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VETERANS
QUALITY NETWORK FOR VETERANS MENTAL HEALTH SERVICES

Standards for Veterans Mental Health Services

Third Edition

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Artwork displayed on the front cover of this report was created by Kevin Reilly, entrant of the QNVMHS Artwork Competition (2022).

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Introduction

The Quality Network for Veterans Mental Health Services has been established in 2020 to support in the quality improvement of veteran mental health services in the UK. It is one of over 20 networks within the College Centre for Quality Improvement (CCQI) within the Royal College of Psychiatrists. Our purpose is to support and engage individuals and services in a process of quality improvement as part of a review cycle. We report on the quality of veterans mental health services and allow services to benchmark their practices with other similar services.

These standards have been developed from recommendations in key literature, research and in consultation with a range of stakeholders. Care has been taken to ensure that the development of these standards has taken into consideration a wide range of sources, including research, policies, NICE Guidelines and the views of professionals working in veteran mental health services.

This is the second edition of the standards which have been revised to acknowledge feedback collated from member services and to account for new developments within the field of veterans mental health.

Categorisation of standards

Each standard has been categorised as follows:
Type 1: Essential standards. Failure to meet these would result in a significant threat to service user safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment.
Type 2: Expected standards that most services should meet.
Type 3: Desirable standards that high performing services should meet.

The full set of standards is aspirational and it is unlikely that any service would meet them all.

Acknowledgements

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The Standards

Section 1: Assessment and referrals

Std No	Type	Standard	Ref
Access, referral and waiting times			
1	3	Everyone can access the service using public transport or transport provided by the service.	1
2	2	The team offers appointments both in person and virtually and veteran preference is taken into account.	1
3	1	The service provides information about how to make a referral and waiting times for assessment and treatment. *Guidance: This can be made verbally initially but would need to be followed up with written confirmation.*	1
4	2	Referrers, veterans and carers are provided with clear information on who can access the service.	2
5	2	If the service is open to self-referrals, it can demonstrate that it is actively promoting this to different sections of the community.	2
6	1	The team assess veterans, who are referred to the service, within four weeks from the receipt of referral.	1
7	2	There are systems in place to monitor waiting times and ensure adherence to local and/or national waiting times standards. *Guidance: Consideration is given to priority groups.*	2
8	2	Veterans are not excluded based solely on comorbid drug or alcohol misuse problems.	1, 2, 4
Assessment			
9	1	The team makes written communication in advance of the veteran's assessment taking place. This includes: • The name and title of the professional they will see; • An explanation of the assessment process; • Information on who can accompany them; • How to contact the team if they have any queries or require support (e.g. access to an interpreter, how to change the appointment time or have difficulty in getting there).	1, 2
10	1	Veterans feel welcomed by staff members when attending their appointments. *Guidance: Staff members introduce themselves to veterans and address them using their preferred name and correct pronouns.*	1

11	1	Veterans are given accessible written information which staff members talk through with them as soon as is practically possible. The information is in line with legislation and includes: • Their rights regarding consent to treatment; • Their rights under the Mental Health Act (or equivalent); • How to access advocacy services; • How to access a second opinion; • Interpreting services; • How to view their records; • How to raise concerns, complaints and give compliments.	1
12	2	The team ensures that screening, assessment and interventions are culturally and linguistically appropriate.	3
13	1	Veterans have a comprehensive evidence-based assessment which includes their: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development. • Suicide risk. *Guidance: This is still covered in assessments for services that do not prescribe*.	1, 3, 4
14	2	Assessments include consideration of activities that promote social inclusion such as education, employment, volunteering and other occupations such as leisure activities and caring for dependents.	2
15	2	Assessments include consideration of adverse circumstances that may be maintaining presenting difficulties (e.g. debt, employment situation, housing situation, social isolation).	2
16	1	A physical health review takes place as part of the initial assessment, or as soon as possible. This includes an assessment of comorbid chronic pain and brain injury, where relevant. *Guidance: If the service does not carry out physical health checks, there are links to ensure this is carried out by the veteran's GP*.	1, 3

17	1	Veterans have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies in line with safeguarding guidelines (with consideration of confidentiality). *Guidance: The assessment considers risk to self, risk to others and risk from others.*	1, 4
18	1	All veterans have a documented diagnosis and/or a clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.	1
19	2	The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment. The veteran receives a copy. *Guidance: Consent to share is sought as necessary.*	1, 4
Capacity and consent			
20	1	Assessments of veterans' capacity to consent to care and treatment are performed in accordance with current legislation.	1

Section 2: Care and treatment

Std No	Type	Standard	Ref
Following up people who do not attend appointments			
21	1	The team follows up veterans who have not attended an appointment/assessment. If veterans are unable to be engaged, a decision is made by the assessor/team, based on veteran need and risk, as to how long to continue to follow up the veteran. *Guidance: Where veterans consent, the carer is contacted.*	1
22	1	If a veteran does not attend for an assessment/appointment, the assessor contacts the referrer. *Guidance: If the veteran is likely to be considered a risk to themself or others, the team contacts the referrer immediately to discuss a risk action plan*	1
Care and treatment: Therapies and activities			
23	1	Veterans begin evidence-based interventions, which are appropriate for their bio-psychosocial needs, within an agreed timeframe. Any exceptions are documented in the case notes.	1, 2, 4

24	1	All treatments delivered are in accordance with appropriate guidelines e.g. NICE guidelines, Matrix for Scotland and Welsh Matrix for psychological therapies. *Guidance: Where the interventions do not fit with these guidelines, this is clearly explained.*	1, 4
25	2	The team supports veterans to undertake structured activities such as work, education and volunteering. *Guidance: For veterans who wish to find or return to work, this could include supporting them to access pre-vocational training or employment programmes. This includes referral to the Individual Placement and Support service where appropriate.*	1
26	1	The team supports veterans to undertake activities to support them to build their social and community networks.	1
27	2	The number of sessions of psychological therapies is informed by the evidence base and individual need. *Guidance: Therapeutic input should be time limited, unless a clear plan and rationale for ongoing therapy is made.*	2, 4

Section 3: Care planning

Std No	Type	Standard	Ref
Reviews and care planning			
28	1	Veterans know who is co-ordinating their care and how to contact them if they have any questions.	1
29	1	Every veteran has a written care plan, reflecting their individual needs. Staff members collaborate with veterans and their carers (with veteran consent) when developing the care plan and they are offered a copy. *Guidance: Where possible, the veteran writes the care plan themselves or with the support of staff*	1, 2
30	1	Veterans are actively involved in shared decision-making about their mental and physical healthcare, treatment and discharge planning and supported in self-management.	1
31	1	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews. *Guidance: Referrals that are urgent or that the team feel do not require discussion can be allocated before the meeting.*	1

32	1	The team records which veterans are responsible for the care of children and adults at risk of harm and takes appropriate safeguarding action when necessary.	1, 4
Discharge planning and transfer of care			
33	1	When veterans are transferred between community services there is a handover which ensures that the new team have an up-to-date care plan and risk assessment.	1, 4
34	2	Teams provide support to veterans when their care is being transferred to another community team, or back to the care of their GP.	1, 3
35	1	There are consistent arrangements for liaison with referrers at the end of therapy, if appropriate, and signposting to other services, if required.	2
36	2	A discharge letter is sent to the veteran and all relevant professionals involved (with the veteran's consent) within 10 days of discharge. The letter includes the plan for: • On-going care in the community/aftercare arrangements; • Crisis and contingency arrangements including details of who to contact; • Medication, including monitoring arrangements; • Details of when, where and who will follow up with the veteran as appropriate.	1
Clinical outcomes and measurement			
37	2	Progress against veteran-defined goals is reviewed collaboratively between the veteran and staff members during clinical review meetings and at discharge.	1, 4
38	1	Clinical outcome measurement data is collected at two time points at a minimum (assessment and discharge). *Guidance: This includes veteran-reported outcome measurements where possible.*	1, 4
39	2	The service's clinical outcome data are reviewed at least six-monthly. The data are shared with commissioners, the team, veterans and carers, and used to make improvements to the service.	1, 4
40	2	Outcome monitoring includes changes in functioning, quality of life, well-being etc., i.e. goes beyond monitoring changes in clinical symptoms.	2

Section 4: Physical healthcare

Std No	Type	Standard	Ref
Care and treatment: Medication			
41	1	When medication is prescribed, specific treatment goals are set with the veteran, the risks (including interactions) and benefits are discussed, a timescale for response is set and veteran consent is recorded. If the team does not prescribe, this information is requested from the GP or relevant service.	1
42	1	Veterans have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.*	1
43	1	Veterans who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then annually. If a physical health abnormality is identified, this is acted upon.	1
44	1	Veterans, carers and prescribers can contact a suitable clinician to discuss medications.	1
Physical healthcare			
45	1	Staff members arrange for veterans to access screening, monitoring and treatment for physical health problems through primary/secondary care services. This is documented in the veteran's care plan. *Guidance: This could be done by the veteran's GP.*	1
46	1	Veterans are offered personalised healthy lifestyle interventions, such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the veteran's care plan.	1

Section 5: Veteran and carer experience

Std No	Type	Standard	Ref
Veteran and carer involvement			
47	1	The service asks veterans and carers for their feedback about their experiences of using the service and this is used to improve the service.	1

48	2	Services are developed in partnership with appropriately experienced veterans and carers and have an active role in decision making.	1
Carer engagement and support			
49	2	Carers (with veteran consent) are involved in discussions and decisions about the veteran's care, treatment and discharge planning.	1, 3
50	2	Carers are offered individual time with staff members to discuss concerns, family history and their own needs.	1
51	2	The team provides each carer with accessible carer's information. *Guidance: Information is provided verbally and in writing (e.g. carer's pack). This includes:* • *The names and contact details of key staff members in the team and who to contact in an emergency;* • *Local sources of advice and support such as local carers' groups, carers' workshops and relevant charities;* • *Advice about how the carer can access specific care through the Veterans Gateway and/or similar;* • *Advice on how they can support the veteran accessing treatment, including what to do if they do not engage with, or drop out of treatment.*	1
52	3	The service actively encourages carers to attend carer support networks or groups. There is a designated staff member to support carers.	1
53	2	Carers are supported to access a statutory carers' assessment where applicable, provided by an appropriate agency. *Guidance: This advice is offered at the time of the veteran's initial assessment, or at the first opportunity.*	3
Compassion, dignity and respect			
54	1	Staff members treat veterans and carers with compassion, dignity and respect.	1
55	1	Veterans feel listened to and understood by staff members.	1

Section 6: Information for veterans and carers

Std No	Type	Standard	Ref

Providing information to veterans and carers			
56	1	Veterans are asked if they and their carers wish to have copies of correspondence about their health and treatment.	1
57	2	The service uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The veteran's relatives are not used in this role unless there are exceptional circumstances.	1, 3
58	1	The service can provide information in a range of formats to suit individual needs. *Guidance: The service should be able to provide key information in languages other than English, and in an accessible format for people with sight, hearing, learning or literacy difficulties).*	2
59	1	Veterans (and carers, with veteran consent) are offered written and verbal information about the veteran's mental illness and treatment. *Guidance: Verbal information could be provided in a one-to-one meeting with a staff member or in a psycho-education group. Written information could include leaflets or websites.*	1
60	2	Veterans are provided with information on their treatment (covering choice of time of day, venue, type of therapy, therapist gender and access in a language other than English).	1, 3
61	2	Veterans are provided with information about who to speak to if they are experiencing difficulties with the therapy process, which they do not feel able to speak to the therapist about.	2
62	3	The service supports veterans to access peer support groups.	3
Veteran confidentiality			
63	1	Confidentiality and its limits are explained to the veteran and carer, both verbally and in writing. Veteran preferences for sharing information with third parties are respected and reviewed regularly.	1, 4
64	1	The team knows how to respond to carers when the veteran does not consent to their involvement.	1
65	1	Staff know how to respond if a veteran discloses instances of unlawful behaviour while serving and have an understanding of moral injury and war crimes. This includes how to escalate concerns.	

66	1	All veteran information is kept in accordance with current legislation. *Guidance: This includes transfer of veteran identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	1, 4

Section 7: Staff training and support

Std No	Type	Standard	Ref
Leadership, team working and culture			
67	3	Staff members are able to access reflective practice groups at least every six weeks where teams can meet to think about team dynamics and develop their clinical practice.	1
68	1	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.	1
69	1	Staff know how to escalate concerns about a veteran's risk to more senior staff.	4
Staff recruitment, induction and supervision			
70	2	Veteran or carer representatives are involved in the interview process for recruiting potential staff members. *Guidance: These representatives should have experience of the relevant service*	1
71	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. *Guidance: This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met.*	1
72	1	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. *Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.*	1, 4
73	2	All staff members receive line management supervision at least monthly.	1

74	1	All staff members who deliver therapies and activities are appropriately trained and supervised.	1, 4
75	1	Where therapies are provided by an outsourced organisation, the service takes reasonable and practicable steps to ensure that all members of staff who provide therapies on behalf of their service have received formal training to perform as a competent practitioner in each of the therapies they provide. *Guidance: This might take the form of a formal memorandum of understanding or service level agreement between the two organisations which clearly sets out the responsibilities for ensuring therapists are appropriately trained and supervised.*	2, 4
Staff wellbeing			
76	1	The service actively supports staff health and wellbeing. *Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.*	1
77	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *Guidance: Staff have the right to one uninterrupted 20-minute rest break during their working day if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.*	1
78	1	Staff members, veterans and carers who are affected by a serious incident are offered post incident support. Guidance: This includes attention to physical and emotional wellbeing of the people involved and post-incident reflection and learning review.	1
Staff training and development			
79	1	The team including bank and agency staff are able to identify and manage an acute physical health emergency.	1
80	1	Staff receive training on the use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	1
81	1	Staff have an understanding of physical health problems, including when to refer the veteran for specialist input.	1

82	1	Staff receive training on safeguarding adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.*	1, 4
83	1	Staff receive training on risk assessment and risk management. *Guidance: This includes assessing and managing suicide risk and self-harm.*	1, 4
84	1	Staff receive training in the principles of trauma-informed care and treating trauma related disorders including PTSD.	1
85	1	Staff receive training on military culture covering issues such as: • The regimental system (and equivalent) • Implications/effects of deployment on active service • How those in the armed forces are supported • The unique military bond with colleagues • Military vocabulary and communication • The challenges of transition to civilian life	1
86	1	Staff have an understanding on recognising and communicating with veterans with neurodevelopmental disorders.	1
87	2	Staff receive training on carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	1
88	2	Veterans and carers are involved in delivering and developing staff training.	1
89	1	All qualified clinical staff are registered with a relevant professional or regulatory body.	2

Section 8: Governance

Std No	Type	Standard	Ref
Interface with other services			
90	1	Veterans can access help, from mental health services, 24 hours a day, 7 days a week. *Guidance: Out of hours, this may involve crisis/home treatment teams, psychiatric liaison teams, Veterans Gateway.*	1, 2

91	1	The team supports or signposts veterans to access: • Housing support; • Support with finances, benefits and debt management; • Social services.	1
92	2	The service/organisation has a care pathway for the care of women in the perinatal period (pregnancy and 12 months postpartum) that includes: • Assessment; • Care and treatment (particularly relating to prescribing psychotropic medication); • Referral to a specialist perinatal team/unit unless there is a specific reason not to do so.	1
93	1	Where management is shared between primary and secondary care, healthcare professionals should agree who is responsible for monitoring the veteran. This agreement should be put in writing (if appropriate, using the Care Programme Approach) and involve the veteran and, if appropriate, their family or carers.	3
Staffing levels			
94	1	The service has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-essential services.	1
95	1	When a staff member is on leave, the team puts a plan in place to provide adequate cover for the veterans who are allocated to that staff member.	1
The service learns from feedback, complaints and incidents			
96	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	1, 4
97	1	When serious mistakes are made in care this is discussed with the veteran themselves and their carer, in line with the Duty of Candour agreement.	1, 4
98	1	Lessons learned from untoward incidents are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.	1, 2, 4

99	2	The team is actively involved in quality improvement activity.	1
100	2	The team actively encourages veterans and carers to be involved in quality improvement initiatives.	1
Governance			
101	1	The service has a written policy on managing different levels of risk.	2, 4
102	1	There are measures in place to ensure staff are as safe as possible when conducting home visits. These include: • Having a lone working policy in place; • Conducting a risk assessment • Identifying control measures that prevent or reduce any risks identified	1
103	1	The service reviews data at least annually about the people who use it. Data are compared with local population statistics and actions taken to address any inequalities of access that are identified.	1
104	2	There is a service-level equality and diversity strategy in place to promote inclusion for staff, veterans and carers. *Guidance: This should take into account consideration of different protected characteristics*.	2
105	1	The service can demonstrate that it promotes culturally sensitive practice. *Guidance: This includes issues concerning military families including children; as well as minority groups*.	2
106	2	Where demographic data is available in feedback received from veterans and carers, this is analysed and explored to identify any differences of experiences according to protected characteristics.	1
107	2	There are coherent care pathways linking the service with other health and social care provision.	2
108	1	There is a complaints and compliments policy/procedure in place. Periodic analysis should be carried out to identify trends or themes and issues reported and action taken accordingly.	4
109	2	Gaps in local service provision are identified and steps are taken to improve availability of appropriate treatment options for veterans with unmet needs, either within the service or by highlighting the need for the development of alternative services.	2

110	3	The service reviews the environmental and social value of its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/ minimising waste and low carbon interventions). *Guidance: Progress against this improvement plan is reviewed at least quarterly with the team.*	1

Section 9: Service environment

Std No	Type	Standard	Ref
Service environment			
111	2	The environment is clean, comfortable and welcoming.	1, 2
112	1	Clinical rooms are private, and conversations cannot be overheard.	1
113	1	The environment complies with current legislation on disabled access. *Guidance: Relevant assistive technology equipment, such as handrails, are provided to meet individual needs and to maximise independence.*	1
114	1	There is a system by which staff are able to raise an alarm if needed.	1
115	2	The team avoid exposing people to triggers that could worsen their symptoms or stop them from engaging with treatment, for example, assessing or treating people in noisy or restricted environments.	3

Glossary of terms

Term	Definition
Bank staff	Workers who can be contacted by an employer when the need arises to take on temporary shifts.
Carer	Anyone, including children and adults who support a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction. This includes, but is not limited to, statutory carers.
Clinical Diagnosis	The process of identifying and determining the nature of a disease or disorder by its signs and symptoms, through the use of assessment techniques (e.g., tests and examinations) and other available evidence.
Clinical Formulation	A theoretically-based explanation or conceptualisation of the information, obtained from a clinical assessment to help understand a person's problems.
Clinical Outcome Measurement Data	Clinical outcomes are measurable changes in health, function or quality of life that result from our care. Clinical outcomes can be measured by activity data such as re-admission rates or agreed scales, to determine progress and efficacy of care and treatment provided by healthcare providers.
Confidentiality	When collecting patient information every organisation that provides health and care services has the responsibility to: Keep data secure Use data that cannot identify the patient whenever possible Use data to benefit health and care Not use data for marketing or insurance purposes (unless the patient requests this) Make it clear why and how data is being used
Consent to care and treatment	A person must give permission before they receive any type of medical treatment, test or examination. This must be done on the basis of an explanation by a clinician.
Co-production	Refers to engaging and communicating with the service user and their family members (where appropriate) in the development of various

	documents to ensure that support is person-centred.
Disabled access	The design of products, environments, and services that ensure people with disabilities can access them.
Duty of Candour	Obligation under *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20*. Stipulates that service providers need to be open and transparent with people who use their services.
European Working Time Directive	Initiative designed to prevent employers requiring their workforce to work excessively long hours, with implications for health and safety.
Evidence-based	The integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences.
Handover	The process of a structured patient handover during transitions of care. This includes sharing complete and up-to-date care information with the new care provider and clearly defining roles and responsibilities between current and new care providers.
Lone working	Any situation or location in which someone works without a colleague nearby or when someone is working out of sight or earshot of another colleague.
Mental Capacity Act	A law which is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment.
Mental Health Act	A law under which people can be admitted or kept in hospital, or treated against their wishes, if this is in their best interests or for the safety of themselves or others.
Neurodevelopmental disorders	Types of disorder that influence how the brain functions and alters neurological development, causing difficulties in social, cognitive, and emotional functioning.
Peer Support Groups	Groups that bring together people with shared experiences to help and support each other.
Protected characteristics	Everyone is protected under the *Equality Act 2010* from discrimination because of: age disability

	gender reassignment marriage and civil partnership pregnancy and maternity race religion or belief sex sexual orientation
Psychological therapies	Effective and confidential treatments delivered by fully trained and accredited practitioners.
PTSD	Post-traumatic stress disorder is an anxiety disorder caused by very stressful, frightening or distressing events.
Quality improvement	A method used to make improvements. This includes identifying the quality issue, understanding the problem, developing a theory of change, testing potential solutions and implementing the most appropriate solution
Referral	The professional makes contact with the referral service and/or professional directly on behalf of the client.
Reflective Practice	The ability for people to be able to reflect on their own actions and the actions of others to engage in continuous learning and development.
Safeguarding	Protecting people's health, well-being and human rights, and enabling them to live free from harm, abuse, and neglect.
Signpost	The professional directs people to useful information and/or other professionals to offer support and advice.
Statutory carers' assessment	An assessment that looks at how caring affects a carer's life, including for example physical, mental and emotional needs, the support they may need and whether they are able or willing to carry on caring.
Veteran	Anyone that has actively served in the armed forces for at least one day.
Whistleblower	A whistleblower is a worker who reports certain types of wrongdoing. This will usually be something they have seen at work – though not always. The wrongdoing they disclose must be in the public interest.

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