VETERANS NHS WALES

Annual Report

April 2023 – March 2024

GIG CYMRU NHS WALES

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

MINISTRY OF DEFENCE

Contents

Service Aim - to improve the provision of mental health care to veterans living in Wales

Veterans' NHS Wales - is the first point of contact for ex-service personnel residing in Wales, with a 'service related' mental health problem

Welcome

Dear Reader,
Veterans' NHS Wales (VNHSW) is outpatient psychological therapies service for British military veterans living in Wales. The service started in Cardiff in 2008 as a MoD and Welsh Government funded pilot for two years led by Prof. Jonathan Bisson and Neil Kitchiner. Following a successful pilot the Welsh Government funded the all-Wales veterans' mental health and well being service in 2010. Since then, the service has grown and had a name change to Veterans' NHS Wales (VNHSW). VNHSW provides military mental health clinical expertise to treat veterans across Wales through our skilled clinical, administrative and peer mentor staff.

At time of writing this, we have just celebrated 15 years of the service in Cardiff Bay. At our celebration event on 30th April 2025 our peer mentors, based in three of the seven health boards, talked about their work as part of the multi-disciplinary team at VNHSW. As military veterans themselves (see their biographies on page 5-6), their work with our services users is invaluable, providing additional support to veterans and their families with a range of psychosocial issues, alongside their out-patient psychological therapy with our highly experienced psychological therapists.

For example, peer mentors help our veterans reengage with activities they used to enjoy, provide advice for social or economic stressors and importantly, lend an understanding ear using their own lived experience.

Given the value of their work, my colleagues and I continue to work hard to gain additional peer support provision in all seven NHS Wales health boards. I hope in future versions of this report I can update that we have been successful with this mission.

I would like to acknowledge that a wide range of organisations that support and promote our service. These colleagues make sure our service is accessible and meets our veterans' needs. I would also like to thank all the staff at Veterans' NHS Wales who have worked extremely hard over 2023-2024 and continue to do so today.

This report will describe service data from 1st April 2023 - 31st March 2024. Data was recorded by team administrators and analysed by Helen Dare, Assistant Psychologist. The report has been written and compiled by Helen Dare, Dr Gwen O'Connor and myself. Acronyms are used in this report, if needed see Appendix 1 for full breakdown. If you wish to discuss this report further, please contact us via admin.vnhswcandv@wales.nhs.uk.

Finally, you can find more information about Veterans' NHS Wales by visiting our website (www.veteranswales.co.uk) or by scanning the QR code. If you know a veteran who may need support, you can also make a referral via our website.

Neil J Kitchiner

Dr Neil J Kitchiner

Director & Consultant Clinical Lead, Cardiff and Vale University Health Board and Honorary Research Fellow, Cardiff University

Executive Summary

Referral

- Six-hundred and twenty-eight referrals were received by Veterans' NHS Wales (VNHSW) from 1st April 2023-31st March 2024. This is slightly less referrals than the previous year (n=14).
- Most commonly, referrals were self-referrals (n=262, 42%) followed by Primary Care referrals (n=195, 31%).
- The service had a higher number of re-referrals than previous years (47%, +8%).
- Eighty-one percent of referrals (n=507) were appropriate referrals, 19% of referrals were inappropriate (n=121).
- The mean age of veterans referred to VNHSW was 47 years.
- Most referrals were male (91%, n=574), but the service continues to see a growth in the percentage of female veterans accessing the service (9%, n=54 in 2023-2024, 6% in 2022-2023, 5% in 2021-2022).

Opt-in

- Of the 507 appropriate referrals, 374 opted in (74%).
- Annually, referral to opt-in has consistently been the stage that the service sees the largest drop-off in number of veterans. The service continues to explore ways to maximise engagement at this stage.

Assessment

- All 374 veterans who opted-in were offered an assessment.
- Eighty percent (n=299) attended their assessment.
- Seventy-three percent (n=219) of those veterans were offered treatment and placed on treatment waiting lists.

Presentations at assessment

For the first time, this report presents a detailed analysis of common presentations at assessment using clinical measure data.

- Where data was available, we found that 50% of veterans reported childhood abuse as a non-military trauma.
- Thirty-eight percent (n=84) of veterans who were assessed had experienced 4 or more Adverse Childhood Experiences (ACEs). This figure is significant when compared to the wider population 14% of Welsh people have four or more ACEs (Public Health Wales, 2015).
- We also looked at the presence of probable Anxiety (89%, n=234), Depression (89%, n=235), PTSD (84%, n=212), and Insomnia (69%, n=174) at assessment. It is worth noting that high rates of anxiety are not surprising given there is a cross over of symptoms between Generalised Anxiety Disorder (GAD) and PTSD.
- Forty percent of veterans (n=101) has an increasing or high risk of alcohol misuse.

Treatment offer and start

- Some veterans who attended assessment disengaged whilst on the waiting list (n=18), but 201 veterans were offered a first treatment date.
- The service aims to offer a first treatment session within 26 weeks of assessment and 85% (n=159) of veterans were offered their first treatment session in this timeframe.

Treatment outcomes

- When analysing data for this report 41 veterans who were referred in 2023-2024 were still in treatment and not included in treatment outcome figures.
- Of the remaining 160 veterans who were offered a first treatment session: 90 veterans (56%) completed treatment.

Clinical Outcomes

- Overall, an improvement after treatment was found in a range of mental health symptoms.
- Before treatment, the mean score on clinical measures for PTSD, Depression, Anxiety and Insomnia were above case-ness thresholds, which indicates a probable diagnosis for these disorders.
- After treatment, all mean scores were below case-ness for these disorders.
- Reliable improvement data, spanning the past five years (2019-2024) showed that improvement rates for Depression, Anxiety and Insomnia have gradually decreased in the last two years whereas rates for PTSD improvement have increased and remained steady.

Service Overview

Service Aims

- To improve the mental health and wellbeing of veterans with a service-related mental health problem
- Develop sustainable, accessible and effective services that meet the needs of veterans with mental health and wellbeing difficulties who live in Wales

Service Eligibility

Any veteran living in Wales who has served at least one day with the British Armed Forces, as either a regular service member or as a reservist, who has a 'service-related psychological injury' is eligible to self-refer/be referred and be assessed by a VNHSW clinician.

Veterans with a 'service-related' mental health injury are eligible to receive outpatient treatment (psychological and/or medication). Those with a 'non-service related' mental health injury are signposted to appropriate services for ongoing treatment. See Appendix 2 for the full care pathway.

Key Features of the Service

- An All-Wales NHS outpatient service for veterans with service-related mental health problems
- A multi-disciplinary team comprised of staff with personal experience working in and for the military and/or extensive experience of working with the mental health needs of veterans
- Veterans receive a comprehensive assessment that accurately assesses their psychological and social needs
- Veterans are signposted or referred to appropriate services for any physical needs that are identified
- Following assessment, veterans, and others involved in their care (e.g. family) members, are collaboratively involved in the development of an individualised management plan to address health and psychosocial needs
- The service promotes a recovery model so that veterans can maximise their physical, mental and social wellbeing in line with Welsh Governments Prudent Healthcare policy (Welsh Government, 2019)
- The service provides psychological interventions (approximately 16-20 outpatient therapy sessions) in addition to Consultant Psychiatrist outpatient clinics for diagnostic assessment, second opinion and medical reviews
- The service shares expertise and raises awareness of the needs of veterans and military culture to ensure improved treatment and support across services
- The service is committed to ongoing evaluation and research on the needs of veterans in the community to inform future policy making and commissioning of services

Our Teams

VNHSW operates via a 'Hub and Spoke' model. Cardiff and Vale (CAVUHB) host the national 'hub' for VNHSW and the service 'spokes' are in Aneurin Bevan (ABUHB), Betsi Cadwaladr (BCUHB), Cwm Taf Morgannwg (CTMUHB), Hywel Dda (HDUHB) and Swansea Bay (SBUHB). Veterans residing in the Powys Teaching Board area are referred to their neighbouring health boards in ABUHB, BCUHB, SBUHB (see Appendix 3).

All teams work within the guidelines of the VNHSW Pan-Wales Operational Policy. Each team is broadly made up by a Clinical Lead, Veterans' Therapist(s) and Administrator. The Hub team also includes the Director who is also the Consultant Clinical Lead, Highly Specialist Clinical Psychologist and Assistant Psychologist. All health boards have access to a Consultant Psychiatrist who offers two sessions per month (total = 7.5 hrs). Details of each team and its members can be seen in the map below.

Several clinicians have personal experience of military life. Dr Neil Kitchiner, Director and Consultant Clinical Lead (CAVUHB), served as a Captain with 203 (Welsh) Field Hospital based in Cardiff, HQ. Neil deployed to Afghanistan during Herrick 19a (Oct 2013 – Jan 2014) as part of the two-person field mental health team. Neil retired from the army in 2016.

Julie Graham, Lead Therapist (HDUHB) has worked as a civilian community psychiatric nurse with SSAFA, the Armed Forces Charity, based in Germany for several years, delivering mental health care to serving personnel from various MoD mental health facilities.

Our peer mentors have a wide range of experience and expertise to bring to their role in supporting veterans. Damon Rees, Peer Mentor (ABUHB) served for 28 years in the army retiring as a Platoon Sergeant in 2016. Damon completed two tours of Northern Ireland, the Gulf War 1990-1991 and the Iraq War 2003.

Ian Moore MBE, Peer Mentor (CTMUHB) served 44 years and retired in April 2024. Ian served in 1st The Queens Dragoons Guards (The Welsh Cavalry) for 24 years and 3rd Battalion and the Royal Welsh for 20 years. Ian achieved the rank of Captain in the role of Operational Support Officer and was deployed to Northern Ireland three times, UN Cyprus, Bosnia Op RESOLUTE, the Gulf War 1990-91 Op GRANBY and the Gulf War 2003 – Op TELIC.

Jordan Lloyd, Peer Mentor (BCUHB) joined the army in 2010 serving with the 1st Battalion Welsh Guards and was medically discharged in 2016. During his time in service Jordan deployed to Afghanistan OP HERRICK and took part in multiple ceremonial duties in London as well as being part of the regional army recruitment team.

Kevin Hackett, Peer Mentor (BCUHB) joined the Royal Navy in 1978 as a Weapons Engineering Mechanic (Ordnance). Kevin was deployed to the Falklands in 1982 following the Argentine invasion, as part of the second task force. Kevin was discharged in 1991 as a Leading Weapons Engineering Mechanic (Ordnance) and spent his later career working for North Wales Police. He joined VNHSW as part of Change Step peer mentoring programme in 2017 and has been a peer mentor for the service ever since.

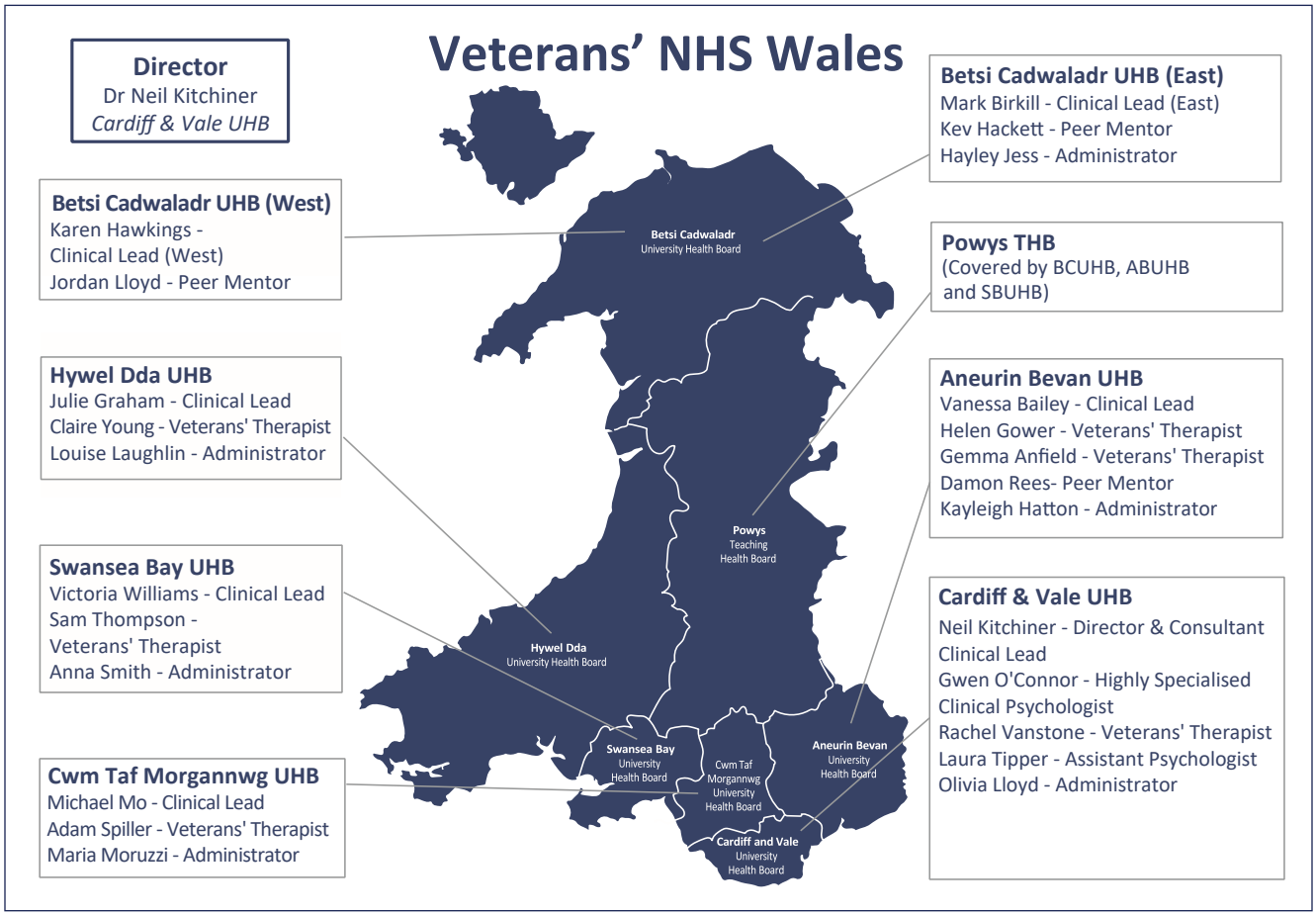


Figure 1: Map of Wales

Evidence-based Psychological Therapies and Interventions

Our clinical staff are trained in a range of psychological therapies and interventions, these include:

- Acceptance and Commitment Therapy (ACT)
- Cognitive Analytic Therapy (CAT)
- Cognitive Behavioural Therapy (CBT) Trauma-Focussed CBT
- Compassion Focussed Therapy (CFT)
- Cognitive Processing Therapy (CPT)
- Emotional regulation training (STAIR/DBT)
- Eye Movement Desensitisation and Reprocessing (EMDR)
- Interpersonal psychotherapy (IPT)
- Integrated Psychotherapy (IP)
- Prolonged exposure (PE)
- SPRING and Military-SPRING – online guided self-help interventions
- Schema Therapy
- The REWIND Technique

Stakeholder Involvement

VNHSW continues to host six-monthly national steering groups, in addition to attending key stakeholder meetings and contributing to armed forces forums in most health boards. The service engages in the following stakeholder groups:

- Armed Forces Community Covenant meetings
- Armed Forces Local Health Board Forums
- UK National Veterans Mental Health Network meetings
- Welsh Government Cross Party Group for Armed Forces and Cadets
- Welsh Government Armed Forces Expert Group
- Armed Forces and Veterans Champions meetings
- Welsh Prison Veterans' meetings

Projects and Research Involvement

The service continues to run quality improvement projects, service evaluations and is involved in research trials to contribute to the advancement of evidence-based treatments for veterans. In 2023-2024, VNHSW teams engaged in the following activity:

Operational Policies and Service Developments:

- Pan-Wales Prison Pathway
- Pan-Wales Operational Policy
- Swansea Bay GP referrals audit to streamline the referral process

Research Projects and Publications by VNHSW staff:

- Thompson, S. (2024). Recognising mental health challenges and barriers to treatment among veterans in the UK. British Journal of Mental Health Nursing, 13(4), 1-3.
- Bisson, JI., Ariti, C., Cullen, K., Kitchiner, NJ., Lewis, C., Roberts, NP., et al. (2023) Pragmatic randomised controlled trial of guided self-help versus individual cognitive behavioural therapy with a trauma focus for post-traumatic stress disorder (RAPID). Health Technol Assess 27(26). https://doi.org/10.3310/YTQW8336.
- Whiteford, S., Quigley, M., Dighton, G., Wood, K., Kitchiner, NJ., Armour, C., & Dymond, S. (2024). Anxiety, distress tolerance, and the relationship between complex posttraumatic stress disorder symptoms and alcohol use in veterans. Journal of Clinical Psychology, 80, 158–169. https://doi.org/10.1002/jclp.23604.
- Astill Wright, L., Barawi, K., Kitchiner, NJ., Kitney, D., Lewis, C., Roberts, A., Roberts, NP., Simon, N., Ariti, C., Nussey, I., Muss, D., Bisson, JI. (2023) Rewind for Posttraumatic Stress Disorder: A Randomised Controlled Trial. Depression and Anxiety, 6279649, https://doi.org/10.1155/2023/6279649
- Simon, N., Lewis, C., Smallman, K., Brookes-Howell, L., Roberts, NP., Kitchiner, NJ., Ariti, C., Nollett, C., McNamara, R., & Bisson, JI. (2023). The acceptability of a guided internet-based trauma-focused self-help programme (Spring) for post-traumatic stress disorder (PTSD). European Journal of Psychotraumatology, 14(2) https://doi.org/10.1080/20008066.2023.2212554
- Lewis, C., Bailey, L., Ariti, C., Kitchiner, NJ., Roberts, NP., Simon, N., & Bisson, JI. (2023). Social support as a predictor of outcomes of cognitive behavioral therapy with a trauma focus delivered face-to-face and via guided internet-based self-help. Journal of Traumatic Stress, 36, 511–523. https://doi.org/10.1002/jts.22947
- Hannigan, B., van Deursen, R., Barawi, K., Kitchiner, NJ., & Bisson JI (2023) Factors associated with the outcomes of a novel virtual reality therapy for military veterans with PTSD: Theory development using a mixed methods analysis. PLOS ONE 18(5): e0285763. https://doi.org/10.1371/journal.pone.0285763.

Accreditation Processes:

- Royal College of Psychiatrists Veterans' Mental Health Accreditation, mid-point self-review and audit (CAVUHB)
- Pride in Veterans Standard Accreditation (CAVUHB)

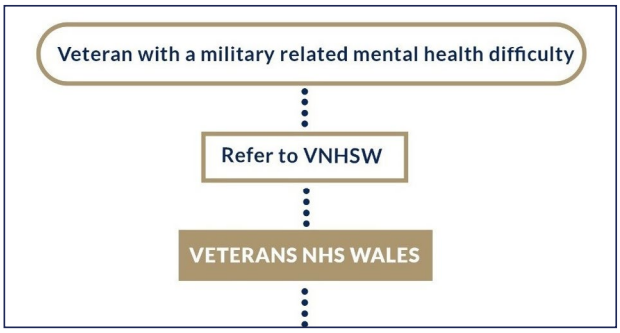
Conferences and Training:

- Panel discussion at Kings College London veterans' mental health conference on integrating health systems (Dr Gwen O'Connor, CAVUHB)
- Military Mental Health training for student mental health nurse cohorts (Mark Birkill and Kevin Hackett, BCUHB)
- Workshop at BABCP Annual Conference, Cardiff University. The development of Spring for treating PTSD (Dr Neil Kitchiner, C&VUHB)
- Skills based workshop at BABCP Annual Conference, Manchester University. The development of Spring and Military Spring (Dr Neil Kitchiner, C&VUHB)
- Keynote at 12 Annual Vilnius Trauma Conference, Vilnius University (Dr Neil Kitchiner, C&VUHB)

Service Demand and Performance

VNHSW conducts the same operational process across all Wales UHBs. Once a referral is received, the veteran is required to opt-in (consent to accessing VNHSW and the service accessing their MoD records), before the assessment is booked. After assessment, treatment decisions are made following a discussion in the weekly multi-disciplinary team meeting and if deemed appropriate for the service offered various courses of treatment (psychological and/or medication).

Appendix 2 presents this process in more detail. Data presented in the coming sections breaks down VNHSW performance and demand across 1st April 2023–31st March 2024 through these broad stages (Referral, Opt-in, Assessment, Treatment, and Discharge).

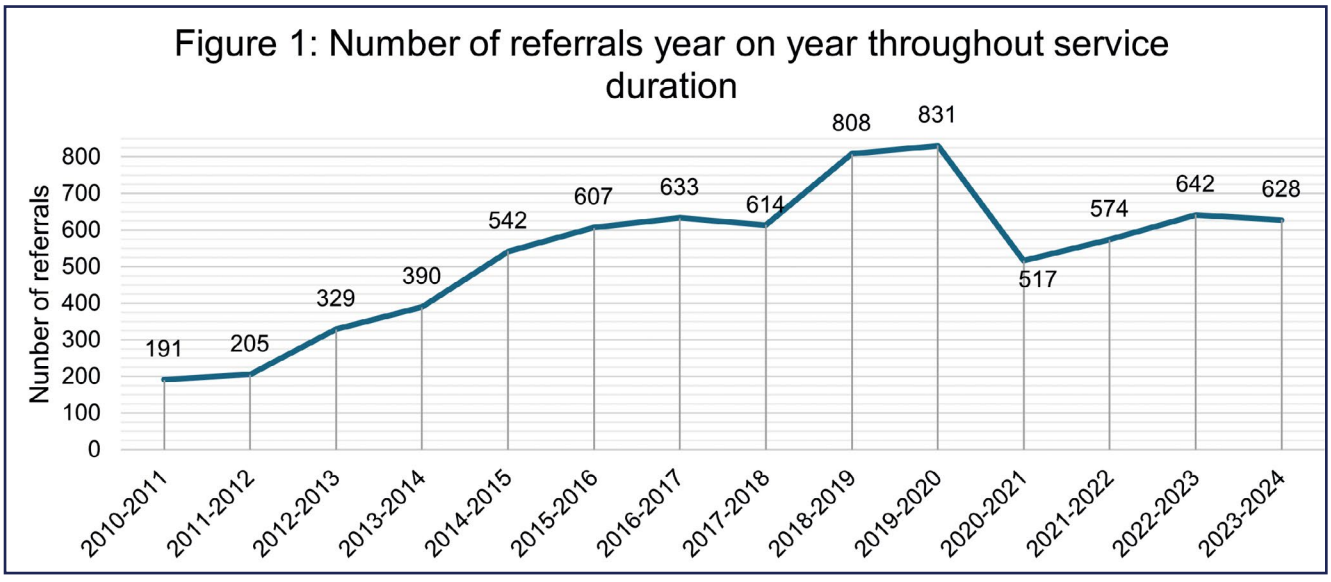


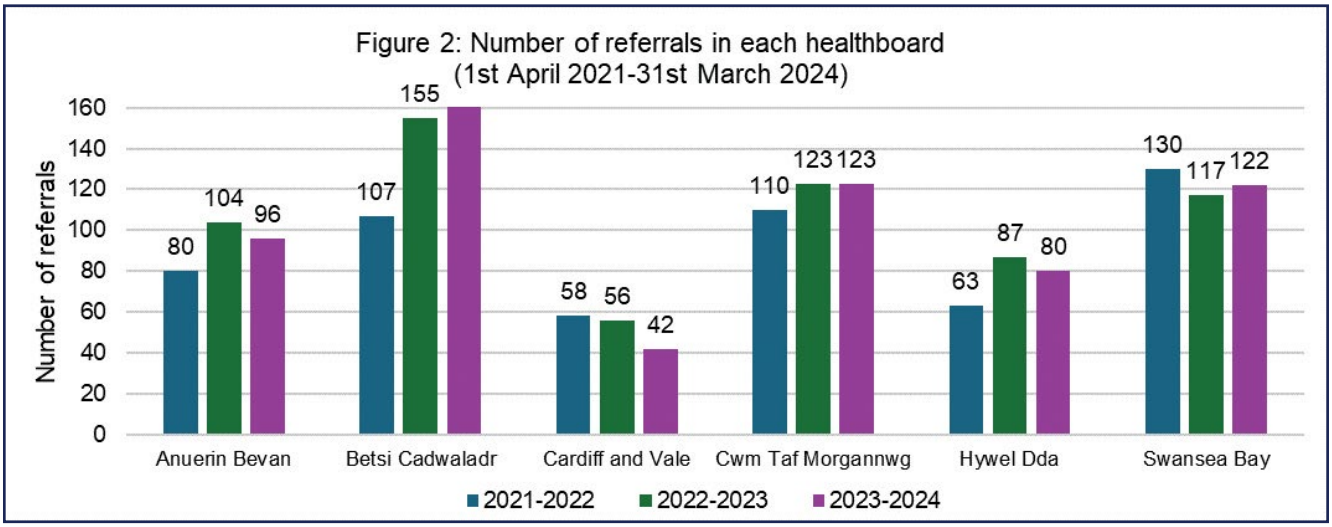
Referral stage

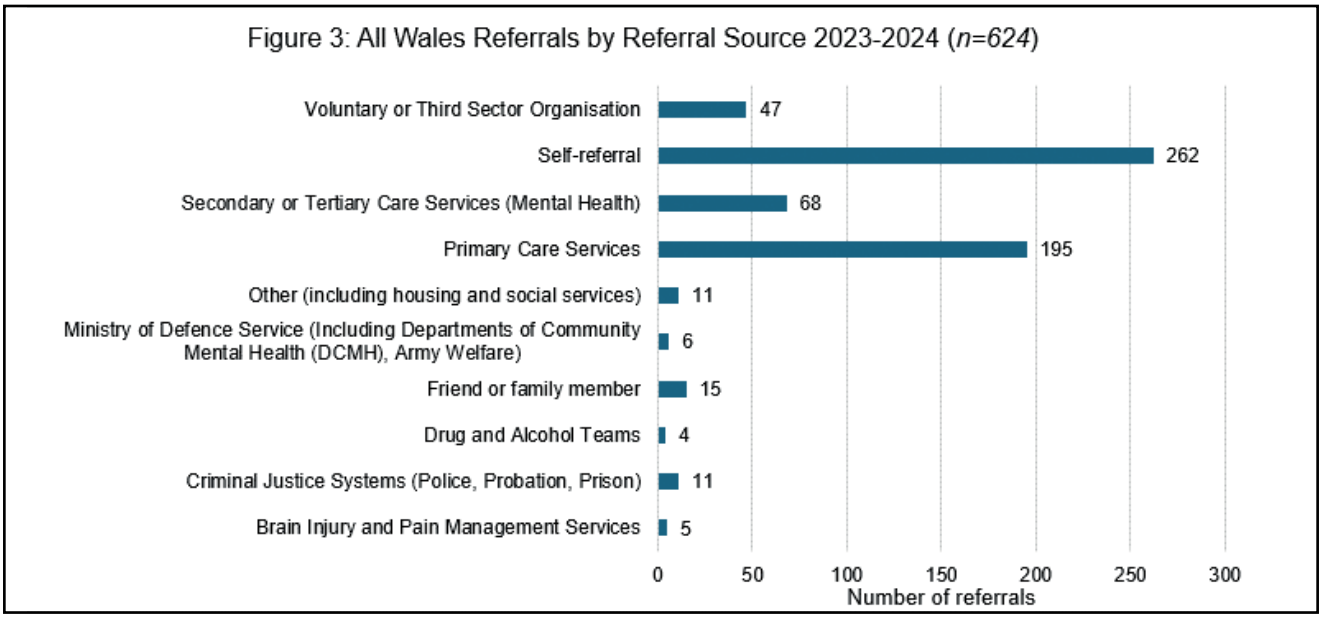
In 2023-2024, the service received 628 referrals. This is a slight decrease (n=-14) from 2022-2023. The number of referrals from 2010 (service start) 2024 can be seen in Figure 1.

BCUHB had the most referrals (n=160) in 2023-2024, followed by CTMUHB (n=123) and SBUHB (n=122). The fewest referrals were received in CAVUHB (n=42). This trend has been seen in the previous two years, for full health board referral numbers see Figure 2.

Fifty-two percent (n=329) of referrals were received online via the VNHSW website. This is higher than the previous year (42%). Most referrals (n=262, 42%) were self-referrals, primary care services (e.g. GPs) were the second most common referral source (n=195, 31%) consistent with previous years. This trend was mirrored when looking at individual LHBs. Figure 3 shows full, all-Wales referral source details.







In recent years, the service has begun tracking re-referral rates. In 2023-2024, 47% (n=293) of referrals were re-referrals which is the highest percentage in the past three years (see Figure 4). Re-referral rates in 2023-2024 for each health board are reported in Table 1.

Previous reports have outlined multiple reasons why a veteran may be re-referred to the service. In addition to possibly needing further treatment, a veteran's previous referral may not have been appropriate, the veteran may not have opted-in or disengaged at assessment or treatment. However, a veteran may now be in a better position to engage with the service.

The service currently has no further data on the reason veterans are re-referred to the service. This data will be collected and reported in the future.

Figure 4: Percentage of re-referral 2021-2024 *(n=623)*
1st April 2021-31st March 2024

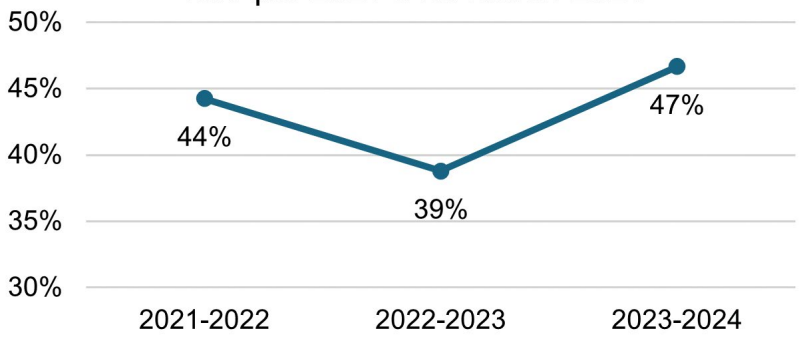


Table 1: Percentage of re-referral per LHB in 2023-2024 *(n=623)*	
Local health board	**Percentage of re-referral**
Aneurin Bevan	91
Betsi Cadwaladr	111
Cardiff and Vale	73
Cwm Taf Morgannwg	33
Hywel Dda	15
Swansea Bay	26

Across all-Wales referrals, 81% (n=507) of referrals were appropriate referrals, 19% (n=121) were inappropriate referrals. Inappropriate referrals are defined as those where the individual referred does not meet VNHSW inclusion criteria, for example, where the individual's mental health difficulty is not related to military service. Table 2 outlines the percentage of inappropriate referrals in each health board.

Table 2: Inappropriate referrals in 2023-2024 *(n=623)*							
	Health Board						
	Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf Morgannwg	Hywel Dda	Swansea Bay	All Wales Total (Mean)
Percentage of inappropriate referrals	16%	20%	8%	28%	34%	5%	19%

Opt-in stage

Of the 507 appropriate referrals, 374 opted into the service (74%). One hundred and thirty three veterans did not return opt-ins and were therefore discharged from the service at this stage. The service was quick to triage and respond to referrals with opt-in packs. Eighty six percent of opt-ins packs were sent to veterans within a week of referral receipt, and 40% of opt-in packs were sent on the same day.

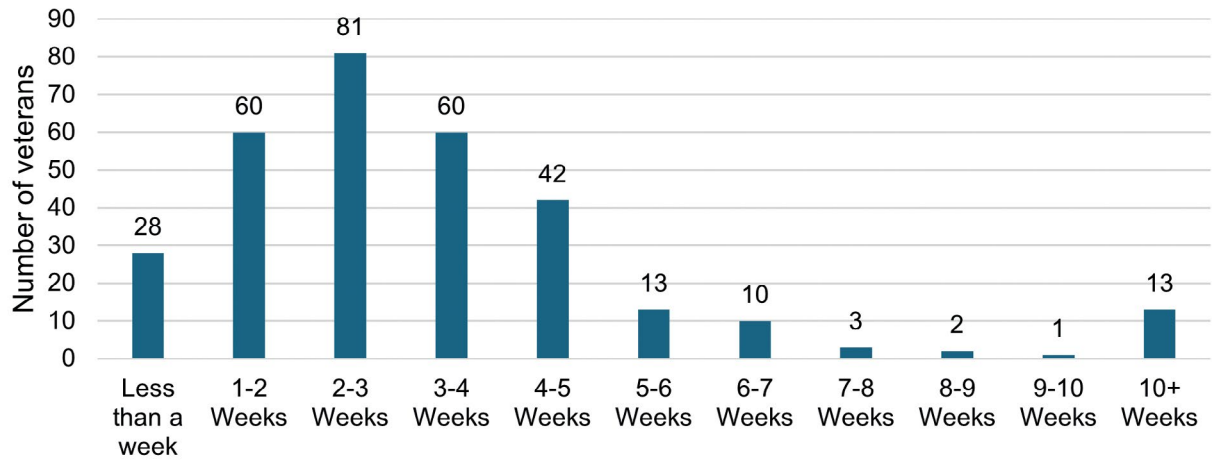
Where data was available, analysis showed that there is a disparity between opt-in returns and veterans' sex. Thirty five percent (n=19) of female veterans did not return their opt-ins whereas 20% (n=114) of male veterans did not return theirs. VNHSW may need to consider additional support to encourage initial female veteran engagement with the service. For example, the service could contact female veterans to further discuss their referral on receipt, provide information about the service and encourage engagement. If the service had female peer mentors these could also be a first point of contact.

Assessment stage

Assessment appointments were offered to each of the 374 veterans who opted in. VNHSW attempts to see veterans for assessment within four weeks of opt-in paperwork being received. This 4-week target is set by Welsh Government. Primary Care services are expected to meet this target for a minimum of 80% of cases.

Data is available for 313 veterans (61 data points missing) when reviewing opt-in to assessment wait times. Of the available data 73% of veterans were seen in 4 weeks or less for assessment. This is under the 80% target expected of Primary Care services. However, most referrals were responded to in 5 weeks or less (87%). Full opt-in to assessment wait-time data can be seen in Figure 5. Eighty percent of veterans attended their assessment appointment (n=299).

Figure 5: Wait time from opt-in to assessment during 2023-2024 *(n=313)*



Assessment to treatment offer

In 2023-2024, 73% (n=219) of those who attended their assessment appointment were offered treatment. The percentage of veterans offered treatment ranged from 63-83% across health boards. SBUHB had the highest percentage of veterans who were offered treatment after assessment. Table 3 outlines assessment to treatment offer data.

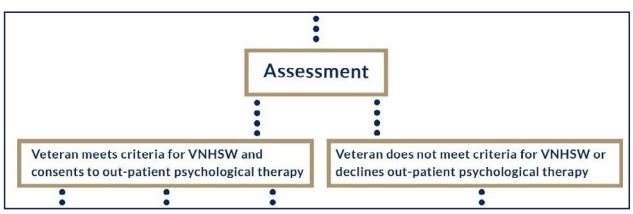
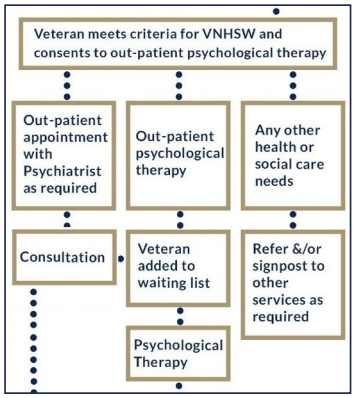


Table 3: Assessment attendance to treatment offered in 2023-2024							
	Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf Morgannwg	Hywel Dda	Swansea Bay	All Wales Total (Mean)
Attended assessment	50	80	25	61	24	59	299
Offered treatment	37	50	20	49	14	49	219
Percentage offered treatment	74%	63%	80%	80%	58%	83%	73%

Treatment stage

Once offered treatment, veterans are placed on a waitlist until there is a Veterans' Therapist available to treat them. In 2023-2024, 201 (92%) veterans were offered a first treatment date. Veterans' NHS Wales aims to start treatment 26 weeks, or less, after the assessment appointment. This target is set by Welsh Government. In 2023-2024, 85% (n=159) of veterans were offered a first treatment session within 26 weeks after assessment (See Figure 6, 22 data set unavailable).



At the end of the reporting period, 41 veterans were still in treatment and are not included in the following treatment outcome figures.

Of the 160 veterans who were offered a first treatment date, 90 veterans (56%) completed treatment. A further 31 veterans (19%) dropped out of treatment early. Seventeen veterans (11%) suspended or postponed treatment and 12 veterans (8%) did not attend their first treatment session. A small percentage (4%, n=6) of veterans never booked their first treatment date when contacted. Table 4 summarises these results.

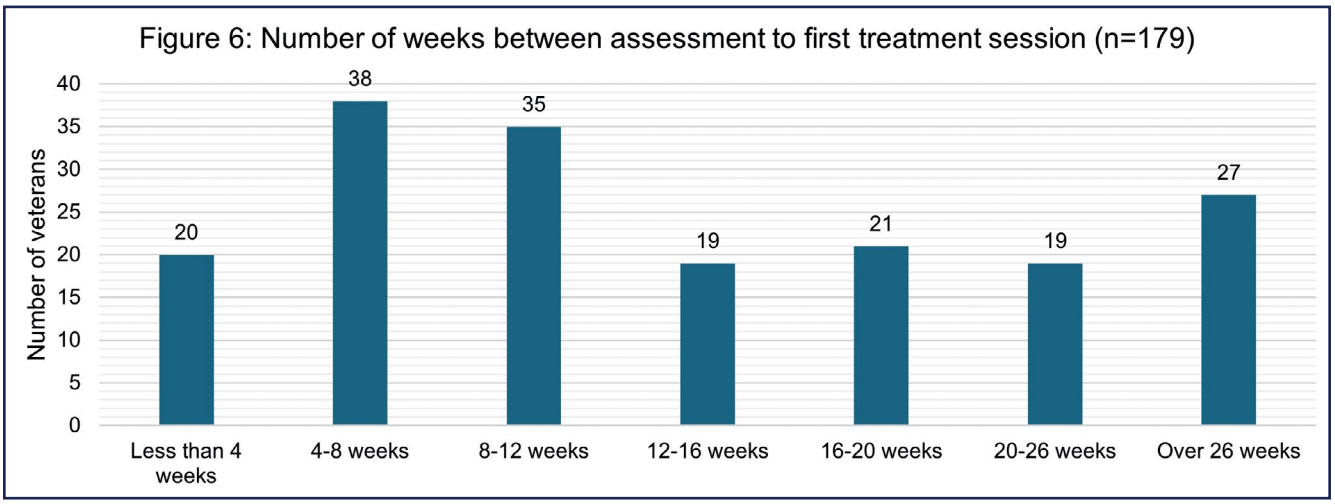


Table 4: Discharge outcomes for veterans offered first treatment session in 2023-2024 *(n=160)*		
Discharge outcomes	Number of veterans	Percentage of veterans
Completed treatment	90	56%
First treatment session not booked (no contact)	6	4%
Did not attend first treatment session	12	8%
Dropped out of treatment early (Did not attend and/or no contact)	31	19%
Treatment suspended/postponed	17	11%
Discharge data unavailable	4	3%

Demographics

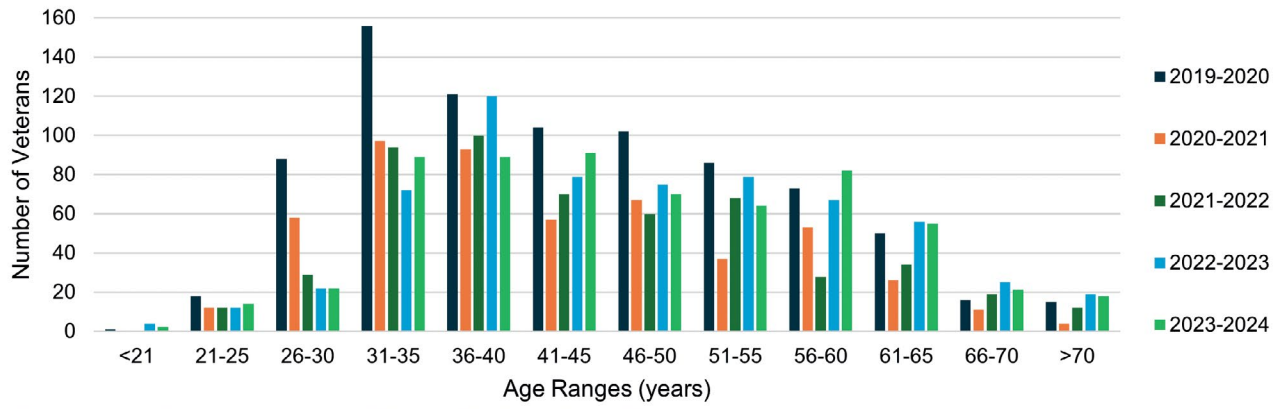
The following section outlines veterans' demographic data from 2023-2024. Age and sex data is collected at referral. Remaining data is taken at assessment stage.

Age

In 2023-2024, the mean veteran age was 47 years. Just under 80% of veterans fell between ages 31 and 60. The youngest veteran seen in 2023-2024 was 18 and oldest 98.

The service is seeing a gradual trend toward its population getting slightly older over time. The average age bracket was 26-30 years from 2015-2019, increasing to 41-45 service years in the current year. Despite this, most veterans continue to fall between 31-60 years. See Figure 7 for veterans age statistics year on year (2019-2024).

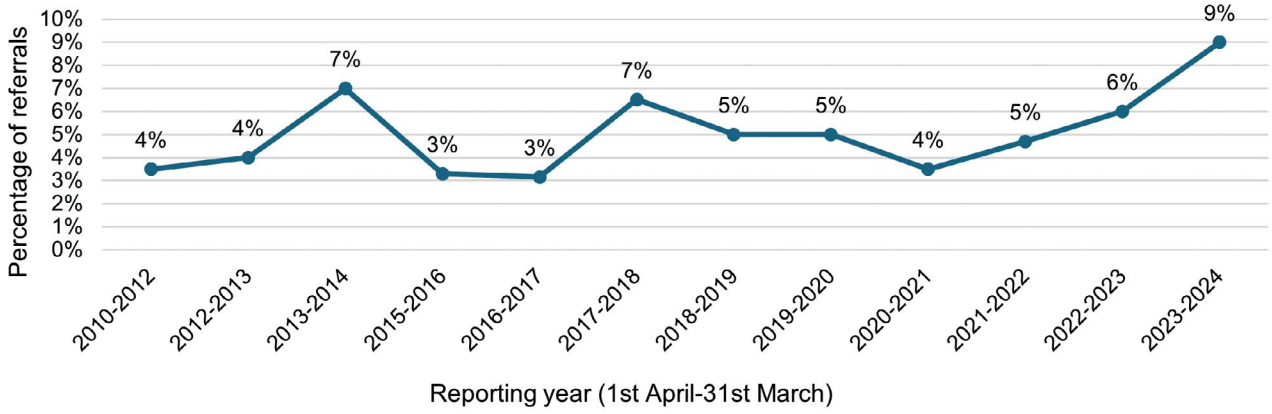
Figure 7: Veterans' age year on year (1st April 2019 - 31st March 2024)



Sex

Consistent with previous reporting years, most referrals were male (91%, n=574). The service has seen an increase in female veterans referred. In 2023-2024, 9% (n=54) of veterans were female compared to 6% in 2022-2023. The percentage of female referrals from 2010-2024 can be seen in Figure 8.

Figure 8: Percentage of female referrals year on year



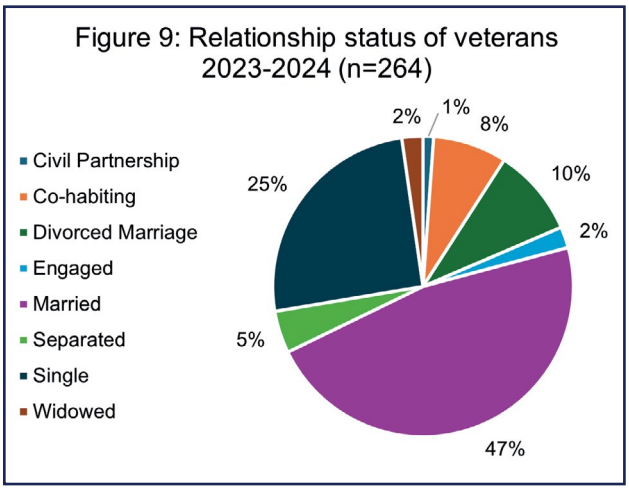
Identity, cultural and social demographics

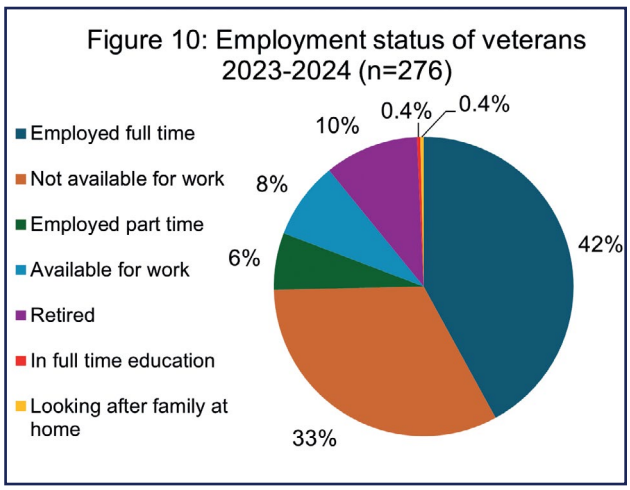
Two thirds of veterans identified as British (66%, n=186) and 28% (n=79) identified as Welsh. Most veterans were white British, or from another white background (97%, n=238). Over half of veterans (61%, n=168) reported a disability. Table 5 outlines national identity, ethnicity and disability data.

Figures 9-10 present relationship and employment status of veterans. Almost half of veterans were 'Married' (47%, n=124), and a further 25% (n=67) were 'Single'. Most commonly, veterans were 'Employed Full-Time' (42%, n=116) or 'Not Available for work' (33%, n=90).

Table 5. Identity, ethnicity and disability demographics

Demographic item	Veterans, n (%)
National Identity (n=281)	
British	186 (66%)
English	9 (3%)
New Zealand	1 (0.4%)
Scottish	4 (1%)
Welsh	79 (28%)
Prefer not to say	2 (1%)
Ethnicity (n=246)	
Black, Black British Caribbean, African or any other Black background	1 (0.4%)
Mixed White & Black Caribbean, White & Black African, White & Asian or any other mixed background	7 (2.8%)
White British or any other white background	238 (96.8%)
National Identity (n=281)	
British	186 (66%)
English	9 (3%)
New Zealand	1 (0.4%)



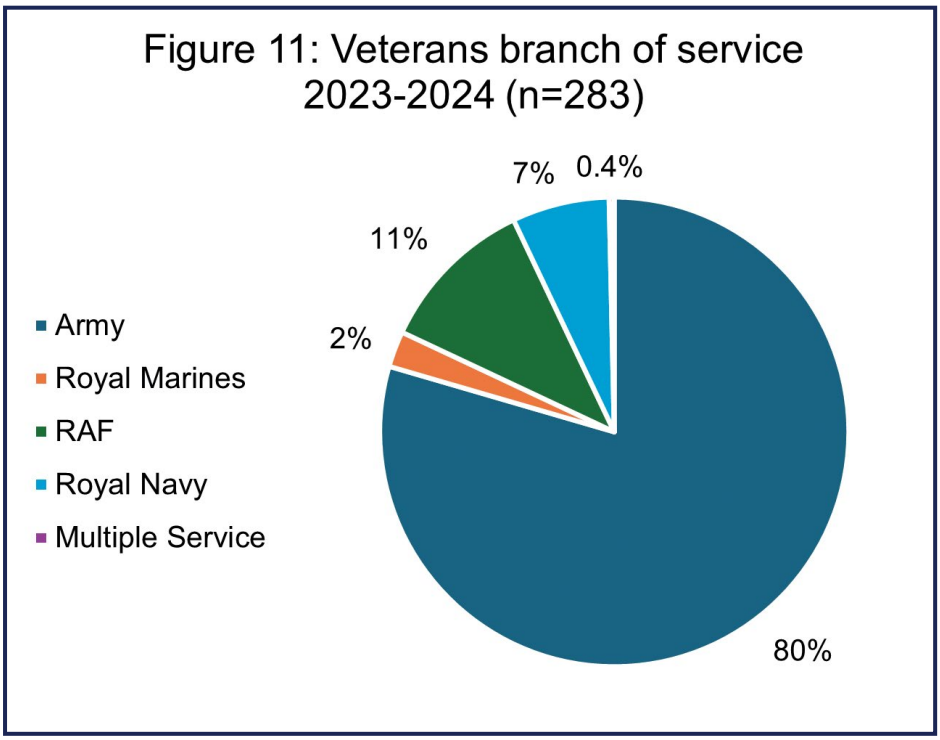


Military demographics

As shown in Figure 11, most veterans assessed by the service served in the Army (80%, n=225), followed by the Royal Air Force (11%, n=31) and the Royal Navy (7%, n=19). One veteran (0.4%) had served in multiple armed forces.

Veterans' time in service ranged from under one year to 50 years. The mean length of service was 12 years.

Only 12% (n=33) of veterans had never been deployed. Most veterans had been deployed either once (26%, n=68) or twice (24%, n=64). The most common deployment location was Afghanistan, followed by Northern Ireland.

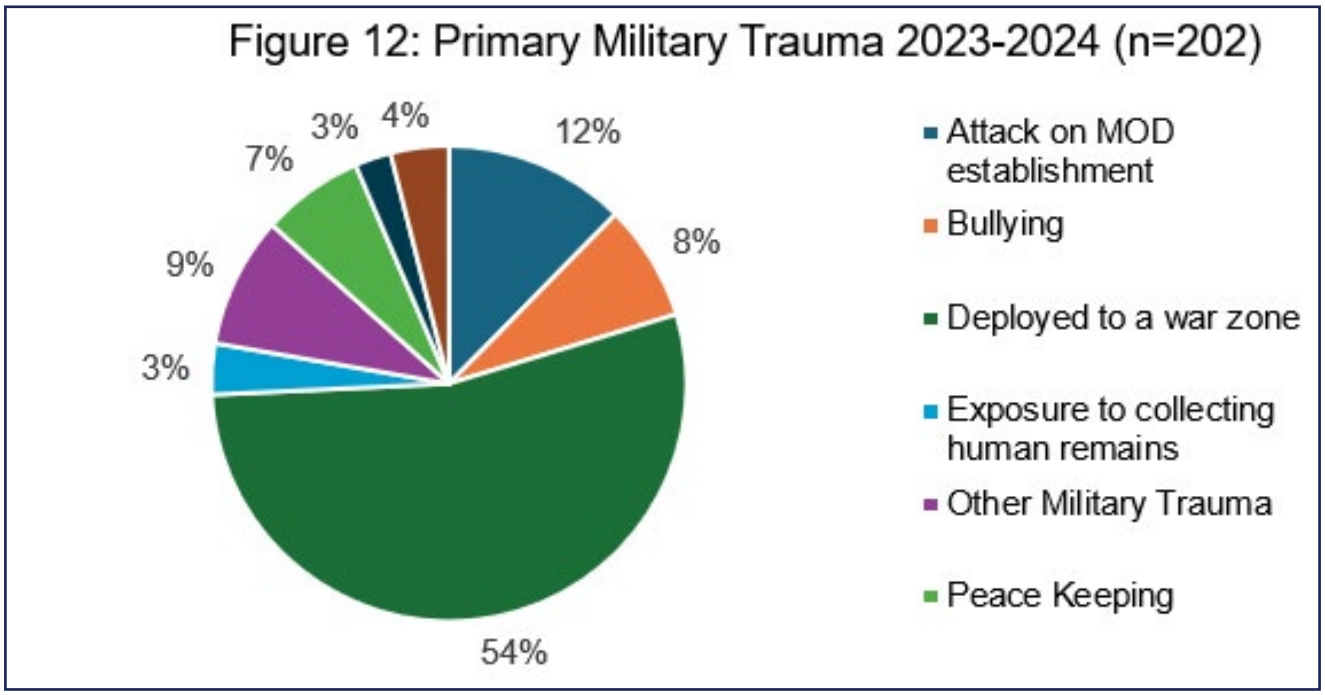


Trauma Experiences

Detail on traumatic events experienced are also taken at assessment. Where data is available, the next section reports primary military trauma, primary non-military trauma and Adverse Childhood Experiences. Exposure to traumatic events increases the likelihood of common mental health problems (Public Health Wales, 2016).

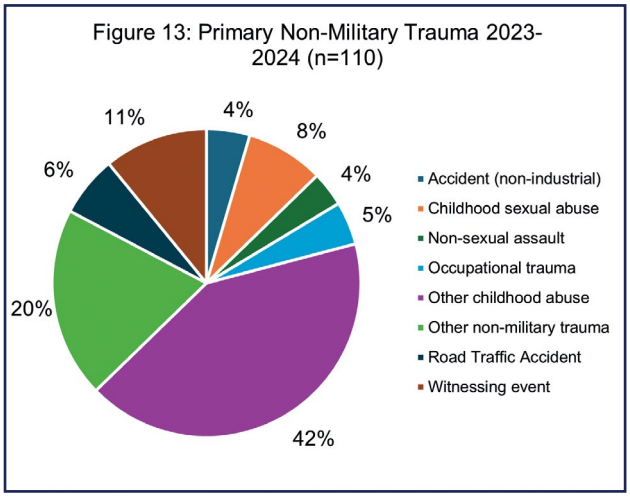
Primary Military Trauma

The most common primary military trauma reported was 'Deployment to a war zone' (54%, n=109), followed by 'Attack on a MOD establishment' (12%, n=25), 'Bullying' (8%, n=16), and 'Peace Keeping' (7%, n=14). 'Other military trauma' equates to 9% of trauma-types reported and includes Training exercises, Vicarious Trauma, Sexual Assault or Rape and Witnessing Suicide. Individually, each 'other military trauma' made up 2% or less (n≤4). Figure 12 shows full details.



Primary Non-Military Trauma

The first, and third, most common primary non-military trauma reported were linked to childhood abuse ('Other childhood abuse (non-sexual)' 42%, n=46, and 'Childhood sexual abuse' 8%, n=9). The second most common non-military trauma reported was 'Witnessing event' (11%, n=12). This may include Witnessing suicide, or Violent events. 'Other non-military trauma' equates to 20% of the overall data. However, each individual item made up 3% or less (n≤3). Items include Miscarriage, Imprisonment, Natural disaster and Industrial Accident. These items are combined within 'Other non-military trauma' and presented in Figure 13.

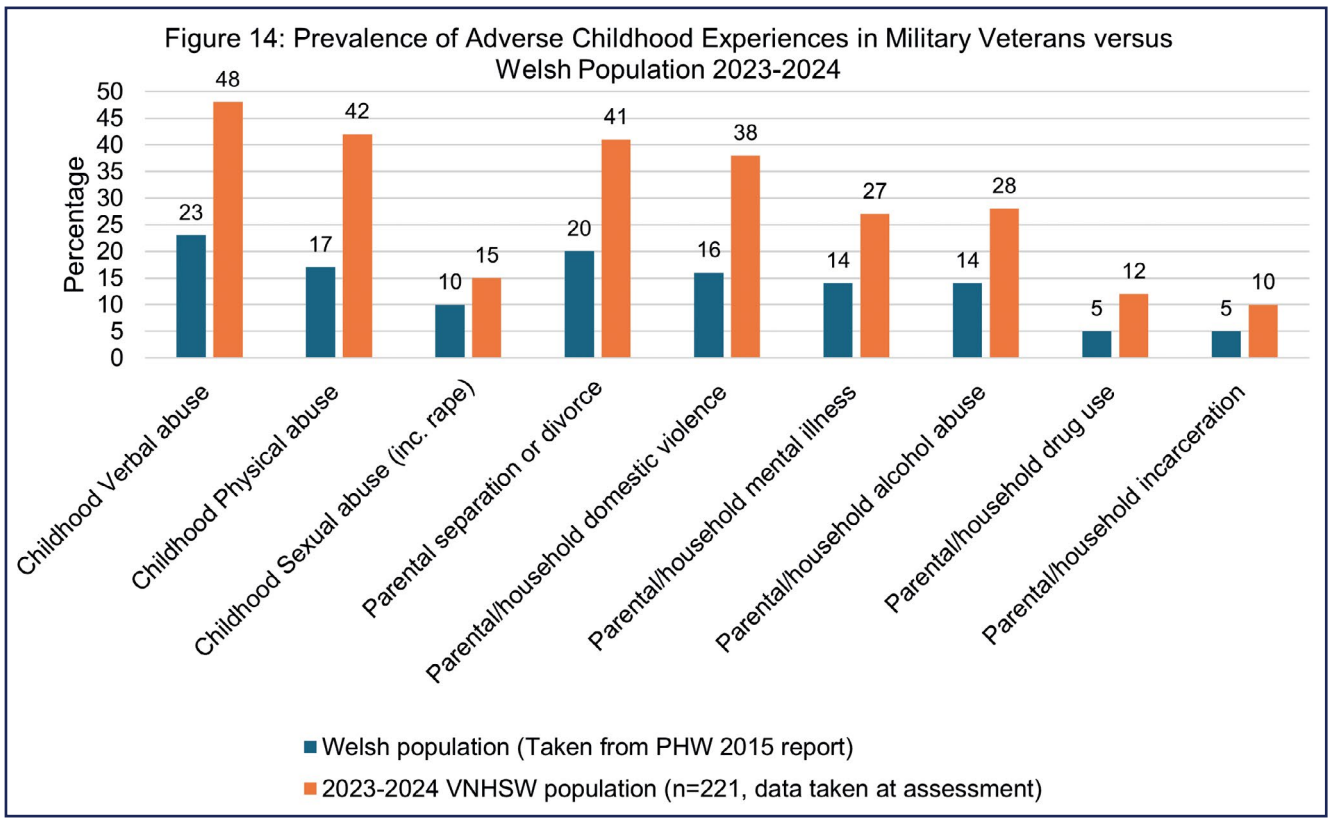


Adverse Childhood experiences (ACEs)

Fifty-percent of primary non-military traumas reported were linked to childhood abuse. VNHSW administers the Public Health Wales's ACE questionnaire at assessment to identify childhood (pre-18) experiences of adversity or trauma.

Fourteen percent of people living in Wales have four, or more, Adverse Childhood Experiences (ACEs) (Public Health Wales, 2015). In 2023-2024, 38% (n=84) of veterans who were assessed had experienced 4 or more ACEs.

Figure 14 highlights the prevalence for individual ACEs in 2023-2024 for veterans at assessment (n=221), versus the wider Welsh population (Public Health Wales, 2015). Veterans presented with higher percentage of ACEs on all items, compared to the Welsh population. This data may be biased as it is taken at assessment from treatment seeking veterans with mental health problems. ACEs significantly increase the risk of mental health difficulties in adult life, therefore VNHSW population could be skewed towards a higher prevalence of ACEs. Regardless, the data in Figure 14 highlights high percentage of ACEs in VNHSW population which suggests potential complexity in trauma presentations and psychological treatment.



Mental Health Presentations

This section will discuss the prevalence of common mental health difficulties, comorbid presentations and treatment outcomes in the 2023-2024 VNHSW population.

Veterans' complete self-report psychometric measures for Post Traumatic Stress Disorder (PTSD), Depression, Anxiety, Insomnia, Alcohol and Substance Misuse at assessment, start of their treatment and completion of treatment. A veterans' probable diagnosis is indicated by psychometric measures and clinician judgment following the veteran's biopsychosocial assessment.

The psychometric measure data is presented in this section. These screening measures provide a picture of each veteran's probable diagnosis and presenting symptoms but are self-report measures and should be interpreted with caution. However, these measures provide the best data we have of the mental health presentations veterans attending VNHSW present with.

Psychometric measures used are:

1. PTSD (PCL-5)
2. Depression (PHQ-9)
3. Anxiety (GAD-7)
4. Insomnia (ISI)
5. Alcohol and substance use (ASSIST LITE)

A higher score on each of these measures indicates a higher severity of symptoms.

Single probable diagnosis at assessment

The data below shows the percentage of veterans screening for a common mental health difficulty or substance misuse issue at assessment.

Three-hundred and seventy-four veterans were offered an assessment and sent our clinical measures to complete before they were assessed. Not all veterans engaged with assessment or completed online measure questionnaires, data is included where available. The prevalence rate detailed below for probable PTSD, Depression, Generalised Anxiety Disorder and Insomnia are presented in Figure 15.

PTSD

- Eighty four percent (n=212) of veterans met the threshold for PTSD indicated by their PCL-5 (score ≥33)
- Presentation rates ranged from 82% (HDUHB, SBUHB) - 89% (CTMUHB) across each health board

Depression

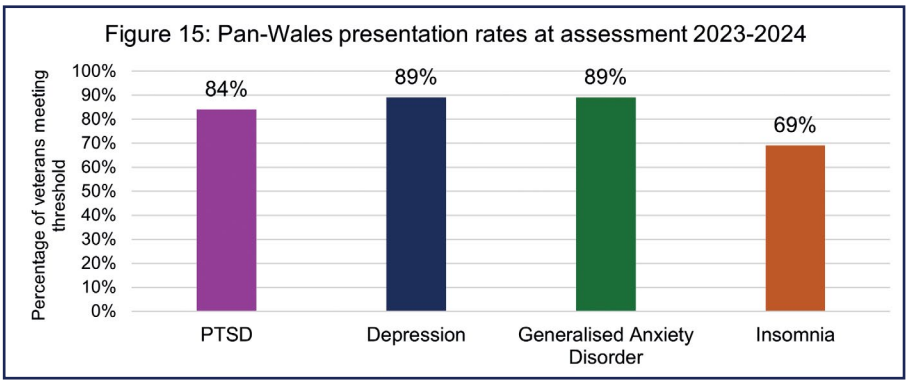
- Eighty-nine percent (n=235) of veterans met the threshold for Depression indicated by the PHQ-9 (score ≥10)
- Presentation rates ranged from 75% (CAVUHB) – 96% (HDUHB) across each health board

Generalised Anxiety Disorder

- Eighty-nine percent (n=234) of veterans met the threshold for Generalised Anxiety Disorder indicated by the GAD-7 (score≥8).
- Presentation rates ranged from 75% (CAVUHB) - 95% (ABUHB) across each health board

Insomnia

- Sixty nine percent (n=174) of the veterans met the threshold for Clinical Insomnia indicated by the ISI (score ≥15)
- Presentation rates ranged from 57% (CAVUHB) – 84% (CTMUHB) across each health board



Alcohol and Substance use

- Forty percent (n=101) of veterans had either "increasing risk" (score=5-7), "higher risk" (score=8-10) or "high-risk" (score=11-12) alcohol misuse indicated by the ASSIST-Lite self-report clinical measure
- "Increasing risk", "higher risk" or "high-risk" substance use was prevalent for 9% of Veterans: for Cannabis, 7%, for Sedatives, 7% for Stimulants, 2% for Opioids and 2% for any other substance

Common Comorbidities

The above data looks at each mental health presentation individually, but the service sees many veterans with multiple difficulties. In fact, the number of veterans presenting with only one probable diagnosis at assessment are small to non-existent. For example, only four (1.5%) veterans met probable PTSD threshold at assessment but did not meet thresholds for anxiety or depression. Three of these four veterans still met clinical insomnia threshold. The high rate of comorbidity seen across the self-report screening measures is not surprising given the cross over of symptoms within these diagnostic categories.

The following section highlights some of the most common comorbidities in our veteran population according to assessment self-report clinical measures. Outcomes for comorbid groups are also presented. Outcomes are defined by service discharge outcome (e.g. 'dropped out of treatment', 'completed treatment').

PTSD and Depression Comorbidity

- Eighty one percent (n=202) of veterans had a probable comorbid PTSD and Depression
- Thirty three percent (n=66) of veterans with probable comorbid PTSD and Depression completed treatment, compared to 63% (n=5) with PTSD and no Depression, and 25% with Depression and no PTSD (n=5)

Alcohol Use Comorbidity (Depression)

- Thirty six percent (n=91) had probable comorbid Depression and increasing Alcohol use risk
- Thirty percent (n=27) of veterans with comorbid Depression and increasing Alcohol use risk completed treatment

Alcohol Use Comorbidity (with PTSD)

- Thirty two percent (n=76) of veterans had probable comorbid PTSD and increasing Alcohol use risk
- Thirty three percent (n=25) of veterans with probable comorbid PTSD and increasing Alcohol use risk completed treatment

Across comorbid presentations, the dropout rate of therapy was between 10-11%. This is lower than the therapy dropout rate for overall 2023-2024 population (16%). This indicates that no combination of presentations assessed increases the likelihood of therapy dropout.

Clinical Outcomes of Treatment

Veterans' complete self-report clinical measures to screen for probable diagnosis at assessment as listed in the previous section. These measures also indicate symptomatic change and are repeated at the start (pre) and end (post) of treatment. The following section compares pre- and post-treatment data for the ninety veterans who completed treatment in 2023-2024.

Analysis has been conducted using complete data sets only, whereby veterans have completed start of treatment self-report clinical measures, finished treatment, and completed end of treatment measures. Number of data points (N=x) are reported in each section as some data points are missing.

Table 6 summaries the clinical outcome data reported in this section for each clinical measure.

Table 6: Description of Clinical Outcomes of Treatment

Outcome Measure	Outcome Description
Mean pre and post treatment scores	Mean pre and post treatment scores are reported for each clinical measure. This is the mean score of all veterans who completed treatment in 2023-2024
Clinical measure threshold, pre and post treatment	Of those who completed treatment, the number of veterans who were above the case-ness threshold pre-treatment, compared to post-treatment.
Reliable Recovery	Reliable recovery is found when a veteran meets case-ness at the start of treatment, but not at the end. Reliable recovery is only reported for veterans who met case-ness at the start of treatment.
Reliable Improvement	Reliable improvement is found if a veterans' score reduces by a specified value, or more, after treatment compared to before treatment. Each clinical measure has a different value for improvement change score, these are defined in the relevant sections below. Reliable improvement is reported for all veterans who completed treatment and pre- and post- treatment measures.
Clinically Significant Improvement	Clinically significant improvement is found where both reliable recovery and improvement are met.
NB: Case-ness is defined when an individual is regarded as a clinical case on the clinical measure. Individual clinical measures have case-ness cut-point thresholds.	

PCL-5 for symptoms of PTSD (n=85)

Figure 16 presents a mean pre and post-treatment PCL-5 score for 85 veterans. A total score of 33 or higher indicates case-ness for probable PTSD. Pre-treatment, the mean PCL-5 score was 49 and above case-ness. Post-treatment mean was 24 and no longer met case-ness.

At the start of treatment 67 veterans met case-ness threshold for PTSD. After treatment, only 22 veterans met this threshold. These results indicate an improvement in PTSD symptoms after treatment with VNHSW. These results are summarised in Table 7.

Additionally, Table 7 presents Reliable Recovery, Improvement and Clinically Significant Improvement rates. Eighty-five percent of veterans showed reliable improvement and 69% of veterans reliably recovered from PTSD. Overall, 69% showed clinically significant improvement in the PTSD symptoms.

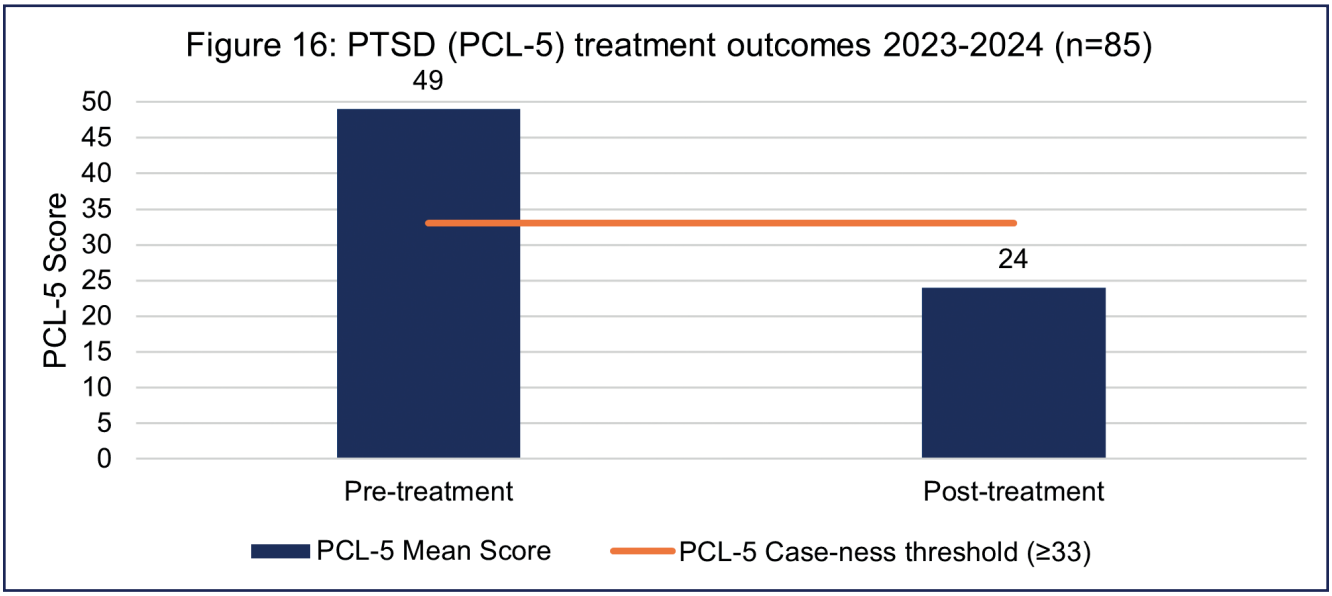


Table 7: Outcome measures for PTSD using PCL-5 pre and post treatment scores (n=85)		
Mean PCL-5 scores (n=85) (See Figure 16)	Pre-treatment = 49	Post-treatment = 24
Veterans above clinical measure threshold (≥33) (n=85)	Number of veterans	
	Pre-treatment = 67 (79%)	Post-treatment = 22 (26%)
Reliable Improvement (≥5 point reduction in PCL-5 score post-treatment) (n=85)	85% (n=72)	
Reliably Recovered (≥33 pre-treatment and ≤33 post-treatment) (n=67)	69% (n=46)	
Clinically Significant Improvement (n=67)	69% (n=46)	

PHQ-9 for symptoms of Depression (n=85)

PHQ-9 clinical ranges are 0-4 = normal range, 5-9 = mild depression, 10-14 = moderate depression, 15-19 = moderately severe depression and 20-27 = severe depression.

Figure 17 presents mean pre- and post-treatment PHQ-9 score for 85 veterans. At start of treatment, the mean PHQ-9 score was 17, which indicates moderately severe depression. After treatment, the mean score had reduced to 9, indicating mild depression. This shows a reduction in mean score by two clinical ranges and the post-treatment mean score dropping below the case-ness threshold of ≥10. Overall, these figures suggest a reduction in self-reported depression symptoms for veterans completing treatment.

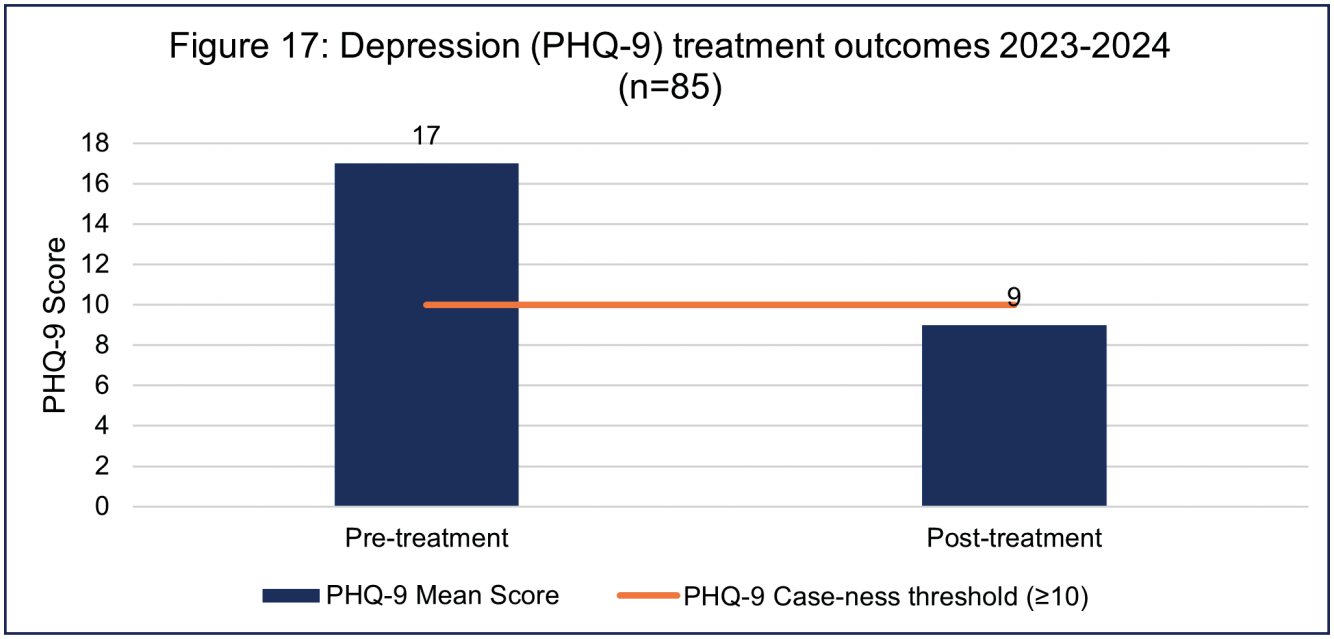


Table 8 presents these results alongside depression Reliable Recovery, Improvement and Clinically Significant Improvement results. Of 85 veterans, 58% (n=49) veterans met reliable improvement threshold. Of 71 veterans, 58% (n=41) showed reliable recovery and 51% (n=36) met the threshold for clinically significant improvement.

Table 8: Outcome measures for Depression using PHQ-9 pre and post treatment scores (n=85)

Mean PHQ-9 scores (n=85)	Mean PHQ-9 Score	
	Pre-treatment = 49	Post-treatment = 24
Veterans above clinical measure threshold (≥10) (n=85)	Number of veterans	
	Pre-treatment = 71 (84%)	Post-treatment = 34 (40%)
Reliable Improvement (≥6 point reduction in PHQ-9 score at post-treatment) (n=85)	58% (n=49)	
Reliably Recovered (≥10 pre-treatment and ≤10 post treatment) (n=71)	58% (n=41)	
Clinically Significant Improvement (n=71)	51% (n=36)	

GAD-7 for symptoms of Generalised Anxiety Disorder (n=85)

The GAD-7 clinical ranges are: 0-4 = normal range, 5-9 = mild anxiety, 10-14 = moderate anxiety and 15-21 = severe anxiety.

Figure 18 presents a mean pre- and post-treatment GAD-7 score for 85 veterans. At start of treatment, the mean GAD-7 score was 14 which indicates moderate anxiety. After treatment, the mean score was 7, indicating mild anxiety. These results demonstrate a reduction in average anxiety score by one clinical range and that the mean post-treatment score drops below the GAD-7 case-ness threshold of ≥8. These figures suggest a reduction in self-reported anxiety symptoms.

Figure 18: Generalised Anxiety Disorder (GAD-7) treatment outcomes 2023-2024 (n=85)

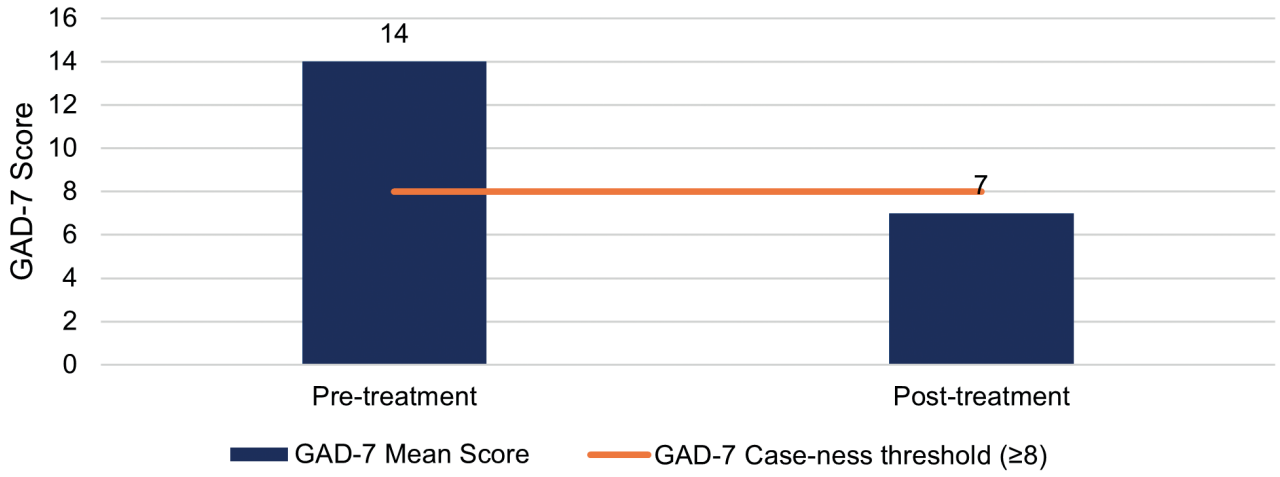


Table 9 presents these results alongside Reliable Recovery, Improvement and Clinically Significant Improvement results for anxiety. Of 85 veterans, 66% of veterans met the reliable improvement threshold for anxiety symptoms. Seventy-one veterans met the GAD-7 case-ness threshold for clinically significant anxiety pre-treatment. Of these 71 veterans, 37% met reliable recovery and 37% also met both improvement and recovery measures for anxiety symptoms.

Table 9: Outcome measures for Generalised Anxiety Disorder using GAD-7 pre and post treatment scores (n=85)

Mean GAD-7 scores (n=85) (See Figure 18)	Mean GAD-7 Score	
	Pre-treatment = 14	Post-treatment = 24
Veterans above clinical measure threshold (≥10) (n=85)	Number of veterans	
	Pre-treatment = 71 (84%)	Post-treatment = 34 (40%)
Reliable Improvement (≥4 point reduction in GAD-7 score at post-treatment) (n=85)	66% (n=56)	
Reliably Recovered (≥8 pre-treatment and ≤8 post treatment) (n=71)	37% (n=26)	
Clinically Significant Improvement (n=71)	37% (n=26)	

ISI for symptoms of Insomnia (n=59)

The ISI clinical ranges are: 0-7 = no clinically significant insomnia, 8-14 = subthreshold insomnia,15-21 = clinical insomnia (moderate severity) and 22-28 = clinical insomnia (severe).

Figure 19 presents a mean pre and post-treatment ISI score for 59 veterans. At start of treatment, the mean ISI score=17, which indicates moderate severity clinical insomnia. After treatment, the mean ISI score=12 which is categorised as subthreshold insomnia. This shows a reduction in mean score by one clinical range. The post-treatment mean score also drop below the ISI has a "case-ness" threshold of ≥15.

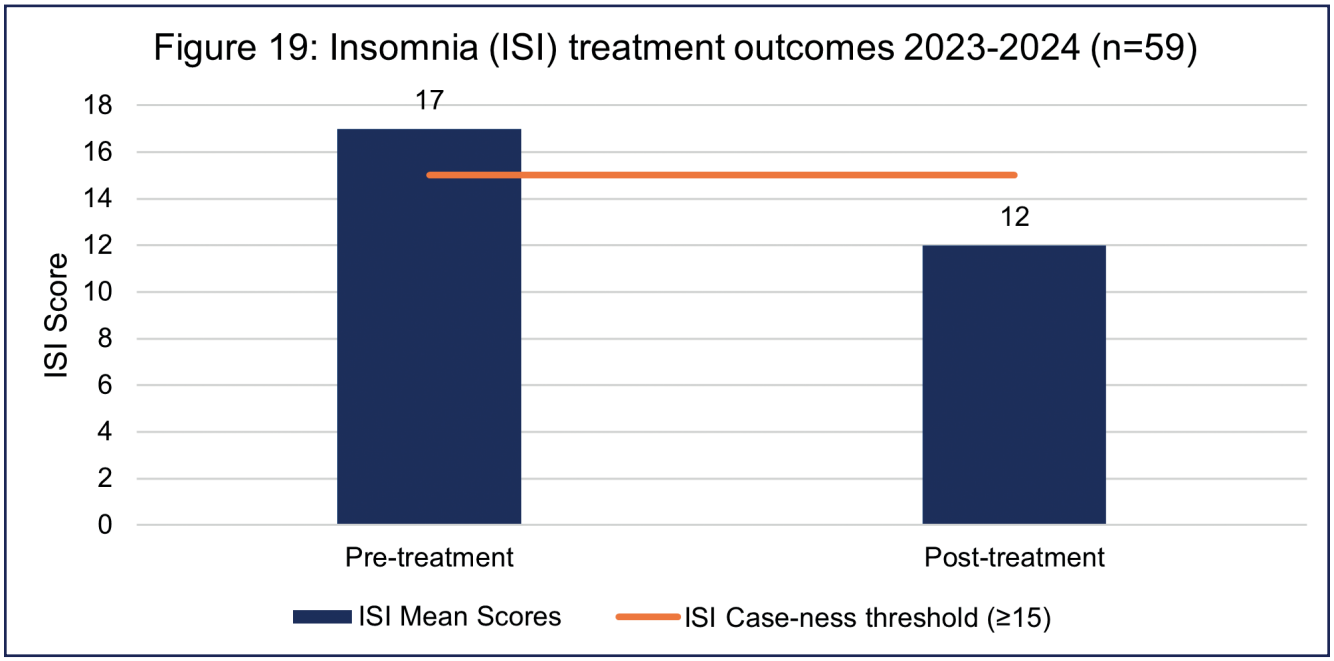
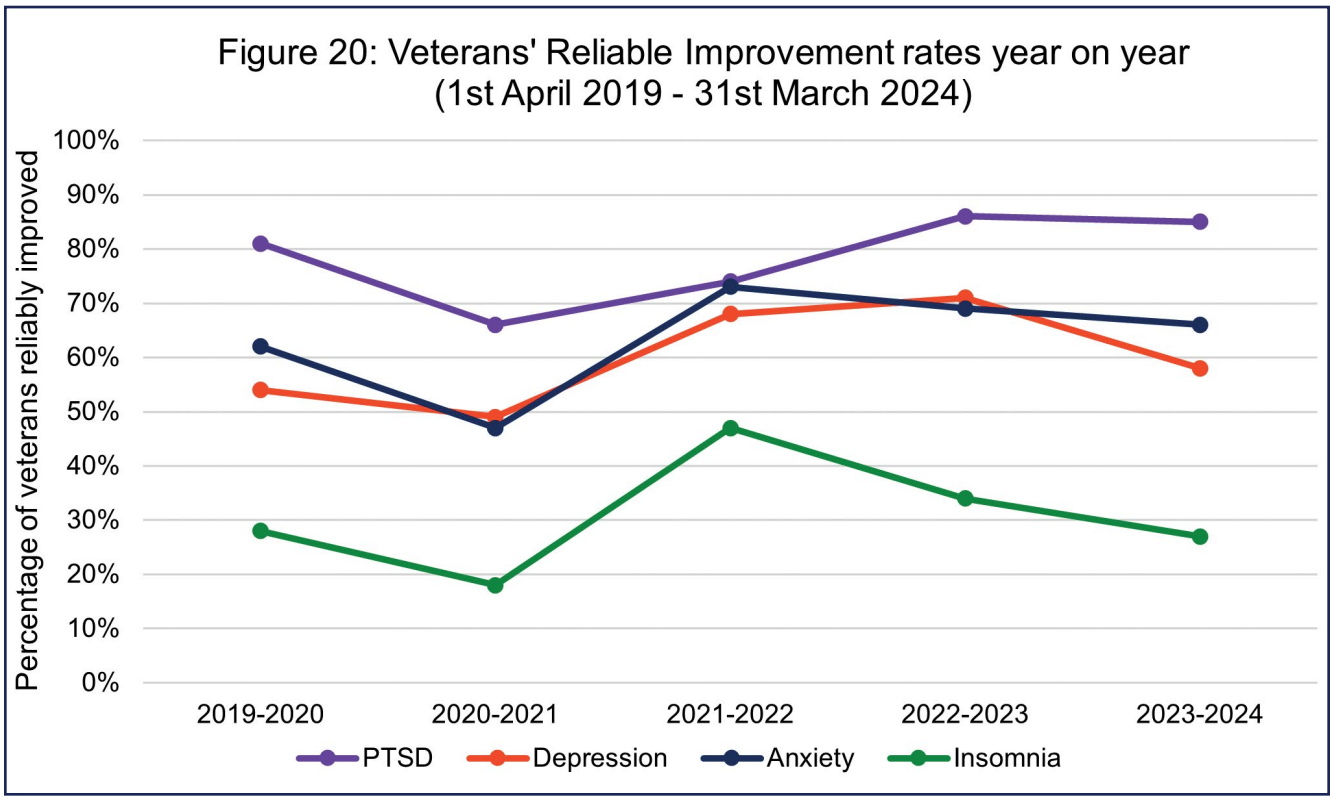


Table 10 presents recovery and improvement rates for insomnia, in addition to the figures above. Only 27% of veterans showed reliable improvement (8-point reduction in their ISI score). It is worth noting that an 8-point reduction is the highest value reduction of all four clinical measures reported. Fifty-one percent (n=20) showed reliably recovery and 36% (n=14) of veterans met the threshold for clinically significant improvement.

Table 10: Outcome measures for Insomnia using ISI pre and post treatment scores (n=59)		
Mean ISI scores (n=59) (See Figure 19)	Mean ISI Score	
	Pre-treatment = 17	Post-treatment = 24
Veterans above clinical measure threshold (≥10) (n=85)	Number of veterans	
	Pre-treatment = 39 (66%)	Post-treatment = 22 (37%)
Reliable Improvement (≥8 point reduction in ISI score at post-treatment) (n=59)	27% (n=16)	
Reliably Recovered (≥15 pre-treatment and ≤15 post-treatment (n=39)	51% (n=20)	
Clinically Significant Improvement (n=39)	36% (n=14)	

Reliable improvement over time

Figure 20 presents reliable improvement rates for PCL-5, PHQ-9, GAD-7 and ISI over the last five years. Improvement rates for Depression, Anxiety and Insomnia have gradually reduced in the last two years whereas rates for PTSD symptom improvement have increased and remained steady.

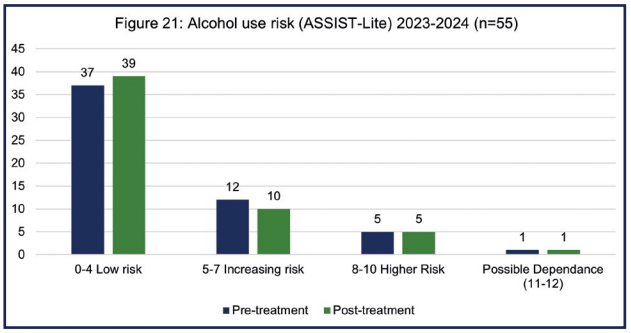


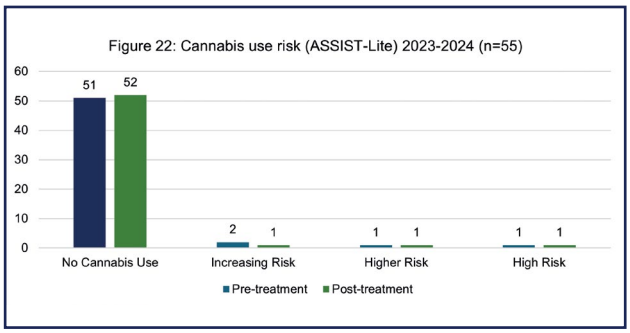
ASSIST-Lite for alcohol and substance use

The ASSIST-Lite is scored over several subsections, rather than as an overall measure. However, the maximum score is = 28 when all subsections are combined. In 2023-2024, the mean ASSIST-Lite scores reduced after treatment. Before treatment, the mean, combined ASSIST-Lite score = 4, and after treatment, the mean combined score reduced to = 2. This indicates a trend in symptom improvement for alcohol and substance misuse difficulties.

A more representative picture of veterans' alcohol misuse pre and post-treatment in 2023-2024 is presented in Figure 21. This graph shows the number of veterans in each of the alcohol risk categories pre and post-treatment. Post-treatment, only two veterans reduced in risk. Moving from "increasing risk" to "low risk".

Figure 22 presents the same data for veterans' cannabis misuse and highlights that one veteran dropped in risk category in 2023-2024. Data sets for other substances are too small to present, but figures presented here for alcohol and cannabis use show limited symptom improvement post-treatment.





Service User Feedback

In 2023-2024, 24 veterans (27%) completed service experience questions (SEQ) after completing treatment. Overall, all feedback was positive with all 24 veterans responding as 'strongly agree' when asked if they would recommend the service to other veterans.

Below, are quotes from our feedback forms. Veterans were asked to tell us about their experience of the service.

Excellent service and would recommend to others (ABUHB)

From my initial call at the start, I have been treated with empathy and kindness. The therapists have been extremely supportive, and I cannot thank them enough for all the help, support and encouragement they have given to me since starting therapy. I can honestly say they brought me back and out of a very dark episode that I was struggling with (CAVUHB)

From the initial contact by a Peer Mentor, through to therapy from my Veteran's Therapist, I have received very professional care process (BCUHB)

I can't thank you enough. I have now changed into the man I used to be, still a long way to go but I'm on the up, thanks to you all (HDUHB)

I had quite a few issues which were taken and dealt with very quick... I felt valued (CTMUHB)

It was extremely helpful and gave me ways to deal with my problems, being able to talk through all my issues and be listened too, with care and understanding (ABUHB).

My relationship with my therapist was excellent, they were someone I could trust. They talked me through every step of the treatment plan and explained in depth of how each treatment worked (CAVUHB)

When I first started, I felt like I was a broken man and had nowhere to go in life but after months being with my therapist, I am totally changed person. I feel 100% better than I was and my whole experience has been fantastic. I cannot thank my therapist enough for what he has helped me achieve within the last 9 months and I feel I am back to the person I used to be (BCUHB)

This Service is outstanding for Veterans it's a real game changer. I didn't know about this service until my GP informed me (BCUHB)

Walk and Talk experience was excellent being outside I felt relaxed to open up. Appointment times were flexible. Therapist was easy going and approachable. I felt listened to for the first time ever (HDUHB)

Excellent rapport and understanding from the therapist and selection of the therapy. Explanation of the process confirmed my understanding (CAVUHB)

Very Professional, Supportive and insightful (HDUHB)

The high degree of professionalism and ability to make me feel comfortable when we spoke (SBUHB)

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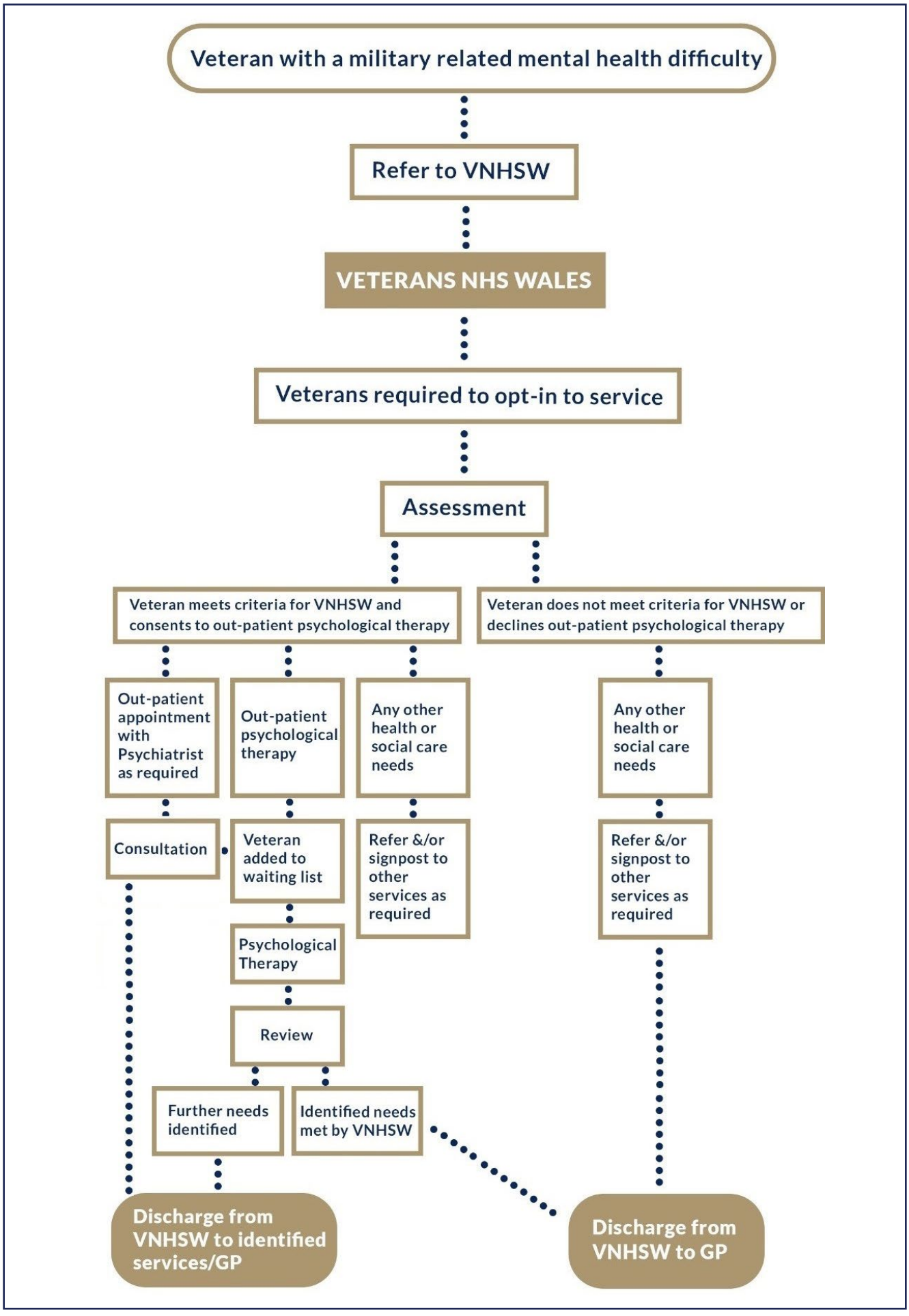
Appendices

Appendix 1: Acronyms Table

Acronym	Full Name
ABUHB	Aneurin Bevan University Health Board
BCUHB	Betsi Cadwaladr University Health Board
CAVUHB	Cardiff and Vale University Health Board
CTMUHB	Cwm Taf Morgannwg University Health Board
HDUHB	Hywel Dda University Health Board
PTSD	Post Traumatic Stress Disorder
SBUHB	Swansea Bay University Health Board
SEQ	Service Evaluation Questionnaire
VNHSW	Veterans' NHS Wales

Appendix 2: Veterans' NHS Wales Care Pathway



Appendix 3: Powys Teaching Health Board VNHSW Out-Patient Clinics

VETERANS NHS WALES

Website: **www.veteranswales.co.uk**
(For useful information on the Veterans' NHS Wales and links to other helpful websites)