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Veteran Informed Prisons

A guide to improving the health and well-being of prisoners in Wales who are veterans

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FOREWORD

In a civilised society imprisonment should always be a last resort and any period of custody needs to aim purposefully at rehabilitating the persons concerned so that they can, at some future point, re-engage with their communities as productive and valued members of society.

The prisoner community is diverse and the reasons why an individual ends up serving a custodial sentence are numerous and can only be considered on a case by case basis. However, what we can say for certain is that the prison community is made up of a significant number of military veterans.

The Welsh Government recognises that the veteran prison community may require special consideration due to their service experiences. This is especially true in relation to their healthcare, where military experiences may have left physical and, in particular, emotional scars, which may need specific support or adjustment of healthcare provision. This guidance aims to help commissioners, planners and service providers to identify the needs of veterans in prison and steer them to the most appropriate source of support, to ensure an individual prisoner's healthcare needs are met, in the most efficient and effective way. Supporting the veteran during their time in prison and enabling the prison authorities to ensure a safe and suitable environment for the individual is vital, as is ensuring necessary access to housing, financial and other advice when that person leaves prison.

I wish to thank the members of the multiagency task and finish group which developed this guidance for their work and for the improvements which I am sure will flow from it.

Professor Mark Drakeford AM
Minister for Health and Social Services
July 2013

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1. INTRODUCTION

1.1 '*Veteran Informed Prisons: A guide to improving the health and well-being of prisoners in Wales who are veterans'* is intended to support commissioners, planners and staff across health and prison services in Wales. It has been produced by a Task & Finish Group (see **Annex E)** comprising representatives of the Welsh Government, NHS Wales, the National Offender Management Service (NOMS), prison staff, the Ministry of Defence (MoD) and third sector support organisations for ex-service personnel. All share a common interest: to ensure that prisoners in Wales who are veterans of the Armed Forces have their health and welfare needs met.

2. BACKGROUND

2.1 Relative to population, i.e. 5% of the UK total, Wales provides a disproportionate number of recruits into the Armed Forces, contributing about 10% of serving personnel. Current estimates put the number of ex-service personnel living in Wales at in excess of 200,000. There is currently no way of collecting accurate figures of ex-service personnel and where they live post service.

2.2 For various reasons, not least non-disclosure on the part of the individual, there are no accurate figures for the number of prisoners in Wales who are also veterans. Based on what is known and UK estimates the proportion is likely to be about 3 – 4% of the adult male prisoner population. If this is the case, veterans constitute an identifiable sub-set within the prisoner population as a whole.

2.3 During their time in the Armed Forces, service men and women have a clear chain of command and welfare support to deal with problems as well as comrades who can provide peer support or advice. As with many jobs, members will have their own abbreviations and shared common language which can seem incomprehensible to civilians.

2.4 In the past personnel who were discharged early from the Armed Forces often left at short notice without time to plan their transition to civilian life, some Service organisations suggest there has been limited change to this provision for this group. Resettlement for those who serve longer is, in part, graduated on length of time served. In recent years there has been considerable improvement, i.e. those leaving are able to attend specific courses addressing, for example, future housing, education and employment needs.

2.5 The majority of service leavers make the transition to civilian life without problem. For all there is a period of adjustment/re-adjustment to civilian life and some manage this better than others. Problematic transition may be due to a variety of reasons related, or unrelated, to service in the Armed Forces, including childhood factors, physical and mental health problems.

2.6 This guidance identifies why it may be difficult for some veterans to engage with health services in general, and how this can manifest itself. It offers suggestions for interventions and signposting to services, available both in prison and in the community which can provide appropriate care and support.

3. DEFINITION OF 'VETERAN'

3.1 Within the context of this guidance the term 'veteran' refers to anyone who has served for at least one day in the Armed Forces (Regular and Reserve), as well as Merchant Navy seafarers and fisherman who have served in a vessel that was operated to facilitate military operations by the Armed Forces.

3.2 It is important to emphasise that this definition of 'veteran' includes **all** who have served at least one day, irrespective of the manner and circumstances in which they left service. It does not apply exclusively to those who have been engaged in combat in any theatre of military operations.

4. SCOPE OF THIS GUIDANCE

4.1 In February 2011 the National Assembly for Wales (NAfW) Health, Wellbeing and Local Government Committee published a report on '*Post-traumatic stress disorder for services veterans*'[1]. It highlighted problems with the identification of Post-Traumatic Stress Disorder (PTSD) in veterans, a lack of data, and inadequate and inappropriate evidence based treatment services for veterans with PTSD. The Committee made several recommendations including the following:

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

4.2 Other recommendations within the report also have relevance to health provision for prisoners, notably those relating to primary care, substance misuse, and the Priority Treatment scheme for veterans. In addition, the '*Welsh Government Package of Support for the Armed Forces Community in Wales*'[3] lists a number of commitments relating to healthcare provision for service and ex-service personnel.

4.3 More recently the Welsh Government has published '*Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales*'[4], together with an associated Delivery Plan for 2012 - 2016[5]. Both documents make reference to the need to ensure that veterans receive services appropriate to their mental health needs.

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[1] http://www.assemblywales.org/cr-ld8408-e.pdf
[2] Now the All Wales Veterans Health & Wellbeing Service (AWVHWS)
[3] http://wales.gov.uk/docs/dsjlg/policy/111107afpackageen.pdf
[4] http://wales.gov.uk/docs/dhss/publications/121031tmhfinalen.pdf
[5] http://wales.gov.uk/docs/dhss/publications/121203planen.pdf

4.4 With the above in mind the Task & Finish Group agreed upon an approach to improving the health and well-being of prisoners who are ex-service personnel that encompasses all of their health needs. This approach has been informed by a growing body of evidence, which indicates that many of the physical and mental health problems experienced by veterans in prison are the same as those affecting the wider population and requires comparable treatment responses. It also recognises that services will need to be more culturally sensitive in terms of delivery if they are to engage veterans effectively, as well as the specific needs of those with service-related PTSD.

4.5 The 'responsible commissioner' for health services for prisoners in the public sectors prisons in Wales is the Local Health Board (LHB) in which the prison is located. Prisoners are regarded as normally resident in the prison irrespective of their area of origin. The NHS is also responsible for the secondary care of prisoners held in private sector prisons. The following guidance therefore applies to all prisoners held in the prison estate in Wales.

4.6 Prisoners who are Welsh and held in the prison estate in England are similarly the responsibility of health commissioning bodies in England, and therefore outside the reach of this guidance. The Welsh Government will continue to work with NOMS to ensure that Welsh prisoners held in England and requiring access to specialist health provision in Wales on release from prison are identified and referred as necessary to the AWVHWS.

5. VULNERABILITY, OFFENDING AND HEALTH

5.1 In 2009 the Howard League for Penal Reform launched an inquiry[6] into former Armed Forces personnel in prison. The inquiry was established with the remit of discovering why so many ex-service personnel become involved with the criminal justice system. In particular, the problems they face on leaving the Armed Forces, the sorts of offences they have committed, the reasons for their offending, how the needs of this group can best be met both in the community and in prison, and what can be done to reduce the number who commit offences resulting in custody.

5.2 For many personnel service life is a great leveller, i.e. a positive experience, (especially for disadvantaged young people who enter service early) allowing them to enjoy a more favourable life pathway. The majority of personnel leaving the Armed Forces lead constructive and productive lives after discharge and do not at any stage become involved in the criminal justice system.

5.3 That said, according to the Howard League, it is clear that the conventional problems associated with criminal behaviour such as drug and alcohol abuse, homelessness, low educational attainment and financial pressures, and a poor ability to deal with emotions, appear to be as common among ex-service personnel in prison as they are among the prison population as a whole.

[6] The Howard League for Penal Reform, '*Report of the Inquiry into Former Armed Service Personnel in Prison*' (2011)

5.4 In terms of vulnerability to offending, the Howard League identified three different though not mutually exclusive groups from a series of interviews with ex-service personnel in prison:

- those who had experienced traumatic and difficult lives prior to enlisting in the Armed Forces, e.g. witnessing or suffering violence, periods in local authority care, some involvement in criminal activity, and drug/alcohol misuse;

- those who experienced difficulties during their time in the Armed Forces, e.g. mental health problems, physical injury, sometimes resulting in early discharge;

- those who experienced problems post-discharge, e.g. difficulty in adjusting to civilian life after a successful career in the Armed Forces. There may also be vulnerability to late onset of trauma, not apparent in service or during the immediate post-discharge period.

Three factors occurred frequently in the accounts of offending of those they interviewed, i.e. social isolation and exclusion, alcohol and financial problems.

5.5 The Howard League report observes that much of the media coverage of the process of transition from service to civilian life has tended to focus on the issue of PTSD where problems arise. This has overshadowed discussion of other mental health problems suffered by veterans, in a context where one in four of the general population will experience mental ill-health at some point in their lives. Other health issues have also attracted less attention, e.g. common mental disorders (anxiety and /or depression and substance misuse).

5.6 No discussion of the problems experienced by veterans who find themselves in prison should ignore PTSD – one section of the guidance that follows specifically addresses PTSD – but it should not be assumed that it is a problem uniquely related to service in the Armed Forces. There is evidence to suggest a consistent connection, via PTSD, between military service and offending[7]. There is some evidence that the prevalence of PTSD among veterans is slightly higher than the general population[8]. But PTSD is often present with co-morbidities such as alcohol misuse which can be damaging of both physical and mental health in the longer term, and contribute to offending.

5.7 It should also be a matter of concern that while the rate of completed suicide for veterans is the same as for the general population, the risk of suicide in young ex-service personnel (i.e. under 24 years) is two to three times higher[9]. This is also the group termed early service leavers who serve less than 4 years.

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[7] Needs, A, Hodgman, G & Pollard, E: '*UK Veterans in Prison: An Exploration of Current Symptoms and Contextual Issues*' – available via the Veterans in Prison Association website: http://www.veteransinprison.org.uk/

[8] Howard, G, '*Draft Veterans' ('ex-military') Health Needs Assessment for Kent &* Medway', NHS Kent & Medway, October 2011

[9] ditto

6. CULTURAL ISSUES AND HEALTH

6.1 During their time in active service some Armed Forces personnel can become institutionalised and less self-reliant. Others remain proud, reluctant to accept help, and determined to sort themselves out when they face difficulties. Both mindsets can lead to resettlement problems on discharge as supports and social networks fall away. A culture of help-seeking and awareness of mental ill health symptoms among the ex-service population needs to be encouraged.

6.2 A lack of knowledge and understanding of ex-service personnel by health professionals, and insufficient awareness of their specific needs, may be a barrier to improving their access to appropriate health service provision. This can, in some cases, be coupled with a lack of confidence in dealing with individuals who may be hostile and distrusting.

6.3 Some ex-service personnel will choose not to disclose their status, either voluntarily or when asked, particularly if they are concerned about their mental health. During service there are a number of factors that may contribute to a perception and/or experience of stigma associated with seeking help for emotional and psychological distress. These may be due to a feeling of weakness and failure on the part of the individual, or a fear of reduced promotion prospects and medical discharge.

6.4 Ex-service personnel can also find it difficult to reconcile the differences between their experience of health service provision while they were in the Armed Forces, and their experience of the NHS on discharge. The accessibility and immediacy of assessment and treatment in the Armed Forces service compared to normal diagnosis and treatment timescales within the NHS may, at worst, compound feelings of not being valued for the risks they have taken on behalf of their country.

6.5 All of the above suggests that the manner in which services are accessed and delivered, and the skill-set required by health professionals will need to be adapted and developed to better meet the health needs of ex-service personnel. The following are some of the features of more successful health services for veterans currently operating, and they have an equal applicability within prison environments:

- ability to self-refer
- provided by staff who are ex-service themselves
- provided by staff with relevant training and expertise
- the availability of group work with other ex-service personnel
- multi-agency clinics
- provided by teams that are badged as being specifically for ex-service personnel
- assessment and treatment provided together, i.e. little or no wait between the two
- joint work and information sharing with other agencies
- routine accessing of service medical records

In Wales the NHS All-Wales Veterans Health & Wellbeing Service (AWVHWS) has been established in recognition of the need for a dedicated service following a successful two year pilot in the Cardiff and Vale and Cwm Taf NHS Trusts.

7. MULTI-DISCIPLINARY AND CROSS-SECTOR WORKING IN PRISONS

7.1 The prison service has traditionally attracted recruits from the Armed Forces on completion of their military service. This includes a small number of healthcare staff, chaplains, and staff working in other specialist departments in prisons. Increasingly, many will be encouraged to continue to serve as Reservists. The relevance of this point is that working within most prisons, and at all levels, there are a number of staff who will understand very well what it means to be ex-service personnel, and how best to engage with those who have found themselves in difficulties. Although it should be acknowledged that sometimes these staff may also carry their own difficulties and may wish to distance themselves from this population.

7.2 There are a number of agencies that support both men and women currently serving in the Armed Forces, their dependants and families. They also provide a variety of services for ex-service personnel, including those in prison. Agencies currently working with prisons and prisoners in Wales include:

- Combat Stress
- Royal British Legion (RBL)
- Service Personnel & Veterans Agency (SPVA) – Veterans UK
- Soldiers, Sailors, Airman and Families Association (SSAFA)

All have a differing role and function, but with some overlapping areas of work. Further details are available on pages 16 - 19 and in **Annex A.**

7.3 While there may be some healthcare staff working in prisons with a background in, or connection to, the Armed Forces, the majority will have little awareness of service life and culture, how this might have impacted on the individual, how best to elicit information from ex-service personnel about their health needs, and how best to engage them in treatment where need is indicated.

7.4 With ex-Armed Forces personnel working in various departments within most prison establishments the opportunity to develop and deliver in-house military awareness-raising sessions for staff should be exploited. This may not be sufficient for health practitioners working in more specialist areas, e.g. primary and secondary mental health care, and links with the local AWVHWS should be established to draw on their experience and expertise. The Wales Deanery has developed an e-learning module for all primary care staff to improve their understanding of veterans mental health needs.[10] GPs and other primary care staff can also access a '*Veterans Health in General Practice'* e-learning course which is available via the Royal College of General Practitioners (RCGP) On-line Learning Environment[11], and

[10] http://gpcpd.walesdeanery.org/index.php?option=com_content&view=article&id=60&Itemid=222
[11] http://www.rcgp.org.uk/news/2011/october/new-online-course-for-gps-to-improve-care-for-thousands-of-veteran.aspx

a Briefing Note 9 entitled '*Mental Health and Ex-Service Personnel (Veterans)*' via the Wales Mental Health in Primary Care (WaMH in PC) website[12].

7.4 As indicated in paragraph 6.5, some of the most successful health services for ex-military currently operating are provided by staff with relevant training and expertise, involve staff who are ex-service themselves, and incorporate joint work with other agencies. There are clearly benefits to be derived from adopting this approach within prisons, and already examples of good practice where this has been developed.

7.5 However, all too often such initiatives are reliant on individual staff members to champion the cause, commit the extra time, and negotiate the resources required. As a consequence sustainability can be difficult to achieve. Nevertheless this guidance recommends an integrated approach to the delivery of support and care of veterans within prisons. Such an approach may not only improve health outcomes, but also contribute to a reduced risk of re-offending, of harm to self and others, and continued isolation and exclusion.

8. STATUS AND PURPOSE OF THIS GUIDANCE

8.1 This guidance does not supplant any existing health or criminal justice policies, or clinical guidance such as the National Institute for Health and Clinical Excellence (NICE) Guidelines on Common Mental Health Disorders[13] or Post-traumatic Stress Disorder (PTSD)[14]. Rather it is intended to address the potentially disadvantageous position of ex-service personnel who are prisoners in Wales in accessing and receiving support, care and treatment for their health and related needs during their time in custody.

8.2 The following sections of this guidance provide practical advice on ameliorating some of the difficulties experienced by ex-service personnel who are prisoners and improving their health and well-being. Pathways to appropriate assessment and interventions for various health conditions and other problems are described and illustrated.

[12] http://www.wamhinpc.org.uk/sites/default/files/information-sheet-9.pdf
[13] http://www.nice.org.uk/guidance/cg123
[14] http://www.nice.org.uk/cg26

CONTEXT

All prisoners newly received in prison go through clearly defined reception and induction processes to ensure that they are received into the prison safely. They will be seen by a number of different staff and disciplines, e.g. residential officers, healthcare, education, chaplaincy, and some other specialists such as drug treatment providers. Anyone or all of these may identify a prisoner as ex-military, but in the absence of a co-ordinated response there can be duplication of effort or, worse still, prisoners requiring further assessment, support or specific interventions can slip through the net. If they do indicate that they are a veteran this information should now be recorded on the prisoner information system, i.e. P-NOMIS.

GUIDANCE AND GOOD PRACTICE

Co-ordination of assessment and support

All prisons in Wales have introduced a single point of contact (SPOC) for veterans, and some the specific role of Veterans in Custody Support Officers (VICSO) or Ex-Forces Lead Officers (EFLO). These are individual members of staff, often veterans themselves, who have volunteered to work alongside Offender Management Units and other departments to ensure that the status of the ex-service personnel is verified, and that they have information on and access to specialist support services. This is not an identified job role, (i.e. it is not 'profiled') within prisons, and other prisons therefore continue to rely on non-dedicated staff, e.g. chaplains, to fulfil this function.

It is clearly preferable to have an identified point of contact and co-ordinator of support for ex-service personnel. Some veterans will have complex needs, requiring further assessment and/or prioritisation of interventions to meet them. Others will be more straightforward, and provision of information and/or facilitating access to relevant support agencies, either in prison or on release may be sufficient to meet their needs. Whichever the case, it is important that by the end of the induction period the various disciplines and departments have a shared understanding of the needs of the individual prisoner and an agreed way forward, e.g. a support or care and treatment plan. It is possible to utilise P-NOMIS for the capture and communication of support, care and treatment plans, but some may prefer to use a paper based process.

Identification and verification

All prisoners have a first-night healthcare reception screen/risk assessment to identify and meet their most immediate health needs. This process effectively 'registers' them with the health service in the prison. The screening template now includes the question:

> "*Have you ever served in the Armed Forces?"*

A Read Code is automatically entered on the patient record if there is an affirmative response. The following read codes are used within the NHS:

· "Served in armed forces"	13q3. (v2)	Ua0T3 (v3)[15]
· "Left military service"	13JR. (v2)	XE0pb (v3)
· "Armed forces NOS"	091Z. (v2)	XE0P5 (v3)
· "History relating to military service"	13JY. (v2)	Xa8Da (v3)

Similarly, discipline staff in registering the prisoner on the Prison National Offender Management Information System (P-NOMIS) will ask the same question. Although the dual processes are not intended as a 'double-check' it does ensure that enquiry is made at the earliest opportunity.

Assuming an agreement exists for an individual staff member to verify status, e.g. a VICSO or EFLO or SPOC, this information should be passed to them as soon as possible. In the event that there is no SPOC available it is imperative that verification is pursued by the healthcare team. Verification can be obtained via the contacts listed in **Annex B.**

If immediate health problems are identified the response at this stage should be no different to that for any other prisoners. For example, if possible medical and prescribing history should be obtained from GP/treatment providers, prescribing, treatment and support needs met, referral to Safer Custody team and opening of Assessment, Care in Custody and Support (ACCT) document if risk of self-harm or suicide, referral to drug treatment and/or mental health services at appropriate level. In some cases it may be necessary to admit the prisoner to the in-patient facility or a crisis bed, e.g. for alcohol detoxification, high risk of self-harm, or acute mental illness.

Induction and secondary health screening

Over the next few days prisoners will be provided with a considerable amount of information about life in the prison. They will also be interviewed by various disciplines and staff, and they will be offered a full health assessment (secondary health screen). Where a VICSO or EFLO is involved in the induction process it affords opportunity for them to engage on an individual basis with prisoners who have identified themselves as ex-military.

The Life Force Guide[16] recommends that veterans are asked the following questions:

- What was their service number?
- The dates when they joined and left i.e. how long did they serve?

[15] This is the Read code currently embedded in the SystmOne Reception Screen template
[16] NHS Hull, SAMH, Combat Stress, '*Life Force: Hull and East Riding – A Practical Guide for Working with Military Veterans*', SAMH available via the following link: http://www.humber.nhs.uk/Downloads/Services/HTSS/Lifeforce.pdf

- What was their job/trade – infantry, logistics etc? [This will provide a clearer picture of the types of experiences they encountered]
- What was their rank on leaving? [This may suggest how they fitted in and how others rated them and their abilities]
- What Corps and Regiment did they serve in while in the Armed Forces?
- How did they leave the services – end of contract, voluntary retirement (served notice), medical discharge, administrative discharge (disciplinary, compassionate etc), circumstances of discharge?
- Were they ill in service? Did they attend a DCMH (Dept of Community Mental Health)?
- Do they have a copy of their medical and service documents?
- What operations were they deployed on?
- What agencies have they engaged with, Veterans and Non-Veterans?
- Were they Regular or Reservist or both?

These questions are important – the information obtained may assist in identifying the vulnerability to health/mental health problems and the type of problems, as well as other welfare issues.

But who should ask these questions? The consensus view is that ex-service personnel are likely to be more comfortable and forthcoming if the questions are asked by a member of staff who has knowledge and understanding of service life. Someone who will not only phrase the questions in language they can comprehend, but also understand the answers they provide. If there is no provision for a VICSO, EFLO or other designated member of staff to ask these questions through the induction process at least some of these questions should be incorporated in the secondary health screen.

If, during secondary health screening, there is an indication of service related health problems the Healthcare Team should seek the consent of the prisoner to obtaining not only their most recent medical records, but also their service medical records. Contact details for service medical records can be found in **Annex B.**

Following secondary screening the prisoners should be referred for any further diagnostic assessments and/or treatments required. Relevant guidance can be found in following sections of this document.

Continuing support and care

As previously indicated, it is recommended that a multi-disciplinary support/care and treatment planning process is completed at the end of the induction process, bringing together the assessments of the various disciplines to complete a case formulation and develop a plan for any interventions required. Whether or not this is a process co-ordinated by a designated member of staff (the preferred method), or a ‘virtual’ process that involves communication and sharing of findings between departments will depend on the resource available.

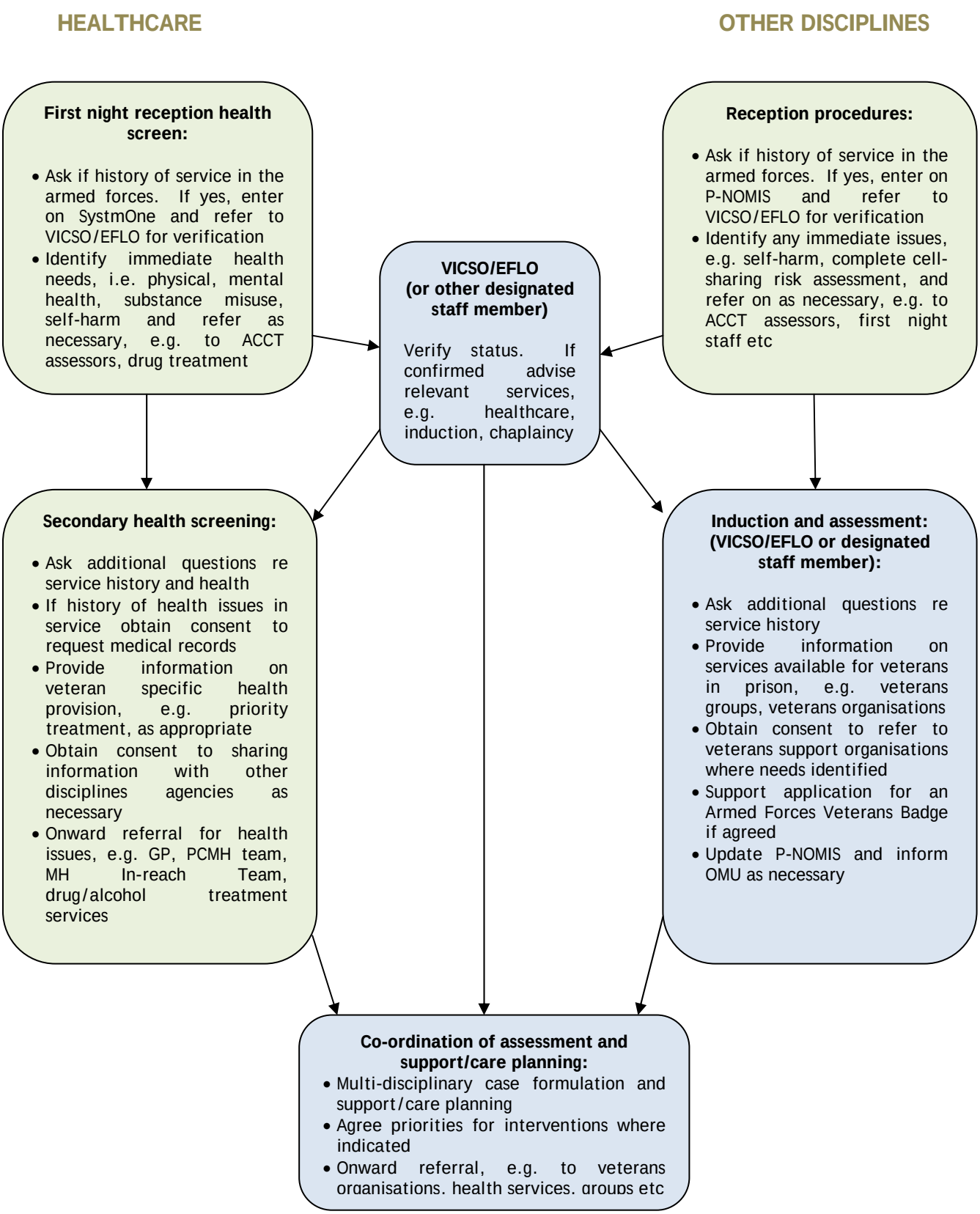
Unless there are overriding reasons for sharing medical information without the consent of the prisoner, e.g. to protect them as individuals or to protect others, the consent of the prisoner must be sought before disclosure in the context of multi-

disciplinary support/care and treatment planning. It is important that the reasons for disclosure are fully explained, i.e. what information will be shared and why, and that the prisoner understands that only the information specific to their continuing support/care needs will be shared.

EARLY DAYS IN CUSTODY – ASSESSMENT AND SUPPORT/CARE PLANNING PROCESS

The following diagram captures the essentials of an assessment and support/care and treatment planning process for veterans who are prisoners during the early days in custody.

EARLY DAYS IN CUSTODY
IDENTIFICATION/ASSESSMENT/SUPPORT & CARE PLANNING



VETERAN SPECIFIC SUPPORT AND CARE SERVICES

CONTEXT

Ex-service personnel who are prisoners may present with multiple problems that will require an integrated approach to the delivery of support, care and treatment, involving veteran specific organisations as well as various disciplines and departments within prisons.

For some, non-medical sources of support may be more acceptable than medical sources. This relates to the points made earlier regarding issues of culture, communication and stigma. Also, bringing ex-service personnel together into a mutual support group has proved popular and effective in several prisons, creating opportunity to share experiences, re-kindle comradeship, and encourage a more open and receptive response to any help that may be offered, but requires skilled facilitators to keep it therapeutic.

GUIDANCE AND GOOD PRACTICE

Reaching ex-service personnel in prison

Prison In-Reach (PIR)[17] is a joint RBL and SSAFA initiative that aims to ensure that all veterans in prison (or on probation), their families and those working with the resettlement services are fully aware of the support available from the Service Personnel and Veterans Agency (SPVA) and other ex-Service organisations. This includes help before and after release.

The Ex-Service Offenders Working Group promotes the PIR initiative and contributes to the wider UK Government goals of reducing the risk of re-offending. The Ministry of Justice (MoJ) leads this Group which brings together UK Government Departments including the Ministry of Defence (MoD), the National Offender Management Service (NOMS), the prison service, third sector organisations, and representatives from the devolved administrations.

The Group has ensured that staff in prisons are aware of the SPVA's Veterans UK website, and that they can access the website from the prison IT system. They should now be better informed on the work of the SPVA, and the services and support available from many other service providers. Prison staff can share this information as appropriate with ex-service personnel in prison.
http://www.veterans-uk.info/prison_in_reach/prisonsinreach.html

The Royal British Legion (RBL), Soldiers, Sailors, Airmen and Families Association – Forces Help (SSAFA), Service Personnel and Veterans Agency (SPVA) and Combat Stress all provide welfare visits to veterans in prison and to their families. These visits do not count against a prisoner's personal visit allowance. It is important that

[17] PIR should not be confused with MHIRT, i.e. Prison Mental Health In-Reach Teams that are NHS services provided by Local Health Boards in each prison in Wales

veterans in prison, especially those close to their release date, have access to such visits if they need them so that they can be supported through the crucial period either side of release.

The Veterans in Prison Association (core aim – to reduce re-offending) also has a website which provides information and access to a variety of sources of support. The Association was established by prison officers working in HMP Isle of Wight. http://www.veteransinprison.org.uk/

The Veterans in Custody Support Scheme (VICS) developed in HMP Everthorpe provided the model for the introduction of the role of VICSOs or EFLOs. The Scheme uses the analogy of a wheel in which veterans constitute the hub and the Service organisations the rim. The VICS Scheme is designed to form the spokes, i.e. the VICSOs or EFLOs, which connect both.

The Confederation of Service Charities (COBSEO) is an organisation that exists to work for the interests of the Armed Forces community. It is made up of service and ex-service charities and organisations. All member organisations are expected to sign up to the COBSEO regulations as a condition of membership. Although not explicit, COBSEO would appear to provide a degree of quality assurance as not all applicant organisations are necessarily accepted as members. The COBSEO website can be viewed via the following link: http://www.cobseo.org.uk/

Co-ordination of support and care

It would clearly simplify and assist if a VICSO, EFLO or SPOC could act as the conduit for referral, and subsequently as the co-ordinator and/or facilitator of interventions provided by both the ex-Service organisations and other agencies and departments within the prison. Such an approach would build on the process during the early days in custody. However, it is acknowledged that the availability of personnel fulfilling these roles, the commitment of associated resources, and the precise functions of the role, are at the discretion of the prison Governor/Director as they are not currently profiled job roles in prisons.

In the absence of a lead officer, and where healthcare assessments have indicated that inputs from other departments and services may assist, healthcare practitioners should either signpost to services, or facilitate referrals, working this into any care and treatment plan required.

It is imperative that Offender Managers are aware of and/or involved in agreeing the interventions to be offered by specialist agencies to offenders who will be released on licence.

Joint working across departments and sectors

There are three, if not more, possible ways in which the various departments and sectors could work together to respond to the needs of veterans in prison:

- individually, but within an integrated/co-ordinated approach, with each party providing interventions in respect of differing needs;

- jointly, but on an individual basis with prisoners, e.g. where the prisoner consents a representative of a veterans agency could work with a health practitioner to assist with communication, understanding, and breaking down any other barriers;

- with groups of veterans, either a general support/peer group or perhaps one that specifically addresses mental health issues.

There are examples of the latter approach in practice across the prison estate in England and Wales. These include:

- a recent, albeit trial only, peer support group in **HMP Cardiff**, jointly initiated by an officer and the Primary Care Lead Nurse, and facilitated by a Client Support Officer from the RBL. The response from the ex-service personnel in the prison was very positive, and discussions continue regarding the possibility of running the group on a regular basis;

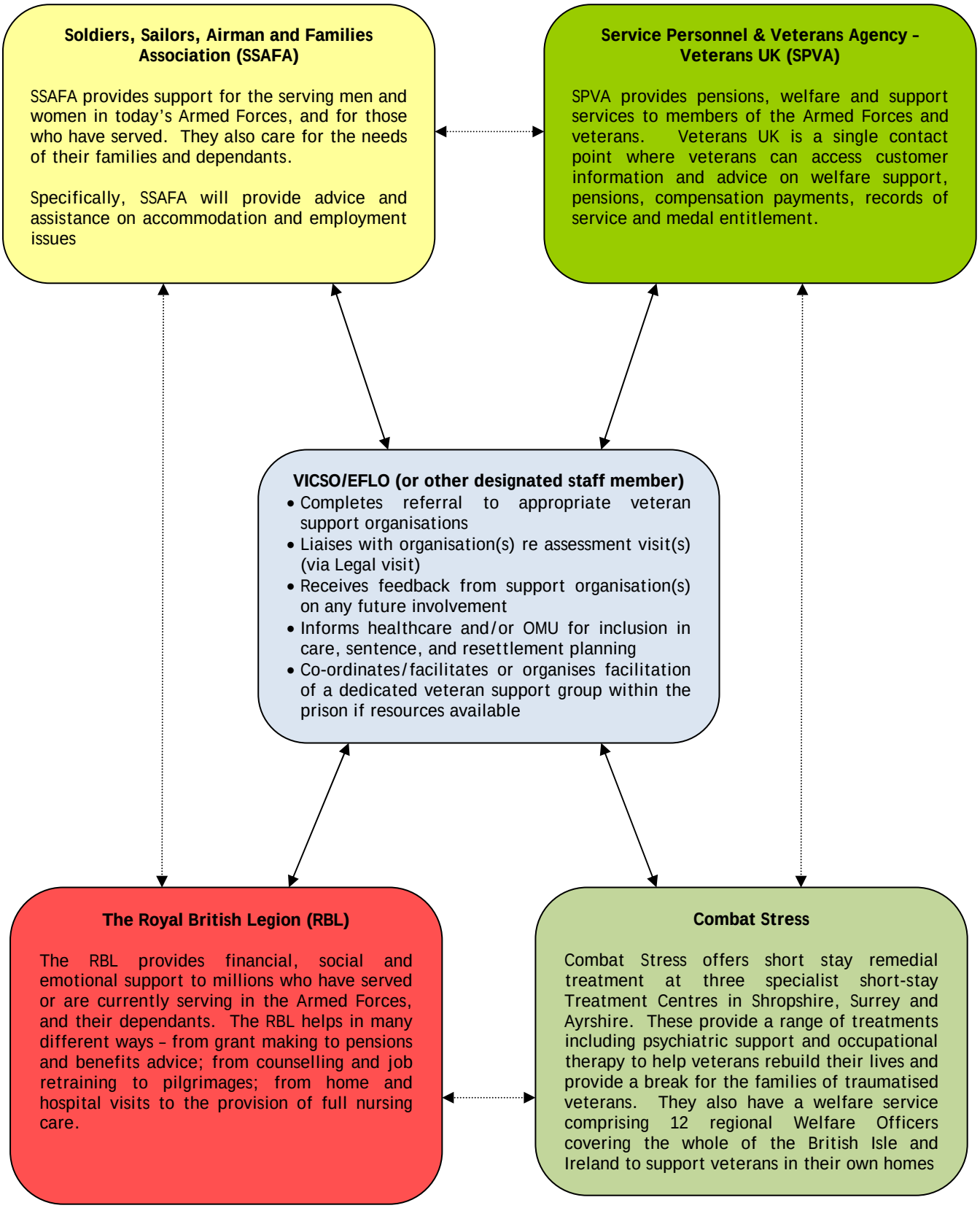
- the EFLO in **HMP Swansea** is exploring the possibility of having an 'ex-forces day' to enable the majority of ex-service organisations to visit the prison, but also to provide an opportunity for the ex-service personnel to come together, to have fun by participating in military-type competitions, and to start the process of developing their own community support network;

- Johanne Tomlinson, staff nurse at **HMP Stafford**, won the overall Nursing Standard Nurse of the Year award for establishing a dedicated service for veterans in prison. She made contact with Combat Stress, which now offers help and advice to the prisoners in Stafford, including individual planning for their release. In addition Johanne runs an anxiety management group solely for veterans, enabling them to share their feelings with those who have had similar experiences;

- **HMP/YOI Parc** has pursued a number of initiatives over the past year including:

    - applying for and receiving the Veteran Pin for the majority of ex-service personnel in Parc (staff and prisoners);
    - formation of a prisoner sub-group in support of fund raising for Armed Forces charities;
    - holding a Mark of Remembrance in the chapel for all ex-service personnel on which was well-received;
    - Poppy Appeal run and controlled by ex-service personnel which raised a substantial sum for the RBL;
    - the prison's Writer in Residence is running poetry groups with ex-service personnel;
    - a referral system to RBL and SSAFA is in place.

VETERAN SPECIFIC SUPPORT AND CARE SERVICES



CONTEXT

For many individuals service in the Armed Forces is, at least in the short-term, a positive intervention in health terms. Certain standards of fitness are required prior to recruitment, and these are then maintained throughout service. A physically active job, regular balanced meals, and regular health checks mean that routine service can contribute towards a healthier lifestyle than many would have experienced in civilian life. However, during active service many will also be exposed to health-threatening conditions, e.g. military exercises in extremes of climate, chemicals, combat in hostile environments and cultures often far from the UK, and a minority suffer both mentally and physically as a consequence.

In 2008 the War Pensioners' entitlement to Priority Treatment in the NHS was extended to include all ex-service personnel with health conditions which may be related to their service in the Armed Forces – see **Annex D**.

GUIDANCE AND GOOD PRACTICE

Physical health needs of veterans

The majority of elderly veterans now living are now more likely to have physical health problems that are age-related rather than due to service in the Armed Forces. For younger ex-service personnel it can be difficult to unpick whether service has contributed to any observed ill-health other than the obvious injuries received during training and combat. Given that recruitment, particularly to infantry regiments, is disproportionately from some of the more deprived communities in the UK, it is possible that poor health post-discharge may be associated with other life experiences prior to joining the Armed Forces.

The only group of veterans that have had their health status observed during recent years have been those who served in the first Gulf war (1990-1991). Out of 53,500 UK troops involved, around 7000 veterans have injuries relating to this conflict, including a variety of symptoms such as irritability, chronic fatigue, headaches, skin rashes, chronic diarrhoea, and respiratory problems that have tended to be described by the umbrella term 'Gulf War Syndrome'[18].

However, all modern wars over the last 150 years have been linked with a particular set of symptoms, labelled a syndrome that is best described as 'medically unexplained'. These syndromes appear to be influenced by advances in medical science at the time of the particular war, changes in the nature of warfare, the terms used to describe the syndrome, explanations offered by servicemen and doctors, and underlying cultural forces. Future war syndromes should be described as an understandable pattern of normal responses to the physical and psychological stress

[18] King's Centre for Military Health Research, '*A fifteen year report: What has been achieved by fifteen years of research into the health of the UK Armed Forces?*', KCMHR, September 2010 available via the following link: http://www.kcl.ac.uk/kcmhr/publications/15YearReportfinal.pdf

of war. This normalising approach may in turn improve the management of these distressed service personnel and veterans[19].

A guide for GPs has been published jointly by the RCGP, RBL and Combat Stress. http://www.qni.org.uk/docs/Veterans_Healthcare.pdf .

Treatment of veterans as a special group

Apart from the obvious uncertainties and dangers of service life, members of the Armed Forces relinquish some of their own civil liberties and put themselves in harm's way to protect others. For example, the overall risk of death for an Army recruit is about 150 times greater than for a member of the general working population, and the risk of serious injury, e.g. loss of limbs, brain injury, and sensory impairments, is also substantially increased. For this reason the Welsh Government recognises the 'Military Covenant', i.e. no disadvantage to veterans and their families due to their military service, and has published a Welsh Government '*Package of Support for the Armed Forces Community in Wales*'.

Priority NHS treatment for veterans

The criteria for Priority Treatment is '*any condition **aggravated** or **attributable** to time in the service*' and could include, for example, injury, skin cancers, frostbite, and asthma if aggravated. However, the recent Healthcare Inspectorate Wales (HIW) review, '*Healthcare and the Armed Forces Community in Wales*'[20] found that some veterans expressed little confidence that eligibility for Priority Treatment was properly reflected in the referral process and, even when mentioned, was properly taken into account within secondary care.

The concept of 'Priority Treatment' is not for veterans to be seen more quickly than patients with greater clinical need. Rather, that for conditions related to military service, veterans, at their first out-patient appointment, would be scheduled for treatment more quickly than other patients of similar clinical priority. The WaMH in PC Information Sheet 9 offers suggested wording for referral letters to specialist services and also offers helpful information on dealing with veterans who present in primary care.
http://www.wamhinpc.org.uk/blog/information-sheet-9-mental-health-and-ex-service-personnel-veterans

If the process of obtaining medical records is slow it may be possible to identify prisoners that could be eligible for Priority Treatment by checking whether they are in receipt of a service invalidity payment, or Armed Forces compensation scheme payment, an Armed Forces pension for physical or mental problems that led to their medical discharge from service.

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[19] Jones, E, Hodgins-Vermaas, R, McCartney, H, Everitt, B: '*Post-combat syndromes from the Boer War to the Gulf War: a cluster analysis of their nature and attribution*', British Medical Journal, 2002: 324: 1-7.

[20] http://www.hiw.org.uk/Documents/477/Armed%20Forces%20Report%202012-04-03%20-%20English%20-%20Web%20PDF.pdf

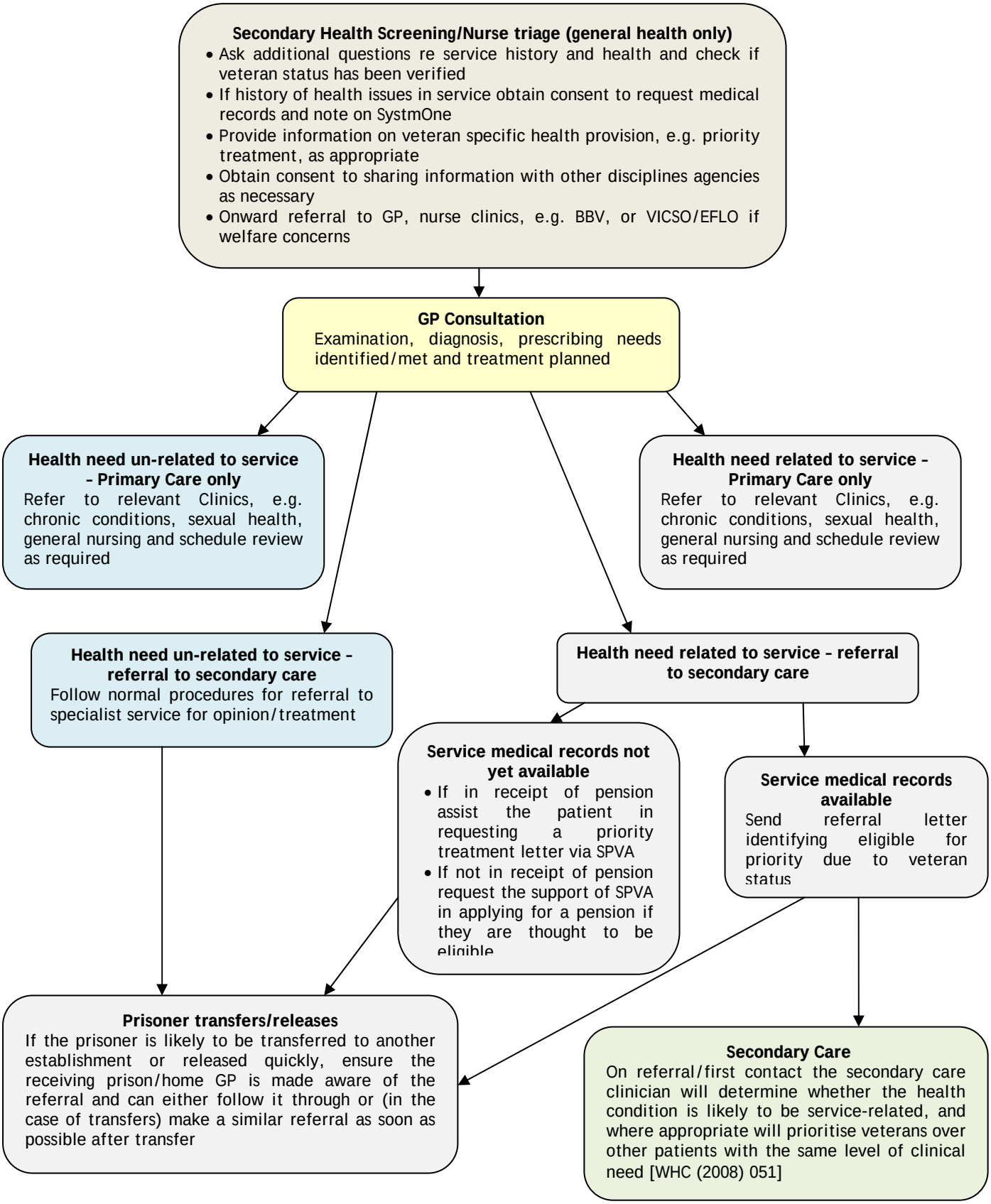
The SPVA can provide a Priority Treatment letter at the request of the prisoner/patient if medical records are awaited. And if the prisoner is not normally in receipt of pensions the prison could request that the SPVA or RBL support the prisoner in applying if they are thought to be eligible.

It is important that ex-service personnel who are prisoners are provided with information about Priority Treatment, and equally important that they clearly understand the limitations. It is recommended that LHBs and prison healthcare teams work jointly on the development of a leaflet, preferably an easy-read that describes how the Priority Treatment process works in each of their localities.

GENERAL HEALTH/PRIMARY CARE/PRIORITY TREATMENT REFERRALS

The following diagram captures the essentials of primary care assessment and a referral process for Priority Treatment for veterans who are prisoners with service-related health conditions.

GENERAL HEALTH
PRIMARY CARE/PRIORITY TREATMENT REFERRAL PATHWAY



CONTEXT

The majority of veterans who are prisoners will have the same type of common mental health disorders as the general prisoner population, e.g. anxiety and depression, and there may be co-morbidity with drug or, more often, alcohol problems. An appropriate range of primary mental health care interventions will be required to meet the needs of ex-service personnel, but these interventions will also need to be culturally sensitive, i.e. delivered by staff with an awareness and understanding of veterans needs.

Unpicking the extent to which any identified mental health problems among veterans is due to their service in the Armed Forces is not straightforward. For example, their early life experiences may have been traumatic and troubled; they may have found it difficult to cope with the demands of life in the Armed Forces, whether or not they were deployed to combat; they may have experienced loss in the widest sense since discharge. All or any of these factors can be relevant to poor mental health and well-being in veterans.

Work with UK veterans has found that those who are single and have served in the Army, infantry in particular, at lower rank have an increased risk of mental ill health[21]. A survey of veterans living in Wales noted that a sub-group of veterans who had typically served in Northern Ireland and the Falklands conflict had very high levels of mental health problems and difficulties with social, occupational and interpersonal functioning[22].

Specifically excluded from this section of the guidance is reference to treatment for PTSD, whatever the genesis of the trauma, and whatever the level of treatment response required. PTSD is covered in a separate section on pages 31–36.

GUIDANCE AND GOOD PRACTICE

Mental Health (Wales) Measure 2010

Part 1 of the Measure places statutory duties on LHBs and local authorities to provide 'local primary mental health support services'. The legislation specifically includes provision for prisoners. Although it is recognised that the arrangements may differ to those in the community, the range of provision should be equitable.

Primary Mental Health Support Services (PMHSS) are expected to provide care for those who are suffering mild to moderate and/or stable severe and enduring mental health problems. It is also expected that earlier intervention and treatment will lead to both an improved experience and better clinical outcomes for patients.

[21] Iversen, A, et al '*Goodbye and good luck: the mental health needs and treatment experiences of British ex-service personnel*', British Journal of Psychiatry (2005), 186, 480-486
[22] Wood, S et al, '*Mental health, social adjustment, perception of health and service utilisation of three groups of military veterans living in Wales: a cross-sectional survey*', (undated)

The five components of PMHSS are:

- Comprehensive mental health assessments for those whom a GP considers a more detailed assessment is required;
- Short-term interventions, individually or through group work, e.g. counselling, a range of psychological interventions including Cognitive Behavioural Therapy (CBT), solution-focussed therapy, stress management, bibliotherapy and education;
- Onward referral and the co-ordination of next steps with secondary care mental health services;
- Provision of support and advice to GP's and other primary care providers;
- Provision of information and advice to individuals and carers about interventions and care, as well as signposting to other sources of support.

More detail on referral, assessment, treatment and onwards referral within the National Service Model for PMHSS can be found in the relevant guidance: http://wales.gov.uk/docs/dhss/publications/110914mhnatservicemodelen.pdf

Stepped-care model

A stepped care (or tiered) model of mental health services allocates appropriate resources to ensure that expertise and interventions match complexity of need, and should minimise the necessity for multiple assessments. But it is important to remember that a stepped-care model is a conceptual framework not a rigid structure, and the flows and linkages between the steps are as important as the content.

An example of a stepped-care model is provided in the National Institute for Health and Clinical Excellence (NICE) quick reference guide on '*Common Mental Health Disorders: Identification and pathways to care*'[23]. With the caveats above, steps 1-3 would normally fall within the remit of PMHSS, while step 4, which has been added, would be specialist/secondary care services. A summary of a stepped-care model (adapted from the NICE guidance) can be found on page 28.

Mental health presentations – ex-service personnel

The King's Centre for Mental Health Research (KCMHR) cohort study into the physical and psychological health of those who took part in the invasion of Iraq in 2003, and those who have since been deployed to Afghanistan, has found that the mental health of veterans is broadly similar to that of the general population, albeit that their military career provides a very specific context for some presentations[24].

[23] http://www.nice.org.uk/nicemedia/live/13476/54523/54523.pdf
[24] http://www.kcl.ac.uk/kcmhr/research/kcmhr/Newsletter2011.pdf

Particularly noticeable is the level of alcohol misuse which will be addressed in a later section of this guidance, as will PTSD. But other typical presentations include anxiety disorders and depression.

Anxiety disorders are neither minor nor trivial. They can cause considerable distress and are often chronic in nature. It may be difficult to distinguish the different disorders, and co-morbidity is common with other anxiety disorders, depression, or other mood disorders.

A range of effective interventions is available to treat anxiety disorders, including self-help (guided), psychological therapies (sometimes referred to as 'talking therapies'), and medication.

Depression is a broad set of diagnoses, central to which is depressed mood, loss of pleasure in most activities, and a range of associated emotional, cognitive, physical and behavioural symptoms. As with other disorders, the range of symptoms can be mild to severe, but this can sometimes be difficult to determine. Persistence, severity, the presence of other symptoms, and the degree of functional and social impairment generally form the basis of that distinction. Depression is often accompanied by anxiety.

The presentation of depression may vary with age. Younger people may display more behavioural symptoms, while older adults may complain less of low mood and display more somatic symptoms. Many veterans may describe symptoms consistent with depression, particularly if they also have PTSD, and diagnosis of the underlying problem can be missed.

Although less common, **mild traumatic brain injury** should also be considered as an additional complication in the ex-military population where there is evidence of exposure to a head injury via explosion, road traffic collision etc.

Effective treatment interventions for veterans

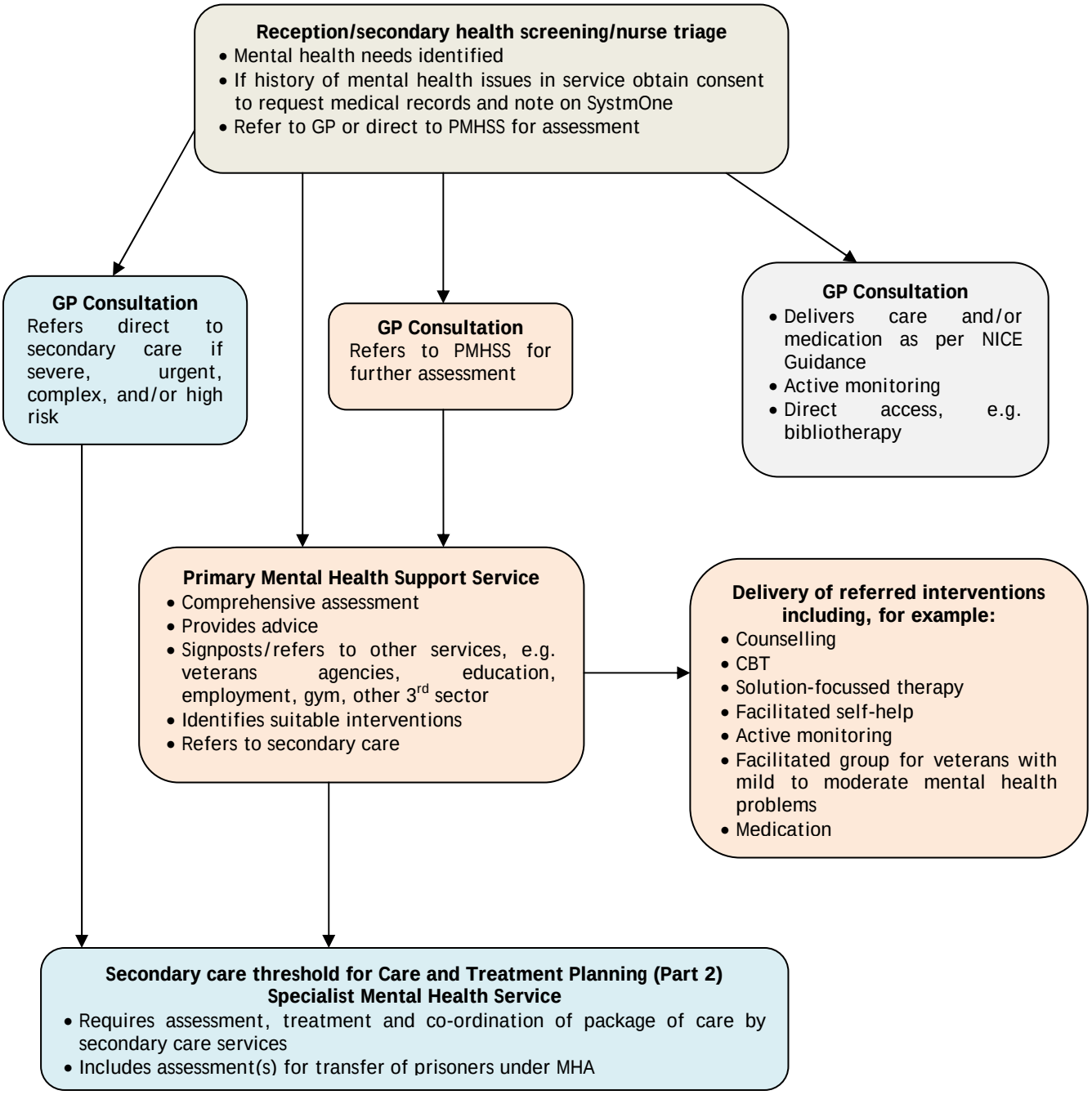
The treatment response at primary care level is in principle no different for ex-service personnel. However, as discussed previously, the model of delivery and the skill set of the staff delivering the interventions may need to adapt to better meet their needs.

Specifically, delays between assessment and treatment should be minimised so far as possible. Staff delivering interventions will require a degree of awareness of the cultural issues associated with military service that can impact on engagement with NHS provision. Consideration should be given to group work with other veterans with similar presentations where there is research evidence to support its use.

PRIMARY MENTAL HEALTH CARE – ASSESSMENT AND TREATMENT PROCESS

The following diagram captures the essentials of a referral, assessment and treatment pathway for veterans with common mental health disorders.

MENTAL HEALTH
PRIMARY MENTAL HEALTH SUPPORT SERVICES



MENTAL HEALTH STEPPED –CARE MODEL

Focus of the intervention

STEP 4
Depression: Severe and complex depression, risk to life, severe self-neglect;
GAD: Complex treatment – refractory GAD and very marked functional impairment such as self-neglect or a very high risk of self-harm;
Panic disorder, OCD: severe disorder with complex co-morbidities, or those who have not responded to treatments at Steps 1 – 3.

STEP 3
Depression: Persistent sub-threshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention; initial presentation of moderate or severe depression;
GAD: Marked functional impairment or not responded to a low intensity intervention; moderate to severe panic disorder;
OCD: with moderate or severe functional impairment.

STEP 2
Depression: Persistent sub-threshold depressive symptoms or mild to moderate depression;
GAD:
Panic disorder: mild to moderate panic disorder;
OCD: mild to moderate;.

STEP 1
All known and suspected presentations of common mental health disorders

Nature of the intervention

STEP 4
Depression: Highly specialist treatment, e.g. medication, high intensity psychological interventions, combined treatments, multi-professional/in-patient care, crisis services, ECT;
GAD: Highly specialist treatment, e.g. complex drug and/or psychological treatment regimens, input from multi-agency teams, crisis services, day care or in-patient care;
Panic disorder, OCD: Specialist services according to individual need and clinical judgement.

STEP 3
Depression: CBT, IPT, behavioural activation, counselling, short-term psychodynamic psychotherapy, antidepressants, combined interventions, collaborative care, self-help groups;
GAD: CBT, applied relaxation, drug treatment, combined interventions, self-help groups;
Panic disorder: CBT, antidepressants, self-help groups;
OCD: CBT (including ERP), antidepressants, combined interventions and case management, self-help groups;
All disorders: Support groups, befriending, rehabilitation programmes, educational and employment support, referral for further assessment and interventions.

STEP 2
Depression: Individual facilitated self-help, computerised CBT, structured physical activity, group-based peer support (self-help) programmes, non-directive counselling, antidepressants, self-help groups;
GAD and panic disorder: Individual non-facilitated and facilitated self-help, psycho-educational groups, self-help groups;
OCD: Individual or group CBT (including ERP), self-help groups;
All disorders: Support groups, educational and employment support services, referral for further assessment and interventions

STEP 1
All disorders: Identification, assessment, psycho-education, active monitoring, referral for further assessment and interventions

CONTEXT

In 2002 the Welsh Government made provision for the delivery of secondary care Mental Health In-Reach services in all the prisons in Wales and these services have been mainstreamed in the NHS since 2006. In the main the services are provided by a combination of nurses, clinical psychologists or psychotherapists, and occupational therapists with support from general and forensic psychiatrists relative to the level of risk and severity/complexity of need.

Mental Health In-Reach Teams (MHIRTs) will work with those prisoners whose symptoms and level of need are described in Step 4 of the stepped care model, Unless their needs are so significant that transfer to hospital under the Mental Health Act is deemed more appropriate. Each prisoner on the caseload of the MHIRT will have a Care Co-ordinator and Care and Treatment Plan in accordance with the requirements of the Mental Health (Wales) Measure 2010.

GUIDANCE AND GOOD PRACTICE

Mental Health (Wales) Measure 2010

Welsh Government Policy Implementation Guidance on Primary Mental Health Support Services (PMHSS) and Secondary Mental Health Services for the purposes of the Measure defines secondary care services, in practice, as:

- being delivered by specialist mental health practitioners in the community and in hospital settings;
- caring for those with more severe and/or enduring mental disorders where the level of need, risk and complexity requires the provision of specialist care;
- with access being determined via assessment of specialist practitioners.

Part 2 of the Measure places statutory duties on LHBs and local authorities to ensure that patients in secondary mental health services in Wales have a Care Co-ordinator and a Care and Treatment Plan.

Part 3 of the Measure requires LHBs and local authorities to have arrangements in place to deal with requests for assessments from former users of secondary mental health services who believe that their mental health may be deteriorating following discharge.

Assessment and treatment in prisons

Given the rapid throughput and turnover (‘churn’) of prisoners within the remand/local prisons, i.e. HMPs Cardiff and Swansea, the MHIRTs may have

relatively little time in which to complete their assessments and provide appropriate interventions. Treatment interventions can become 'first aid' within these environments. The primary task may be one of gathering clinical history and all relevant information from Care Co-ordinators in the community (where the prisoner is currently known to secondary care services), and/or making referrals or arrangements for continuity of care on release from prison.

Within the training or open prisons, e.g. HMPs Parc, Usk and Prescoed, there may be more time and opportunity for practitioners in MHIRTs to deliver an appropriate range of interventions, but as with PMHSS few of these practitioners will have specific expertise in working with ex-service personnel. Similar training of staff and adaptation of approach will therefore be required for veterans.

All Wales Veterans Health and Wellbeing Service (AWVHWS)

At all levels of mental health service provision in prisons, and especially at secondary care level, there is potential for overlap with the service provided by the AWVHWS – see **Annex C**. However, the AWVHWS does not provide a prison in-reach service, and it would not be appropriate to escort prisoners on an out-patient basis to the out-patient treatment centres in the relevant localities as, for security reasons, the majority of prisoners on escort must be physically constrained at all times. There may be an exception for prisoners held at HMP Prescoed, but given the potential consequences of treatment, especially for PTSD, out-patient treatment may not be a viable option.

On the face of it this may appear to disadvantage ex-service personnel who are prisoners in terms of accessing specialist service provision. But the AWVHWS has a remit to "*provide expert advice and support to local services on the assessment and treatment of veterans who experience mental health difficulties to ensure local services, including addictions services, are able to meet the needs of veterans"*. This extends to the MHIRTs in prisons, and will have the effect of enabling practitioners within these teams to deliver treatment interventions adapted to meet the needs of ex-service personnel, albeit in an environment that can never be entirely conducive in therapeutic terms.

There are particular issues around the assessment, diagnosis and treatment of prisoners who are ex-military with PTSD. The following section of this guidance will address these issues.

POST-TRAUMATIC STRESS DISORDER (PTSD) ALL LEVELS OF CARE

CONTEXT

Post-Traumatic Stress Disorder (PTSD) is the psychological response to an event of an intensely traumatic nature such as deliberate acts of interpersonal violence, severe accidents, disasters or military action. Many trauma survivors do not develop PTSD, but others do, sometimes long after the event. Whether or not people develop PTSD depends on their subjective perception of the traumatic event as well as on the objective facts. Those at risk of PTSD include not only those who are directly affected by a horrific event, but also witnesses and perpetrators[25].

In recent years there has been extensive high quality research into the prevalence of PTSD among service personnel and veterans, notably the KCMHR has been examining the health consequences of the 1991 Gulf War[26], and more recently the consequences of the war in Iraq and Afghanistan[27]. The findings are detailed and cannot be summarised in a few short sentences, but there is strong evidence that those in combat roles and particularly reservists deployed in either conflicts are reporting probable PTSD and other mental health problems, including excessive alcohol use and common mental disorders.

NICE published guidance on the management of PTSD in adults and children in primary and secondary care[28]. Within the guidance it is recognised that, when experienced by ex-military personnel, PTSD is frequently co-morbid with other disorders, and there are often other important psychosocial issues that need to be addressed (including the impact of being discharged from the Armed Forces protective environment and all that entails). The adjustment from military to civilian life can be difficult with potentially problematic social circumstances occurring including difficulty securing appropriate housing, debt management, finding meaningful occupation and relationship problems. These factors and the often prolonged and intense nature of traumatic exposure can result in a complex PTSD presentation that is potentially difficult to treat.

It follows that, as with the population in general, some of these ex-service personnel may present within prison with previously undiagnosed and untreated PTSD (and other common mental health and substance use disorders) of varying complexity. The following outlines a prison-specific pathway for addressing the needs of these prisoners.

[25] http://www.nice.org.uk/cg26
[26] http://www.kcl.ac.uk/kcmhr/publications/15YearReportfinal.pdf
[27] http://www.kcl.ac.uk/kcmhr/research/kcmhr/Newsletter2011.pdf
[28] http://www.nice.org.uk/cg26

GUIDANCE AND GOOD PRACTICE

Presentation

The main presenting complaint of PTSD sufferers does not necessarily only include reliving the traumatic event, e.g. intrusive memories, nightmares and flashbacks of the event. Patients may present with a co-morbid depression, anxiety disorders, somatic complaints, irritability, inability to work, and sleep problems. They may not relate their symptoms to the traumatic event, especially if significant time has elapsed. In the case of ex-service personnel, alcohol and illicit drug problems may also be an indicator of poor mental health and attempts to control the above symptoms.[29]

The Mental Health/Primary Care section of this guidance (page 24) highlighted the difficulty that can be encountered in identifying the genesis and the nature of mental health problems among ex-service personnel. While ex-service personnel as a population group may be at increased risk of developing PTSD, they may also have experienced trauma as a result of other life events, e.g. physical and/or sexual assault as a child or other traumatic events such as witnessing domestic violence. Many trauma survivors have experienced a range of different traumatic experiences over their life span, and can develop problems besides PTSD, e.g. depression, low self-esteem, self-destructive behaviours, and poor impulse control. These problems have some prevalence in prisoner populations in general, and assessment and diagnosis may not be straightforward.

Screening and assessment

Prisoners who are ex-service personnel presenting with symptoms indicative of possible PTSD, either during the early days in custody or at a later stage, should be screened in the first instance by primary care practitioners and/or the Primary Mental Health Support Service (PMHSS).

During screening it would be useful to ascertain whether the prisoner underwent a Trauma Risk Management (TRiM) assessment[30] while serving in the Armed Forces, or had treatment from a Ministry of Defence Department of Community Mental Health.

The Trauma Screening Questionnaire (TSQ)[31] is a useful tool and can be developed as a questionnaire within SystmOne, i.e. the clinical information system, for use across the Welsh prisons. Use of the TSQ does have training implications for staff that will need to be addressed. A prisoner scoring 6+ on the TSQ should be referred to the MHIRT for assessment. Given the potential for complex presentations and varying levels of risk related to offending within the ex-service personnel prisoner population, this process reflects the considered advice of clinical specialists in Wales who currently provide health and social support to ex-service personnel in the community. The MHIRT can refer back to the PMHSS as appropriate.

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[29] Clinical guidelines, CG26 - Issued: March 2005
[30] http://www.army.mod.uk/welfare-support/23245.aspx
[31] http://www.completepractitioner.com/assessment/PSD.pdf

The use of a validated screening tool, i.e. the Impact of Event Scale – Revised (IES-R)[32], is recommended for use by MHIRTs for further assessment of PTSD in ex-service personnel. The main strengths of this tool are that it is short, easily administered and scored. Nevertheless, if MHIRT staff are not already trained and experienced in the use of the IES-R and/or the assessment and diagnosis of PTSD there will be training implications.

Treatment considerations

NICE guidance and expert group advice suggests; if screening and clinical assessment arrives at a diagnosis of PTSD, the next steps in the management of the disorder will be dependent on several factors in varying combinations. These include:

- the genesis and complexity and of the PTSD;
- the level of risk associated with the history of offending;
- the willingness of the prisoner to commence a trial of therapy in prison;
- the length of sentence/remand;
- the availability of suitability skilled and experienced clinicians;
- the availability of a suitable treatment environment;
- the availability of appropriate support for the prisoner during the course of therapy; and
- the availability of appropriate clinical supervision for the therapist.

Whether or not PTSD is the problem that should be the focus of treatment depends on the severity and urgency of other disorders and problems, for example, suicide risk, housing, debt, and family breakdown. It is important to ascertain what symptoms or problems trouble the prisoner most, whether they think they would need help with their other problems if the PTSD symptoms could be treated, and whether or not the other problems were present before the traumatic event.

Ex-service personnel with PTSD may misuse alcohol, and sometimes illicit drugs, in an attempt to cope with their symptoms, and treatment of their PTSD may help them to reduce their substance misuse. If substance dependence is diagnosed, this will need to be treated and managed before the individual can benefit from trauma-focused psychological treatments as recommended by NICE and recent research into what therapies work with ex-service personnel[33].

Interventions in primary care

The PMHSS may be able to provide information and advice, via psycho-educational interventions, and other trauma-focused psychological interventions for **simple trauma**[34] consistent with the NICE guidance, e.g. Eye Movement Desensitisation

[32] http://consultgerirn.org/uploads/File/trythis/try_this_19.pdf
[33] Kitchiner, NJ et al, '*Systematic review and meta-analyses of psychosocial interventions for veterans of the military*', European Journal of Psychotraumatology, 2012
[34] Simple trauma can be defined as a single isolated event that occurs in the context of relative emotional and physical safety.

and Reprocessing (EMDR) and trauma-focused Cognitive Behavioural Therapy (TF-CBT).

Trauma-focused psychological treatment should **only** be provided when the therapist, prisoner and healthcare staff consider it safe to proceed. The prisoner should also be provided with information about the range of emotional responses and possible change in risk that may develop as a consequence of the treatment. Sources of support for the prisoner should be identified, including residential unit staff if the prisoner consents to the sharing of pertinent information regarding their treatment.

The duration of trauma-focused psychological treatment should normally be 8-12 sessions when the PTSD results from a single event, and extended for complex presentations with multiple traumas. Treatment should be offered by competent individuals who have received appropriate training. These individuals will require clinical supervision from a suitably qualified mental health practitioner.

If the prisoner is unlikely to be able to complete a course of treatment, i.e. because they are on remand, a short sentence, or likely to be transferred elsewhere, the PMHSS, with the consent of the prisoner, should make the assessment and treatment need known to the PMHSS in the home area by way of referral, or to the receiving prison.

While NOMS employed Forensic Psychologists may have the skills and expertise to screen, assess and provide psychological treatments, this is not their primary function within prisons and they are not resourced to provide this service. Nevertheless they would welcome involvement in discussions and the development of services for veterans, and may be able to act in a consultancy role on a case by case basis where referred/necessary.

Interventions in secondary/specialist care

For prisoners requiring interventions beyond the level appropriate to primary care several pathways may be followed. The management should be determined on an individual case basis, with the risks, needs and the preferences of the prisoner being paramount considerations.

One of the first considerations has to be the feasibility of commencing a trial of trauma-focused psychological therapy in prison. If the prisoner is on a relatively short remand or sentence it may be more appropriate to signpost them to community based services, allowing them to self-refer, or to refer on their behalf while they are in prison, securing an initial appointment for them to attend post-release. If they are referred to the NHS All Wales Veterans Health & Wellbeing Service (AWVHWS) the service should be contacted by telephone, email or via the on-line referral form from the AWVHWS website: www.veteranswales.co.uk.

Other factors influencing the feasibility of treatment in prison, irrespective of sentence length, may relate to the prisoner's sense of trust and personal safety both in the clinician and the environment in which the treatment will be provided. They may be concerned about the emotional and behavioural effects of treatment, and

their ability to cope with them in prison. In such instances treatment may be deferred, and the prisoner can be signposted or referred to community based services, e.g. the NHS AWVHWS.

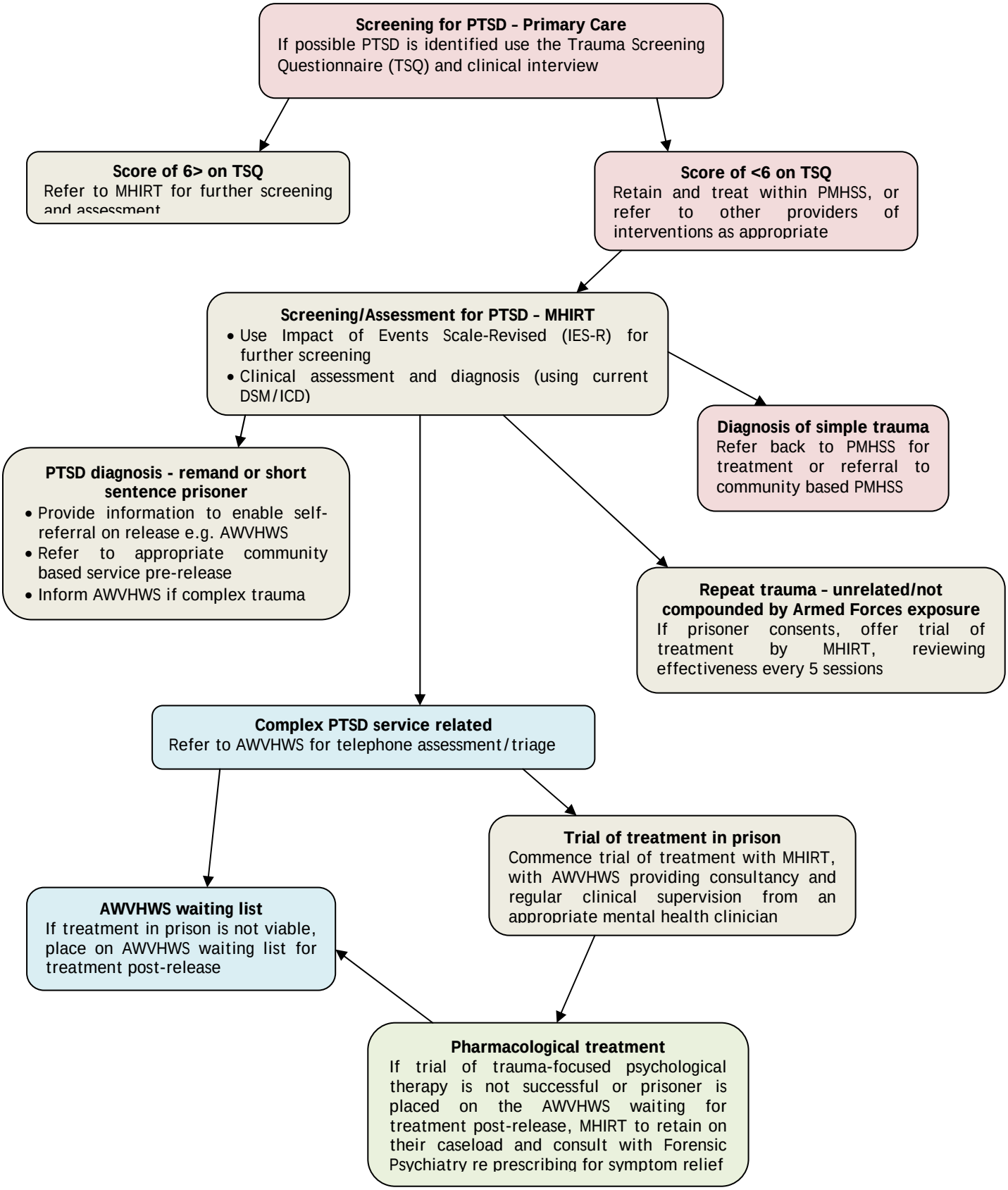
PTSD can arise not simply from single events but also from repeated trauma, e.g. childhood abuse, and may be unrelated to or compounded by exposure to trauma events during service in the AF. In these cases a trial of treatment, i.e. trauma-focused psychological therapy, can be provided, with the consent of the prisoner, by the MHIRT or other competent individual (e.g. Forensic Psychologist) within prison. It is recommended by the expert group that treatment is reviewed every session, and at session five a clinical review is undertaken by repeating all psychometric self-report taken at the pre-therapy stage, e.g. IES-R. The prisoner should be appropriately and adequately supported for the duration of the treatment. Good clinical governance requires the practitioner have appropriate and regular (minimum monthly) clinical supervision.

Ex-service personnel who are prisoners with complex PTSD should be referred to the AWVHWS. Providing the prison can facilitate, the AWVHWS will be able to conduct a telephone assessment (triage) of the prisoner and advise the MHIRT on suitable management. They may suggest a trial of treatment/therapy in prison, acting in a consultancy role for the MHIRT, or that the prisoner is placed on the waiting list for treatment by a community veterans' therapist from the AWVHWS on release from prison. In these instances, or where treatment/therapy does not appear to be an option in the foreseeable future, they may advise that the prisoner is held on the MHIRT caseload and, with the support of a Forensic Psychiatrist, where symptoms can be treated pharmacologically.

PTSD – SCREENING, ASSESSMENT AND TREATMENT PROCESS

The following diagram captures the essentials of a screening, assessment and treatment pathway for ex-service personnel who are prisoners with signs and symptoms of PTSD of varying degrees of complexity.

POST-TRAUMATIC STRESS DISORDER (PTSD) ALL LEVELS OF CARE



CONTEXT

Mental health problems can be complicated by co-occurring substance misuse, especially among those exposed to multiple traumas and who go on to develop PTSD, as well as those who suffer chronic PTSD. Integrated care and support for prisoners with substance misuse problems is already well-established through joint working between health providers and the NOMS-commissioned Counselling, Assessment, Referral, Advice and Through-care Services (CARATS) which provide the non-clinical elements of drug treatment.

However, the Welsh Government has separately commissioned the development of guidance on improving access to substance misuse treatment for veterans which will encompass provision for offenders, both in the community and in prison, which should be referred to appropriately

GUIDANCE AND GOOD PRACTICE

Prevalence of drug and alcohol misuse

The number of ex-service personnel in Wales with a substance misuse problem is unknown but the predominant problem is likely to be alcohol misuse. A recent study of military veterans living in Wales found that the rate of probable alcohol dependence in those studied was no higher than in the general population[35], but it should be noted that the sample used in this study may not be representative of all ex-military personnel resident in Wales. Participants were predominantly males and white with a mean age of 48.4 years. A sub-group in the study, recruited through Combat Stress, had rates of probable alcohol dependence higher than the general population.

A review of alcohol use by the military by Jones & Fear (2011) concluded that historically its use is claimed to have a positive effect, promoting group bonding during training, providing confidence during combat, and helping soldiers sleep in its aftermath[36]. Despite this, heavy drinking is recognised as problematic within the Armed Forces, i.e. 67% of men in the UK AF, compared to 38% of men in the general population (even after accounting for age) are reported to be drinking at a level considered by the World Health Organisation to be harmful to health[37]. In recent years this has been addressed by restrictions on alcohol use for those

[35] Wood, S et al, '*Mental health, social adjustment, perception of health and service utilisation of three groups of military veterans living in Wales: a cross-sectional survey*', (undated)
[36] Jones, E & Fear, N, '*Alcohol use and misuse within the military: a review*', International Review of Psychiatry, April 2011, 23: 166-172 http://www.kcl.ac.uk/kcmhr/publications/assetfiles/alcoholsmoking/Jones2011-Alcoholuseandmisusewithinthemilitary.pdf
[37] Fear, N et al, '*Patterns of drinking in the UK armed forces*', Addiction, 102, pp 1749-1759, (2007)

actively deployed, and gradual reintroduction whilst attending third location 'decompression' in Cyprus[38].

The recent Welsh veterans' study found that (with the exception of the group recruited through Combat Stress), illicit drug use among the veterans surveyed was comparable with or lower than rates in the general population[39]. Cannabis was the most frequently used substance. The proportion of the Combat Stress Group dependent on cannabis (the report did not clarify how dependence was assessed) was comparable to the general population, but among the other participants the proportion was lower. A greater proportion of the Combat Stress group were dependent on another drug or drugs (tranquilisers, amphetamines, cocaine, and heroin) than in the general population.

Assessment and treatment

There is already an expectation that prison healthcare staff should routinely carry out alcohol misuse screening as an integral part of practice. Discussions should take place:

- on first reception
- during induction
- when screening for other conditions
- when managing chronic disease
- as part of medicine reviews
- when promoting sexual health

A validated screening questionnaire should be completed:

- using Alcohol Use Disorder Identification Test (AUDIT) to decide whether to offer a brief intervention or whether to make a referral to specialist services;
- or, if time is limited, using an abbreviated version such as AUDIT-C, AUDIT-PC, SASQ, OR FAST.

Links to AUDIT and FAST Manuals can be obtained via the following links:
http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf
http://www.nice.org.uk/niceMedia/documents/manual_fastalcohol.pdf

Prisoners who are ex-service personnel and identified as drinking a hazardous amount of alcohol (i.e. scoring 8 – 15 on AUDIT) should be offered a brief session of structured advice regarding alcohol.

Prisoners who are physically dependent on alcohol will require more intensive forms of treatment, including alcohol detoxification, which should be completed in accordance with current clinical guidelines.

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[38] Fertoute, M et al, '*Third location decompression for individual augmentees after a military deployment*', Occupational Medicine 2012, 62:188-195

[39] Wood, S et al, '*Mental health, social adjustment, perception of health and service utilisation of three groups of military veterans living in Wales: a cross-sectional survey*', (undated)

Similarly, prisoners who are dependent on other substances, particularly opiates, requiring either stabilisation and/or maintenance on an opiate substitute, or detoxification, should again be treated in accordance with the clinical guidelines already in use.

Drug and alcohol problems are ameliorated by the combined effects of a breadth of clinical, psychological and social interventions. It is important that health and CARAT services in prisons not only work together, but also refer through the established treatment pathways to the Drugs Intervention Programme or to NHS/third sector addictions services in the community as the prisoner approaches release.

By way of an example of good practice, **HMP Swansea** has the following process in place:

- all newly received prisoners are screened for alcohol misuse on their first night and assessed for withdrawal. Medication is available under a Patient Group Direction (PGD) to assist with safe withdrawal;
- the following day prisoners have a secondary health assessment, and those identified as having alcohol issues are seen by a mental health nurse who will screen using the AUDIT tool;
- if the AUDIT screen indicates problems with binge drinking or alcohol dependence the prisoner is referred to the Alcohol Clinic (see below);
- completion of AUDIT is, in itself, a brief intervention as it encourages the prisoner to look at their alcohol use and lifestyle, and can generate advice and signposting for those individuals;
- following the AUDIT screen some prisoners will be seen by the GP for prescribing, i.e. for detoxification, Vitamin B and Thiamine, and they will be monitored by the nursing team during the withdrawal process;
- a weekly Alcohol Clinic is held by the primary care team and it provides opportunity for completion of an alcohol dependence readiness to change questionnaire. It enables prisoners to consider their lifestyle choices and to objectively set goals;
- alcohol use is varied and interventions are tailored to the needs of the individual, e.g.
    - interventions may take the form of advice on the effects of alcohol on health, relationships and lifestyle, providing health promotion materials and signposting to agencies;
    - some prisoners may have Liver Function Tests and Routine Blood Tests to check physical health;
    - others may be referred to Alcoholics Anonymous (AA) and CARAT teams;
    - the primary care team can liaise with GP's and external substance misuse services to commence prescribing of medication for release to help people abstain from alcohol;
    - the prison also has a 'Recovery Wing' where there is group-work available on alcohol awareness.

Veteran specific and co-morbidity issues

The Howard League inquiry found that alcohol featured in a range of offences, particularly violent and sexual offences, committed by ex-service personnel in prisons. As alcohol plays a part in military 'decompression' (24-36 hours enforced stay in Cyprus en route from theatre to UK post deployment) the use of alcohol to deal with a range of stressful situations in life pre and post discharge from service can become an acquired habit. More specifically, alcohol misuse can become a coping strategy for dealing with unmet mental health needs.

The Poppy Scotland evaluation of the Gateways for Veterans pilot project[40], which was designed as a service to support ex-service personnel who misuse alcohol, found that one of the most significant challenges was engaging with vulnerable veterans who they describe as "notoriously hard to reach". The uptake for the service they offered (in the community) was well below the target they set. They concluded, based on responses from ex-service personnel who did engage, that the service did not necessarily need to be provided by veterans (which is at variance with other reports). Also, that it was useful to do some "gentle probing" with ex-military individuals about their drinking habits as this helped to identify those who did not wish to disclose their true level of consumption, and those who did not see their drinking as problematic. They suggest that a 'buddying' scheme might be worth considering.

There is already an example of a comparable scheme in Wales. In North Wales the CAIS Drug and Alcohol Agency leads the peer mentoring and advice service, Change Step, for military veterans and others with PTSD or probable substance misuse issues who want to make positive changes to their lives. The service is delivered by veterans for veterans and offers peer support and training opportunities, as well as counselling and detoxification from drugs or alcohol where required. Change Step aims to work collaboratively with statutory bodies and other relevant organisations to ensure an accessible and comprehensive framework by which to guide individuals towards the most appropriate service. Details can be obtained from the CAIS website: http://www.cais.co.uk/support-community.php?title=Change-Step

Practitioners in prisons will need to have regard to three modules of the Substance Misuse Treatment Framework for Wales, all of relevance:

- Offender Treatment[41]
- Alcohol[42]
- Co-occurring Mental Health and Substance Misuse problems[43].
- The guidance for improving access to substance misuse treatment

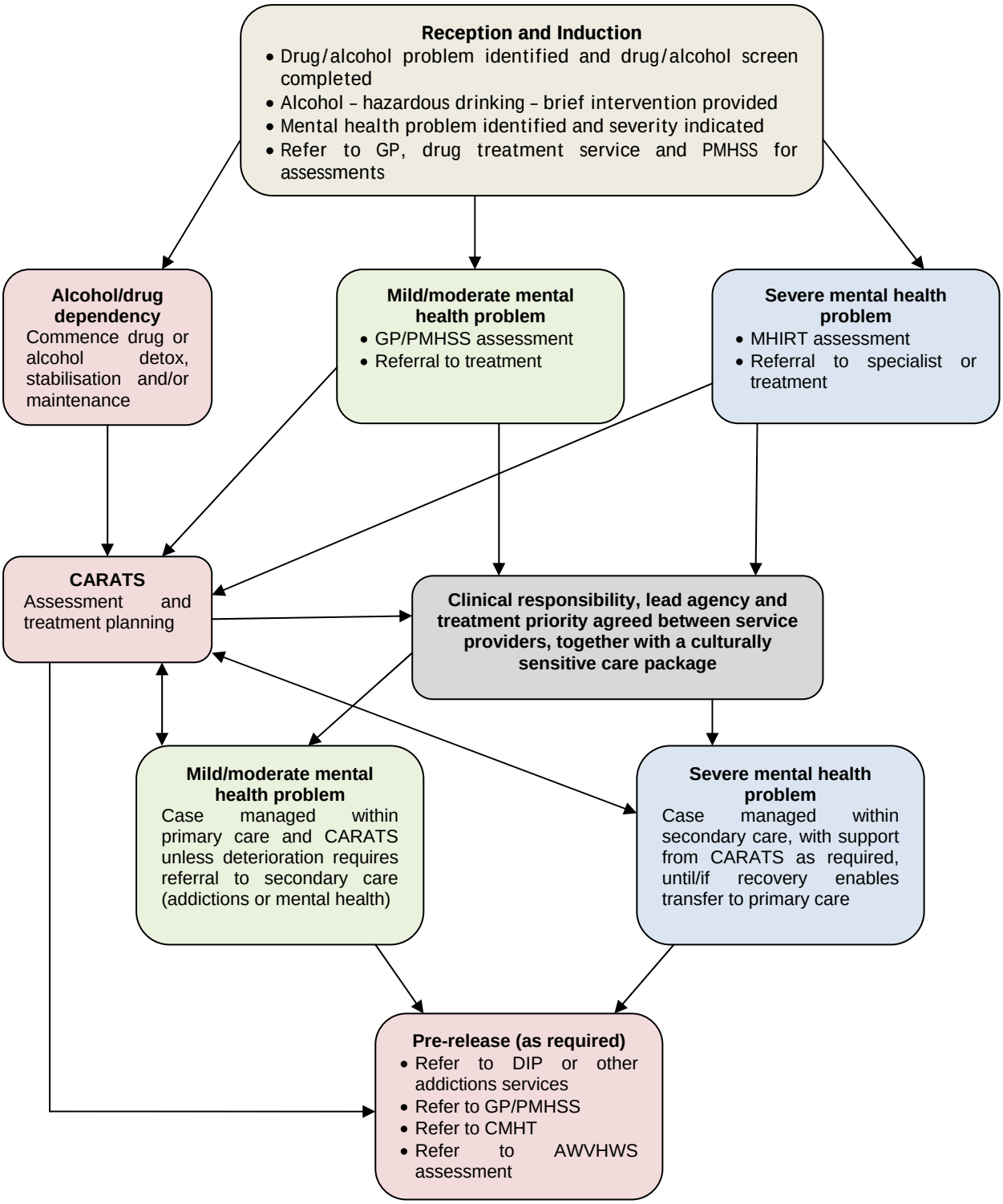
[40] http://www.poppyscotland.org.uk/docs/PublicationAndDownloads/Inverclyde%20Alcohol%20Project%20Executive%20Summary.PDF
[41] http://wales.gov.uk/docs/dsjlg/publications/commsafety/090430smtfoffenderse.pdf
[42] http://wales.gov.uk/dsjlg/publications/commmunitysafety/submisusetreatframework/alcohole.pdf;jsessionid=B36B4DA0432FE32C6FEDE41AFC620745?lang=en
[43] http://wales.gov.uk/dsjlg/publications/commmunitysafety/submisusetreatframework/cooccurringe.pdf;jsessionid=B36B4DA0432FE32C6FEDE41AFC620745?lang=en

The latter stresses the importance of unambiguous clinical responsibility for those with a dual diagnosis, and for a joint liaison/collaborative approach between treatment providers. The Offender Treatment module also underlines the point that effectiveness is determined by how a treatment service is provided as much as what is delivered.

CO-OCCURRING SUBSTANCE MISUSE AND MENTAL ILLNESS – A COLLABORATIVE APPROACH

The following diagram outlines a treatment and care pathway for prisoners who are veterans with co-occurring substance misuse and mental health problems.

CO-OCCURRING SUBSTANCE MISUSE AND MENTAL HEALTH PROBLEMS



RELEASE AND RESETTLEMENT

CONTEXT

Whether a prisoner will be subject to statutory supervision by probation on release or not, from the point of first reception in prison they should be supported in preparing and planning for their release.

Where possible they should be enabled to engage with services, e.g. employment, housing, financial advice, health and social care, that either operate within the area they are returning to, or have links to comparable services in the area.

Similarly, they should be encouraged to participate in any personal and/or skills development activities that will enhance their prospects of better integrating into the community, pursuing education or employment, sustaining family relationships, and desisting from offending on release.

Where there is continuing health and social care needs, appointments should be arranged with GPs, specialist services such as drug and alcohol treatment providers, mental health community teams, or the NHS AWVHWS as appropriate. At the very least, information should be provided on how they might access health services if they decline referral from the prison.

Those who are subject to statutory supervision on release, i.e. those serving sentences of 12 months or more, will be supervised by probation for the period of their Licence. The Offender Management Unit in the prison should liaise with the Responsible Officer in probation prior to their release.

GUIDANCE AND GOOD PRACTICE

Rehabilitation and resettlement in prison

Prison Service Instruction (PSI) 12/2012[44] requires the Governors/Directors of prisons to make a 'core rehabilitative offer' that incorporates access to information or services that can assist prisoners to overcome the impact of imprisonment and address basic issues linked to their offending.

Governors/Directors retain the freedom to deliver services flexibly in conjunction with local partners and providers. In effect this affords opportunity, where need is identified, for prisons to provide or facilitate additional targeted services. The PSI also requires Governors/Directors to ensure that contact time between prisoners and service providers is maximised.

[44] PSI 12/2012, '*Rehabilitation Services Specification – Custody*', NOMS/Ministry of Justice, March 2012

HM Inspectorate of Prisons expects "*the needs of the [prison] population [to be] met by effectively co-ordinated and targeted resettlement services that draw adequately from external statutory and voluntary agencies, as well as internal resources*"[45].

Many prisoners, including ex-service personnel, have future employment, housing, finance, family welfare and support needs. While prisons and their partners may provide a range of rehabilitation and resettlement services and activities, veterans can additionally benefit from the Prison In-Reach Service (PIR) provided by RBL and SSAFA, and the support of other ex-Service organisations. These organisations are ready and willing to work with groups of ex-service personnel and with individual prisoners. Opportunities to extend or formalise partnerships within the context of the PSI provisions should be considered and exploited where possible.

Continuity of healthcare

Prison Service Order (PSO) 3050[46] sets out the requirements for ensuring the continuity of healthcare for all prisoners. It is important that the healthcare team is actively involved in planning for the discharge of ex-service personnel who are prisoners where health care needs have been identified, so that adequate referral arrangements can be made and that the prisoner can be told what these are.

The challenges of successfully resettling into the community are exacerbated for prisoners with health problems because they may face substantial interconnected barriers in areas such as access to housing and primary care. Primary healthcare can often be a gateway to other services and so the failure to connect with a GP has wide-ranging consequences.

All prisoners should be encouraged to register with a GP on release. If a prisoner who is receiving medical care that needs to continue after discharge does not have a GP, it is particularly important that health care staff help the prisoner to register with one prior to discharge. Similarly, healthcare staff must arrange follow-up appointments with NHS providers for all continuing secondary health care needs, and supply sufficient medication appropriate to clinical need until a GP prescription can be obtained. Subject to the consent of the prisoner, details of their care and treatment in prison should be forwarded to the GP.

If the prisoner has been held on the MHIRT caseload they should have been allocated a Care Co-ordinator and have a Care and Treatment Plan in accordance with Part 2 of the Mental Health (Wales) Measure. If they have continuing care and treatment needs within secondary care they should be allocated a Care Co-ordinator in the community, i.e. within a Community Mental Health Team in the area in which they will be resettling. If the prisoner is held on the NHS AWVHWS waiting list the AWVHWS should be notified of their release and future contact details, and the prisoner provided with details of how to contact the AWVHWS.

[45] HMIP Expectations Version 4, 2012,
[46] PSO 3050/2006, '*Continuity of Healthcare for Prisoners*', HM Prison Service, 2006

Through the gate and beyond

Continuing engagement with support services through the prison gate and beyond is especially important for prisoners serving short sentences who will not be subject to statutory supervision on release. Irrespective of length of sentence, it is now recognised within the Ministry of Justice that mentoring for prisoners during the early days of release could make a difference in terms of their desistance from behaviours that may result in re-offending.

In Wales, NOMS and the Welsh Government have commissioned G4S to support community resettlement for short-term prisoners who have substance misuse problems and associated violent offending. Known as the Transitional Support Scheme (TSS), the objectives are as follows:

- to support ex-offenders by reducing reoffending;
- to enable offenders to access appropriate services prior to release and ensure safe and supportive community resettlement by collaboratively supporting other agencies to meet their objectives in offender engagement;
- to provide offenders with ongoing voluntary support so that they are motivated to establish a stable and responsible lifestyle;
- encourage and manage appropriate peer mentoring to provide longer-term additional support;
- work toward the cessation of drug abuse;
- support the responsible management of alcohol consumption and associated violent behaviour, including domestic violence;
- support ex-prisoners and their families to improve relationships.

In addition, the ex-service organisations such as RBL, SSAFA, SPVA and Combat Stress are positioned to provide not only support to ex-service personnel, but also to their families during the post-custody period. This support can be provided in conjunction with any statutory supervision by probation or inputs from other services. A number of probation teams or offices in Wales now have designated Ex-Forces Leads who may act as first points of contact for prison staff involved in the discharge planning process, e.g. Offender Management Units, resettlement teams, EFLOs or VICSOs.

Community Covenant schemes

A number of areas in Wales have now joined the Community Covenant Scheme[47]. Community Covenants are voluntary statements of mutual support between Armed Forces (including veterans) and civilian communities. They are intended to complement, at a local level, the UK Armed Forces Covenant. They aim to:

- encourage local communities to support the Armed Forces community in their area;
- nurture public understanding and awareness of the issues affecting the Armed Forces community;

[47] http://www.britishlegion.org.uk/campaigning/latest-campaign

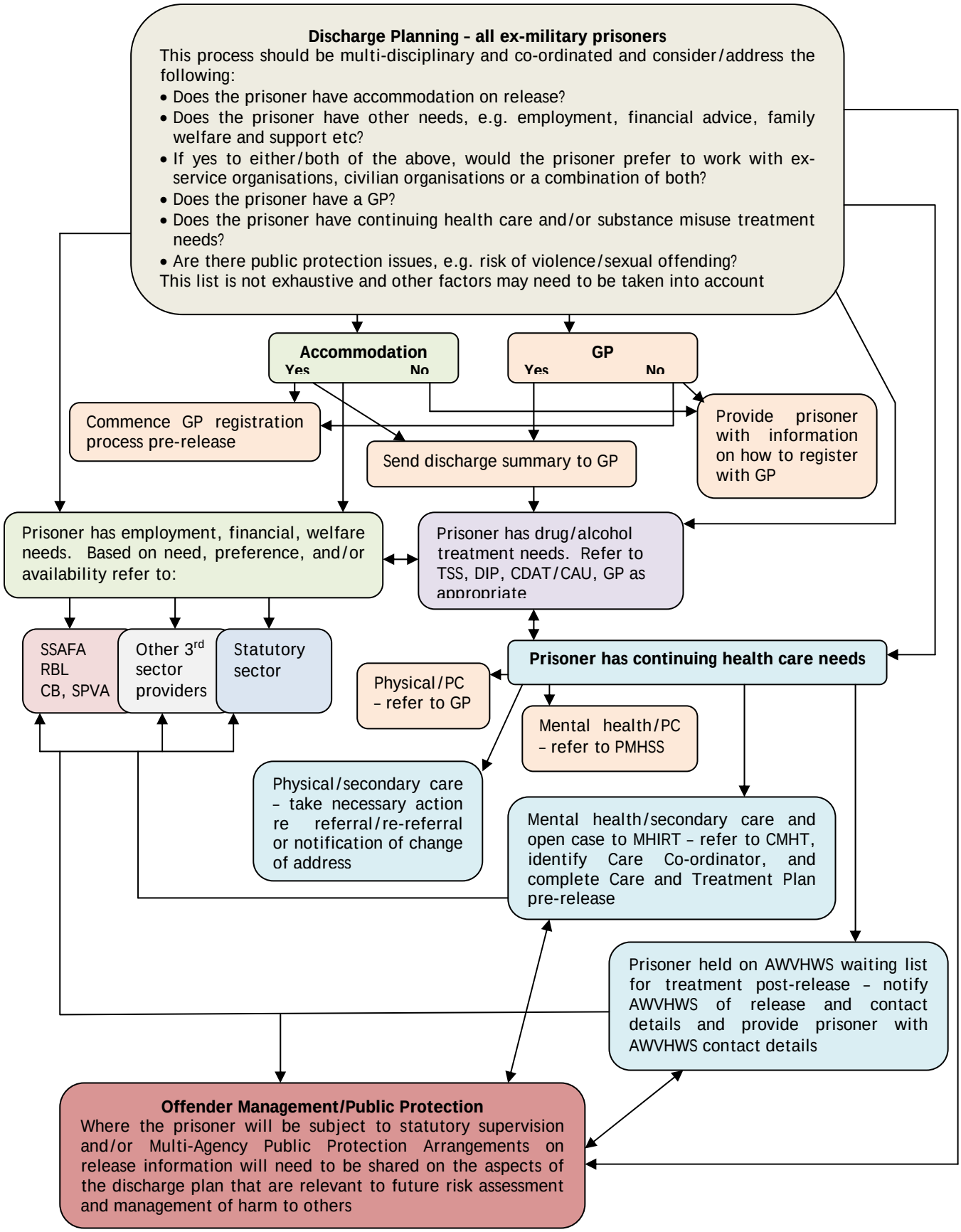
- recognise and remember the sacrifices made by the Armed Forces community;
- encourage activities which help to integrate the Armed Forces community into local life;
- encourage the Armed Forces community to help and support the wider community to help and support the wider community, whether through participation in events and joint projects, or other forms of engagement.

The Vale of Glamorgan Council was the first local authority in Wales to sign a Community Covenant. As a consequence they are asking anyone who contacts their customer services centre whether they or family members have served in the Armed Forces. This has improved provision for the Armed Forces community as it has helped in signposting to appropriate services.

Prisons and probation in areas where there are Community Covenant schemes in place (they are steadily increasing in number in Wales) may want to pursue opportunities for engagement in their localities.

RELEASE AND RESETTLEMENT – THROUGH THE GATE AND BEYOND

If resettlement is to be effective it needs to be integrated, with a veteran's diverse needs being addressed in a holistic way. It is difficult to capture this diagrammatically, particularly if the prisoner has multiple, complex needs, but the following chart captures some of the key flows and linkages.


Discharge Planning – all ex-military prisoners
This process should be multi-disciplinary and co-ordinated and consider/address the following:
• Does the prisoner have accommodation on release?
• Does the prisoner have other needs, e.g. employment, financial advice, family welfare and support etc?
• If yes to either/both of the above, would the prisoner prefer to work with ex-service organisations, civilian organisations or a combination of both?
• Does the prisoner have a GP?
• Does the prisoner have continuing health care and/or substance misuse treatment needs?
• Are there public protection issues, e.g. risk of violence/sexual offending?
This list is not exhaustive and other factors may need to be taken into account
Accommodation
Yes
No
GP
Yes
No
Commence GP registration process pre-release
Send discharge summary to GP
Provide prisoner with information on how to register with GP
Prisoner has employment, financial, welfare needs. Based on need, preference, and/or availability refer to:
Prisoner has drug/alcohol treatment needs. Refer to TSS, DIP, CDAT/CAU, GP as appropriate
SSAFA
RBL
CB, SPVA
Other 3rd sector providers
Statutory sector
Prisoner has continuing health care needs
Physical/PC – refer to GP
Mental health/PC – refer to PMHSS
Physical/secondary care – take necessary action re referral/re-referral or notification of change of address
Mental health/secondary care and open case to MHIRT – refer to CMHT, identify Care Co-ordinator, and complete Care and Treatment Plan pre-release
Prisoner held on AWVHWS waiting list for treatment post-release – notify AWVHWS of release and contact details and provide prisoner with AWVHWS contact details
Offender Management/Public Protection
Where the prisoner will be subject to statutory supervision and/or Multi-Agency Public Protection Arrangements on release information will need to be shared on the aspects of the discharge plan that are relevant to future risk assessment and management of harm to others

ACRONYMS

AA	**Alcoholics Anonymous**
ACCT	**Assessment, Care in Custody and Teamwork**
AUDIT	**Alcohol Use Disorder Identification Test**
AWVHWS	**All Wales Veterans Health and Wellbeing Service**
CARATS	**Counselling, Assessment, Referral, Advice and Through-care Services**
CBT	**Cognitive Behavioural Therapy**
COBSEO	**Confederation of Service Charities**
DCMH	**Department of Community Mental Health**
DH	**Department of Health**
EFLO	**Ex-Forces Liaison Officer**
EMDR	**Eye Movement Desensitisation and Reprocessing**
ESL	**Early Service Leaver**
GAD	**Generalised Anxiety Disorder**
GP	**General Practitioner**
HIW	**Healthcare Inspectorate Wales**
HMP	**Her Majesty's Prison**
IES-R	**Impact of Events Scale - Revised**
KCMHR	**King's Centre for Military Health Research**
LHB	**Local Health Board**
MHIRT	**Mental Health In-Reach Team**
MoD	**Ministry of Defence**
MoJ	**Ministry of Justice**
NaFW	**National Assembly for Wales**
NHS	**National Health Service**
NICE	**National Institute for Health and Clinical Excellence**
NOMS	**National Offender Management Service**
OCD	**Obsessive Compulsive Disorder**
OMU	**Offender Management Unit**
PGD	**Patient Group Direction**
PIR	**Prison In-Reach**
PMHSS	**Primary Mental Health Support Service**
P-NOMIS	**Prison National Offender Management Information System**
PSI	**Prison Service Instruction**
PSO	**Prison Service Order**
PTSD	**Post Traumatic Stress Disorder**
RBL	**Royal British Legion**
RCGP	**Royal College of General Practitioners**
SPOC	**Single Point of Contact**
SPVA	**Service Personnel and Veterans Agency**
SSAFA	**Soldiers, Sailors, Airmen and Families Association**
TF-CBT	**Trauma Focused Cognitive Behavioural Therapy**
TRiM	**Trauma Risk Management**
TSQ	**Trauma Screening Questionnaire**
TSS	**Transitional Support Scheme**
VICS	**Veterans in Custody Scheme**
VICSO	**Veterans in Custody Support Officer**
VIPA	**Veterans in Prison Association**
WaMH in PC	**Wales Mental Health in Primary Care**
YOI	**Young Offender Institution**

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ANNEX A

SERVICE ORGANISATIONS WORKING WITH PRISONS AND PRISONERS IN WALES:

COMBAT STRESS	
Helpline:	0800 138 1619
General enquiries:	01372 587 000
Email:	contactus@combatstress.org.uk
Address:	Combat Stress Tyrwhitt House Oaklawn Road Leatherhead Surrey KT22 0BX

THE ROYAL BRITISH LEGION (RBL)	
Area Office The Royal British Legion Suites 28, 31 & 33 15th Floor Brunel House 2 Fitzalan Road Cardiff CF24 0EB Tel: 02920 232016	
County Welfare Officers	County Welfare Officers are responsible for welfare case management, Caseworker retention and training and the promotion and development of working relations with other partner organisations including ex service charities.
Ms Kinsey Shepherd	E: kshepherd@britishlegion.org.uk
Ms Rosamund Vining	E: rvining@britishlegion.org.uk
Advice and Information Team Leader	
Julie Ann Evans	E: JAEvans@britishlegion.org.uk
Benefits and Money Adviser	There is a Benefits and Money Adviser based in our Cardiff Office.
Mr Andrew Bridges	E: abridges@britishlegion.org.uk
Regional Outreach Officer	The Client Support Officer is on hand to support those that require it.
Ty Harrison	T: 07901 110818 E: tharrison@britishlegion.org.uk

SERVICE PERSONNEL AND VETERANS AGENCY – VETERANS UK (SPVA)	
Free Veterans Helpline:	0800 169 2277
Textphone:	0800 169 3458
Website:	www.veterans-uk.info

SOLDIERS, SAILORS, AIRMAN AND FAMILIES ASSOCIATION (SSAFA)

Anglesey
Tel: 020 7463 9224
Email: Anglesey@ssafa.org.uk

Caernarfonshire
Tel: 020 7463 9224
Email: caernarfonshire@ssafa.org.uk

Cardiff & The Vale of Glamorgan
Tel: 02920 383 852
Email: office@ssafacardiff.org

Clwyd
Tel: 01978 842 149
Email: Clwyd@ssafa.org.uk

Glamorgan West
Tel: 01792 653 432
Email: West.Glamorgan@ssafa.org.uk

Gwent
Tel: 01633 246 269
Email: Gwent@ssafa.org.uk

Meirionnydd
Tel: 01654 710 804
Email: welfare@ssafa.org.uk

Mid Glamorgan
Tel: 01656 785 435
Email: daved43@sky.com

Powys
Tel: 01874 613 304
Email: Powys@ssafa.org.uk

ANNEX B

CONTACTS FOR VERIFICATION AND SERVICE/MEDICAL RECORDS

If the prisoner already has contact with a Welfare Officer with the SPVA, or a welfare officer with any other ex-service organisation, it should be possible, with the consent of the prisoner, to contact the Welfare Officer and confirm status.

If the prisoner does not have contact with the SPVA either telephone the Veterans UK helpline: **0800 169 2277** or follow the links on the Veterans UK website: **http://www.veterans-uk.info/service_records/service_records.html.** This will take you to a new .Gov website and the relevant forms for obtaining service and medical records as well as the contact addresses.

Otherwise, for enquiries about service medical records you can contact the following:

Royal Navy (signed consent form required)
RN Service Leavers
Institute of Naval Medicine
Crescent Road
Gosport
Hampshire
PO12 2DL
Tel: 02392 768 201/063
Fax: 02392 768 113

Army
APC MS Support - Disclosures 2
MP 535
Kentigern House
65 Brown Street
Glasgow
G2 8EX
Tel: 0845 600 9663
Fax: 0141 224 3172
Email: APC-Sp-ParlDiscl-Dis2-Mailbox@mod.uk

Air Force (signed consent form required)
RAF Disclosures Section
Room 221b
Trenchard Hall
RAF Cranwell
Sleaford
LINCS
NG34 8HB
Tel: 01400 266711
Ext 8161/8159 (Officers)
Ext 8163/8168/8170 (Other Ranks)
Email: CRN-Stn-BSW-CCO@Mod.uk

ANNEX C

ALL WALES VETERANS HEALTH AND WELLBEING SERVICE

Full details of the All Wales Veterans Health and Wellbeing Service can be obtained from the website: http://www.veteranswales.co.uk/ .

This includes contact addresses for the Veterans Therapists and Secretaries in each of the Local Health Board areas, and information leaflets/referral forms that can be download from the website for circulation and completion.

The Service operates on a 'hub and spoke' basis. The following outlines the fundamentals of the service:

The All Wales Veterans Health and Wellbeing Service was funded by the Welsh Government in April 2010, following a successful two year pilot project based in Cardiff & Vale NHS Trust.

The day to day running of the service will be delivered by the NHS in Wales. Each Local Health Board (LHB) has appointed an experienced clinician as a Veterans Therapist (VT) with an interest or experience of military health problems. This VT will accept referrals from health staff, GP's, veteran charities and self-referrals from ex-service personnel.

The appropriate VT can be contacted by going to their LHB page on this website and using one of the contact methods including telephone, email or fax. Appointments will be arranged as close to the veteran's home as possible in a suitable NHS venue. **The service is not able to respond to emergency referrals. Veterans in crisis should contact their GP or the Out of Hours Service. There is usually a Psychiatrist on-call at all Accident and Emergency Units.**

Following the assessment the veteran may be offered treatment by the VT or referred onto other NHS teams or departments for further treatment. The VT will also refer to veteran charities for help with debt management, benefits and war pension/armed forces compensation claims as indicated.

If you would like to discuss a referral or require further information about the service contact details can be found on the service website: http://www.veteranswales.co.uk

ANNEX D

WELSH HEALTH CIRCULARS AND WELSH GOVERNMENT PACKAGE OF SUPPORT FOR THE ARMED FORCES COMMUNITY IN WALES

Welsh Health Circular (2008) 051 - Priority Treatment and Healthcare for Veterans
http://www.google.co.uk/url?sa=t&rct=j&q=www.wales.nhs.uk%2Fdocuments%2Fwhc(2008)051%2520full.pdf%E2%80%8E&source=web&cd=1&ved=0CC8QFjAA&url=http%3A%2F%2Fwww.wales.nhs.uk%2Fdocuments%2FWHC(2008)051%2520full.pdf&ei=xzTtUcu1BIm57Aam_ICwBQ&usg=AFQjCNE_5CNehHkPWOM8Ps9_B52yKbnYCg&bvm=bv.49478099,d.ZGU

Welsh Government Package of Support for the Armed Forces Community in Wales
http://wales.gov.uk/topics/housingandcommunity/safety/armedforces/packagesupport/;jsessionid=4EEB6A057375BCD76C20D9BE89818097?lang=en

ANNEX E

TASK & FINISH GROUP MEMBERSHIP

Rowena Williams (Facilitator)	National Leadership & Innovation Agency for Healthcare, NHS Wales
Julia Letton (Secretariat)	Mental Health & Vulnerable Groups Division, Welsh Government
Richard Hockey (Secretariat)	Mental Health & Vulnerable Groups Division, Welsh Government
Jenifer French	Nursing/Policy Divisions, Welsh Government
Neil Kitchiner	All Wales Veterans Health & Wellbeing Service
Eryl Drew	National Offender Management Service (Wales)
Phillipa Thody	National Offender Management Service (Wales)
Jackie Leggett	Wales Probation Trust
Vicky Warner	Cardiff & Vale University Local Health Board
Julie Devlin	Cardiff & Vale University Local Health Board
Hannah Roan	Abertawe Bro Morgannwg University Local Health Board
Steve Jones	Abertawe Bro Morgannwg University Local Health Board
Marie Phillips	HMP Swansea Healthcare Team
Rick Owen	HMP Swansea
Clare Frost	HMP/YOI Parc (G4S) Healthcare Team
Lee Hearse	HMP/YOI Parc (G4S)
Don Perkins	HMP/YOI Parc (G4S)
Libby Payne	HMP/YOI Parc (G4S)
Eddie Evans	Combat Stress
Mike Bailey	Service Personnel & Veterans Agency – Veterans UK
Ty Harrison	The Royal British Legion
David Singletary	Soldiers, Sailors, Airman and Families Association
Rhiannon Hobbs	Public Health Wales NHS Trust