meet the needs of the students. The co -production process results in well designed and relevant material which in turn ensures we are providing practical help to enable students move forwards. Co-production and co-delivery of courses is truly collaborative, bringing together both professional and personal experience.

Theresa Mitchell, Psychological Wellbeing Service Development Lead has been involved in the co-production of a number of courses and really values the contribution the Peers bring to the process:

"*It has been a joy to work with our peers on the co-production and facilitation of these courses. We are delivering a product and experience that we can be sure has the beneficiary at its heart. The input, knowledge and experience of our Peer Trainers is invaluable and the process is very creative. Each course is produced and delivered with the student in mind – it is not something done to them.*""

Our Peers tell us:

"I never envisaged a couple of years ago that I would have made such progress and it's great to now have the opportunity to work with H4H in support of the Veteran community. I find it extremely rewarding to utilise my personal experience of illness and recovery to help other veterans and their families."

"The Peers are very much a fundamental part of the Recovery College, influencing all aspects of the development and delivery of the courses to great effect. I truly feel that our 'lived' experience has proven invaluable and is greatly appreciated by both the beneficiaries and charity alike."

The Help for Heroes Recovery College prospectus has been developed following consultation with our beneficiaries and is based on their expressed needs. We currently offer fourteen online facilitated courses, covering topics such as:

- Mind, Mood and Body
- You, Me and Anger
- Living with Low Mood and Depression
- Being Anxious, Feeling Worried
- Wellness Action Plan
- The Art of Sleep
- Living with, and beyond, your Pain
- Suicide Awareness and Self Help

Each course provides an overview of the subject matter, helping students understand why they may feel the way they do, or why their body reacts in a particular way. Content is interactive and engaging, using videos, diagrams, tools, and strategies that students can take away and implement. There is a great deal of opportunity for group discussion and feedback so students can learn from each other and share what they think and feel about each topic as the courses progress. Many of the courses have an experiential element and use breathwork to assist individuals with uncomfortable symptoms.

Our students tell us:

The Art of Sleep:

"It's a good course and sharing ideas with other people suffering the same issues is of great benefit"

"I thoroughly enjoyed this course. Thank you so much for facilitating"

Mind, Mood and Body:

"Great course. I like being connected with others on the course. It makes it normal to know it's not just you'."

"If anyone is in the same place as me, it's important to take all the help you can get"

Being Anxious, Feeling Worried:

"Very professionally and well-presented course. Run with enthusiasm and knowledge"

"Course was very informative and helped in practising breathing techniques and using them before you have a bout of anxiety"

We are also pleased to share our self-help guides on the same subjects, these are available for anyone to view on our website.

Project 100: Raising the bar on practice-based evidence

Bill Andrews, *Research Coordinator*

Bill Andrews, originator of the Pragmatic Tracker online outcomes measurement tool, describes the innovative Project 100 being undertaken by PTSD Resolution.

Therapists increasingly recognise the need to provide proof of efficacy in the work they do. Those whose registers are accredited by the Professional Standards Authority will, for instance, know that each is now required to supply evidence that their work is beneficial to the public.

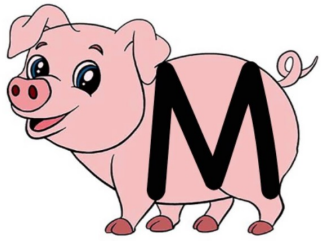
Randomised controlled trials are still seen as the gold standard for evidence but are prohibitively expensive for a small charity. However, the Improving Access to Psychological Therapies (IAPT) programme has made collection of practice-based evidence routine, raising its value and acceptability, and representing a welcome trend on which to build.

The Human Givens Institute was routinely collecting (and publishing) data about therapy before IAPT even got started. Data for PTSD Resolution shows that, of almost 2,000 veterans treated, 85 per cent went through to an agreed ending and symptom scores dropped down from 23 to 12 – an enormously positive change.

However, potential funders now want more. They want evidence of a safe, effective, sound rationale behind services, delivered reliably to certain standards. Project 100 will measure forensically everything that happens to PTSD Resolution clients over a set period – creating a snapshot in time to provide rich data from referral right through to aftercare.

Project 100 is so named because we are aiming for 100 completed cases to provide a wealth of information, captured through Pragmatic Tracker, a web-based tool for tracking change in psychotherapy clients.

The acronym MPIG helpfully encapsulates the process. M stands for measurement. Our practitioners will use the same outcome measures as are used in IAPT, including standard anxiety, depression, trauma scales, as well as some additional ones. This will make it easier to demonstrate comparative outcomes.



Measures / problems / interventions / goals

P stands for problems and the circumstances around them. When clients are screened, they are asked not only why they are seeking help, but where they served, how they arrived at PTSD Resolution, what previous treatment they have had, if any, and what has been helpful or not. Project 100 formalises this, labelling reasons for attendance - e.g. poor sleep, ongoing nightmares, deteriorating relationships, anger problems at work – so that we can categorise them. Importantly, we also record chronicity, as working with a recent onset issue is very different from working with one that has been plaguing someone for decades.

Sessions are date and time stamped, so, if the first problem is dealt with and something else emerges at session 3, the new problem is captured too.

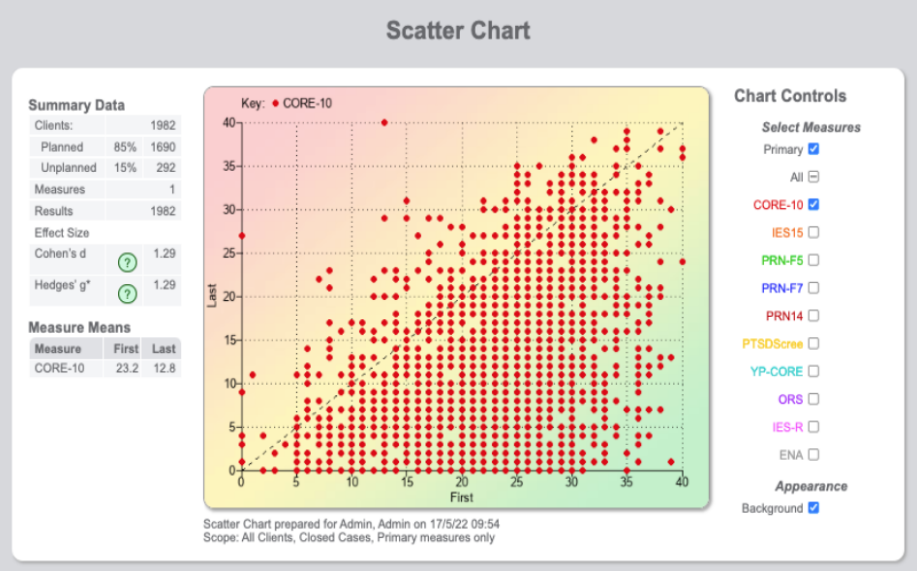
I stands for interventions. Therapists record all the interventions they use each session, choosing from a list of 26 separate skills and techniques (such as calming down methods, reflective listening, psychoeducation, and guided visualisation) that are used in Human Givens Therapy. This enables the relationship

between particular interventions and shifts in outcome to be tracked.

G stands for goals. If a client's goal is to sleep better, we also need to know how, in the client's terms, sleeping better can be measured. Clients' own words are recorded (for instance, "I will wake refreshed and feel ready to start my day") and then re-presented to them mid- and end of therapy, so that they can measure the success of the treatment in their own terms.

As this all adds up to a lot of extra work for the therapists, PTSD Resolution has agreed that each therapist will have an extra paid hour per client, which they can choose to spend with the client (seven sessions rather than the usual six) or on the extra administrative work. There are also two paid training hours at the start, all of which is built into the funding.

Project 100 started in April. In mid-May, at time of writing, we had 24 clients, three of whom had already had their third sessions. We hope to have 100 completed cases within 6-12 months, then a year of follow up. My other hope is that, even after the project ends, therapists will want to continue collecting data in this way – and that therapists from other modalities will see the benefits and want to join us.



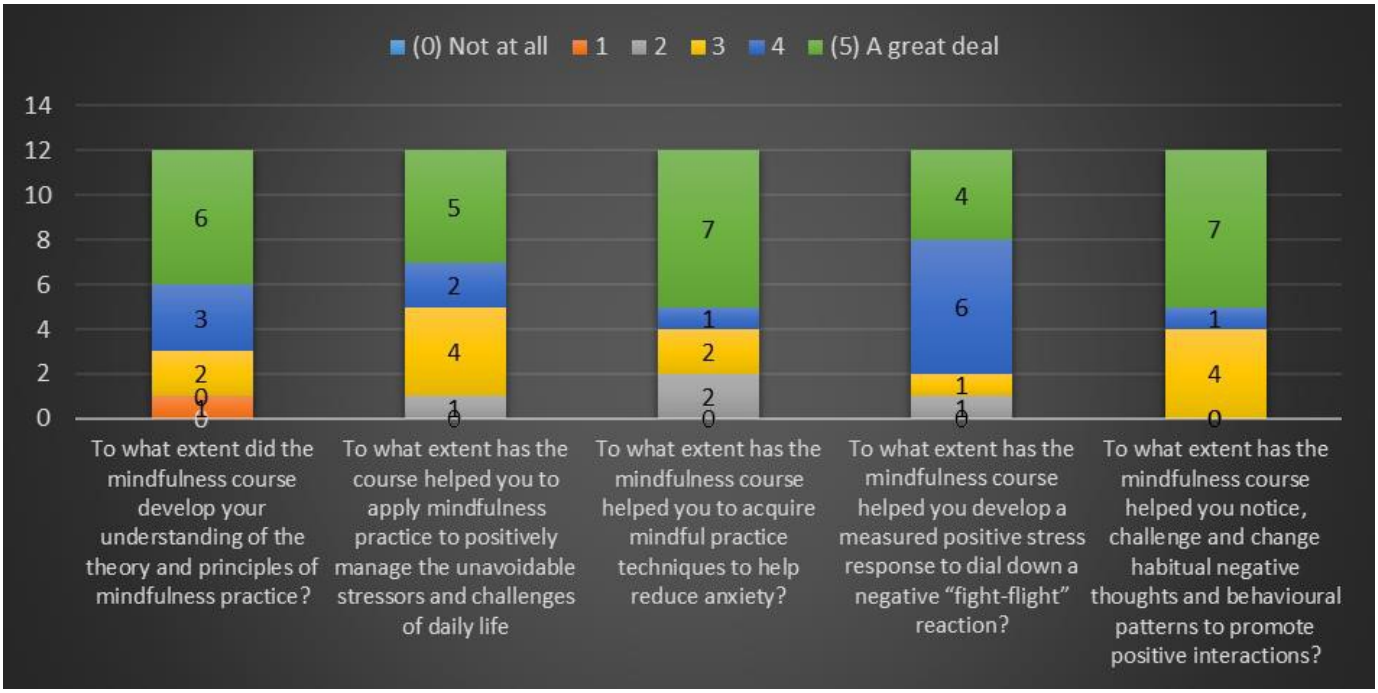
The Beacons - A mindful peer support

David Cameron, *Consultant Clinical Lead Psychologist, Inspire and the Beacons – veteran peer support group*

The so-called beacon of hope, a veteran peer support group emerged naturally out of a Mindfulness Based Stress Reduction program (MBSR; Kabat-Zinn, 2003) delivered to Northern Ireland veterans as part of the Tackling Serious Stress Recovery Together Program. Facilitated by Inspires Lead Mindfulness practitioner and adapted specifically for veterans, the trauma sensitive (Treleaven, 2018) experiential-skills based program ran over 6-weeks. The primary focus was on increasing veteran's awareness of and attention to inter-related habitual negative and rigid thought and behavioural patterns alongside stepping back from dysregulated emotions which drive and are driven by an automatic, mindless fight – flight reactivity.

For a cohort of 12 veterans who completed the mindfulness program they rated their experience on each of six questions using a Likert Scale which ranged from (0) not at all to (5) a great deal. As highlighted in Figure 1. above positively, a substantial majority reported that mindfulness practice helped lessen anxiety, reduce reactivity, challenge and break negative thought and behavioural patterns towards more positive and wholesome interactions with others.

Figure 1. Veterans self-rated experience of the 6-week mindfulness programme



Notwithstanding the small numbers and the limitation of not using a standardised psychometrically validated scale, the positive trends were corroborated by the personal testimonies of the participants.

"I came to Mindfulness as an agnostic, but went away a believer in the benefits. During my two weeks away from the group I experienced a very bad flashback episode. I was alone at the time and used the Mindfulness techniques to bring me back into the present and get perspective. I use the breathing techniques to calm my hypervigilance and anxiety".

"I came to mindfulness to be convinced of its benefit, but very quickly came to realise the benefit of being grounded in the moment through self- awareness. It has also helped me be gentler with myself and more reflective about my illness".

"I was skeptical about "mindfulness", but decided to stick at it and I am so glad I did, ... not just a "wallflower also attended", a close knit band of brothers".

Beacon of hope

John – Kabat Zinn is attributed as introducing mindfulness to the Western world in a form palatable to our distinctive cultural heritage (Kabat – Zinn, 1990) a "beacon of hope" in an unprecedented global increase in the prevalence of mental health conditions - generalized suffering (World Health Organisation, 2022). Importantly, however, mindfulness is a 2,600 year old practice steeped in and which emerged out of Eastern culture and inter-related wisdom, which posits a very distinct conceptualization about the nature, cause of and how to alleviate suffering. Core amongst these so-called four "noble truths" is the unavoidable reality that everyone suffers. The realization that suffering is universal, inherent to the human condition cultivates compassion, which translates literally as co-suffering. Counterintuitively, but supported by contemporary neuroscientific evidence (Chierchia & Singer, 2017) by turning towards and embracing the suffering of others paradoxically we ease our own suffering. From this perspective alongside the aforementioned explicit benefits of the MBSR program a

compassionate mode of inquiry seemingly permeated the group, captured by the poignant testimony of one participant who commented "peer support and kindness to one another in our discussions was welcomed by everyone".

Admirably, as these conflict – hardened veterans courageously let go of their defensive, rigid invincibility, perceived shame, fear and anger gradually gave way to speciousness, compassion, trust and loving kindness, empowering them to talk about, tolerate and share their vulnerabilities. A so-called "band of brothers" selflessly turning towards, transforming and easing each of the others suffering and which became the genesis for the "Beacon of Hope" veteran peer support group. Comprised of six service veterans with severe mental health and physical challenges, through their WhatsApp group 'the Beacons' check in daily providing encouragement, news and comradeship. They have forged a deep bond and it is a support model that clearly works as for example when a member suffered an anxiety attack while out he asked for help through the WhatsApp group and received an immediate response. A member telephoned, remaining on the line while another located him, getting him home safely and he subsequently followed up with Inspire's helpline the next day. The Beacons are also busy and active in the wider veterans' community.

Being A Bit Different - Making veteran mental health care accessible for veterans

Eleanor Duke, *Regional Manager, Veteran Mental Health Services in East England*

Crisis line: A veteran called our crisis line and was really distressed. He hung up. He did mention the name of a veteran in your team, so I'm letting you know.

Me: Thanks, I'll look into it.

Me, talking to my veteran colleague: I just had call, I have a name, he's not on the caseload, but he was distressed.

Veteran Colleague: Sure thing Boss, I'll go and see him face-to-face this afternoon.

Now, this is obviously not how it can work across all NHS services, whilst ensuring safe practice for all. However, it is a snippet of the 'can do' attitude of my veteran colleagues, who take that slightly different approach to ensure a veteran is integrated into services. This attitude emulates the veterans experience of military life and enables us to implement change and faith in wider mental health services.

Within Norfolk and Suffolk NHS Foundation Trust (NSFT) a specific service has been set up to support veterans, alongside their mainstream NHS mental health Team. The Veteran Integrated Service (VIS) offers added interventions which are military sensitive. Offering specific intervention and knowledge by a team who understand the military culture. Having links to this specialist world help build rapport, trust and is ultimately vital to the recovery pathway.

VIS is made up of veterans and individuals with years of experience working with military mental health, and that's just the NSFT staff. Our NSFT team includes a Lead clinical Psychologist, who also runs the Veteran Stabilisation programme (VSP) (a 16 week programme purely for veterans and their psychological needs). An ex-RAF mental health nurse and 2 Armed Forces Practitioners. One of whom served for 32 years in the Army and a nurse of 30 years, a number of which she

worked within military departments of community mental health. VIS works in partnership with Outside the Wire (OTW) and Walking with the Wounded (WWTW). Our colleagues being specialists in substance misuse and, employment and welfare respectively. By working in partnership with these 2 charities, we are working directly with other veterans 'who get it' and identify the specific needs which sometimes veterans can only accept from other veterans.

When VIS work with a veteran we add to their mental health care plan from their NSFT team. This collaborative approach helps educate and raise awareness of veteran mental health within our NHS and of our colleagues. VIS meet once a week to discuss all the veterans on our caseload, we share knowledge and subject matter specialisms ensuring each veterans needs are being met. The veteran may work with all of us at a given time or just 1 of the team. We are goal led and focus on regaining a purpose for the veteran as we know how important this is.

Being referred to VIS enables a veteran to seek support alongside their traditional mental health care. The principles are to offer holistic care, stabilise a veteran and give them a platform for onward recovery. This might be through alcohol reduction, employment support, mental health stabilisation, group therapy via our VSP or attending one of our 'drop in' coffee mornings. Sometimes this access to peer support is a life changer in a veteran's perception of their mental health and capabilities.

Being within NSFT we have the added benefit of being the lead Trust for High Intensity Service, East of England, Op Courage. An NHSE led veteran mental health initiative. This service supports veterans who are in mental health crisis, presenting with complex needs and needing intensive support for short periods of time. HIS is made up of nurses who understand the impact the military has on an individual and work in partnership with WWTW who offer welfare interventions. This asset means if our veterans mental health deteriorates, we can refer them into another service which is veteran aware and sensitive to their lived experiences.

To close. My colleague visited the veteran, checked he was safe and updated his local mental health team. He kept in regular contact with the individual as part of the VIS, his mental health stabilised and he was linked in with veteran specific interventions led by our 3rd sector colleagues, all within 4 weeks. Real change has been seen when acknowledging the power of specialist intervention.

Have you signed up to Knowledge Hub?

Knowledge Hub is an online discussion platform exclusive for veterans mental health services signed up to QNVMHS.

The platform allows members to:

- Ask questions, have conversations, discuss solutions to problems and share experiences
- Network with one another independently
- Upload, share and comment on documents
- Promote forthcoming events and access events and booking forms

If you would like to sign up, please email us so we can send you an invitation.

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King's College London launches 4th phase in Military Health and Wellbeing Study

***Niamh Molloy**, Research Assistant, **Sofia Franchini,** Research Assistant,*
***Dr. Marie-Louise Sharp**, Research Fellow,*
King's Centre for Military Health Research

Who are we?

The King's Centre for Military Health Research (KCMHR) is the leading independent civilian UK centre of excellence for military health research based at King's College London. KCMHR draws upon the experience of a multi-disciplinary team led by Professor Sir Simon Wessely and Professor Nicola Fear.

KCMHR's flagship Health and Wellbeing cohort study began in 2003 and is the largest study investigating the long-term health and wellbeing of the UK Armed Forces (AF).

What it is:
Currently, there have been three phases between 2004-2006, 2007-2009, and 2014-2016. The cohort is a randomly recruited tri-service sample of AF personnel who served during the Iraq and Afghanistan era of deployments. As the cohort aged and left service, we also included replenishment samples of service personnel at phases two and three to ensure the cohort was representative of the UK-AF. An extra wave of data was also collected from the cohorts' ex-service personnel during the COVID-19 pandemic, known as our Veterans-Check study.

Newest data collection wave:
We have now entered the fourth phase and are re-contacting over 8,500 participants from phase three. This sample is projected to include 75% ex-service personnel and 25% currently serving, which has developed to represent an 'era' cohort of those who served during the Iraq and Afghanistan conflicts.

Our Previous Findings:
Main measures of interest in the cohort include probable PTSD, alcohol misuse and Common Mental Disorders (CMD). CMD remain the AF's most prevalent condition, with a small non-significant rise in prevalence to 22% in phase three. There was also a statistically significant rise in probable PTSD rates from 4%-6%. Encouragingly, we found alcohol misuse rates declined to 10% in phase three however these levels remain 2-3 times higher compared to equivalent general population groups. Importantly, our previous phases identified groups within the AF with higher levels of mental ill health than others. Namely, in phase three, ex-service personnel had significantly higher levels of probable PTSD compared to serving personnel (7% v 5%). We also found ex-service personnel who deployed in a combat role had significantly higher rates of probable PTSD and CMD which rose to 17% and 31% (compared to overall rates of 6% and 22%).

Our Impact:
These findings have not only represented the importance of demonstrating which mental health disorders are prevalent in certain groups but have helped inform government and organisations with regards to policy and practice.

The KCMHR cohort data aided the formation of NHS TILS service and Complex Treatment Services (now known as Op Courage) which seek to increase access and treatment to appropriate mental health services for AF personnel approaching discharge and veterans with mental health difficulties. Over almost 20 years of research, we have captured the needs of those transitioning from military to civilian life, informing services like these to target

specific needs veterans may have.

Furthermore, the cohort study provided evidence preventing the Ministry of Defence (MOD) funding the introduction of psychological pre-screening before deployment. KCMHR cohort data demonstrated for every one person correctly identified who did return with mental ill health, five were incorrectly identified. Hence pre-screening would have unduly and incorrectly penalised individuals. Our research allowed the MOD to resist pressure to fund the programme and re-distribute funding elsewhere within the AF.

Several new research topics have been added for the current phase of the study, including gambling, drug use, loneliness, cognitive decline as a precursor to dementia, the impact of Afghanistan withdrawal and COVID-19.

The new results will provide clinicians with up-to-date trends and changes of the AF current health. This will allow services to understand where current targeting is needed, including any changes since the 2014/6 findings. Moreover, the cohorts' new topics like the impact of withdrawal from Afghanistan, will provide knowledge about recent events which may affect the health and wellbeing of UK-AF.

What we ask:
Please find more information about phase four on our website. KCMHR encourages collaborations with this data and our centre. You are welcome to contact us with proposals for collaborative research, but please note we do not make this data publicly available to protect the confidentiality and security of individual cohort members. Any collaborative work occurs as part of a legal collaborative agreement.

Please could you share information about this phase through means like social media, to support our work by gaining the best response rates and having the widest impact possible. For study updates and our other work, please follow us on twitter @kcmhr and look at our most recent blogs.

Combat Stress

Coproduction initiatives with veterans

***Dave Aitken**, Head of Engagement and Social Care*

Introduction
Recognising that the co-production of services was the gold standard to aspire to, in late 2020 Combat Stress and a cohort of veteran volunteers established the National Veterans' Voice (NVV). This early iteration of Combat Stress and the veteran community's foray into the world of co-production was a learning experience for all involved. In addition to some high-quality service developments, both the NVV and Combat Stress experienced challenges to the process and the relationship. It was the desire to work through these challenges that have saw an evolution in relationship between the NVV and Combat Stress, and in turn, a more effective way of working.

Learning from the Journey
The NVV were encouraged to develop their own terms of reference and establish their own operating procedures. Combat Stress hoped asking the veterans to create their own working processes would be an act of

empowerment and a show of trust, however it more than likely sewed an early division into the working relationship. Had these terms of reference been co-produced with veterans and staff, it would have created a greater chance of success.

The initial processes established were intensive on the veterans' time, and overly formalised which did not meet the needs of Combat Stress. Ultimately, the efforts were not working for either party. Despite this dysfunction, there were some incredibly effective pieces of work undertaken where the veteran input shaped the outcomes in a tangible and meaningful way. However, these successes were overshadowed by unmet expectations amongst the volunteer cohort. This unfortunately led to some veteran volunteers stepping away from the NVV.

A Breakthrough

After nearly 12 months of mixed results, COVID restrictions relaxed sufficiently to permit an in-person meeting between the NVV and Combat Stress. An indication of Combat Stress' commitment to improving the efforts to co-produce services was demonstrated by the attendance of the CEO, Medical Director, and Director of Operations. This in person event, held at the NEC in Birmingham permitted a dialogue between the two involved parties that had previously not occurred. During this meeting, a shared vision was established, and people were heard.

From this shared vision, a review of the processes and terms of reference took place. This review sought to make the NVV more desirable for veterans to join, easier pathways to canvas the views of the wider veteran community and more accessibly for staff to participate in the process of co-production. We now have a core group of NVV members that meet monthly to address and raise issues and contribute to solutions, however there is a larger quarterly meeting that is open for all veterans currently in treatment with Combat Stress to access. The format of these meetings have radically shifted from a corporate meeting to one of equitable conversation. In addition to this, we have just appointed a new Veteran Engagement Officer, whose role it will be to monitor the wellbeing of any veteran that is involved with the NVV in any capacity.
In addition to this, Combat Stress have further demonstrated the value they place on the voice of lived experience through the involvement of the Peer Support Team into the NVV. All Peer Support staff are veterans with lived experience, many of whom accessed Combat Stress treatment historically. Yet, until the evolution of the NVV they were largely on the outskirts of co-production efforts. Now, they are central to this as members of the NVV and all staff are encouraged to lean into their expertise whenever appropriate.

The Future

Co-production, although not a new concept, is a hard one to get right, and it is very unlikely all efforts made by veterans' services to embed co-production will be immediately successful. There are still significant milestones to achieve, including but not limited to the mechanism used to ensure the volunteers are compensated for their time and ensuring all staff integrate co-production into their working practices. However, we are moving in the right direction – largely because we prioritised the relationship between veterans and charity. This relationship is now stronger than ever and veterans that now access Combat Stress are benefiting from the input of those that went before them. This veteran centric ethos is easy to espouse, however implementing it in a way that is evident is a process and a challenge – but such a rewarding journey for all involved.

For up-to-date information on the Quality Network, including upcoming initiatives and publications, please visit our website or follow us on Twitter!

www.rcpsych.ac.uk/qnvmhs

@RCPsychCCQI_ #QNVMHS

How veterans' support networks wish to be involved in care and treatment. An involvement initiative

***Dave Aitken**, Head of Engagement and Social Care, **Professor Catherine Kinane**, Medical Director, **Dr Lee Robinson**, Principal Clinical Psychologist and Clinical Lead, England Central, **Dr Vicky Aldridge**, Senior Clinical Psychologist, England Central*

Efforts to Determine Requirements

In 2020, Combat Stress, the UKs leading charity for veterans' mental health, identified that families and loved ones of veterans accessing the charity also needed support. However, acknowledging that the exact nature of what would be best received, was then unknown, three substantial pieces of work were undertaken to identify the most suitable way forward. Firstly, a six-month Family Support Worker pilot was undertaken to assess a partner's needs and facilitate access to emotional support and signposting. Secondly, a survey exploring partners' satisfaction with their engagement from Combat Stress was sent to 300 veteran families. This survey identified a polarising response with nearly 50% of respondents feeling like they were excluded from important decisions and that their needs were not considered during their partner's care. Lastly, a series of focus groups were held with both veterans and veterans' partners to explore their support needs. These strands of work were coupled with the key principles that the service user group needed to be involved, that any recommendations would not duplicate the provision already provided by another service, and that the service would be aligned with Combat Stress' mission to provide support and treatment to veterans with complex mental health problems to help them tackle the past and take on the future.

Recommendations

Identifying the radiating impact of a veterans' mental health difficulties can be profound - families requested support be based on a combination of preference and need, tailored to the family. Combat Stress has determined that there are five potential levels of intervention where a family can be included in the veterans' recovery journey and their needs considered and met alongside the veterans' own.

Level 0 – General Family Inclusive Practice

At the point of clinical assessment, veterans are supported to invite their significant other or a family member. This serves multiple purposes. Firstly it leads to the development of more detailed assessments, including the perspective of family members and a more holistic assessment overall. Secondly, it allows for competing issues to be identified and appropriate support to be sought. It is anticipated that by including families at the earliest opportunity, engagement with treatment may also increase.

Level 1 – Low Level Family Engagement and Wellbeing Check

Consistent with the original pilot Family Support Worker in Scotland, this level of provision allows those identified by the veteran as significant to them to have their own listening ear, and to receive any assistance required to access alternative services or family support, this might be done through engaging with a carer's assessment, for example. The support worker role also creates a conduit of information to flow between the support network and the clinical team as and when appropriate.

Level 2 – Time Limited Intervention

The desire from family members to understand the veteran's struggle and to be given the skills to support them was evident throughout our approach. Connecting with other family members was consistently viewed highly and indicated the need for peer support groups for

families. Within Combat Stress an online psycho-educational webinar now forms a core part of service delivery. It educates partners on trauma and common symptoms and provides them with the mechanisms for both supporting their loved one but also ensuring their own needs are catered for too.

Level 3 – Involvement with Treatment Decision

Combat Stress is currently moving towards a place of full integration of families with treatment planning and decision making. Part of this has involved the introduction of training in open dialogue which, as a psychosocial intervention, might allow the clinical team to function in a way that is truly equitable and recognises the value of contribution from both veterans and their support network.

Level 4 – Treatment of the Support Network for mental health problems

This level is largely aspirational and may take several years before the early scoping work is even considered. At present these needs are referred to the GP for appropriate input and referral.

Summary

Engaging veterans, families and supporters in consultation is essential if we are to understand their needs. Opportunities for service improvement are richer and more suitable if they are co-produced by key stakeholders in collaboration. The involvement of all interested stakeholders has led to discussions and proposals that create the framework of a Family Support Service that is truly responsive to the needs and wishes of the client group. We are seeking funding to deliver on the needs and wishes as identified.

The UK Veterans Family Study

***Glen Dighton**, Postdoctoral Research Associate, King's Centre for Military Health Research (KCMHR)*

Research concerning the health and wellbeing of the families of veterans usually focuses on negative psychological outcomes, specifically as a consequence of the veteran suffering PTSD or other psychological distress (Armour et al., 2022). The focus on veteran health means that there are many gaps in our knowledge of veteran families' wellbeing, and what the key influences are more broadly. Because of these gaps veterans' families are not just overlooked in research but, critically, in the planning of policy and treatment/supportive outreach programs (Armour et al., 2022). It is therefore important that we better understand the health and wellbeing of veteran families.

The UK Veterans Family Study was devised as a multi-study work programme using surveys and interviews to extend our understanding of the influencers of psychological health and wellbeing for veteran families. The study is unique in that it samples veterans and their families from all four nations in the UK and explores a range of psychosocial factors, such as health, housing, education, community, as well as experiences of support. It is being led by researchers at Queen's University Belfast and King's College London, supported by Anglia Ruskin University, Glasgow Caledonian University, Cardiff University, Veterans NHS Wales, and UK veterans' mental health charity, Combat Stress, and is funded by Forces in Mind Trust and the Big Lottery Fund. The study has six core aims and three primary data collection

work packages have been established to respond to these aims:

1. Identify the psychological health and wellbeing needs of veteran families.
2. Identify the drivers that support psychological health and wellbeing in the face of the challenges that come with being the partner/child of a veteran.
3. Examine the relationship between the family members' psychological health and wellbeing and that of the ex-serving person.
4. Understand the contribution of the local community on the families' health and wellbeing.
5. Identify the support accessed, any barriers to accessing support, and views on the quality of that support.
6. Identify the likely future needs of veteran families.

Survey of veterans' families
The survey is a large-scale, UK-wide survey of veterans, their spouses/partners, and adult children of veterans (18 years or over). It examines a wide range of influences on wellbeing including demographics, childhood and lifetime experiences, relationship satisfaction and family dynamics, help-seeking, community integration and community support, the use of support services, and caregiver burden. It also looks at common mental health disorders and alcohol use among these families. We will use this data to investigate and understand the impact of the veteran's psychosocial characteristics on that of the partners and their children and within families.

Interviews with family members
One-to-one interviews are being conducted with spouses/partners and adult (18+ years) children of veterans. The interviews cover key areas of sources of support, positive and negative impacts on wellbeing, and current and future needs. This will give us a deeper understanding of the role of particular influences on health and wellbeing among veteran families and the 'lived' experiences of our participants.

Interviews with service providers
We have also interviewed service providers to gain their perspectives on veteran family access to services and perceived barriers, models of delivery, aspects of wellbeing which can be addressed by services, service evaluation, and perceived future needs. We will compare the findings from service providers to family members to identify gaps in service provision and access to highlight areas of improvement.

What will happen with the findings?
The UK Veterans Family Study will provide important evidence regarding the health and wellbeing of veteran families from across the UK. The study has been guided from the start with input from our participant and public involvement groups to ensure that the study design and outcomes reflect real veteran families. We also have support from experts and representatives of service charities to help ensure that the study outcomes are useful for both policy makers and service providers, with a focus on improving the support available to veteran families.

Recruitment is ongoing!
Please share this research with your teams and networks! This will help us with recruitment and with sharing the findings to improve access to services and support for veteran families!

We are still looking for spouses/partners and adult children (18+ years) of veterans, and veterans from across the UK to take part in our survey, and in our interviews. More information can be found here.

If you would like to know more or would like to help advertise the study, please contact our researchers via email.

UK Veterans Family Study

High Intensity Service: Exploring the new model of supporting Veterans in crisis in the community

***Norgenta Lata**, Assistant Psychologist, High Intensity Service*

The Veterans' Mental Health High Intensity Service

The increasing demand for trauma informed veteran sensitive services led to the launch of The Veterans' Mental Health High Intensity Service (HIS) for all ex-British Armed Forces personnel in need of urgent mental health care and treatment. The HIS is a part of Operation courage and is embedded into the TILS and CTS services improving the integration of veteran care. The pan-London HIS was first commissioned by NHS England in 2020 and is a collaboration with three veteran and Forces-family focused charities- Walking With The Wounded, STOLL and The Ripple Pond.
The service is underpinned by the knowledge of Lived Experience Experts – other Veterans and their friends and families – who bring their understanding of what it's like to need urgent care, to contribute to HIS support. All London HIS staff are trained in Veteran-sensitive practice, and the team includes peer support workers who are ex-Forces.

How it works

The London HIS work intensively alongside existing NHS crisis and inpatient services, providing wrap-around care which addresses the psychological and social issues that contribute to pushing people into crisis. The London HIS, therefore, help to stabilise veterans in acute mental health crisis, with the aim of preventing hospital admission.
The service works with veterans in the London region for a period between three and six months until they are back on their feet. The service accepts referrals from all professionals as well as self-referrals, working to see referrals within 72 hours. Intervention is focused on regulating emotions, tackling alcohol and substance use; and support in areas such as employment, personal finance, and housing. A carers consultation is also offered to the partner or family members of the veteran. They also facilitate ongoing care utilising local NHS and third sector providers in a collaborative effort.

The service in practice

Demographics

Between January 2021-December 2021, The London HIS received a total of 63 referrals. 94% of clients were male, 6% were female. In terms of age range 45% of veterans were aged 31 to 40 and 50% of veterans were in the age range of 41 to 60. The majority of veterans identified as White British (79%) and 17% of veterans identified as from a BAME background. The mean length of service was 9 years.

Intervention

- 77% of veterans were offered 'in-house' intervention for trauma stabilisation
- 100% of those with carers/family were offered a carer's consultation
- 66% of veterans was regularly reviewed by the teams consultant psychiatrist
- 15% of veterans accessed adult social care
- 34% of veterans secured housing (hostel, council, housing association, private rental)
- 48% of veterans engaged with NHS physical health services with the support of The London HIS

Feedback from veteran clients:

"When I was initially referred to The HIS I felt safe and in good hands. The team went above and beyond for me, although there were COVID restrictions in place they continued to visit me. It was so different to any other service I had worked with before."

*"Working with The HIS was a **life changing experience** for me. It completely **turned my life around**. The team helped me so much with not just my mental health but my social care needs. When I started working with The HIS I was in a terrible housing situation and now I am so happy with my new place."*

Feedback from carers:

"The follow up check in calls felt very reassuring. It really took the pressure off of me and made me worry less because I knew that The HIS as a service were there for my son."

"I feel heard and listened to for the first time, I always thought that because I wasn't the one going through it first-hand that I didn't necessarily need the help."

Comment

Based on the quantitative and qualitative data collected, The London HIS appears to be succeeding in its remit of providing urgent care to veterans in acute mental health crisis. The London HIS ensure that integrated treatment is provided, and that services work collaboratively with crisis teams, substance use services as well as other charities. However, veterans continue to face barriers of accessing support in healthcare services, consequently falling through the gaps. The need to identify veterans, through routine inquiry, is therefore paramount. Questions such as "have you ever served in the armed forces?" allows professionals to identify and refer veterans to veteran specific services such as The London HIS. For this reason, it is important that crisis teams, Gps and general health care services are aware of veteran mental health services that are available to veterans in need of urgent care.

How can outcome measures inform best clinical practice with veterans presenting with complex needs?

***Eirini Balampanidou**, Research Assistant Psychologist, South Central OpCourage Veterans' Complex Treatment Service*

This article is a summary of evidence-based practice, focusing on outcome measures when working with individuals presenting with complex presentation, (including Complex Post Traumatic Stress Disorder).

Findings from the literature and empirical practice emphasise the necessity and importance of using routine outcome measures to evaluate clinical practice, audit clinical performance and to assist the care management of clients being seen within a specific service (Foster et al., 2018). For instance, in the United Kingdom, the national Patient Reported Outcome Measures (PROMs) programme requires hospitals to use PROMs for specific interventions (Devlin & Appleby, 2010). Consequently, the use of PROMs has increased in healthcare, and significant progress has been made in preparation for their introduction and use in practice. Nevertheless, there is a need for further understanding of practical challenges that might arise from their implementation and possible ways to overcome them (Callaly & Hallebone 2001; Foster et al, 2018; Calvert et al, 2019;). It seems apparent that data arising from PROMs may offer benefits to patients and wider society, however some view their current use as defective and fragmented (Calvert et al, 2019).

The South Central OpCourage Veterans' Complex Treatment Service (covering regions of Berkshire, Buckinghamshire, Hampshire,

the Isle of Wight and Oxfordshire) uses a set of outcome measures at assessment and throughout the veteran treatment pathway with the aim of supporting clinical decisions to plan care, monitor and adjust treatment options, and evaluate treatment outcomes.

These measures support with assessing symptoms of anxiety, depression, anger, Post Traumatic Stress Disorder (PTSD) and Complex PTSD, dissociation, trauma related shame, impairment in functioning, compassion competences, self-criticism and the ability to self-reassure.

The use of outcome measures within the service is varied due to presenting complexities of the veterans, and there are challenges affecting both the veterans and service. These include experiencing increased distress when recounting current symptoms and difficulties, fatigue and burden of completing multiple questionnaires, missing data hindering reporting and use, difficulties in administrating and interpreting, and a lack of specific ethical guidance.

In addition, another challenge is the frequent lack of standardised, clinically validated outcome measures specifically for veterans, which results in utilisation of measures that have not necessarily been tested and used within this specific population. Nevertheless, as veterans might be presenting with complex needs and comorbid mental health problems, it is essential to be able to assess and monitor all of their relevant presenting symptoms and this could be facilitated by the use of PROMS and conjunction of clinical assessment and formulation.

It is unquestionable that literature highlights the unique challenges and barriers that are linked with the use of PROMS in mental health care services, affecting the entire workforce and patients. These include limitations in policy and technology, absence of training and support for staff, insufficient scientific evidence for quality measures, ethical concerns, measurements' properties, acceptability and cultural validity not being systematically considered, difficulties with data gathering, analysis and interpretation (Callaly & Hallebone, 2001; Foster et al., 2018; Kilbourne et al., 2018; Calvert et al., 2019).

A qualitative study conducted by Crawford et al. (2011) investigating service users' views, highlighted the importance of assessing both negative and positive symptoms as positive changes might not be considered in light of the heavy focus on change in problematic symptoms. Consequently, participants in that specific study questioned and expressed concerns about the sensitivity and specificity of some outcome measures to capture their experiences.

It can be argued that PROMs' utilisation may be valuable to society by supporting with better health outcomes and use of resources. Research findings indicate that there are gaps and work needed to be accomplished in order to maximise the benefits of PROMs. This could be achieved by a coordination and collaborative work across different parties, involving patients, clinicians, legislators, PROMS scientists, NHS technology and data services to share knowledge and good practice.

Furthermore, an integrated, strategic and evidence-based approach for selection, administration, collection, analysis, reporting and interpretation could tackle some of the challenges that may arise from the use of outcome measures in healthcare as stated above (Callaly, 2001; Kilbourne et al., 2018; Calvert et al., 2019).

The South East High Intensity Service – Measuring outcomes holistically

***Tamsyn Howells**, Assistant Psychologist, South East Veterans' High Intensity Service*

The South East High Intensity Service (SE HIS) exists as one part of OpCOURAGE "The Veterans Mental Health and Wellbeing Service". We provide wraparound care for veterans to support their needs within a collaborative model between the NHS and Walking with the Wounded. The service goes beyond the typical statutory care offer and enables intensive support to be offered by a triumvirate of Peer Support Workers (PSW), Veteran Liaison Support Officers (VLSO) and Veteran Mental Health Leads (VMHL). At any one time, a veteran can receive support from all three areas of the service with the average length of time a veteran is open to the HIS being 98 days (14 weeks).

Measuring patient outcomes is common practice within services to provide valuable insight into the impact that service offers have, the change that clients make, and allows services to understand the problems and difficulties that people face, which in turn allows services to evolve and develop to meet the needs of the population it serves. At the South East HIS, we go beyond the typical norm for outcome measurement by assessing and evaluating change holistically by using clinical outcome measures and the outcome star tool.

Clinical Outcome Measures

The clinical measures used are: Generalised Anxiety Disorder Assessment (GAD-7), Patient Health Questionnaire (PHQ-9), PTSD Checklist (PCL-5), Work and Social Adjustment Scale (WSAS), and Alcohol Use Disorders Identification Test Consumption (AUDIT-C). Whilst we do not use these (AUDIT -C). Whilst we do not use these measures as assessments of caseness for accessing the service, we support veterans to complete the measures at entry, mid-point, and exit, to provide indication of the extent of a veteran's difficulties in common problem areas throughout their care pathway with the HIS.

In Table 1, we present data from 47 veterans to review their progress using the clinical outcome measures: GAD-7, PCL-5, PHQ-9, WSAS and AUDIT-C. Figures 1, 2 and 3 demonstrate the change in scores for these 47 veterans on the GAD-7, PCL-5, and PHQ-9. This data reflects the impact of the HIS and highlights veterans' efforts to improve their wellbeing while working alongside us.

Table 1. Data from 47 veterans' outcome measures

Out-come Meas-ure	Clinically meaningful reduction in score		Average change in score (all 47 scores)	Average change in score (of those who reduced in score)
	%	*N*		
GAD-7	40	19	-3	-7
PCL-5	57	27	-10	-15
PHQ-9	51	24	-5	-9
WSAS	60	28	-5	-14
AUDIT -C	47	22	-2	-8

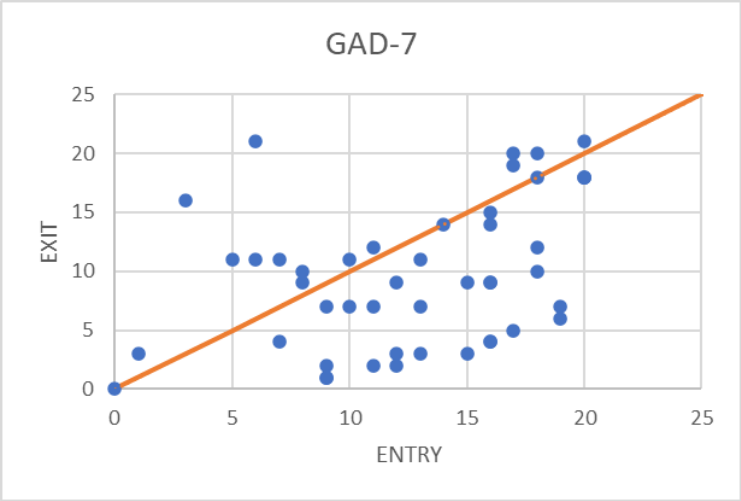


Figure 1: Scatter graph presents 47 veterans' scores from the GAD-7 at point of entry and exit. The diagonal line demonstrates the region where no change has occurred. Dots below the diagonal line reflect cases where exit score has been lower than entry score.

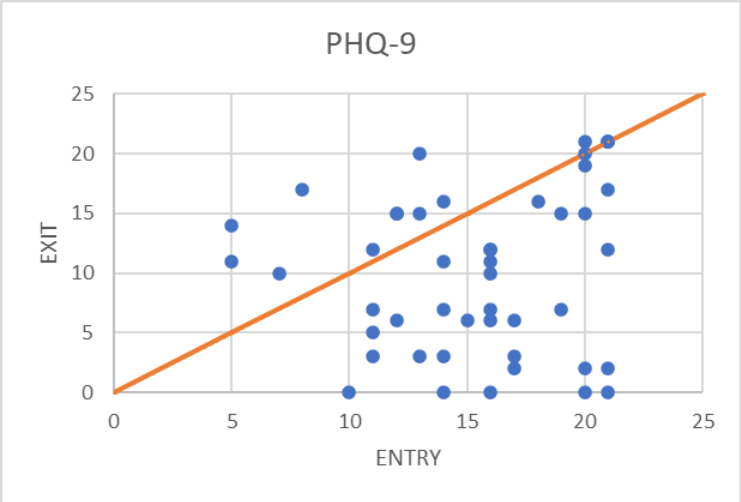


Figure 2: Scatter graph presents 47 veterans' scores from the PHQ-9 at point of entry and exit. The diagonal line demonstrates the region where no change has occurred. Dots below the diagonal line reflect cases where exit score has been lower than entry score.

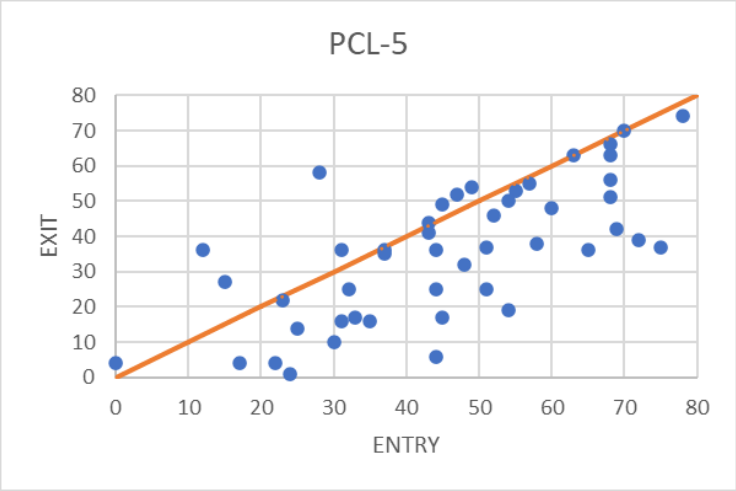


Figure 3: Scatter graph presents 47 veterans' scores from the PCL -5 at point of entry and exit. The diagonal line demonstrates the region where no change has occurred. Dots below the diagonal line reflect cases where exit score has been lower than entry score.

Outcome Star

Walking With The Wounded (WWTW) have 5 VLSOs within the SE HIS who support the clinical team to stabilise veterans and improve wellbeing by working alongside them to break down barriers to treatment by:

- Connecting in a veteran aware way: veteran to veteran
- Working with the individual and other services to reduce debt, manage accommodation, reduce isolation, support with criminal justice issues
- Supporting veterans to engage with activities and regain focus for the future

WWTW use the outcome star personal development toolset to assist the veteran to plan a way forward to improve their current situation. The outcome stars are evidence-based tools designed to support positive change and improve wellbeing. The scales display a journey of change for the veteran and are completed monthly.

The star puts the focus on the service user's perspective and priorities to empower them, highlighting the strengths of the individual and areas that are going well, as well as areas they are having trouble with, it is a person-centred approach.

There are 10 areas of the outcome star: accommodation, living skills & self-care, mental health & wellbeing, friends & community, parenting & caring, relationships & family, drugs & alcohol, positive use of time, managing strong feelings, a crime-free life.
Data shows the positive impact across the duration of VLSO input with significant improvements made. 96% of veterans who had been supported by a VLSO reported they had improved in at least 3 of the 10 areas and on average, they improved in 6.4 out of the 10 support areas.

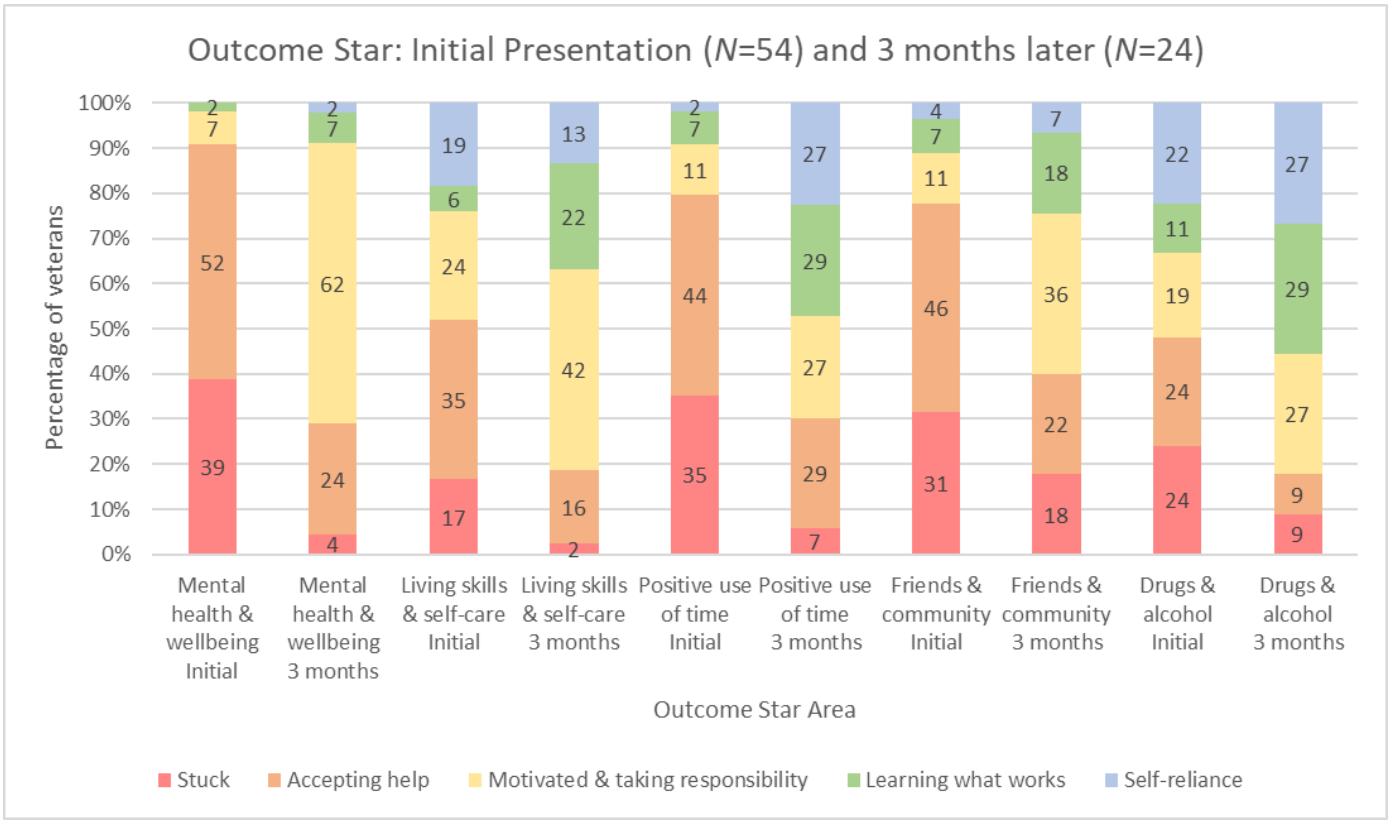


Figure 4: A graph to present the self-report data from five areas of the outcome star. The graph shows the percentages of veterans at each stage on their initial star and their third star 3 months after initial presentation.

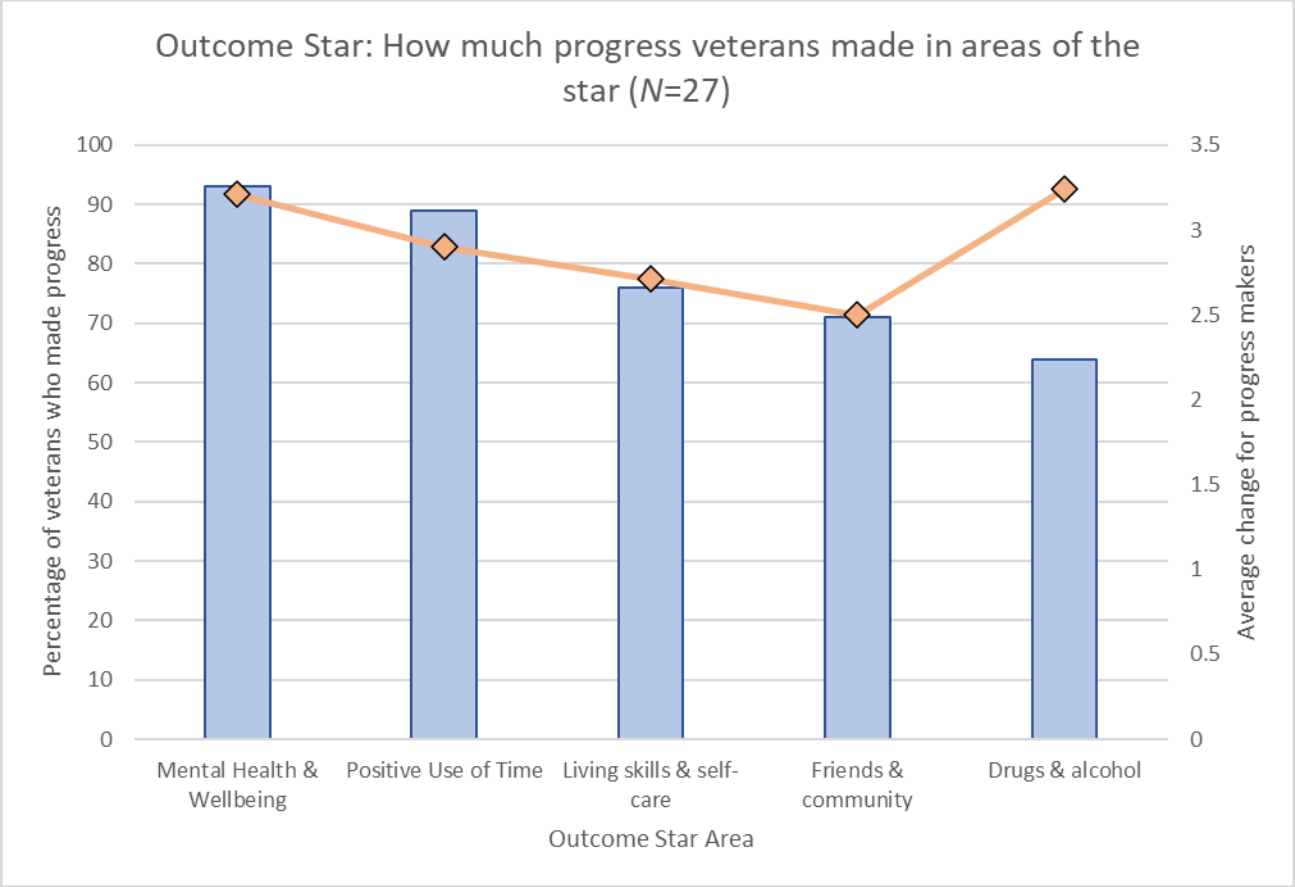
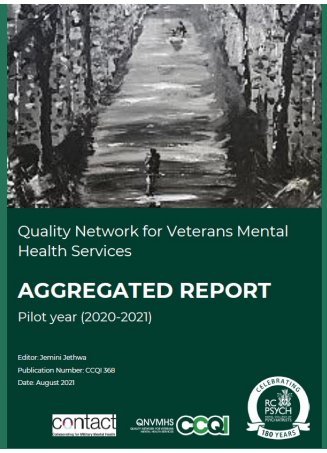


Figure 5: The bar graph shows the percentage of veterans who made progress in the respective areas. The diamonds display the average extent of this progress in terms of 'steps' made where each level (stuck, accepting help, motivated and taking responsibility, learning what works, self-reliance) equates to two steps.

The HIS provides short-term support to veterans and typically their care will transfer from the HIS to another service for talking therapies or further specialised support. These outcomes from short-term input without significant clinical intervention provides insight to the meaningful work that the HIS provides socially and clinically, a claim which veteran feedback supports.



Have you read our Aggregated Report (2020-2021)?

Our pilot year of peer reviews on the Quality Network for Veterans Mental Health Services (QNVMHS) are summarised in our first aggregated report which was published in 2021.

We are pleased to share a great range of good practice examples within this report. There are also helpful findings to demonstrate the average compliance of pilot teams against the QNVMHS standards and the commonly unmet standards.

You can access the report on our website.

Applying the Method of Levels: A transdiagnostic approach to effective and efficient patient perspective treatment

Susan McCormack, *CEO & Clinical Lead, Mode Rehabilitation*

Introduction
The Armed Forces Community (AFC) is a community possessing disciplined working culture. There exists a thin line of discretion between mental health problems and active service, creating the need for advancement in aiding and assisting this vulnerable but ubiquitous group. Henceforth, reasonable efforts must be undertaken to address the unique challenges presented by the generic traditional masculine socialization and specific hyper-masculine "warrior" culture of the military, which so far has not been fully developed.

Current Research
The AFC has emerged as a vulnerable subgroup for mental illness due to men's reticence to seeking professional help and/or accepting the idea that they might need it. The varied models of therapy that contextualize delivery acknowledge that medication for treating posttraumatic stress disorder (PTSD) amongst veterans is a core component of treatment. This has the assumed purpose of reducing and resolving symptoms as well as management of disorders.

Patient decision support tools have been found to help patients become better informed on available treatment options and help them acquire better perspectives on their potential benefits and harms, consequently helping them consider choices consistent with participative decision making and personal values (Stacey et al., 2012). Practice guidelines and government initiatives promote shared decision-making, mainly within physical health settings (Coulter and Collins, 2011; NICE, 2015). However, it is widely understood that without professional involvement, AFC possesses high levels of attrition which is associated with negative outcomes (Reisman, 2016). These include the existence of a high-risk period for relapse in the event of sudden withdrawal (Viguera et al., 1997). Nevertheless, shared-decision making has been poorly adopted, and in this case, within mental health settings (Slade, 2017; Légaré., 2012). Accordingly, psychological interventions, such as Motivational Interviewing (MI) and Cognitive Behavioural Therapy (CBT), help inform individuals "planned" behaviour by perceiving decision-making (See, e.g., Merlo et al., 2010; Riper et al., 2014; Westra and Norouzian, 2018). These interventions help attain the classification and identification of desirable medication-related behaviours, thereby assisting individuals to ensure the occurrence of the same.

A Transdiagnostic Approach to Effective and Efficient Patient Perspective Treatment
Until relatively recently, anxiety and depressive disorders have been dominantly researched and conceptualized through the disorder-specific approach, consequently shaping the development and evaluation of treatments. However, scepticism about the value of medication treatments continues to exist (Reisman, 2016). It is currently reported that 50% of clients do not take their prescribed medications, thereby raising ethical concerns (Brown and Bussel, 2011). This may lead clients to exchange their preferences and priorities, to increased coercion and reduced empowerment since their expressed goals are disregarded (Stovell et al., 2016). Further, disconnects between the military culture and ongoing treatments inadvertently reinforce service user avoidance and fear of stigmatization. Thus, sensitizing professionals for practice within the population is of great importance, especially when addressing moral injury challenges and war-related stress injuries. These factors are then targeted in diagnosis and treatment.

Mode Rehabilitation

Mode Rehabilitation is spearheading the delivery of a novel intervention to help the AFC understand better their decision-making regarding health-seeking behaviour. We designed a bespoke 'Resilience to Civilian Life' adapted from the transdiagnostic 'Take Control' workshops. To ensure the successful transition and resettlement of veterans into sustained employment. The transdiagnostic approach is founded on identifying the core common maladaptive behavioural, interpersonal, emotional, psychological, temperamental, and cognitive processes underpinning the broad diagnostic presentations (Harvey et al., 2004).

The said feasibility and acceptability of a transdiagnostic approach has been assessed, which is based on Perceptual Control Theory (PCT: Powers, 2016) and offers an alternative framework to gain better insight into decision-making when working with medication-related behaviour. In PCT, behaviour is recognised as a goal-direction medium whilst understanding an individual's ability to control their experiences but not their behaviour. The behaviour is understood as a means through which individuals resolve the difference between their expected experience (expected perception) and their present experience. PCT is aimed at increasing the varied personal goals, and awareness individuals hold in relation to medication use. The therapy focus lies in addressing conflict between personal priorities, because the difficulty or ambivalence to execute planned behaviours is caused by conflict.

Method of Levels (MOL) is a flexible, effective, and efficient transdiagnostic cognitive therapy that is informed by PCT (Carey, 2008; Mansell, Carey, Tai, 2012) that helps to develop people's own awareness of significant things in relation to medication use to further find a potential resolution, rather than focusing on specific behaviours. The intervention is patient-led and idiosyncratic; hence the outcome is based on pervasive human nature. The service users tend to increase their knowledge on the impact of medicine usage and the relation of medication to their life. This aims to draw out distilling factors assisting the AFC to become inclined and committed to talking therapy (i.e., identifying solutions).

A video was prepared to accompany this article. Please contact us to access it.

QNVMHS Updates

2022 Peer Reviews

We recently completed our cycle of peer reviews which began in February 2022 until June 2022. We reviewed 27 services and this includes both developmental and accreditation members.

The peer review process starts with a self-review assessment for teams to complete and reflect on their own services. This is followed by a peer-view visit attended by staff from other veterans mental health services to identify achievements and helpful recommendations for further improvements.

Services approached their peer reviews with openness and honesty and were very engaged in the process. We were pleased to see so many great examples of good practice and the sharing of learning through the peer review process. Services were also able to engage in networking opportunities through the peer review visits and during meetings.

Aggregated Report (2021 - 2022)

We are looking forward to sharing the findings from our latest peer review cycle in our next Aggregated Report, which will be published soon.

This will demonstrate the average compliance of standards for members that were reviewed this cycle. It will also highlight some good practice examples and the commonly unmet standards.

The report will hopefully offer a useful insight for members and non-members alike, as to what to expect when undergoing a peer review with QNVMHS.

If you would like to see findings from our pilot year, you can access our first aggregated report here.

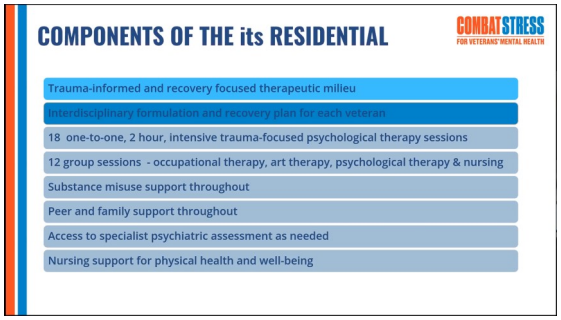
QNVMHS Annual Forum

On the 12th July 2022, we held our second annual forum for the Quality Network for Veterans Mental Health Services (QNVMHS).

The first presentation of the day was by Professor Neil Greenberg from King's College London, who spoke about a treatment trial for the Reconsolidation of Traumatic Memories (RTM) for PTSD.

Anna Owen and Charles Winstanley from the Contact Group then presented on the six priority workstreams within Contact.

Jem Jethwa and Andy Brown presented on an update from the Quality Network including findings from this years' peer review cycle.



Naomi Wilson and Dave Aitken from Combat Stress presented on innovations within Combat Stress including the intensive treatment service for complex PTSD.

Lucy Abraham and Laura Key from Veterans First Point Lothian presented on the mental health and wellbeing action plan development and the involvement with QNVMHS.

Rachel Price and Nick Grace provided a COBSEO update and insight into the new veteran mental health awareness standard.

Charis Winters from Veterans' NHS Wales presented on good practice examples in promoting diversity and inclusion.

Our final presentation of the day was by Joan Clements and Anja Rosler on the nature of caring and how the service supports carers in nature environments.

We hope you enjoyed the day. If you missed it but would like to access the recording, you can find this on Knowledge Hub, or contact us!

Useful Links

QNVMHS Website:
Quality Network for Veterans Mental Health Services | Royal College of Psychiatrists (rcpsych.ac.uk)

The Royal College of Psychiatrists:
www.rcpsych.ac.uk

Contact Group
www.contactarmedforces.co.uk

Veterans' Gateway
Advice and support for veterans & ex-forces | Veterans' Gateway (veteransgateway.org.uk)

Royal British Legion
Veterans' Gateway | Royal British Legion

General queries:
veterans@rcpsych.ac.uk

QNVMHS standards, 2nd edition
Access the standards here

Twitter
Follow us: **@rcpsych @rcpsychCCQI_**
And use **#QNVMHS** for up-to-date information

Royal College of Psychiatrists' Centre for Quality for Improvement
21 Prescot Street, London, E1 8BB

Would you like to be featured in our next newsletter?
If you have an article that you would like to submit for the next edition of our newsletter, please email us!

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