All Wales Veterans' Health

&
Wellbeing Service

Report April 2010 – March 2012

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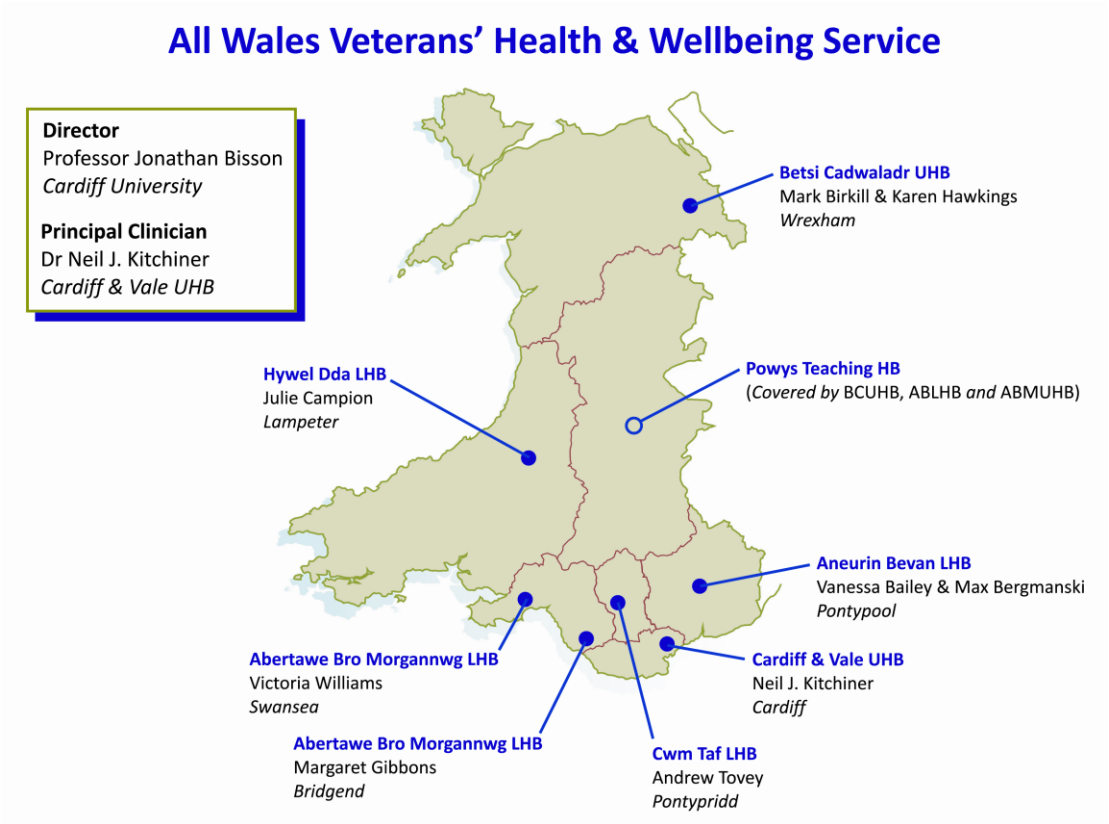
August 2012

Figure 1 AWVHWS with Local Health Board boundaries



All Wales Veterans Health and Wellbeing Service (AWVHWS)

Introduction

This report will describe the activity of the AWVHWS from its inception April 2010 to March 2012. The Welsh Government has agreed to fund the NHS in Wales to set-up and manage a community out-patient service for ex-service personnel who reside in Wales and have a service related mental health condition.

The first veteran therapist (VT) to be appointed was Margaret Gibbons in September 2010, in **Abertawe Bro Morgannwg LHB**. Margaret is based in Bridgend CMHT, 71 Quarella Road and works fulltime. She was joined by a part-time administrative assistant Jacqui Pugh on the 16th June 2011.

Neil Kitchiner was appointed as the Principal Clinician to the AWVHWS and VT for **Cardiff and Vale UHB** 16th January 2011. Neil is based within the Traumatic Stress Service at Monmouth House, University Hospital of Wales. He was joined by Sharon Bowles, administrator who works fulltime for the service in April 2011.

Andy Tovey was appointed as the fulltime VT for **Cwm Taf LHB** July 2011. Andy is based in the Maritime Resource Centre, Woodland Terrace, Maesycoed, Pontypridd. He also provides one assessment session weekly to Cardiff and Vale UHB. He was joined by Maria Moruzz, part-time administrator September 2011.

Vanessa Bailey was appointed as the **Aneurin Bevan LHB** fulltime VT, September 2011. She was initially joined by Sylvia Carr who worked part-time as a VT. Max Bermanski took over this part-time role on the 2nd April 2012. The administrator is Louise Williams who is part-time and started her post XX. The team are based at Talygarn County Hospital, Coed-Y-Gric Road, Pontypool.

Julie Campion was appointed as the fulltime VT for **Hywel Dda LHB**, October 2011. She was joined by part-time administrator Lynne Blesovsky, January 2012. The office is based at Llys Steffan, Temple Terrace, Lampeter, Ceredigion. Julie does have satellite clinics across the LHB.

Karen Hawkings (part-time) and Mark Birkill (full-time) were appointed as the veteran therapists December 2011. They are based in Psychological Therapies Department, Swn-y-Coed, Grove Road, Wrexham with **Betsi Cadwaladr, UHB**. Their administrator has recently left the part-time post and they are currently recruiting.

In **Powys the teaching health board** the veteran service is delivered by neighbouring LHB: Betsi Cadwaladr Health Board for those who live in Montgomeryshire; Aneurin Bevan for those who live in Brecon or Radnorshire; and Abertawe Bro Morgannwg for those who live in Ystradgynlais.

The Welsh Government (WG) remains committed to improving support and treatment for ex-service personnel (military veterans). This, together with the initial success of the Welsh MOD/WAG funded pilot 2008 - 2010, led to the creation of a National Task and Finish Group to develop a service specification for an all Wales service for ex-service personnel. The Group met on five occasions between 16 July 2009 and 3 December 2009. The specification has been informed by evidence obtained from the following sources:

a. Existing literature regarding the needs of veterans and the provision of services for them.
b. Discussions with veterans, their carers and individuals involved in the psychosocial care of veterans.
c. Ongoing psychosocial research into the needs of veterans living in Wales.
d. The experiences of the six Community Veterans Mental Health Service Pilot Projects across the United Kingdom, with particular reference to the Pilot

Project based in Wales which covered the Cardiff and Vale and Cwm Taf NHS Trusts (LHBs from 1 October 2010).

Aims and outcomes

The primary aim of the AWVHWS is to improve the mental health and wellbeing of veterans.

The secondary aim is to achieve this through the development of sustainable, accessible and effective services that meet the needs of veterans with mental health and wellbeing difficulties who live in Wales.

The above LHB veteran services are firmly based within existing NHS and Social Care Services and fully integrated with the other services and agencies that cater for the health and social needs of veterans. The service has developed into the primary service for veterans with service related mental health problems across Wales. It is vital part of the welfare pathway for veterans and part of a stepped care approach to ensure veterans' needs are addressed by the most appropriate agency. The service signposts veterans to appropriate veterans and NHS services if there are any out standing issues after a course of out-patient therapy.

The key outcomes of the service are:

A. Veterans who experience '*service related*' mental health and wellbeing difficulties are able to access and use services that cater for their needs.
B. Veterans in this service are given a comprehensive assessment that accurately assesses their psychological and social needs.
C. Veterans are signposted or referred to appropriate services for any physical needs that are detected.
D. Veterans and others involved in their care are able to develop an appropriate care management plan that takes their family and their surroundings into account.
E. Veterans' families are signposted to appropriate services if required.

F. This service will develop local and national networks of services and agencies involved in the care of veterans to promote multi-agency working to improve outcomes for veterans and their families.
G. The service will link with the military to facilitate early identification and intervention.
H. The service will promote a recovery model so that veterans can maximise their physical, mental and social well being.
I. To provide brief psychosocial interventions.
J. To provide expert advice and support to local services on the assessment and treatment of veterans who experience '*service related*' mental health difficulties to ensure local services, including addictions services, are able to meet the needs of veterans.
K. To raise awareness of the needs of veterans and military culture to ensure improved treatment and support across services.
L. To identify barriers to veterans accessing appropriate services and attempt to highlight and address these as appropriate.
M. To collect data on patterns of referral, routine outcomes and referral on.

Eligibility

Any veteran living in Wales who has served at least one day with the British Military as either a regular service member or as a reservist who has a *'service related'* injury. The service decided to limit eligibility to service related injuries only due to high numbers of referrals where this was clearly not linked. The service has capacity issues with often one clinician in one LHB which has seen waiting lists grow to up to 8 months for treatment.

Access

A centralised open referral system has been adopted whereby veterans are able to self-refer, be referred by their families or by other agencies or services. Referral can be via the service website www.veteranswales.co.uk on line referral form or directly to each LHB.

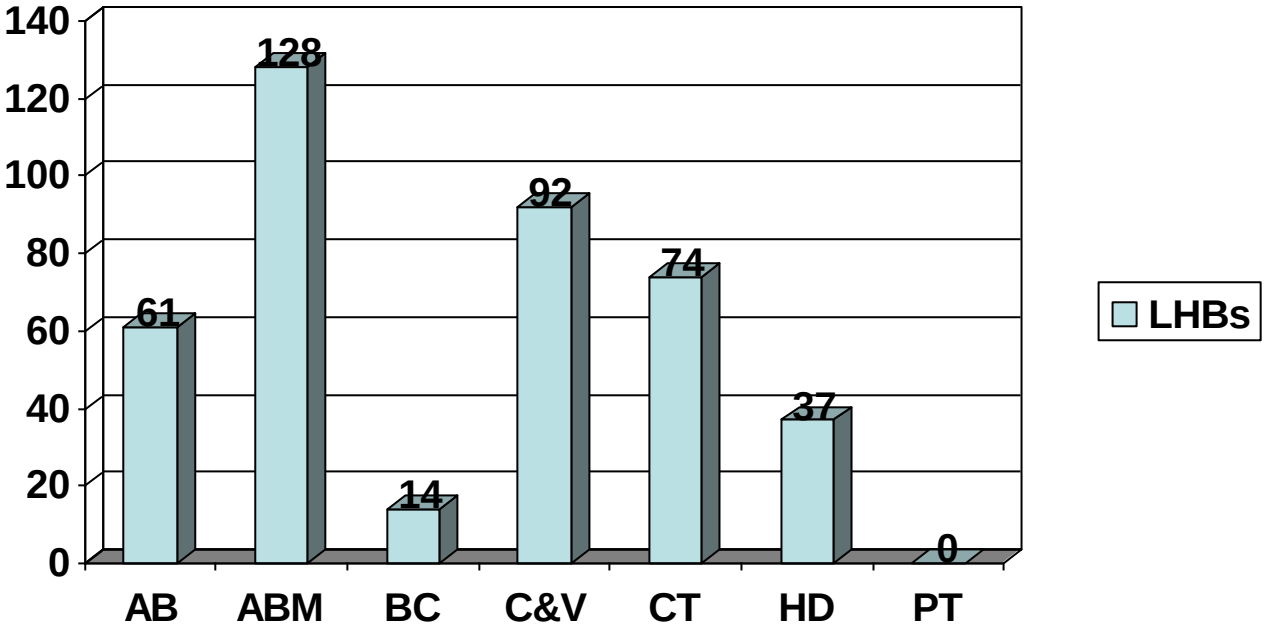
Integrated Care Pathway (ICP) for Ex-service Personnel

The service has developed and tested a specific ICP over several years. ICP's within healthcare are increasingly common. A definition of an ICP is:

"the right people, doing the right things, in the right order, at the right time, in the right place, with the right outcome" (National Electronic Library for Health, 2005).

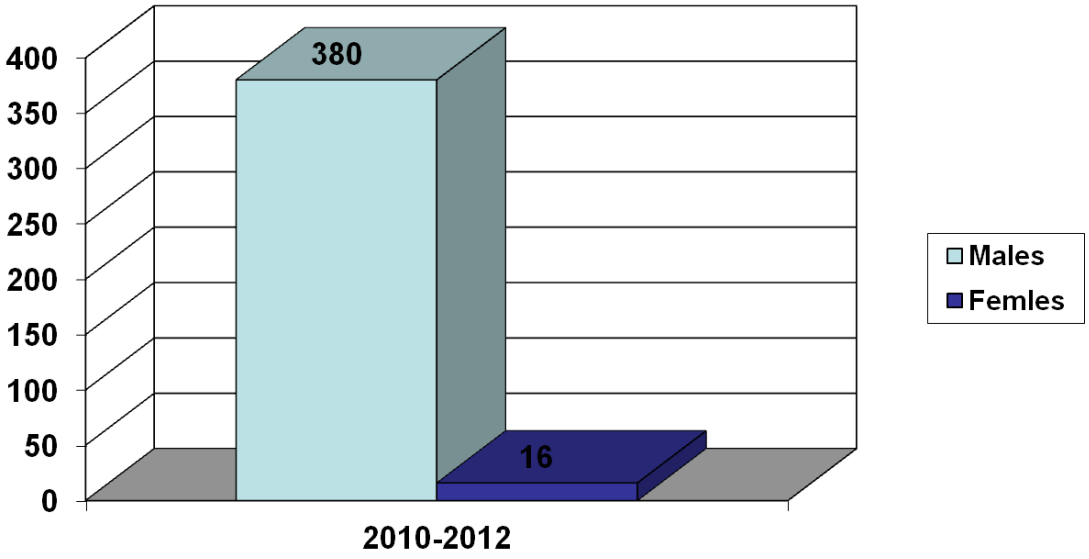
The ICP developed in Cardiff and Vale/Cwm Taf NHS trusts has provided evidence that ex-service personnel will engage with service as out-patients. The ICP has been used as a template for the service across Wales. As part of the ICP there is a standardised minimum data set (MDS) which is collected on each individual assessed by a the veteran therapist and stored centrally in the service hub at Cardiff.

Graph 1 - Number of individuals referred April 2010-March 2012



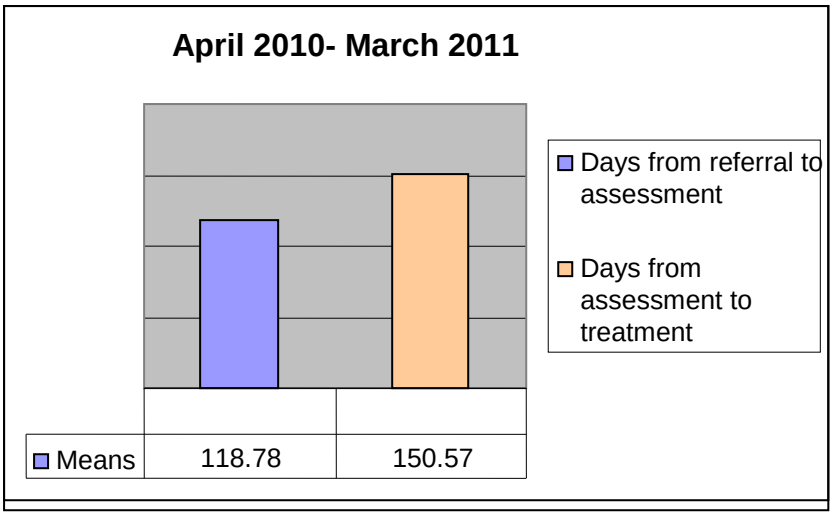
Graph one provides data on the 396 referrals by each LHB since the WG funded the service in April 2010–March 2012. Cardiff and Vale, and Cwm Taf continued to receive a steady number of referrals following the pilot phase 2008-2010. ABM UHB has consistently received a large number of referrals since the VS went live there in September 2010. The high referral rate is probably in part due to the large urban areas within its boundaries of Bridgend, Neath, Port Talbot and Swansea. In contrast BCUHB have received the least amount of referrals so far.

Graph 2 - Referral by gender

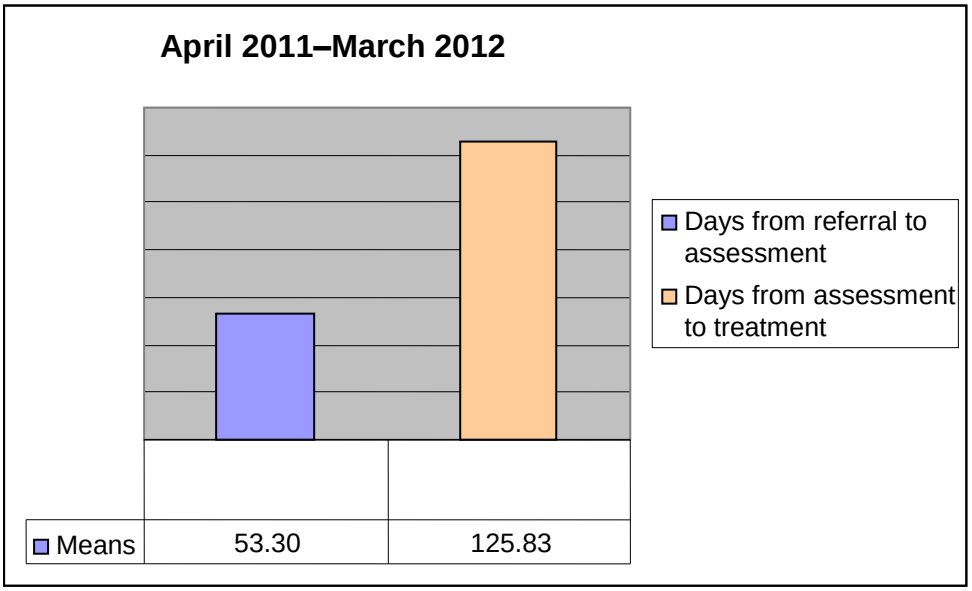


The majority of referrals made to the service were male. Only 3.5% were females referred to the service. This is in contrast to the number of currently serving female personnel which in June 2012 was 9.7%. This low rate might be due to female veterans already accessing traditional NHS mental health services and feel less stigmatised asking for help. The WG has asked all GPs to record all new veteran patient with a specific code.

Graph 3 & 4 - Length of time from referral to assessment, & assessment to treatment with a VT in AWVHWS



Graph 4



The two graphs demonstrate that the VTs are reducing the time individuals referred into the service have to wait for an assessment from 119 to 53 days a reduction of 66 days. Once assessed and added to the service treatment waiting list, individuals wait a mean of 126 days a reduction of 26 days from the previous year. The service expects the introduction of initiatives such as limiting access to individuals with ***service related*** disorders to reduce this figure substantially in the coming year. VTs are also discharging individuals sooner who do not commit to out-patient treatment.

Age range of individuals referred

Graph 5 – mean age

Age Range	Mean
19 – 88	41.58

The age of individuals referred ranged from 19 – 88 with a mean age of 41.5 years. There is a trend of younger veterans being referred to the service from the recent conflicts in Iraq and Afghanistan.

AWVHWS Website

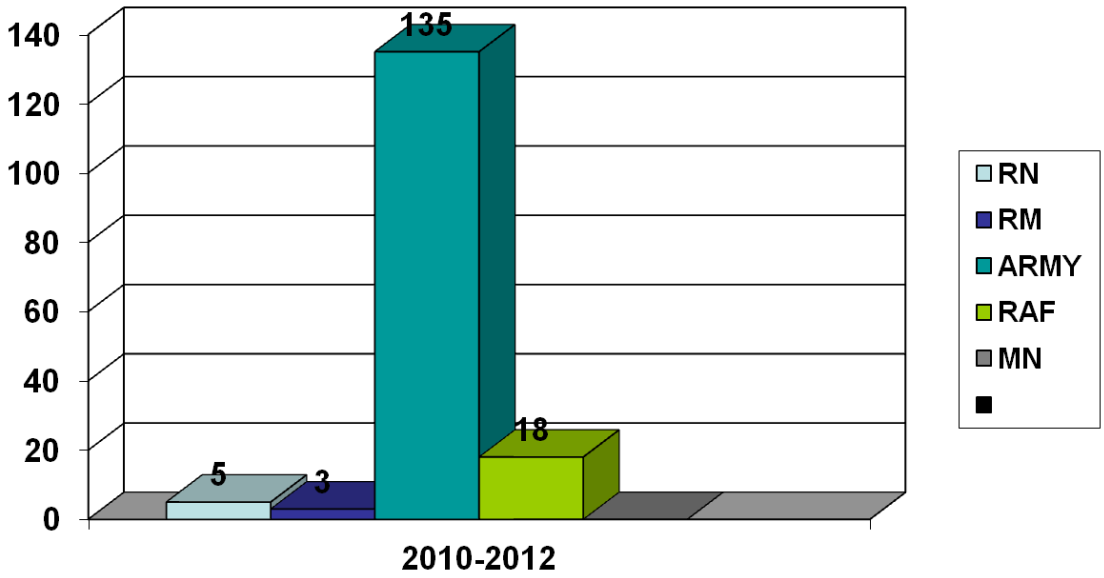
Graph 6 – website referrals

No	Yes
299	50

The website was specifically designed to be a resource for the public and professionals. It contains video clips of the Director and Principal Clinician providing an overview of the service, contact details of each VS LHB, an on-line referral form, and links to a variety of veteran specific agencies and charities. The site has been developed as the service has evolved and will continue to be updated with new information.

The self-referral option form via the on-line referral form resulted in 50 referrals during this period. The webmaster is currently adding an on-line professional/case worker referral form to replace the current paper one which can be downloaded.

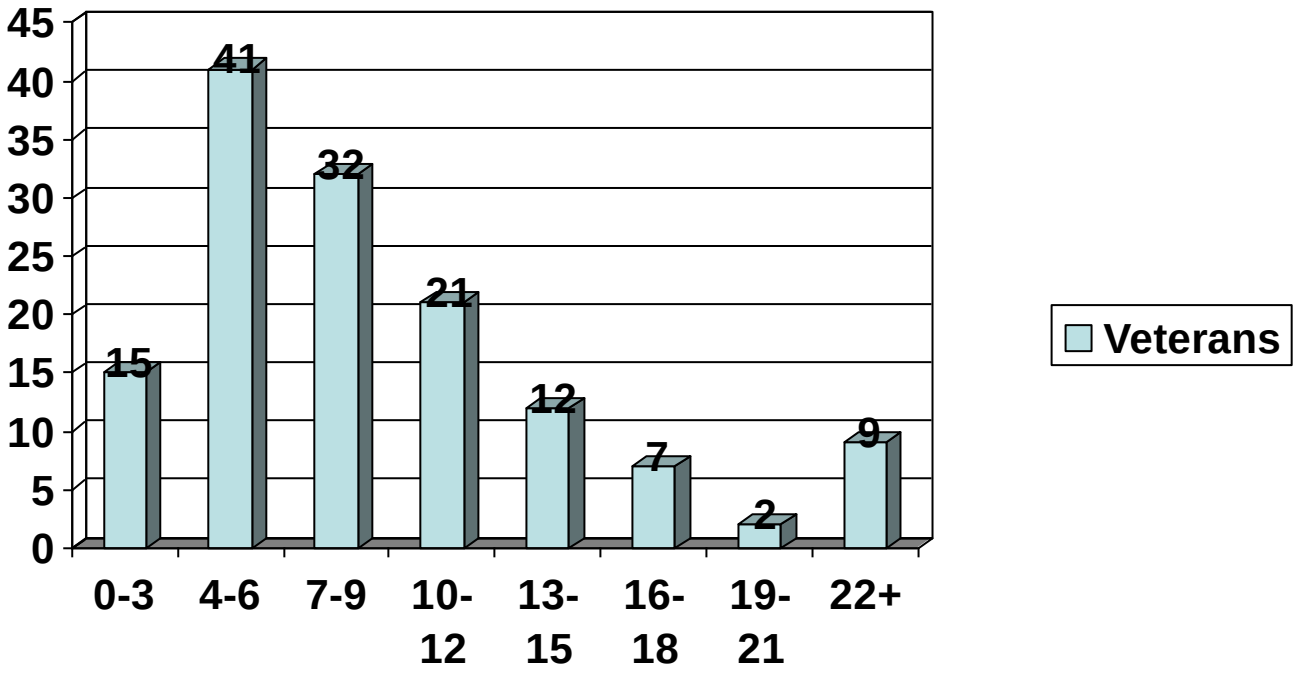
Graph 7 – Referral by service



The majority of referral has served time in the army, particularly within the infantry regiments. This is perhaps not surprising as the army are the largest

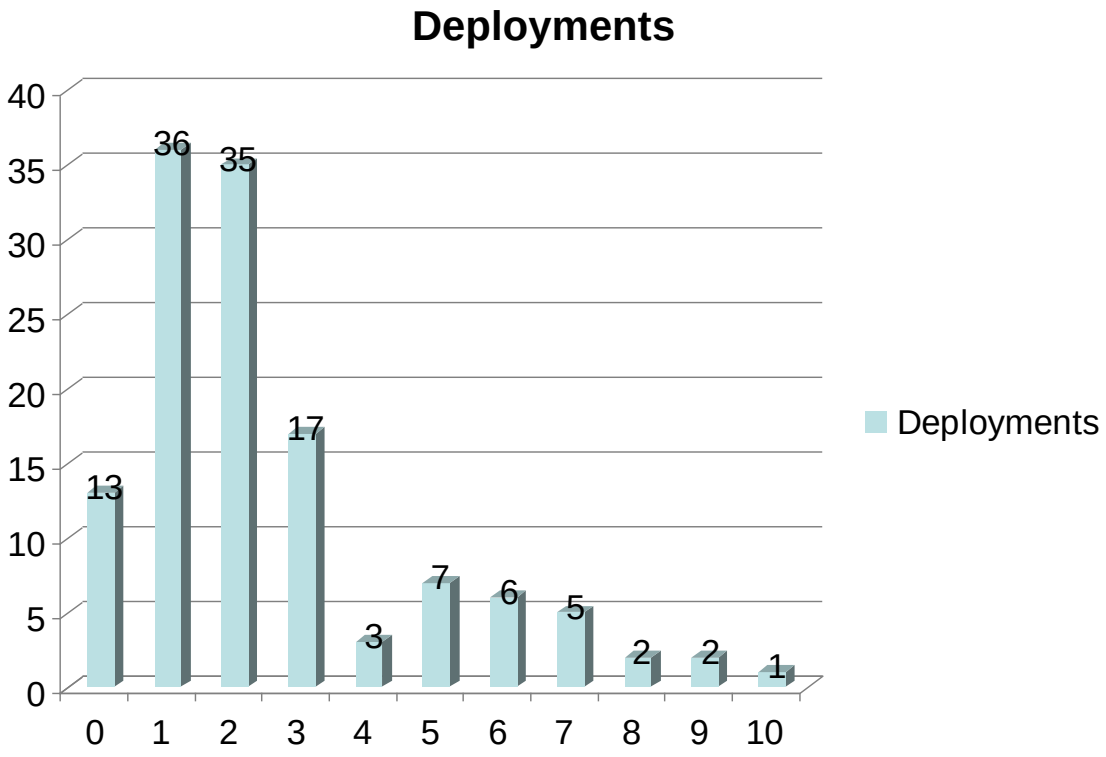
of the AF services. The trained strength of the UK Armed Forces was 168,180 at 1 July 2012. This was a 2.2% deficit against the requirement of 171,980. As of 1/7/12 the Navy employed 32,810, army 97,820 and RAF 37,560.

Graph 8 – Number of years served in AF



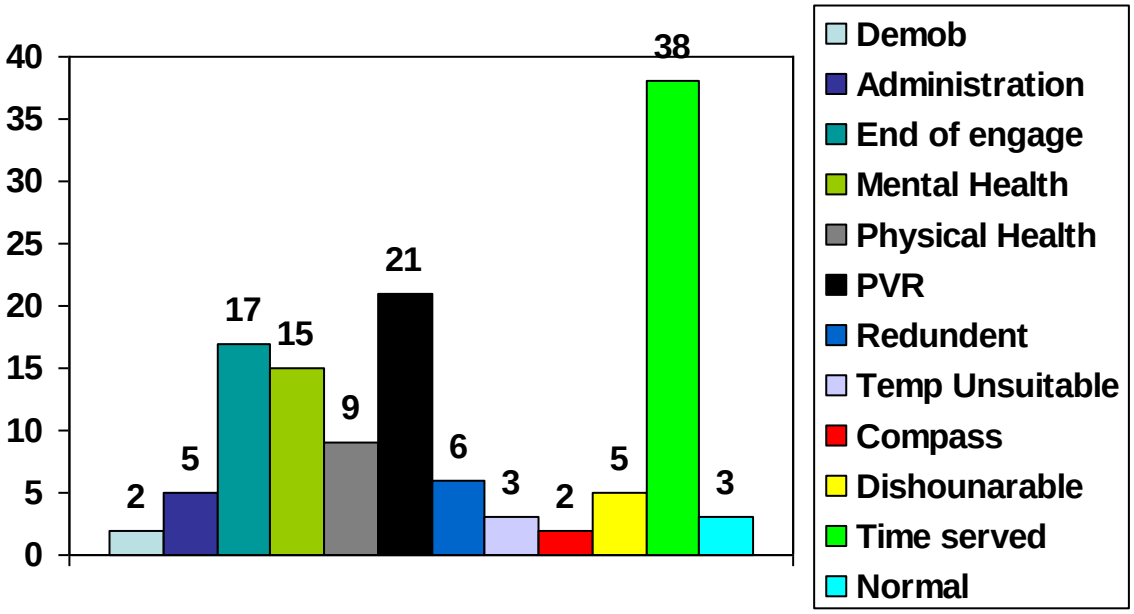
The graph shows that the majority of the veterans being assessed by the AWVHWS completed 3-12 years service. Early service leavers defined as those that leave service within 4 years, with the highest number leaving between 4-6 years. A recent study revealed an association between service personnel hospitalisation for a mental health problem and low rate of retention in service. Discharge from the AF was associated with holding a junior rank, fewer than five years service, having a combat role, being male and receiving AF community mental health team treatment prior to admission (Jones et al, 2009).

Graph 9 – Total number of deployments in AF



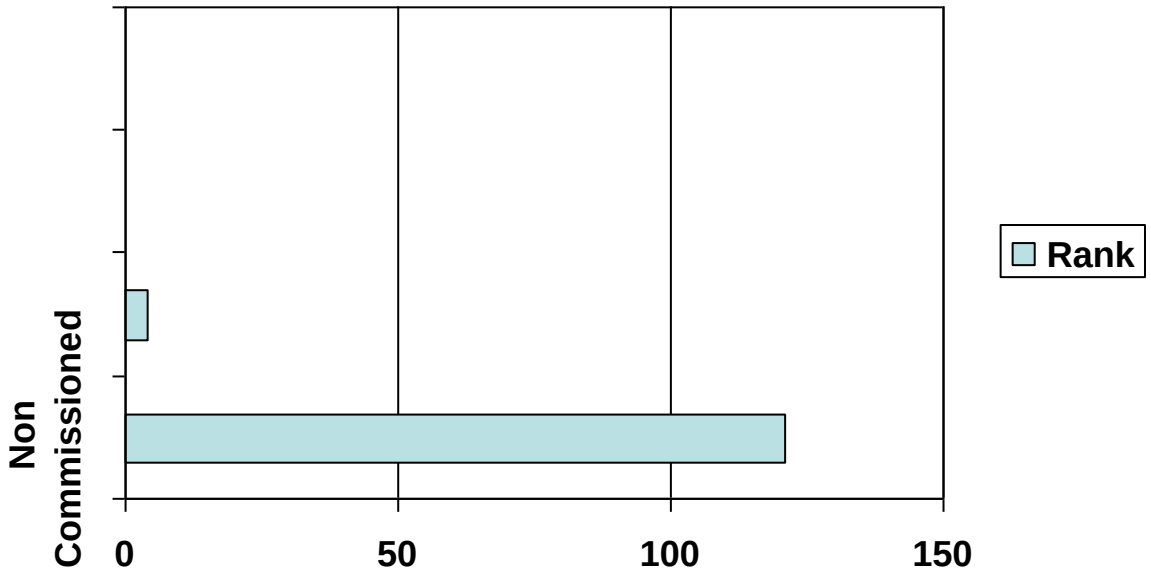
The majority of the veterans screened reported being deployed with the AF usually to a combat theatre. Those that did not deploy were often serving in the Navy or RAF. Northern Ireland was the most common destination reported. Deploying between one to three times was the average rate.

Graph 10 – Reason for discharge



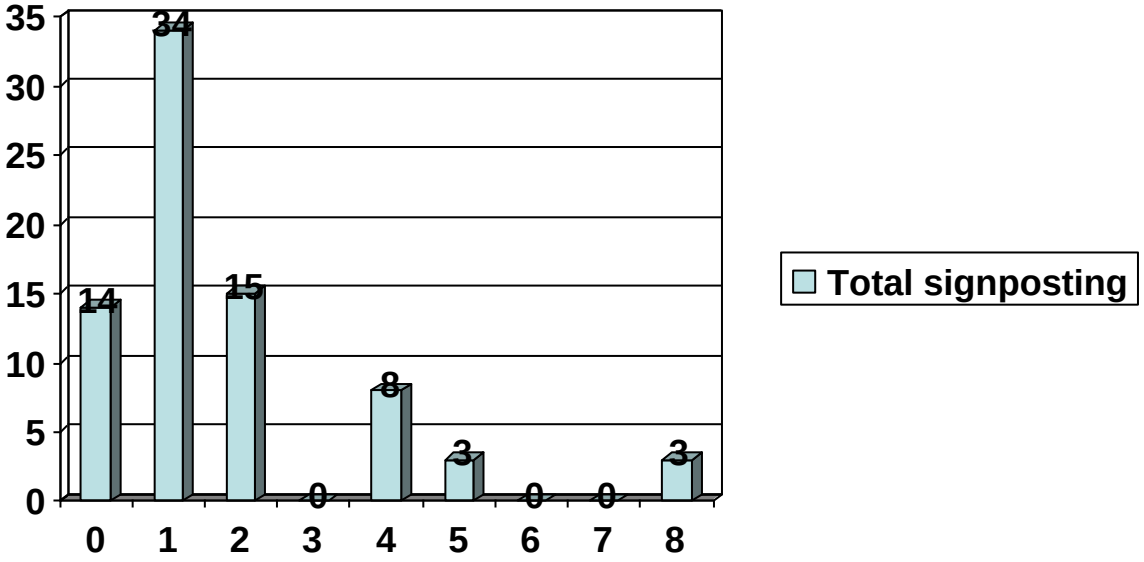
The most common reason for discharge reported was the individual having completed their contracted years and resigning their post or buying their way out of their contact, known as premature voluntary release (PVR). Health related reasons (mental or physical) make up the second largest reason for leaving the AF.

Graph 11 – Highest rank on leaving AF



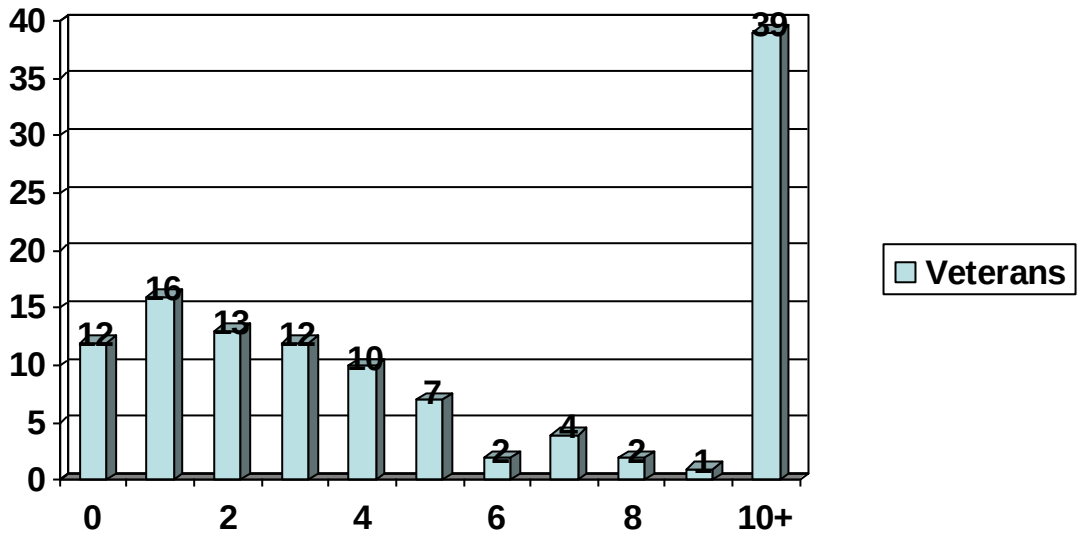
The majority of the veterans referred reported coming from the junior ranks of all three services. Veteran commissioned officers may find it more difficult to seek help for mental health problems due to past rank and the perceived stigma. As already mentioned mental health problems are higher in males from the lower ranks.

Graph 12 – Total number of signposting



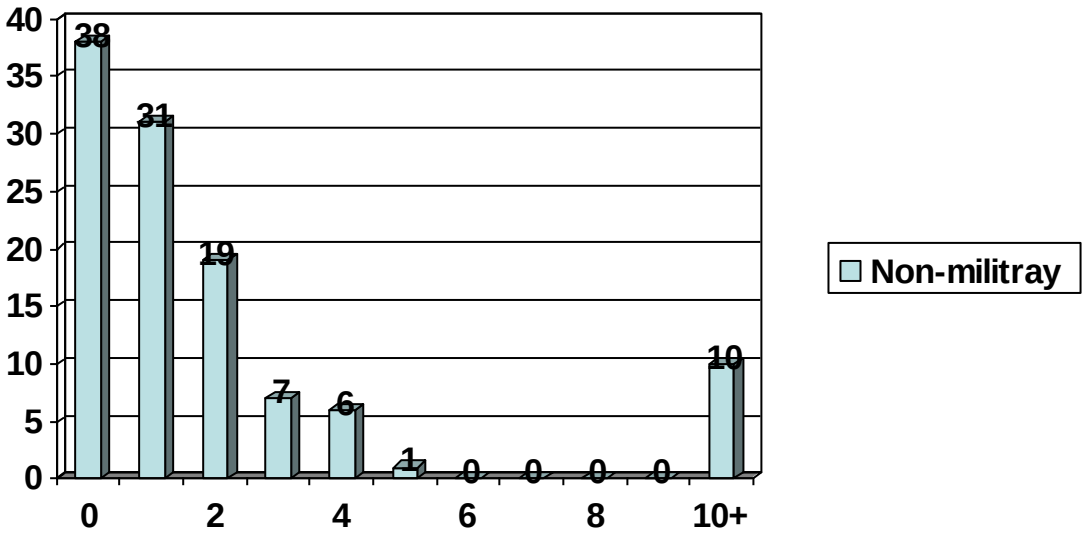
Many of the veterans screened present as complex individuals with a mixture of health and social problems. It usually requires several agencies to become involved to alleviate social issues, including debt advice and management, claiming appropriate benefits, war pension/armed forces compensation claims, obtaining white/brown goods for the home, occupational and training opportunities. The key agencies referred to include the Royal British Legion, Citizens Advice Bureau, Serving Personnel and Veteran Agency, Soldiers, Sailors, Air forces Families Association and the NHS.

Graph 13 – Total number of DSMIV military traumatic events



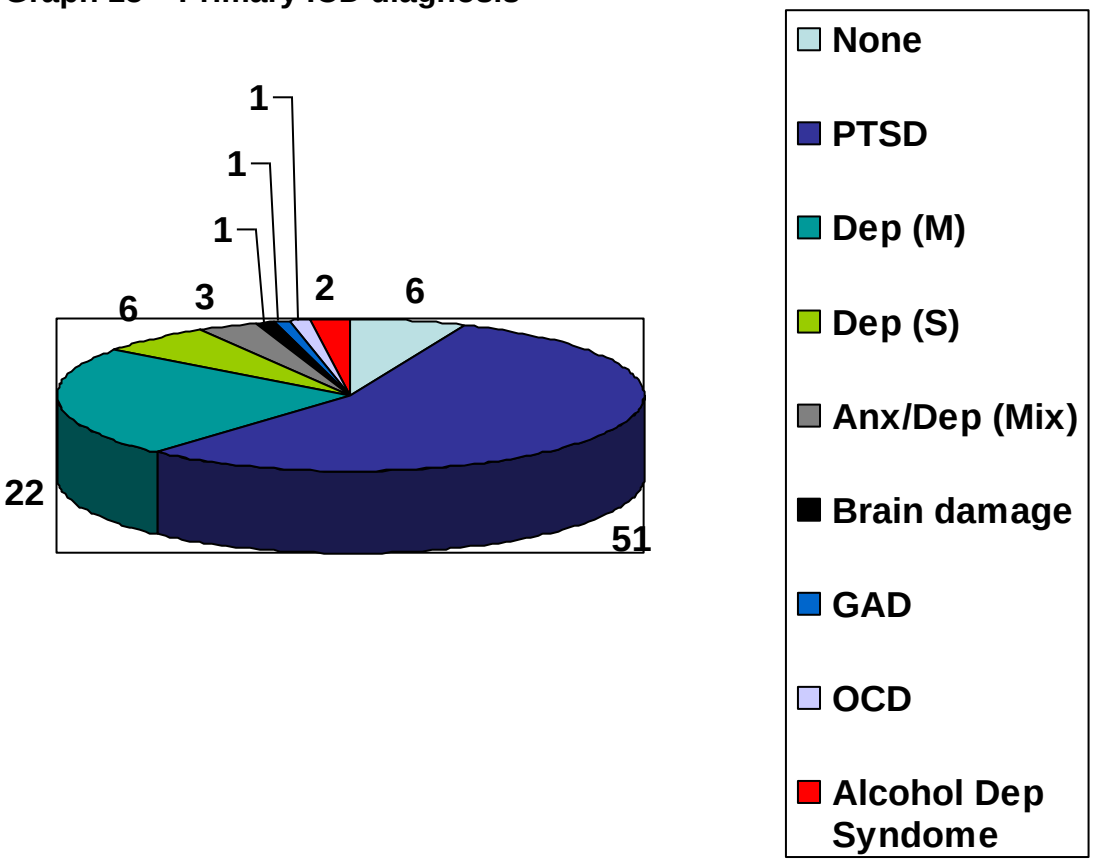
All veterans are asked about traumatic events that may have occurred during AF service and as a civilian, by using the initial questions used to diagnose Post Traumatic Stress Disorder (PTSD) from DSMIV (APA, 1994). Graph 13 indicates that the majority reported at least one traumatic event that would have fulfilled current criteria with many reported several events. More recent veterans with deployments to Iraq and Afghanistan report daily contacts with enemy forces where they feared for their lives and witnessed others being seriously injured of killed with emotions of fear, horror or helplessness.

Graph 14 – Non-military traumatic events



The same question was asked about non-military traumas. The majority also reported traumatic events including abuse in childhood, assault, sexual assault, road traffic collisions, industrial accidents. Those individuals with traumatic histories prior to joining the AF are most certainly predisposed to mental health problems in the future. UK AF studies into the presence of PTSD symptoms was associated with coming from the lower ranks, being un-married, lower educational attainment and a history of childhood adversity (Iversen et al, 2008).

Graph 15 – Primary ICD diagnosis



Of those veterans who were diagnosed with a mental health disorder the majority were among the anxiety and depressive disorders, particularly chronic PTSD often with co-morbidity. Graph 15 only reports on the main mental health disorder.

Minimum data set (MDS)

All veterans are asked to complete a MDS as part of the assessment process. This includes the use of six self-report clinical measures used to measure anxiety, depressive, PTSD, alcohol and quality of life. These are taken at screening, pre, post-treatment and one month follow-up to measure treatment outcomes. The screening data will be presented here to give a flavour of how veterans are reporting their symptoms on first contact with the service.

Screening Impact of Events Scale-Revised 167

Is a 22-item self-report measure that assesses subjective distress caused by traumatic events over the preceding week. It was added to the above measures for veterans reporting traumatic stress symptoms related to a service related trauma. The IES-R includes re-experiencing, avoidance and hyperarousal sub-scales; individuals rate their symptoms on a 0-4 scale. Total possible score = 88.

Many researchers use a cut of score of 33 to indicate a probably PTSD. From 102 individuals screening IES the mean difference was calculated as 54.03. This would suggest our client group is reporting symptoms of PTSD within the last seven days at a level severe enough to have a probable diagnosis for PTSD.

Screening PHQ-9

Is a self-administered questionnaire which scores each of the nine DSMIV criteria for depression as "0" (not at all) to "3" (nearly every day). It has been validated for use in primary care. A score of 0-4 = none, 5-9 mild, 10-14 moderate, 15-19 moderate/severe, 20-27 severe. It is not a screening tool for depression but it is used to monitor the severity of depression and response to treatment. It can be used to make a tentative diagnosis of depression.

A total of 84 veterans' scores gave a mean score of 19.90 which would place their symptoms in the moderate/severe range requiring either a pharmacological/psychological or combination of both.

Screening GAD-7 (261)

Is a self-administered questionnaire, used as a screening tool and severity measure for generalised anxiety disorder. The GAD-7 score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all", "several days", "more than half the days", and "nearly every day", respectively, and adding together the scores for the seven questions. A score of 0-4 = none, 5-9 mild, 10-14 moderate, 15-21 severe.

A total of 83 veterans' scores provided a mean of 16.25 which would place them in the severe range for anxiety/excessive worry requiring a pharmacological/psychological or combination of both.

Screening AUDIT (262)

Developed by the World Health Organisation (WHO) as a simple screening tool to pick up the early signs of harmful drinking and identify possible dependence. Each of the 10 questions has a set of responses to choose from, and each response has a score ranging from 0 to 4. A score of 0-7 – low risk, 8-15 – risky/hazardous, 16-16 – high-risk/harmful level, 20+ high risk/likely dependent.

A total of 99 veterans' scores provided a mean of 9.96 which would place them in the risky/hazardous range requiring advice on reduction or specialist referral to NHS community alcohol services.

Screening EQ5-D

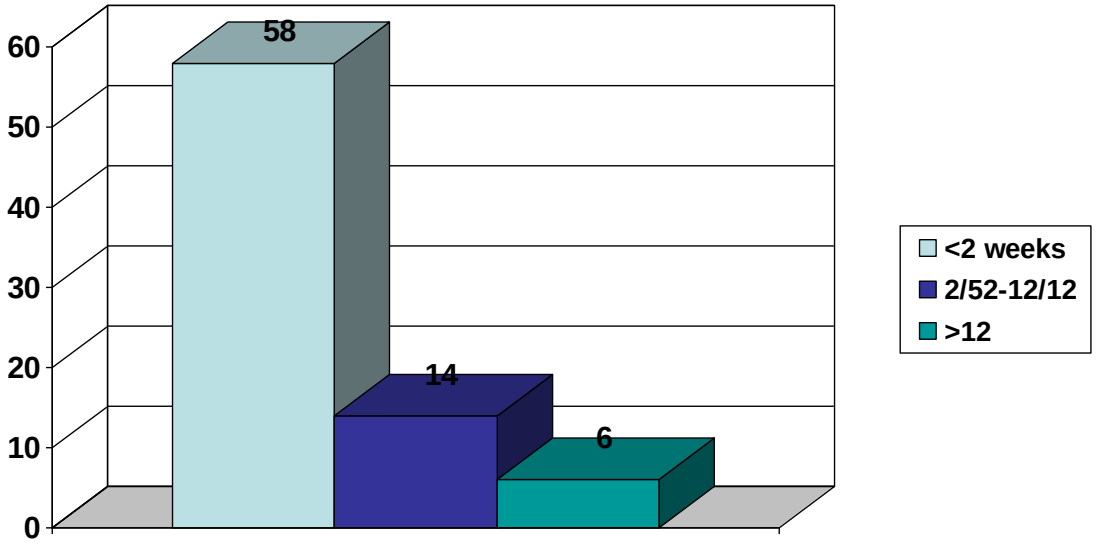
The EQ5D requires participants rate themselves on five dimensions; mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each dimension has three levels, defining 243 health states. It also includes a numerical scale allowing the participant to rate their perceived health on a scale of 0-100, where 0=very poor health and 100 excellent health. Mean data form 3,395 from a representative sample from a UK general population = 85.1 (EuroQol 2009).

Data from a total of 108 veterans scores provided a mean of 37.62 well below the UK average score.

Forensic History

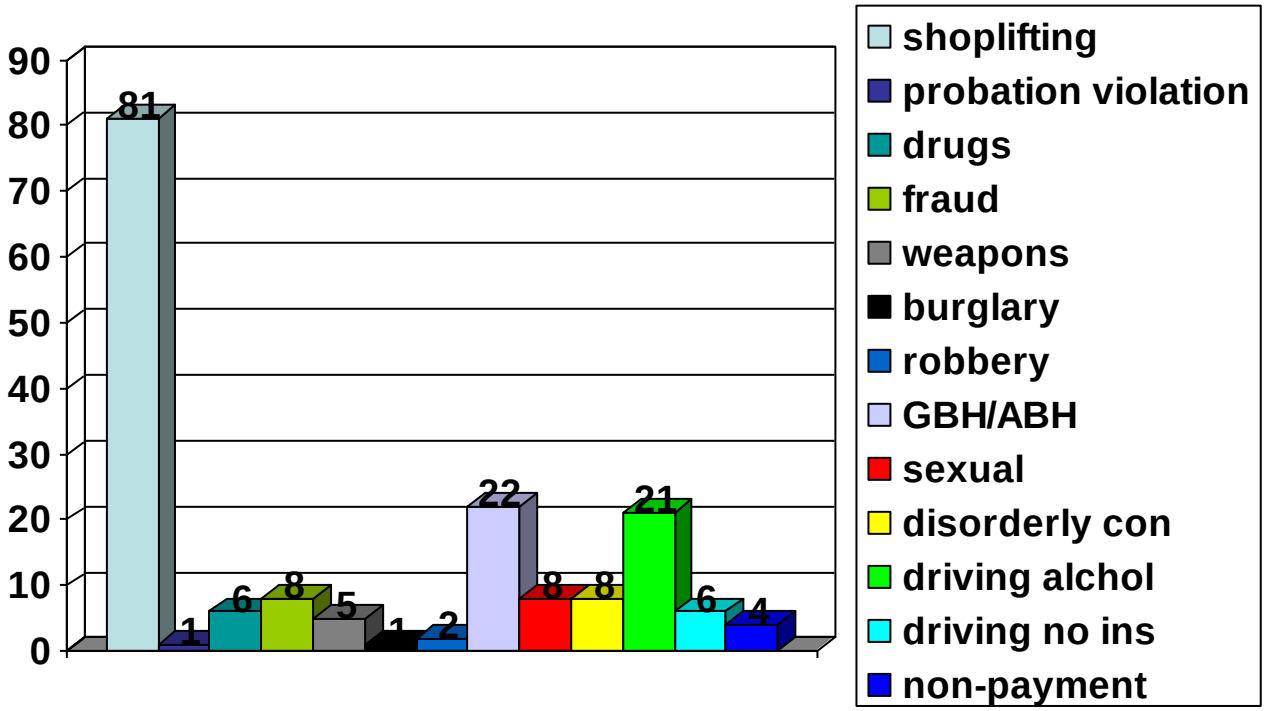
The Howard League for Penal Reform (2010) research suggested that veterans are less likely to be in prison than the general population. Over 99% of veterans in prison are male and likely to be older than non-veterans. They are also more likely to have committed violent and sexual offences.

Graph 16 – Term of imprisonment



Data from 122 veteran screened reported 78 had been sentenced to prison at some point in their life, with the majority for minor offences or on remand for less than two weeks.

Graph 17 – Types of offences



Research

Professor Jonathan Bisson's team completed a cross sectional study into the mental health, social adjustment, perception of health and service utilisation of military veterans living in Wales in 2011. They identified 558 ex-service personnel of whom 207 (37.5%) were interviewed. Most participants were white men, with a mean age of 48.4 years. Results suggested that the prevalence of mental disorder among veterans is comparable to that found in the general population. Many veterans however do not perceive they need help for mental health problems and many do not know where to get help (Wood, Jones, Morrison*, et al*, 2011).

An integrated care pathway programme was systematically developed for ex-service personnel with mental health difficulties following Medical Research Council guidance for the development of a complex intervention. Relevant literature was reviewed, and data was collected from key stakeholders in a series of focus groups and interviews. Qualitative data was analysed using a process of Inductive Thematic Analysis, and used to inform the development of an integrated prototype care pathway for ex-service personnel. The prototype integrated care pathway was piloted twice within the AWVHWS and refined on the basis of qualitative feedback and the quantitative outcome of each study, with further stakeholder consultation at each stage. This pathway has been adopted by all the LHBs within the AWVHWS (Kitchiner, 2009).

Conclusion

The AWVHWS was funded by the WG April 2010 following a successful two year pilot in Cardiff and Vale and Cwm Taf NHS trusts. The appointment of veteran therapists and administration staff across Wales was delayed due to restrictions placed on new posts being appointed across the NHS in Wales. This has impacted on the length of time veterans have taken to be assessed and enter therapy within the AWVHWS.

There have been 396 individuals referred. The majority are middle aged white men who have been referred by health professionals or veteran agencies. Those veterans who received out-patient therapy from the AWVHWS symptoms improved in eight out of ten clinical measures post therapy.

Appendix 1.

Introduction to the AWVHWS Staff and locations

Abertawe Bro Morgannwg LHB

Margaret Gibbons, RMN, MSc

Margaret comes from an armed forces environment, growing up as a daughter of a serviceman, marrying a serving personnel and has a son in the Royal Marines who has served in Iraq. Margaret has 30 years experience within mental health nursing, having worked across many areas including acute, forensic, court diversion schemes, drug and alcohol, and eating disorders. She is a specialist practitioner in community health and MSc in Public Health and Partnerships in Care. She has been working with veterans across the ABMU HB area for 18 months offering therapies that include CBT and EMDR. She is currently studying for a post graduate certificate in CBT from Cardiff University.

Jacqui Pugh

Jacqui has worked within ABMUHB at the Princess of Wales Hospital for 12 years, originally in Health Records, and Access to Health Records. She went on to assist in setting up the Bereavement Service in ABM. She currently works in Pharmacy in POWH as a Secretary to the Head of the Department and as Secretary to the Veterans Mental Health Lead.

Victoria Williams, BSc, RMN, PG Dip CBT

Victoria completed a degree in Psychology in 1991. She went on to train as a registered mental health nurse, completing the course in 1999. She then spent several years working on acute mental health wards and high

dependency Units in Bristol before re-locating to Swansea where she became a deputy ward manager. In 2006 Victoria started working in a Crisis Resolution and Home Treatment team. During this time she started her Post Graduate Diploma in Cognitive Behavioural Therapy, travelling to London on a weekly basis and completed the course in 2010. Since then Victoria has spent the last few years working as a Psychological Therapist in a Psychological therapies team and has more recently joined the All Wales Veterans Health and Wellbeing Service.

Aneurin Bevan LHB

Vanessa Bailey, RMN, Dip, BSc. Hon's, MA CBT

Vanessa qualified as a mental health nurse in 1997 and has worked in a variety of mental health settings since in both Primary and Secondary care and the Prison service. She has an interest in Trauma and has been working in the All Wales Veteran Health and Wellbeing Service since September 2012.

Max Bergmanski, RGN, RMN, MA CBT

Max Bergmanski is an experienced senior mental health nurse and team manager. He has 20 years experience managing both community mental health teams and acute admissions wards. Max completed his General Nurse training in London 1982 and his Mental Health Nurse training in Nottingham in 1984. He obtained his MA in Cognitive Behavioural Therapy in 1998 at Newport University. Since then he has coupled management responsibilities with a clinical caseload, pursuing his interest and expertise in CBT. He is currently managing acute adult mental health services in the Torfaen Borough, and has now joined the Veteran Service as a part-time therapist.

Louise Williams

Louise has worked as a Legal Secretary for 5½ years for a family firm of solicitors. She later worked in a sales team for a telecommunications provider for 6½ years. Louise was seconded to work on the quality team marking customer service calls and as a mentor to new staff. In 2009 she joined the Aneurin Bevan Health Board and worked as a Receptionist for a psychiatric unit on a part time basis. She currently works for the Veteran Service and the Community Mental Health Team at Talygarn, County Hospital.

Betsi Cadwaladr University Health Board

Mark Birkill, BSc, PG Dip CBT

Mark completed a degree in Social Science in 1992 and went on to work in a specialist challenging behaviour team with people with learning difficulties based in Llanfrechfa Grange near Cwmbran. In 1992 he began a Social Work course in Wrexham. In 1994 he began work as a Social Worker in a CMHT in Wrexham becoming an ASW in 1996. From 1999-2004 he worked as a social worker for Denbighshire SSD in Rhyl and Denbigh in Primary Care. In 2005 he gained a Post Grad Dip in Cognitive Therapy from Salford. He worked as a CBT therapist in the Conwy and Denbighshire NHS Trust. From 2008 he was employed for NE Wales NHS Trust (later BCUHB) providing CBT to patients in Flintshire. Mark started with the AWVHWS December 2011 as one of the Veterans Therapist in BCUHB.

Karen Hawkings, BSc, MSc CBT

Karen started her career as a psychologist within the field of Vocational Assessment and Rehabilitation for the Employment Service, working with people having both mental and physical health problems. Promoted to Senior Psychologist for Wales with Jobcentre Plus, Karen was clinical lead and manager of a team of psychologists, delivering psychological interventions for

unemployed jobseekers with mental health problems across the whole of Wales.

As an independent practitioner, Karen provided a specialist service to the Occupational Health team at DVLA, helping people with work related trauma return to work, or avoid losing their jobs. She also set up and was clinical lead for a Condition Management Programme, within the government's Pathways to Work programme in the Black Country, offering biopsychosocial assessments and CBT to people on Incapacity Benefit experiencing mental ill health. Karen has designed and delivered training packages to employers on managing mental health within the workplace. She has studied CBT to masters level, has delivered CBT in both Primary and Secondary care settings, and is working towards accreditation with the BABCP.

Cardiff and Vale UHB

Sharon Bowles

In February 2003 Sharon worked as a Receptionist at Ely Hospital, Cardiff in the department for Women, Children and the Community. She moved to work at Hamadryad CMHT from April 2004 as Receptionist for 4 years, before working as a Ward Receptionist in the Children's Hospital for Wales. She is currently secretary to Neil Kitchiner of the All Wales Veterans Health and Wellbeing Service Cardiff and Vale.

Neil J. Kitchiner, RMN, ENB 650, BA (Hons) (CBT), MSc, PhD

Neil has 27 years experience of working in mental health in the UK and Australia. His core profession is nursing (mental health). He has experience of forensic inpatient and out-patient settings before completing his clinical psychological training in Cognitive Behavioural Psychotherapy 1997 at Sheffield Hallam University. He has worked at the Priory Hospital, Bristol and

for the past 12 years in the University Hospital of Wales within the departments of Liaison Psychiatry and the Traumatic Stress Service and part-time with the South Wales Fire and Rescue Service. Neil ran the Welsh veterans' MoD pilot between 2008-2010. He regularly lectures and runs workshops on the psychological effects of trauma and psychological therapy for medical and non-medical personnel and has written over 30 papers and book chapters. Neil has a PhD from Cardiff University investigating an integrated care pathway for ex-service personnel.

Cwm Taf LHB

Andrew Tovey, RMN, PG Dip CBT

Andrew qualified as a psychiatric nurse with 25 years experience of working in a variety of in-patient and out-patient settings. He worked as a Community Mental Health Nurse in Swansea for five years and more recently as a primary care liaison nurse in Merthyr Tydfil for ten years having set up the service in January 2002. In 2003 Andrew and colleague were UK winners of the Lundbeck award for best practice in depression, winning £ 10,000 to help develop our service. In 2004 they introduced computerised cognitive behavioural therapy into the Merthyr and Cynon valley. In 2006 he trained at Newport University as a counsellor/CBT therapist. He was appointed to my current post in June 2011 as the veterans' mental health therapist for Cwm Taf, LHB.

Hywel Dda LHB

Julie Campion, RMN, PG Dip CBT

Julie qualified as a Registered Mental Health Nurse in 1998. She has gained experience in the acute inpatient environment, modern day hospital setting, secondary care community mental health team, and in primary care

psychological therapy services. Julie has worked in both military and civilian settings and worked in the Military Community Mental Health Teams offering a service to the military population, their dependents and the civilian workforce in British Forces Germany. During her career, Julie has been employed in both clinical and managerial/leadership roles and has been involved in setting up and modernising a number of mental health services. She has also been involved in service development initiatives including developing a service to work effectively with military veterans. Julie has completed her PgDip in Cognitive Behavioural Therapies at the Institute of Psychiatry, London and is subsequently Accredited with the BABCP as Cognitive Behavioural Psychotherapist. Julie is also an EMDR Practitioner working towards accreditation. Julie's particular interest and experience lies in the treatment of psychological trauma, having treated a variety of both military and civilian cases, and also in military mental health.

Lynne Blesovsky

During her career Lynne has undertaken various clerical and financial duties within the secretarial/administrative roles she has been employed in. Lynne has been employed with Hywel Dda Health Board within Mental Health Services since October 1998. Through career progression Lynne has undertaken a number of varied posts whilst employed within Mental Health Services.

Appendix 2

Minimum dataset (MDS)

The MDS was developed and refined during the ICP piloting period. It was also informed by the English Increasing Access to Psychological Therapies (IAPT). It contains the following information:

- Demographic

- Previous psychological treatments
- Current health and social needs
- Military related information
- Signposting
- Offending behaviour
- Substance use (current)
- Mental health diagnosis
- Self-report clinical measures (6)

This data is collated each month by the VTs and the administrator in each LHB and sent to the service hub in Cardiff for storage and analysis. This information will enable the service to conduct an annual audit and produce statistics for the Director of the service and WG.

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