

FOCUS ON

# Armed Forces Charities' Mental Health Provision



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# Contents

Foreword	v
Preface	vi
About the authors	vii
Acknowledgements	viii
About the Directory of Social Change	viii
Executive summary	ix
Introduction	xii
Chapter 1: An overview of charities' mental health provision	1
Introduction	1
Provision for mental health	1
Primary and Secondary providers	4
Charitable expenditure	6
Collaboration and evaluation	8
Chapter one summary	11
References	11
Chapter 2: Mental health service delivery	12
Clinical and non-clinical services	13
Standards of practice	15
Provision for PTSD	19
Provision for depression and anxiety	22
Provision for substance misuse	25
Chapter two summary	28
Chapter 3: The last word: conclusions and recommendations	30
How many forces charities provide mental health support?	30
Which mental health areas are supported?	30
How are mental health services delivered to beneficiaries?	31

What standards of practice, collaboration and evaluation exist?	33
Recommendations	33
References	34

# Foreword



I am so excited about the continued development of this project and our partnership with FiMT, particularly because I grew up in an armed forces family. I know intimately the sense of pride and the sacrifice shared by serving and ex-serving members of our armed forces and their families. I also understand and value the hugely important work that armed forces charities do to support the armed forces community. We are very fortunate to have so many brilliant forces charities in the UK, and it is vital that we continue to illuminate and celebrate their work.

DSC is proud to be funded by the Forces in Mind Trust, and our partnership over the past three years has produced two ground-breaking *Sector Insight* reports (*UK Armed Forces Charities, 2014* and *Armed Forces Charities in Scotland, 2016*). During that time DSC has also developed the searchable online database [armedforcescharities.org.uk](http://armedforcescharities.org.uk), and published our 2016 *Impact Evaluation* of the project.

Using valuable feedback and learning from our Impact Evaluation, the project has evolved to provide a new, deeper perspective on the work of the UK's armed forces charities in supporting their many beneficiaries across a diverse range of provision. The new Focus On series adds to this established body of work by providing a more profound level of insight into the work of armed forces charities.

This report focuses specifically on the range of support provided by armed forces charities for the mental health needs of the armed forces community. The data presented provides robust and unbiased evidence, through which readers can better understand the valuable contribution of charities, while established and emerging charities can enhance their understanding of the landscape in which they operate in regards to mental health.

I am particularly excited by this report. *Focus On: Armed Forces Charities' Mental Health Provision*, is the first of six thematic reports which we will be producing over the next two years. Subsequent reports published in 2017 will cover education and employment, and physical health. In 2018, we will publish three more *Focus On* reports on core topics of charitable support for current and ex-service men and women and their families.

It is our hope and intention that this research has a positive impact on the understanding of armed forces charities and their work, so that policymakers, and those charities providing support, can create a better environment for serving the armed forces community.

Debra Allcock Tyler, Chief Executive, Directory of Social Change

# Preface



Walking across Parliament Square in late 2014, one of our Trustees bumped into a Peer of the Realm he knew well from his work as Chairman of Cobseo, the Confederation of Service Charities. 'Far too many charities, they can't work together and they hoard all their money' proclaimed our ill-informed Lord. 'My Chief Executive will send you something tomorrow' politely responded the wise Trustee. And that brief exchange led to yet another copy of *Sector Insight: Armed Forces Charities* being sent to yet another influencer and policymaker whose interactions with the sector were based on assumption, misconception and that most heinous crime of all, assertion.

The success of our funding the Directory of Social Change to produce the *Sector Insight* and associated website arguably marked the arrival of Forces in Mind Trust as a social change organisation, whose generation of credible and independent evidence, exploited to achieve maximum effect, would lead to better informed decision-makers making better decisions.

It wasn't without its limitations, however; so in considering whether to continue the project, we carefully examined its impact, and how that could be improved. A better website is one such change; the other is the production of a series of shorter (hence more digestible) and more focused reports. I am delighted now to be publishing the first, and the topic *Armed Forces Charities' Mental Health Provision* is a timely one. This year (2017) has seen a remarkable increase in interest in mental health in general, and a national determination to improve access to appropriate services for the whole population. That might be through reducing barriers to access (such as caused by stigma), or through improved services themselves.

With respect to mental health services and ex-Service personnel, decisions on delivery, funding and even types of treatment are too often vulnerable to a lack of understanding. We hope that this report, and the series that follows, will bring insight to those involved in supporting our Armed Forces Community. We don't live in a land of plenty, but we do live in a country that values the contribution the Armed Forces make to society, and where the public are so extraordinarily generous in supporting their wellbeing. It is only right that we invest in credible, independent evidence, such as this report, so that our efforts and resources are deployed where they are most needed, and where they can have the greatest positive effect.

Air Vice-Marshal Ray Lock, Chief Executive, Forces in Mind Trust



# About the authors

## STUART COLE



Stuart is the Research Manager for DSC's Armed Forces Charities project. Since joining DSC in 2015, Stuart has researched forces charities, producing reports including; *Sector Insight: Armed Forces Charities in Scotland* (2016), and *Cobseo Members' Survey* (2015).

Before joining DSC, Stuart held an academic post in public health research, working on projects in partnership with the World Health Organization, Alcohol Research UK and the NHS. Stuart's work focused on violence, traumatic injury and alcohol consumption.

Stuart holds a BA (Hons) in Psychology and Sociology, an MSc in Applied Psychology, and a PGCE in Psychology. He is a qualified teacher and worked for five years as a psychology lecturer at a number of colleges and schools before moving into research.

## ANTHONY ROBSON



Anthony joined DSC in 2017 as a Researcher on DSC's Armed Forces Charities research project. Along with undertaking research and writing of reports, Anthony maintains the project's online database of forces charities.

Prior to joining DSC, Anthony volunteered as a high school Classroom Assistant and also as a member of the Merseyside Police Cadet scheme.

Anthony holds a BA (Hons) in Modern History and an MRes in English Literature and Cultural History from Liverpool John Moores University.

## RHIANNON DOHERTY



Rhiannon joined DSC in 2017 as a Researcher on DSC's Armed Forces Charities research project, where she contributes to the researching and writing of these reports. Rhiannon is also responsible for directing the communications and social media strategy for the project.

Before joining DSC, Rhiannon volunteered for a range of charities including NDCS and Oxfam.

Rhiannon holds a BA (Hons) in English Literature and Communications. She also holds an MA in Politics and Mass Media from the University of Liverpool.

# Acknowledgements

The authors would like to thank all of the armed forces charities which provided invaluable information during the data-collection period of this research.

Special thanks go to Veterans Scotland, Cobseo and Combat Stress for their support during the writing process.

# About the Directory of Social Change

The Directory of Social Change (DSC) has a vision of an independent voluntary sector at the heart of social change. The activities of independent charities, voluntary organisations and community groups are fundamental to achieve social change. We exist to help these organisations and the people who support them to achieve their goals.

We do this by:

- Providing practical tools that organisations and activists need, including online and printed publications, training courses, and conferences on a huge range of topics;
- Acting as a 'concerned citizen' in public policy debates, often on behalf of smaller charities, voluntary organisations and community groups;
- Leading campaigns and stimulating debate on key policy issues that affect those groups;
- Carrying out research and providing information to influence policymakers.

DSC is the leading provider of information and training for the voluntary sector, and publishes an extensive range of guides and handbooks covering subjects such as fundraising, management, communication, finance and law. We have a range of subscription-based websites containing a wealth of information on funding from trusts, companies and government sources. We run more than 300 training courses each year, including bespoke in-house training provided at the client's location. DSC conferences include the Charity Accountants' Conference and Fundraising Fair, as well as DSC's major annual event, Charityfair, which provides low-cost training on a wide variety of subjects.

For details of all our activities, and to order publications and book courses, go to [www.dsc.org.uk](http://www.dsc.org.uk), call 0207 697 4200 or email [publications@dsc.org.uk](mailto:publications@dsc.org.uk).

For details of our research go to [www.dsc.org.uk/research](http://www.dsc.org.uk/research), or email [research@dsc.org.uk](mailto:research@dsc.org.uk).

# Executive summary

DSC's armed forces charities research has, since 2014, been providing information to illuminate a sector of charities which are dedicated to serving the men and women of the Service and veteran communities, and their families.

Now in its third year, the project has grown and currently includes two *Sector Insight* reports (*UK Armed Forces Charities, 2014* and *Armed Forces Charities in Scotland, 2016*), and a searchable online database of armed forces charities.

Following the first three years of the project, DSC undertook a project *Impact Evaluation* report in 2016. Results from the *Impact Evaluation* provided DSC with evidence from which to develop the project and, following a substantial grant from the Forces in Mind Trust, DSC was positioned to mature the established project by providing even more insightful analysis into armed forces charities.

This report is the first of DSC's new *Focus On* armed forces charities series. The *Focus On* series builds upon DSC's *Sector Insight* reports, which provided a bedrock account of the UK armed forces charities sector, allowing the six *Focus On* reports to address individual topics of provision made by armed forces charities to their beneficiaries.

*Focus On: Armed Forces Charities' Provision for Mental Health* is the first of DSC's 2017 reports and is also the first of this new series. The report contains information and analysis on:

- The number of armed forces charities making provision for mental health support
- Which mental health areas are supported by charities
- Clinical and non-clinical treatment and interventions
- Expenditure on mental health provision and the beneficiaries supported
- Exploring of standards of practice, evaluation and collaboration among charities

Data presented in this report is taken from three main sources; a mental health provision survey (undertaken by DSC and sent to charities represented in this report); charity regulator records (including latest annual reports and accounts, where submitted); and information from individual charities (websites, impact reports, email and telephone correspondence).

The report will inform: policymakers; mental health professionals; care providers; statutory health care providers; the media; the charities themselves (and their beneficiaries); and those emerging charities wishing to contribute to mental health support.

## KEY FINDINGS

### How many forces charities provide mental health support?

- This research has identified 76 armed forces charities in the UK which clearly provide mental health support for the armed forces community. This comprises around 7% of the total population of UK armed forces charities.
- Primary providers of mental health support are defined as being those whose charitable objects were solely focused on mental health support. Primary providers accounted for one-third (34%) of charities.
- Secondary providers defined as those whose charitable objects included mental health support as one of several objects. Secondary providers accounted for two-thirds (66%) of charities.

## Which mental health areas are supported?

- The most common provision is for post-traumatic stress disorder (PTSD) with over three-quarters (75%) of charities providing such support.
- Over half (57%) of armed forces charities in the sample provide services for depression and anxiety.
- Over two-fifths (43%) of armed forces charities in the sample provide services for substance misuse.
- Provision for PTSD was more commonly associated with Primary providers (81%) than Secondary providers (72%).
- Provision for substance misuse was more commonly associated with Secondary providers (52%) than Primary providers (27%).
- Support for PTSD, depression and anxiety, and substance misuse was more likely to be undertaken by clinical providers.

## How are mental health services delivered?

- Counselling services were the most commonly provided service, with over half (54%) of Primary providers delivering this service and two-fifths (40%) of Secondary providers delivering counselling to beneficiaries.
- More than four-fifths (82%) of armed forces charities working in mental health provide non-clinical support (defined as services which are not administered by a registered healthcare professional). Conversely, less than one-fifth (18.4%) of charities provide a clinical service (services administered by a registered healthcare professional).
- Delivery of mental health services via another organisation was more common among Secondary providers (56%)
- Clinical providers of PTSD, depression and anxiety, and substance misuse support commonly provide advice/helplines, counselling and therapy.
- Non-clinical providers of PTSD, depression and anxiety, and substance misuse support commonly provide wellbeing and recreational activities.
- The majority of provision across all mental health topics took the form of recreational and wellbeing activities, which were more commonly delivered by non-clinical providers.

## How many beneficiaries are supported?

- Survey data suggests armed forces charities providing mental health support currently serve in the region of 7,000-10,000 beneficiaries per year.
- Survey responses showed the approximate number of beneficiaries who use charities mental health services are most commonly (36.1%) between 1 to 99 individuals annually. In total, 8% of charities provide services to more than 1,000 beneficiaries per year.
- The majority of charities support veterans (91%). Service personnel account for 71% of charities, and spouse/partners 71% of charities.

## What standards of practice, evaluation and collaboration exist?

- Survey data suggests that relatively few armed forces charities working in mental health have engaged in randomised control trials (RCTs) as a way to assess the effectiveness of mental health services for beneficiaries.

- Survey data also suggests that RCTs are not relevant to many charities, although a number of charities had undertaken or plan to undertake RCTs.
- Evaluation by a university was the most commonly reported method of evaluation by survey respondents.
- Partnerships with other organisations were more likely to be with other charities than any other organisation, of which NHS/local health authority was the most common. However with regards to independent evaluation work, evaluation by a local health authority was less commonly found.
- Over four-fifths (85%) of Primary providers delivered mental health services themselves.
- Survey data suggests that relatively few charities which deliver mental health services themselves also report implementing or working towards common guidelines or standards, such as National Institute for Health and Care Excellence (NICE) or Care Quality Commission (CQC) guidelines.

## What level of expenditure do charities apply to mental health?

- Survey data from 12 charities suggests Primary providers' annual expenditure on mental health is at least in the region of £17,450,000 per year.
- Survey data from 28 charities suggests Secondary providers' annual expenditure on mental health is at least in the region of £11,200,000 per year.
- Survey analysis showed that Primary providers were more likely to spend all of their total annual expenditure on mental health, compared to Secondary providers, who are more likely to spend in the region of half of their annual expenditure on mental health.
- More charities provided grants to organisations (24%) than to individuals (18%).

# Introduction

## ABOUT THE PROJECT

In 2014, the Directory of Social Change (DSC) was commissioned by the Forces in Mind Trust (FiMT) to undertake research that would provide an overview and analysis of the armed forces charity sector. The subsequent report was aimed at members of the charity sector, and those interested in it, including those who work in the sector, policymakers, government officials and media organisations. It was also intended as a resource for members of the public with an interest in armed forces charities.

The report, *Sector Insight, UK Armed Forces Charities*, published in 2014, (hereafter *Sector Insight 2014*) provided the most comprehensive account of the armed forces charities sector. Accompanying the report, DSC also produced a free-to-search online database for members of the public and the charity sector alike, to explore details of charities that make provision for the armed forces community.

In 2016, DSC published an *Impact Evaluation* report of the project to date. The learning from which helped shape DSC's 2016 report *Sector Insight, Armed Forces Charities in Scotland, 2016* (hereafter *Sector Insight 2016*). This was the first report to focus on the charities which operate solely in Scotland, as well as cross-border charities registered in England and Wales which also operate in Scotland.

In December 2016, DSC was generously awarded a grant from FiMT to continue this project for another three years. The grant will fund research into key areas of charitable provision for the armed forces community in the form of seven reports over the course of the project. Feedback outlined in DSC's 2016 *Impact Evaluation* report showed a need for smaller, more topical reports, which are easily accessible and digestible for readers. The six topical reports are therefore named the *Focus On* series. DSC will publish three *Focus On* reports in 2017, of which this report is the first.

This *Focus On* report and the five reports to follow will accompany DSC's two *Sector Insight* reports, along with another *Sector Insight* in 2019, five years on from the original report. This body of work will join the free online database [armedforcescharities.org.uk](http://armedforcescharities.org.uk), which will be redeveloped in 2017.

DSC is proud to extend our relationship with FiMT, as this project continues to provide a body of work to illuminate the sustained support being provided by the UK's armed forces charities for their many beneficiaries.

## DSC CLASSIFICATION OF ARMED FORCES CHARITIES

When defining the beneficiary population for armed forces charities, the term 'veteran' is widely used. This term is defined by the UK government to include 'those who have served for at least a day in HM Armed Forces whether as a Regular or as a Reservist' (MOD 2000, p. 4). The collective term is designed to be applied as a clear, wide-ranging definition, and attempts to limit confusion, while providing a broad, inclusive criterion.

For the purpose of this report, and in keeping with the language used in *Sector Insight* (2014) and *Sector Insight* (2016), the term 'ex-Service personnel' will stand to refer to any person who has served in the UK armed forces (for at least one day) and does not include dependants of ex-Service personnel. When referring to ex-Service personnel and their dependants, the term 'ex-Service community' is employed. In order to make reference to both Service and ex-Service personnel, including their dependants, the term 'armed forces community' is henceforth used. Dependants are categorised as: spouses/partners; divorced or separated spouses; widows/widowers; and children of Service and ex-Service personnel.

The definition of an armed forces charity utilised for this report is applied as outlined in *Sector Insight* (2016):

*'Charities that are established specifically to support past and present members of the armed forces and their families (the armed forces community). In this context, an armed forces charity must be able to apply this definition to their beneficiaries.'*

Sector Insight 2016

## ABOUT THIS REPORT

The focus of the report is singularly on those charities defined as armed forces charities which provide for mental health. Undoubtedly, provision exists for mental health support among the wider charity sector, which beneficiaries can access regardless of any affiliation with the armed forces. However, this report will focus on mental health provision from charities who serve the armed forces community.

The World Health Organization, describes mental health as; a state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2014).

This report examines provision made across three areas of mental health: post-traumatic stress disorder (PTSD); depression and anxiety; and substance misuse. The authors realise that other mental health issues exist; however, the above topics were chosen according to the prevalence of charities reporting on supporting these common areas. DSC found these areas of provision to be commonly referred to in charity regulator records and wider information produced by individual charities.

The scope of this report is therefore focused on armed forces charities with a specific remit for mental health, through data that provides an overview and analysis of their valuable work.

## ABOUT THE DATA

DSC maintains a database containing information on almost 1,100 armed forces charities, of which approximately 800 are registered with the Charity Commission for England and Wales (CCEW). Another 320 charities included in the database are registered in Scotland with the Office of the Scottish Charity Regulator (OSCR).

To clarify the number of charities registered with both CCEW and OSCR which provide mental health support for the armed forces community, DSC carried out a comprehensive review of its armed forces database. This reviewing process resulted in 60 armed forces charities being identified as being of interest for the report.

In addition to this reviewing process DSC undertook a systematic searching process, utilising a list of key words to identify armed forces charities and charitable work among the armed forces community from the CCEW and OSCR databases. Further systematic searching was conducted on the Charity Commission for Northern Ireland (CCNI). DSC formed a database of 90 charities which were of interest for which mental health and wellbeing is either the sole object or one of the key charitable objects. Although many charities' objects refer to the mental health, wellbeing and emotional support of and for ex-Services personnel, DSC looked for specific evidence of this beyond their official charitable objects and regulator classifications. This included charities making specific reference to programmes and services addressing mental health issues, funding other mental health organisations to deliver services on their behalf, and highlighting or emphasising mental health-related work among their beneficiaries and actively working with partners to meet such needs.

A number of forces charities generally state in their objects that they make provision for former members who find themselves in need, which includes the possibility of mental health need; however, mental health is not explicitly described in many charities' objects or accounts. Such charities are not included in this analysis unless evidence of mental health provision can be identified in information provided by the charities, either online or via information submitted to the relevant charity regulator.

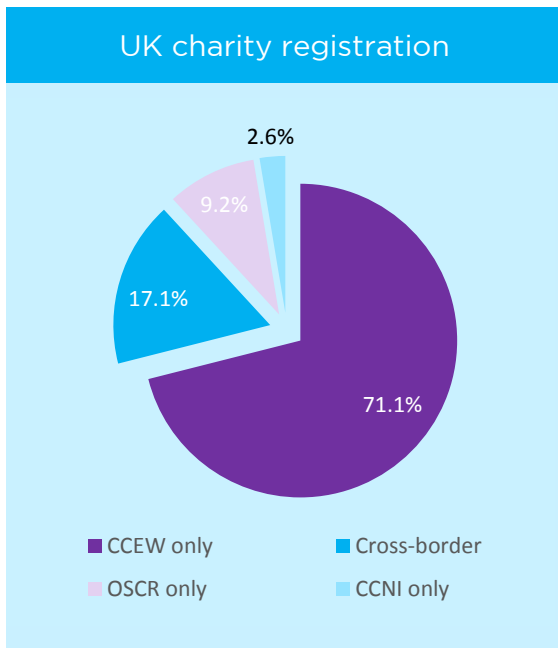
Of the 90 charities that DSC identified for potential inclusion in this report, further investigation of charitable activities in relation to mental health support to beneficiaries allowed DSC to refine the dataset to exclude 14 charities which were deemed to be irrelevant to this report. This was due to certain charities not meeting the criteria which define an armed forces charity, or by further investigation satisfying researchers that mental health support was not part of services provided to beneficiaries.

In February 2017, DSC sent email requests to 76 charities inviting them to take part in a mental health provision survey. This was followed up by a postal invitation to the survey, before a final reminder email was sent out in early March 2017. To bolster the survey data, follow-up phone calls were conducted with charities which had so far been unresponsive to survey invitations. As a result of this, 59.2% of the 76 charities represented in this report as mental health charities (N=45) responded to the survey. The 76 charities included in this research represent approximately 7% of the total number of UK armed forces charities.

The data presented in this report is therefore derived from numerous searches of the three UK charity regulator registers; DSC's own data; and systematic searches of the internet via Google and Bing public search engines. DSC is confident that the charities represented in this report are comprehensive and accurate as of the final data collection and refinement date (08/05/2017). The possibility of charities being excluded from the report due to not being found by researchers is recognised; however, due to the rigour of the search process, this is considered to be unlikely.

Financial data utilised in this report was not gained through means of survey. It was taken from the latest available accounts and annual reports that were submitted to UK charity regulators. The majority (67.5%) of data utilised in this report comes from 2015 to 2016 accounts; with 18.2% being from 2016/17 accounts; and 5.2% being taken from 2014/15 accounts. A total of 9.1% charities had no available accounts listed during the data-collection process, which was predominantly due to charities not yet having been required to submit accounts due to their new registration status.

Figure 1



DSC examined the split of charities by their registration with their respective charity regulators. Figure 1 shows a percentage split of the 76 charities featured in this data.

Charities registered exclusively with CCEW accounted for 71.1% (54) of charities.

Charities registered exclusively with OSCR accounted for 9.2% (7) of charities.

Cross-border charities, which refers to charities registered with both CCEW and OSCR accounted for 17.1% (13) of charities.

Charities registered with CCNI accounted for 2.6% (2) of charities.



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The World Health Organization (2014), 'Mental health: a state of well-being' [web page], [www.who.int/features/factfiles/mental\\_health/en/](http://www.who.int/features/factfiles/mental_health/en/), accessed 26<sup>th</sup> May 2017

# CHAPTER ONE

## An overview of charities' mental health provision

### INTRODUCTION

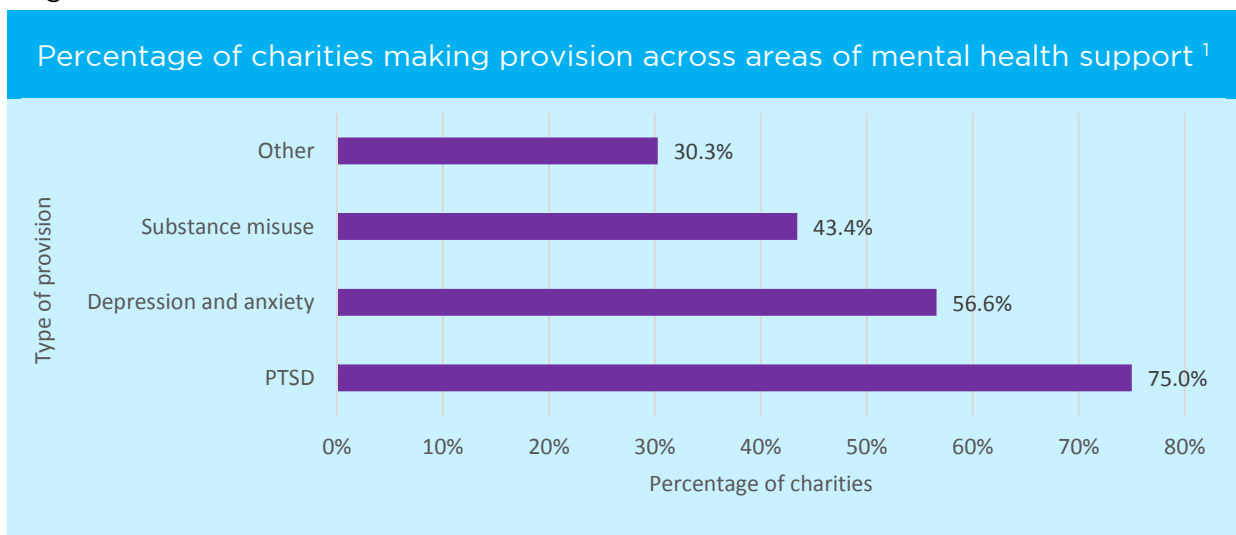
This chapter provides information and analysis on the nature and characteristics of the provision made by forces charities for the mental health of beneficiaries. The chapter is divided into the following sections:

- Provision for mental health
- Beneficiaries accessing mental health support
- Primary and Secondary providers
- Charitable expenditure
- Collaboration and evaluation

### PROVISION FOR MENTAL HEALTH

Figure 2 shows the provision for mental health areas across all armed forces charities which provide support for mental health (N=76). In total, 57 charities, which represent three-quarters (75.0%) of forces charities making provision for mental health, provide support for PTSD. Over half (56.6%) of all charities are making provision for depression and anxiety, and over two-fifths (43.4%) make provision for substance misuse. Close to one-third of all charities (30.3%) provide other support, which includes funding research into mental health.

Figure 2

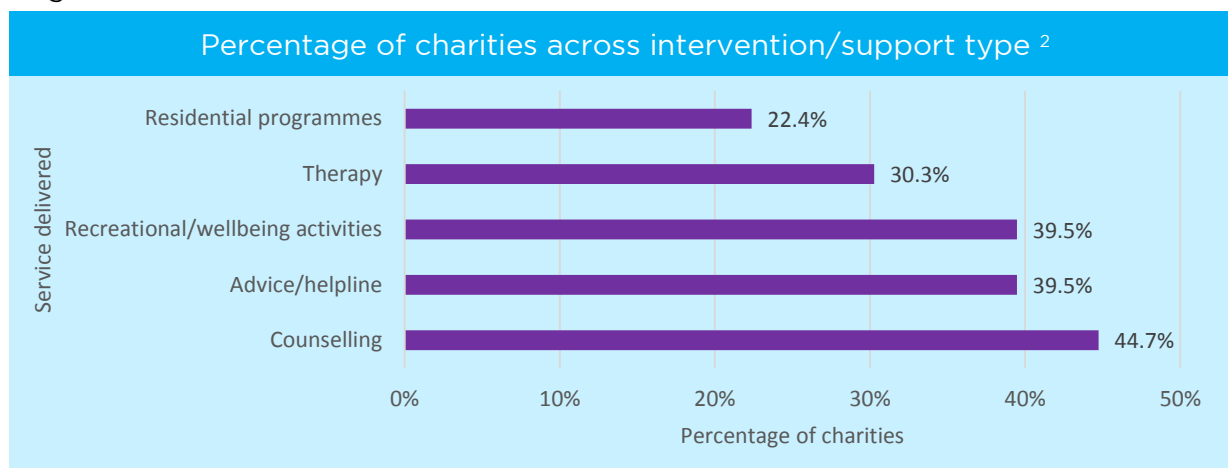


<sup>1</sup> Categories are not mutually exclusive and percentages therefore do not sum to 100%.

Figure 3 shows the range of services offered by charities who provide support for mental health (N=76). In total, over two-fifths (44.7%) of forces charities, make provision for mental health and offer counselling services.

Almost two-fifths (39.5%) of all charities offer advice/helpline and recreational/wellbeing activities, with close to one-third (30.3%) providing therapy. Approximately one-fifth of all charities represented in this report offer residential programmes (22.4%).

Figure 3



## Beneficiaries accessing mental health support

Data collected from survey respondents (N=45) provides a figure for the number of beneficiaries accessing charities services in the last year. Secondary providers were not always able to provide reliable figures of provision for mental health services, as this is often indistinguishable from wider health and wellbeing provision.

The total number of beneficiaries reported by survey respondents is approximately 7,000 beneficiaries per year. However, two charities (each with a very large total beneficiary population) were unable to provide specific figures for the number of beneficiaries seeking mental health support. Therefore, this figure could potentially be closer to 10,000 annual beneficiaries of armed forces charities' mental health services across all charities in this report.

Although the types of beneficiary (e.g. veteran or family member) cannot be distinguished, this figure does provide an indication of service users from a sample of over half of the forces charities DSC identified as making provision for the mental health.

It should also be noted that veterans may access more than one charity for support. Therefore it is not possible with current figures, or through current service providers' record-keeping, to control for such overlap and so figures should be used with caution. Further research on the beneficiary community may be needed to provide an approximate figure of multi-service usage.

Survey respondents were asked to provide the approximate number of individuals accessing their charity's mental health services within the past year. Figure 4 shows survey responses which have been aggregated into 'brackets' of beneficiary numbers in order to provide an overview. Data presented in figure 4 includes responses from both Primary and Secondary providers. The most common bracket was 1 to 99 which accounted for over one-third (36.1%) of survey respondents. In total, 8.3% of respondents reported that their charity made provision for 1,000 plus beneficiaries in the past year.

<sup>2</sup> Categories are not mutually exclusive and percentages therefore do not sum to 100%.

Figure 4

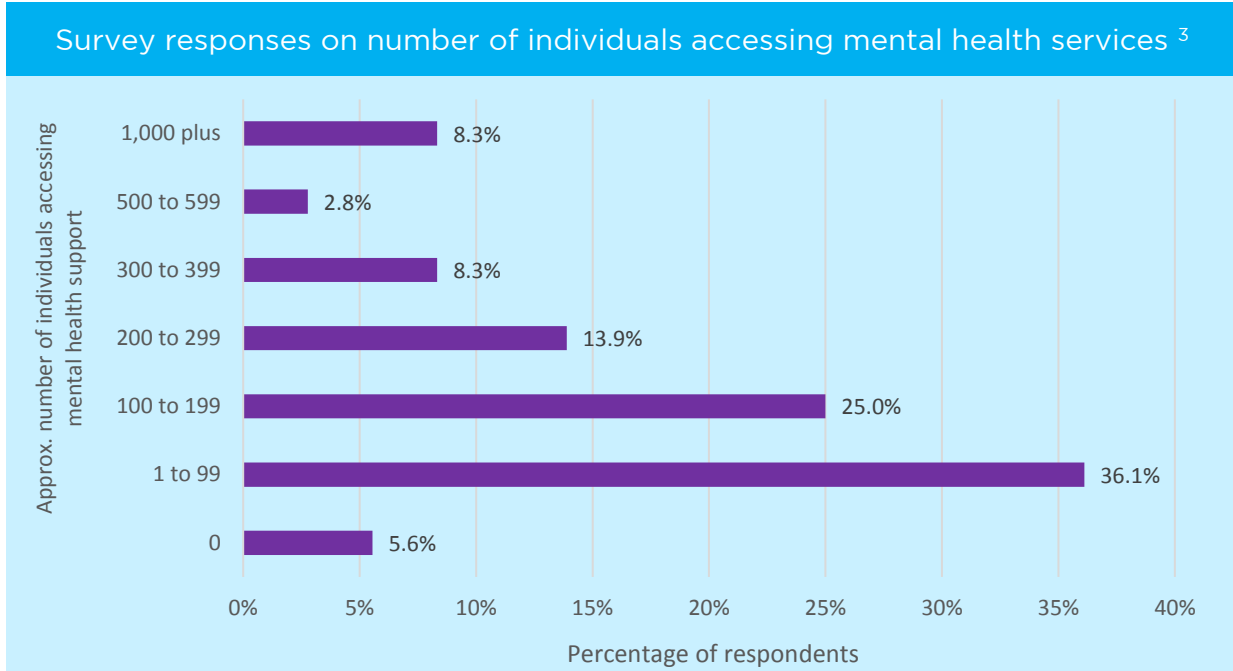
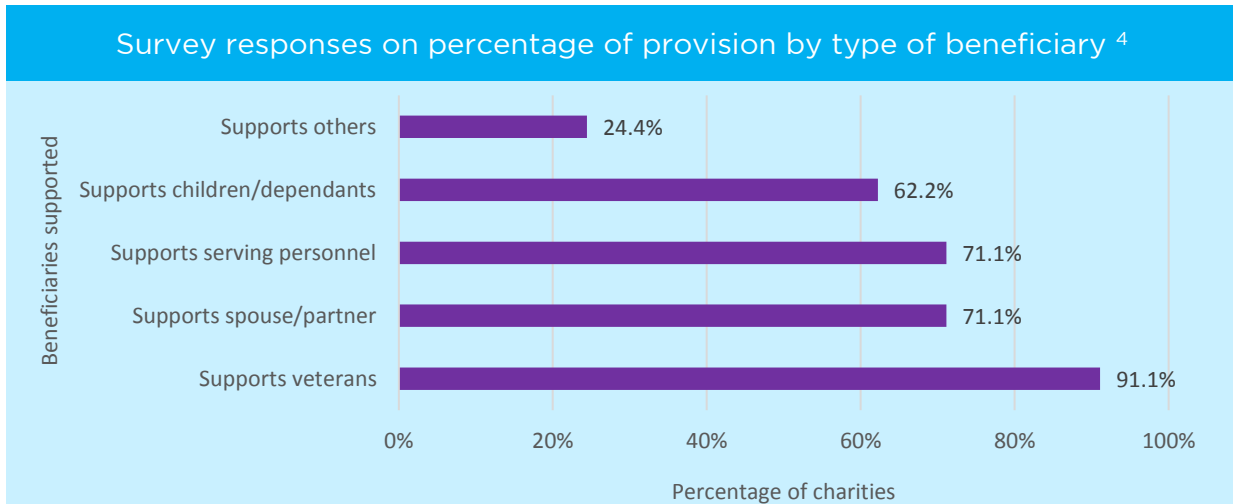


Figure 5 shows the survey responses (N=45) percentage of charities making provision across five main beneficiary categories. The most common beneficiary category was veterans (91.1%) which 41 charities support. Spouse/partner and serving personnel beneficiary categories account for 32 charities (71.1%) respectively. Children/dependants accounted for 28 charities representing 62.2% of charities.

A total of 11 (24.4%) respondents referred to other beneficiaries. They reported that such beneficiaries included emergency services and members of the Merchant Navy who have seen conflict.

Figure 5

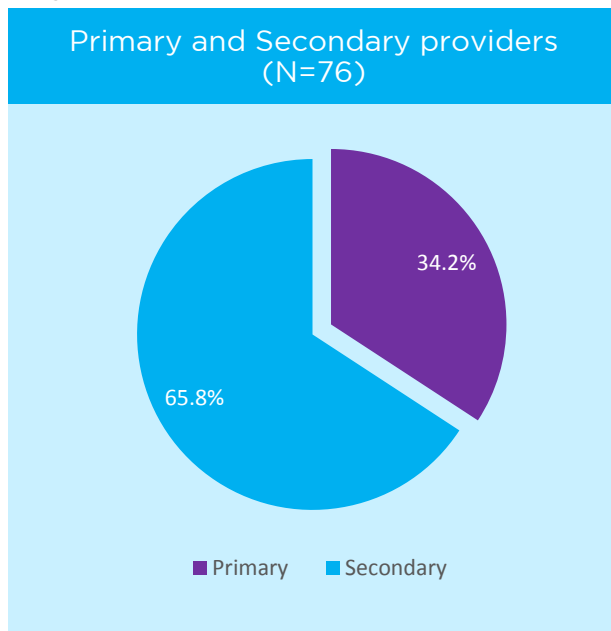


<sup>3</sup> Data is taken from survey responses, where specified (N=36). No responses were given relating to bracket '400 to 499', along with brackets '600 through to 999'. Therefore, those five brackets are removed from figure 4.

<sup>4</sup> Categories are not mutually exclusive and percentages therefore do not sum to 100%.

## PRIMARY AND SECONDARY PROVIDERS

Figure 6



DSC divided charities into two distinct categories, depending on their charitable objects in relation to mental health support. Charities were classified as being 'Primary' or 'Secondary' providers of mental health support.

Figure 6 shows the split of Primary and Secondary mental health providers for all charities identified as making provision for mental health support (N=76). Close to two-thirds of charities (65.8%) were identified as being Secondary providers; with just over one-third identified as Primary providers (34.2%).

Primary charities (N=26) were defined as being those whose charitable objects were solely focused on mental health support or for whom mental health was a major component of their provision. Secondary charities (N=50) were defined as those

whose charitable objects included mental health support as one of several objects which includes those charities who facilitate mental health support.

Each charity was individually categorised, and so it is acknowledged that there is an element of subjectivity in this assessment. This method is useful as a means of distinguishing between those charities for which the mental health of the armed forces community is the primary focus, or for which mental health support is part of a wider provision for the armed forces community.

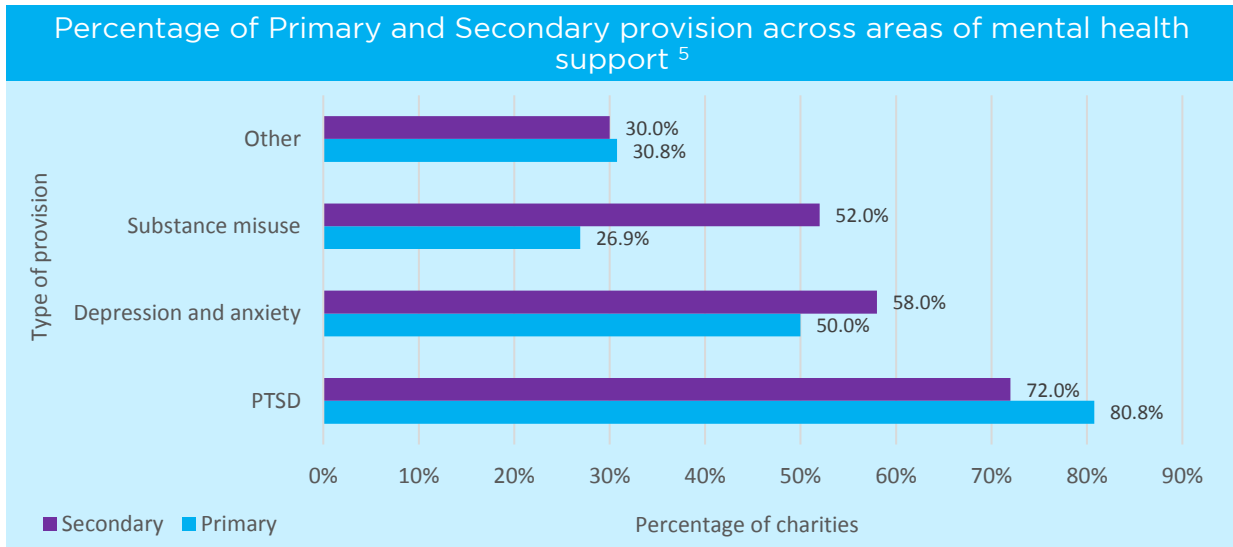
Importantly, this is not in any way a value judgement on charities and their provision. There is no implied quality of provision, or commitment of charities making such support available. It is a means to provide a distinction between charities solely supporting beneficiaries' mental health needs and charities supporting a range of beneficiaries' needs, including provision for mental health.

### Split of Primary and Secondary provision

Figure 7 shows areas of mental health supported by Primary (N=26) and Secondary (N=50) providers which offer mental health provision. Four-fifths (80.8%) of Primary providers make provision for PTSD, compared to Secondary providers (72.0%). Conversely, an additional 8% of Secondary providers offer support for depression and anxiety (58.0%) when compared to Primary providers (50.8%).

Secondary providers were twice as likely as Primary Providers to provide support for substance misuse, as over half of Secondary providers made provision for alcohol/drugs (58.0%) compared with just over one-quarter (26.9%) of Primary providers. Close to one-third of both Primary and Secondary charities (30.8% and 30.0% respectively) make provision for other mental health areas.

Figure 7



Further detailed analysis of PTSD, depression and anxiety, and substance misuse is provided in chapter two of this report.

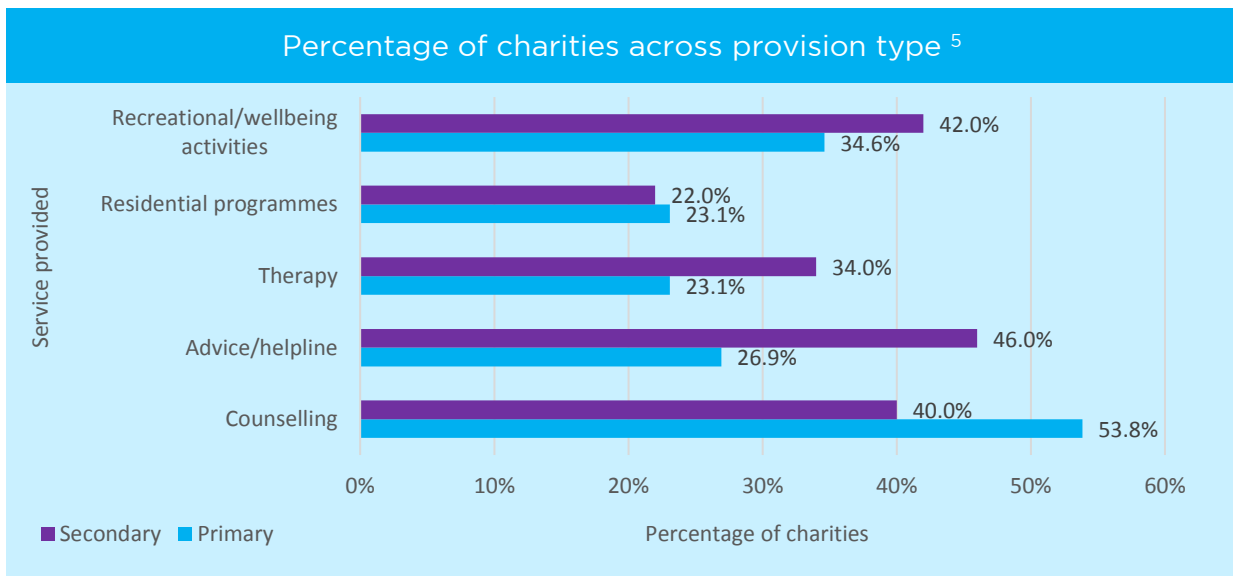
Figure 8 shows the types of mental health support offered by Primary and Secondary providers. Counselling services were the most popular service overall, provided by two-fifths of Secondary providers (40.0%), and over half of Primary providers (53.8%).

Secondary providers were also more likely to provide advice/helpline support (46.0%), and recreational/wellbeing activities (42.0%), compared to Primary providers.

Therapy was offered by over one-third (34.0%) of Secondary providers; in comparison with just over one-fifth (23.1%) of Primary providers. Over one-fifth of both Primary and Secondary providers offer residential programmes (23.1% and 22.0% respectively).

Chapter two provides more information on the clinical or non-clinical nature of services presented in figures 7 and 8.

Figure 8



<sup>5</sup> Categories are not mutually exclusive and percentages therefore do not sum to 100%. Percentages refer to the 76 charities identified in this report.

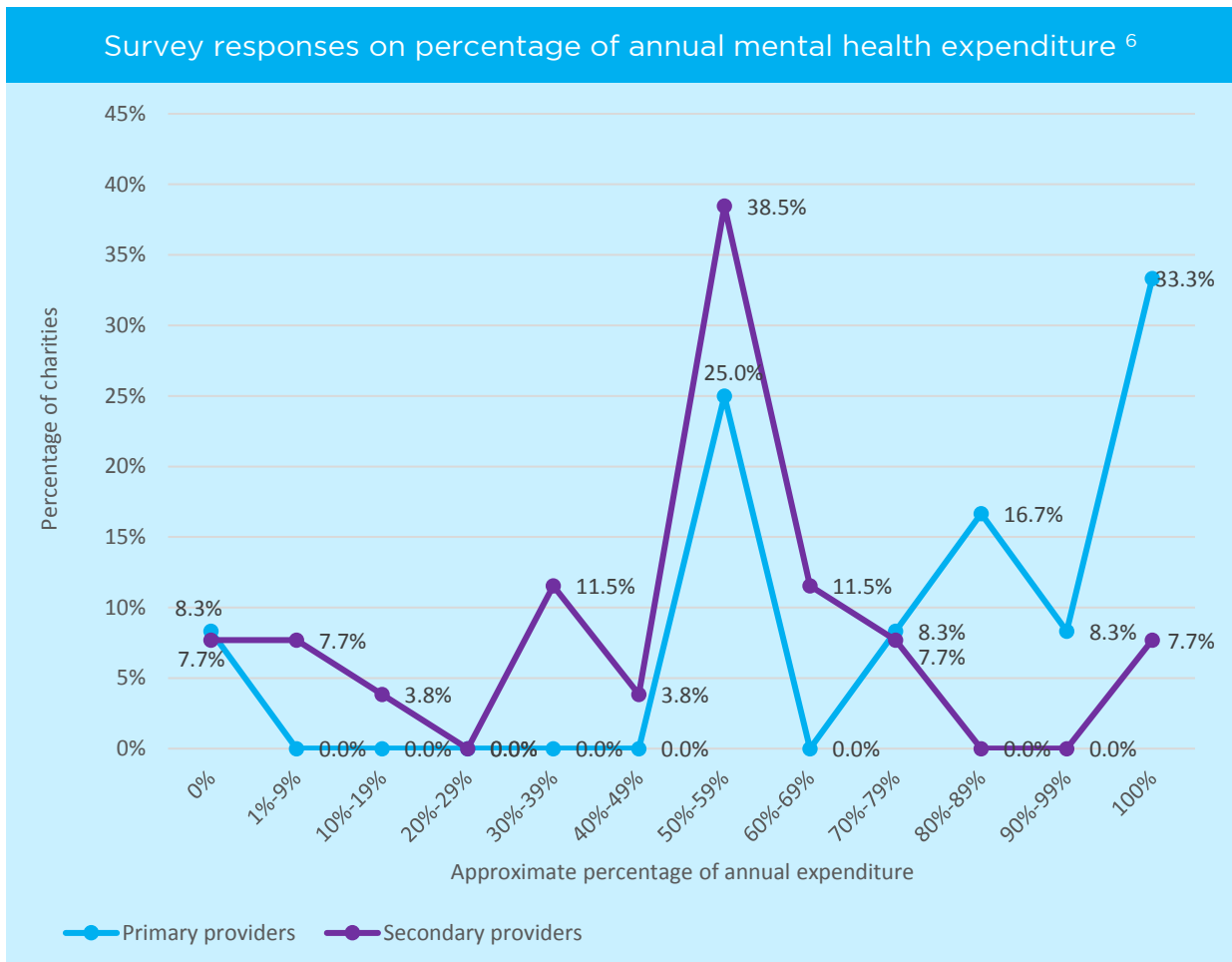
## CHARITABLE EXPENDITURE

Survey respondents were asked to provide the approximate percentage of charitable expenditure that was devoted to mental health provision by their charity in the past year. Responses were aggregated into 'percentage brackets' as can be seen in figure 9.

The most common bracket was 50% to 59%, which accounted for over one-third (38.5%) of survey respondents. In total, one-third (33.3%) of Primary provider respondents reported that their charity spent 100% of charitable expenditure on mental health, which is unsurprising, given that mental health provision is their sole charitable objective.

Primary providers typically devote a larger percentage of their overall expenditure to mental health provision. However, as the survey question asked respondents for an estimate of mental health spending as a proportion of overall expenditure, actual levels of expenditure may differ significantly across Primary and Secondary providers. For example, a financially large Secondary provider which devotes only 30% of their annual expenditure budget to mental health, may in fact be spending more than a financially smaller Primary provider which commits 100% of their expenditure to mental health.

Figure 9



<sup>6</sup> Categories are not mutually exclusive and percentages therefore do not sum to 100%. Data is taken from survey respondents, (Where specified for Primary providers N=12, and Secondary providers N=26.) A small number of Secondary provider respondents reported their mental health expenditure to be 100%. This does not appear consistent with the characteristics of a Secondary provider, however this may be due to changing spending strategies in line with annual expenditure strategies. Researchers remain confident in established Primary-Secondary categorisation.

Further analysis of the data presented in figure 9 provided an approximate figure for the most common percentage brackets. This data was taken from survey responses and so it should be noted that there is a margin for reporting-error from respondents.

**50% to 59% bracket:** Primary provider charities with expenditure in the 50% to 59% bracket (which accounts for 25.0% of charities), represented approximately £132,100 in mental health expenditure. In contrast, Secondary provider charities with expenditure in the same bracket (which accounts for 38.5% of charities), represented approximately £377,200 in mental health expenditure. This accounts for a difference of approximately £312,100 between Primary and Secondary providers expenditure.

**100% bracket:** Primary provider charities with expenditure in the 100% bracket (which accounts for 33.3% of charities), represented approximately £17,072,000 in mental health expenditure. In contrast, Secondary provider charities with expenditure in the same bracket (which accounts for 7.7% of charities), represented approximately £64,500 in mental health expenditure. This accounts for a difference of approximately £17,007,500 between Primary and Secondary providers expenditure; however, this is due to the expenditure of the charity Combat Stress, which provides in the region of £16,600,000 in mental health expenditure.

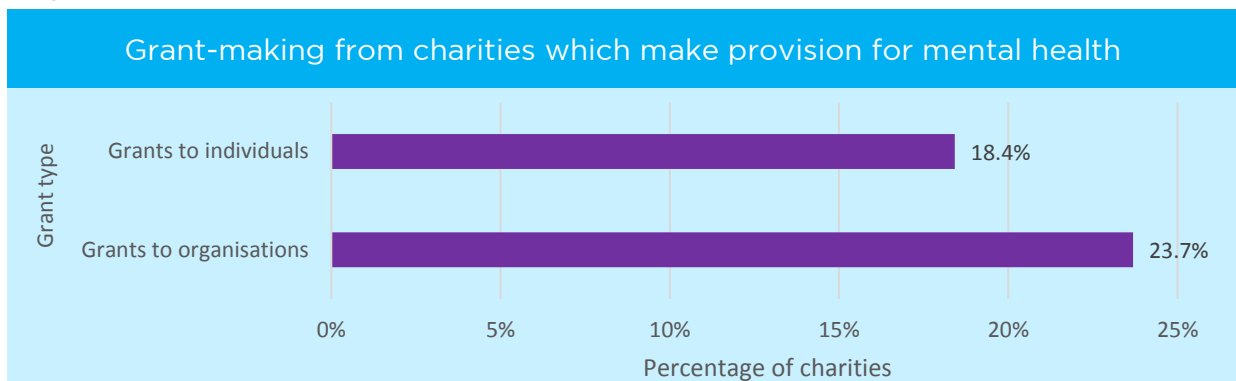
Based on survey responses, the overall approximate annual expenditure on mental health provision from all charities is £28,640,000. The approximate overall annual expenditure from Primary providers is £17,450,000 and from Secondary providers is £11,200,000. It should be noted however, that this amount is taken from survey respondents, where specified (N=40) and is an approximation based on their reported percentage of expenditure only. Each charities response has been back-calculated from charity regulator records on annual expenditure. As survey data is based on approximate percentage of expenditure attributed to mental health support, the above figures should be referred to as an approximate figure only.

## Grant-making

DSC examined the number of charities making provision for mental health with regards to their grant-making. Figure 10 shows the percentage of grants made to individuals and organisations by the 76 charities represented in this report.

In total, 18.4% of charities made grants to individuals, with 23.7% of charities making grants to organisations. It should also be noted that charities may make grants to both individuals and organisations, or indeed neither. This information is taken from charity regulator information; however, previous research undertaken by DSC showed that in practice, only around 10% of those charities which state that they make grants actually do so.<sup>7</sup>

Figure 10



<sup>7</sup>This situation is not specific to the armed forces charity sector. Earlier research by DSC published in *UK Grant-making Trusts and Foundations* revealed that many more charities in general state in their objects that they make grants than do in practice.

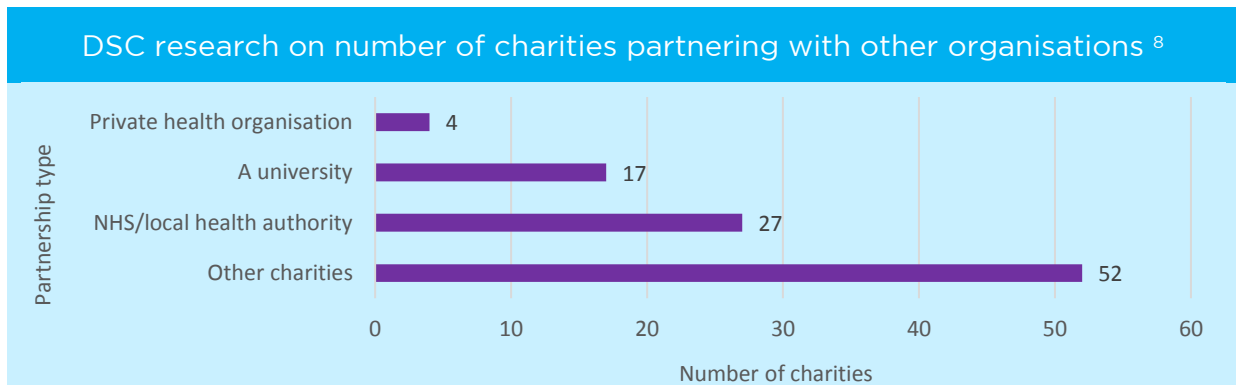


## COLLABORATION AND EVALUATION

Figure 11 shows the amount of partnership between charities and other organisations. Partnership with other charities was the most common form of partnership found, with 52 charities, working in partnership with others. The least common type of partnership was found in partnership with a private health organisation, with four charities using this form of collaboration.

In total, 27 charities work either directly with the NHS or a local health authority, i.e. local area NHS Trusts. When it comes to working in partnership with a university, 17 charities have been identified as undertaking this type of collaboration.

Figure 11



## CASE STUDY: COLLABORATION ON MENTAL HEALTH SUPPORT

Contact is a collaboration of Service charities working in partnership with the NHS and MOD, which operates to help the armed forces community access mental health and wellbeing support.

Contact believes that mental health and wellbeing support should be delivered in the most suitable way with the best possible support for each individual. The organisations which form the Contact collaboration are; Combat Stress, Cobseo, Help for Heroes, The Royal British Legion, Veterans First Point, and Walking with the Wounded. The NHS is represented by NHS England, Veterans NHS Wales, the Royal College of Psychiatrists and King's College London.

Contact combines the diverse knowledge and experience of its partners, in an effort to produce excellent research, develop guidance on best practice for the understanding of beneficiary need and application of beneficiary support.

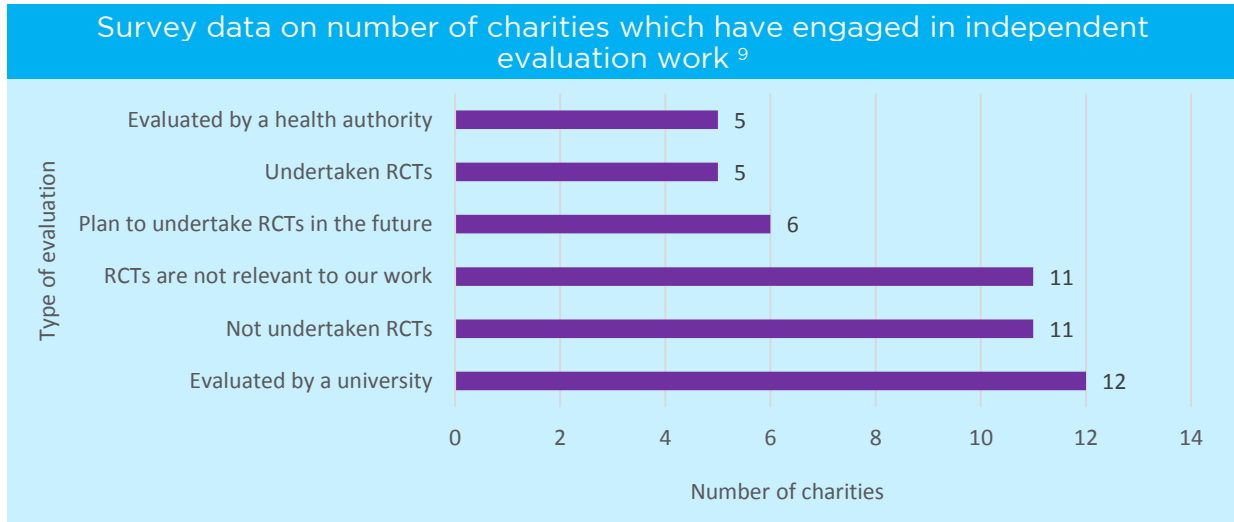
Contact is also the charity partner of Heads Together, a campaign of *The Royal Foundation of the Duke and Duchess of Cambridge and Prince Harry*; which in its own words 'aims to change the national conversation on mental health and wellbeing, and is a partnership with inspiring charities with decades of experience in tackling stigma, raising awareness, and providing vital help for people with mental health challenges' (Heads Together 2017).

<sup>8</sup> Categories are not mutually exclusive

## Independent evaluation

DSC's survey data (N=45), figure 12, shows that randomised control trials (RCTs) have been undertaken by five charities. An additional six charities plan to undertake RCTs in the future while 11 stated RCTs were not relevant to their work. A total of 12 survey respondents stated that their charity's services had been independently evaluated by a university and five charities had undergone evaluation by a local health authority.

Figure 12



## CASE STUDY - INDEPENDENT EVALUATION

Randomised control trials (RCTs) are often referred to as the 'gold standard' of scientific research. They are commonly used to evaluate the effectiveness of medical treatments, educational and social care interventions. RCTs work by comparing treatment outcomes for people who received an intervention with those who did not.

Recently, there has been a resurgence of interest in scientific and technical models of evaluation, including RCTs. Previously, concerns have been raised that qualitative methods traditionally used by voluntary sector organisations are not sufficiently robust enough to measure impact.

RCTs are currently rarely undertaken within the voluntary sector. It may be difficult for charities to conduct RCTs due to:

- Lack of technical skill - smaller charities often lack the expertise and resources required, meaning external evaluator, help may be needed.
- Cost and time constraints - independent evaluations are likely to be expensive and tests may need to be run multiple times in order to ensure accuracy of results.
- Ethical considerations - the concept of a non-treatment group contradicts charities' aim to help as many beneficiaries as possible.
- Complex social interventions prove difficult to control - many complex variables affect the lives of participants e.g. members of the non-treatment group may access help elsewhere.

<sup>9</sup> RCTs: randomised control trials. Categories are not mutually exclusive.

DSC's survey found a total of five charities reporting to have conducted RCTs. Below are two such examples of charities.

#### The Warrior Programme

- The Warrior Programme provides a three-day coaching programme to support individuals struggling with life after transition to civilian life. The programme has been shown to have a positive impact on individuals presenting with common symptoms relating to mental health, such as mood and emotional problems, anger and self-efficacy issues.
- RCTs were conducted by University of Southampton and King's College London, the project was funded by Forces in Mind Trust (FiMT).
- A RCT involving 52 participants validated the charity's treatment techniques. Notably, the treatment group showed significant improvements in wellbeing and functioning.
- '*The Warrior Programme* study has demonstrated that high quality scientific techniques to evaluate a novel intervention can be used within the Service charity sector' (The Warrior Programme 2015).

#### Scars of War Foundation

- The foundation is based within The Queen's College (Oxford University) and aims to examine how traumas of war affect the brain through the undertaking of research.
- Using ground-breaking treatment at John Radcliffe Hospital, Scars of War Foundation treat veterans' physical and cognitive pain via neurosurgical intervention.
- Various neurological research projects have been carried out, including a five-year brain-scanning project to determine neurological effects of traumatic brain injury.
- Veterans with PTSD are compared to matched groups with no psychological symptoms.

RCTs are not always an appropriate methodology for measuring impact. To negate against potential issues, researchers are frequently combining RCTs with other evaluation methods. Nevertheless, The Warrior Programme provides a good example of how RCTs can be effectively utilised as a measure of impact evaluation within the charity sector; this approach could be more widely adopted within the sector.

Alternatively, a further 12 charities represented in the data have had their mental health programmes evaluated by a university. For example, the charity Combat Stress has not carried out RCTs. However, numerous university-led and peer-reviewed research projects have been undertaken by Combat Stress in collaboration with King's College London in order to measure treatment outcomes.

A further alternative to RCTs are observational cohort studies, which follow a group or 'cohort' of people both before and following treatment to determine the level of treatment outcomes. Such studies can arguably provide a more accessible method of assessment; however, there can be issues with participant drop-out during such longitudinal studies.<sup>10</sup>

While these approaches provide a basis for assessment of treatment methods for organisations providing a new or adapted form of treatment, the objective of RCTs and evaluation by a university, and subsequent inclusion in peer-reviewed journals, is to add to the evidence-base of what works for whom in regards to mental health treatments.

<sup>10</sup> York, P (2014): An alternative to RCTs [online] [www.digitalimpact.org/an-alternative-to-RCTs](http://www.digitalimpact.org/an-alternative-to-RCTs)

## CHAPTER ONE SUMMARY

### Provision for mental health

In total, DSC found that three-quarters of charities make provision for PTSD support. Over half of charities make provision for depression and anxiety, with over two-fifths making provision for substance misuse. The most common form of provision, representing over two-fifths of charities was counselling services, with a similar percentage of charities providing therapy services. The least common provision represented in the data was for residential programmes, with over one-fifth of charities offering such services to beneficiaries.

### Beneficiaries

The most common number of beneficiaries supported within the past year was '1-99' (reported by 28.9% of total charities). A small proportion of charities (8.3%) supported over 1,000 beneficiaries within the past year. The four main beneficiary groups for which mental health support was offered were; veterans (supported by 91.1% of charities), spouses and serving personnel (each supported by 71.7% of charities) and dependants (supported by 62.2% of charities).

### Primary and Secondary providers

Over three-fifths (65.8%) of charities in the data are Secondary providers of mental health support. In total, over one-third (34.2%) of charities are Primary providers of mental health support.

### Charitable expenditure

Survey data from 12 charities suggests that Primary providers' annual expenditure on mental health is at least in the region of £17,450,000 per year. Survey data from 28 charities suggests Secondary providers' annual expenditure on mental health is at least in the region of £11,200,000 per year. Close to one-fifth (18.4%) of charities in our dataset make grants to individuals, slightly more (23.7%) make grants to organisations. However, previous research by DSC has found that typically only 10% of charities which state they make grants actually do so.<sup>11</sup>

### Collaboration and evaluation

Partnership with other charities was found to be the most common form of partnership, with 52 charities working to some degree in partnership with each other. In total, 27 charities work either directly with the NHS or a local health authority. A total of 17 charities were identified as partnering with a university in regards to their mental health support for beneficiaries. The least common type of partnership was found to be with private health organisations, with four charities undertaking this form of collaboration.

## REFERENCES

Tom Traynor, Catherine Walker (2015), *UK Grant-making Trusts and Foundations*, The Directory of Social Change 2015

Heads Together (2017), 'About Heads Together' [online] <https://www.headstogether.org.uk/about-heads-together>, accessed 30/05/17

The Warrior Programme (2015), *The Warrior Programme Presents The Findings of The FiMT-Funded Randomised Controlled Trial* [Online] [http://www.warriorprogramme.org.uk/Launch\\_of\\_the\\_Warrior\\_Randomised\\_Controlled\\_Trial](http://www.warriorprogramme.org.uk/Launch_of_the_Warrior_Randomised_Controlled_Trial), accessed 30/5/2017

<sup>11</sup> This situation is not specific to the armed forces charity sector. Earlier research by DSC published in *UK Grant-making Trusts and Foundations* revealed that many more charities in general state in their objects that they make grants than do in practice.

## CHAPTER TWO

# Mental health service delivery

This chapter provides information and analysis on types of services being delivered to beneficiaries across three major topics of mental health provision (PTSD, depression and anxiety, and substance misuse). The chapter is divided into the following sections:

- Service delivery
- Clinical and non-clinical services
- Standards of practice
- Provision for PTSD
- Provision for depression and anxiety
- Provision for substance misuse

### Service delivery

DSC examined which charities deliver mental health services themselves and which are outsourcing provision via another organisation. DSC's research shows that over three-quarters (78.9%) of charities are delivering support for mental health themselves, compared with 43.4% of charities which deliver support via another organisation. It should be noted that a charity may use both methods of service delivery across multiple types of provision. Therefore, as these categories are not mutually exclusive, the percentages do not sum to 100%.

When service delivery is split between Primary and Secondary mental health providers, the percentage of charities delivering the service themselves is noticeably higher for Primary providers (23), compared to Secondary providers (37).

The difference between types of provider is especially apparent when looking at charities which deliver via other organisations, which is much lower for Primary providers (5), compared to Secondary providers (28).

Table 1

Service delivery from Primary and Secondary providers <sup>12</sup>		
	Deliver service themselves	Deliver service via another organisation
Primary provider	23	5
Secondary provider	37	28

<sup>12</sup> Categories are not mutually exclusive and percentages denominators are the total number of Primary charities (N=26) and the total number Secondary charities (N=50).

## CLINICAL AND NON-CLINICAL SERVICES

Charities were divided into two distinct categories based upon whether their mental health provision could be classified as a clinical service or a non-clinical service. Clinical services involve the direct treatment of patients through a registered health-care professional. Conversely, non-clinical treatments do not involve the direct treatment of patients through a registered health-care professional.

Examples of clinical services may include counselling or therapy administered via a qualified mental health professional or assessment by a registered psychiatrist/psychologist. Examples of non-clinical services may include residential services, recreational activities, signposting services and self-help groups.

It should be noted that distinguishing between non-clinical and clinical does not imply a value judgement but serves as a method of categorisation for the type of services delivered by charities.

Figure 13

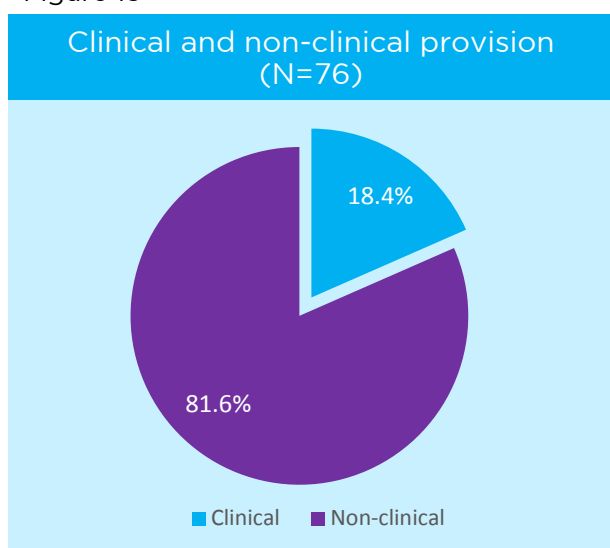


Figure 13 shows the split of clinical and non-clinical provision against Primary and Secondary providers.

In total, there are 14 charities (18.4%) which provide a clinical intervention to beneficiaries.

Of those charities, four are Primary providers and ten are Secondary providers.

The majority of charities (81.6%) provide a non-clinical service (62 charities), of which 40 charities are Secondary providers.

Table 2 shows the split of clinical and non-clinical services across Primary and Secondary providers. In total, non-clinical Secondary providers account for over half (40) of all service delivery for mental health. Clinical Primary provision accounts for 5.3% of all service delivery (4), which is as one would expect given the more specialist nature of clinical provision. Broadly speaking, non-clinical provision is four and a half times more common than clinical provision among charities providing support for mental health.

Table 2

	Clinical	Non-clinical	Total
Primary	4	22	26
Secondary	10	40	50
Total	14	62	76

Figure 14 shows the areas of mental health supported by clinical (N=14) and non-clinical (N=62) providers. Overall, charities which provide clinical treatment were more likely to provision for the treatment of PTSD, depression and anxiety, and substance misuse across the board.

Almost all clinical providers (92.9%) provided treatment for PTSD, compared to only 71.0% of non-clinical providers. Similarly 85.7% of clinical providers treated depression and anxiety, compared to half (50.0%) of non-clinical providers. Substance abuse treatments were offered by 71.4% of clinical providers and 37.1% of non-clinical providers.

Non-clinical providers were more likely to treat 'other' mental health areas, with 35.5% making provision for mental health issues other than those specified, compared to 7.1% of non-clinical providers. Other mental health areas include, but are not limited to equine therapy, and direct funding of research into the mental health needs of the armed forces community.

Figure 14

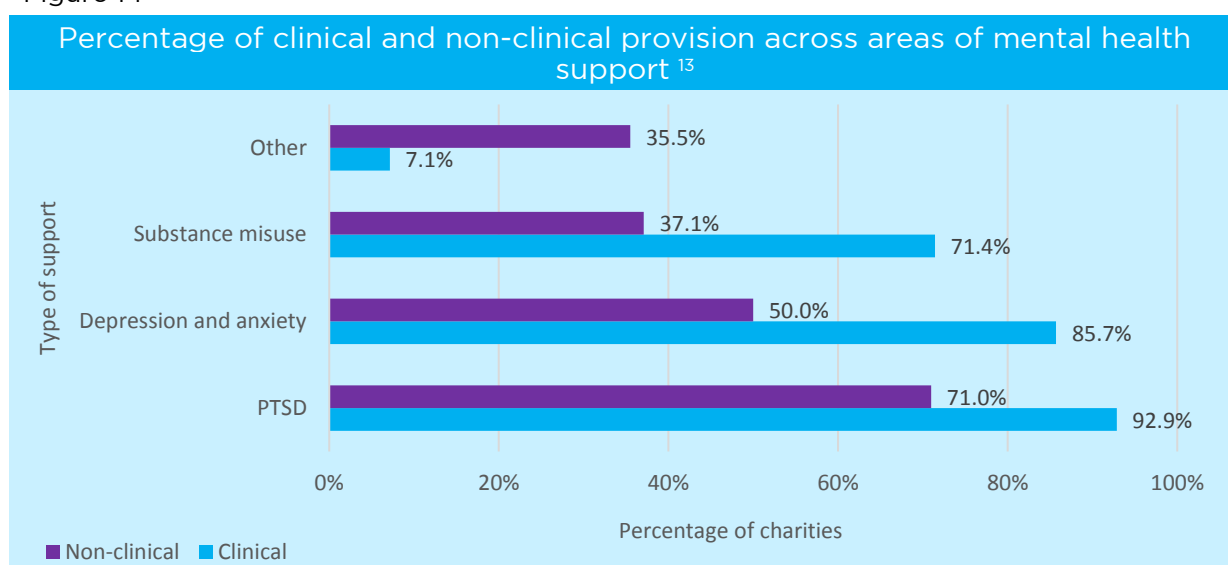


Figure 15 shows the services offered by clinical (N=14) and non-clinical providers (N=62) of mental health support. In total, 85.7% of clinical providers make provision in the form of advice/helplines, with close to four-fifths (78.6%) of all clinical providers offering therapy and/or counselling support.

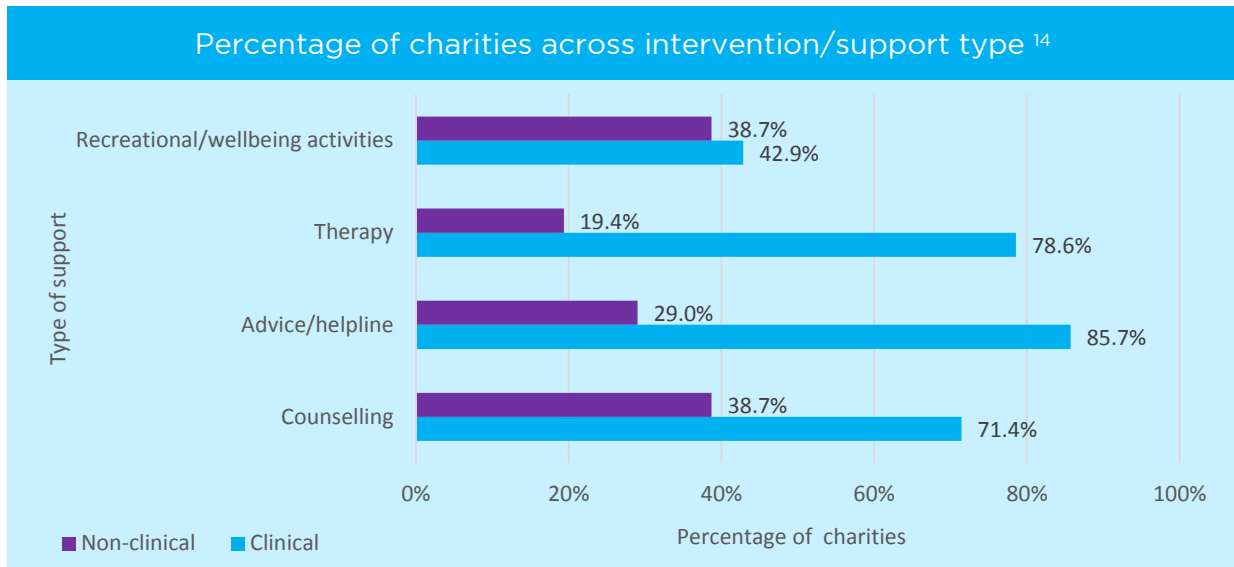
Non-clinical providers were less likely to provide these services, with advice/helplines being provided by less than one-third (29.0%) of charities, and therapy by approximately one-fifth (19.4%) of non-clinical providers.

Counselling was offered by almost two-fifths (38.7%) of non-clinical providers and is the joint highest provision (with recreational/wellbeing activities) made by non-clinical charitable providers.

Overall, recreational/wellbeing activities is the least common form of clinical service, offered by just over two-fifths (42.9%) of clinical providers and only slightly fewer (38.7%) non-clinical providers.

<sup>13</sup> Categories are not mutually exclusive and percentages therefore do not sum to 100%. Data relates to clinical providers (N=14) and non-clinical providers (N=62).

Figure 15



## STANDARDS OF PRACTICE

The term ‘standards of practice’ refers to those principles outlined by health-care experts in the field of mental health in the armed forces community, which set our guidance to organisations which engage in delivery of treatments or interventions which are applied to individuals seeking support for their mental health.

DSC surveyed armed forces charities regarding standards of practice for their mental health service delivery. Charities who undertook the survey were asked whether they are currently achieving or working towards standards of practice are presented in figure 16, which shows the responses from charities who deliver mental health services themselves (N=28).

Under one-fifth (17.9%) of charities reported that they follow the NICE guidelines for mental health care, an additional 7.1% are working towards adopting these guidelines. A total of 10.7% charities currently employ staff members or volunteers who are chartered psychologists (accredited by the British Psychological Society), and 3.6% have a member of staff who is actively working towards achieving this qualification.

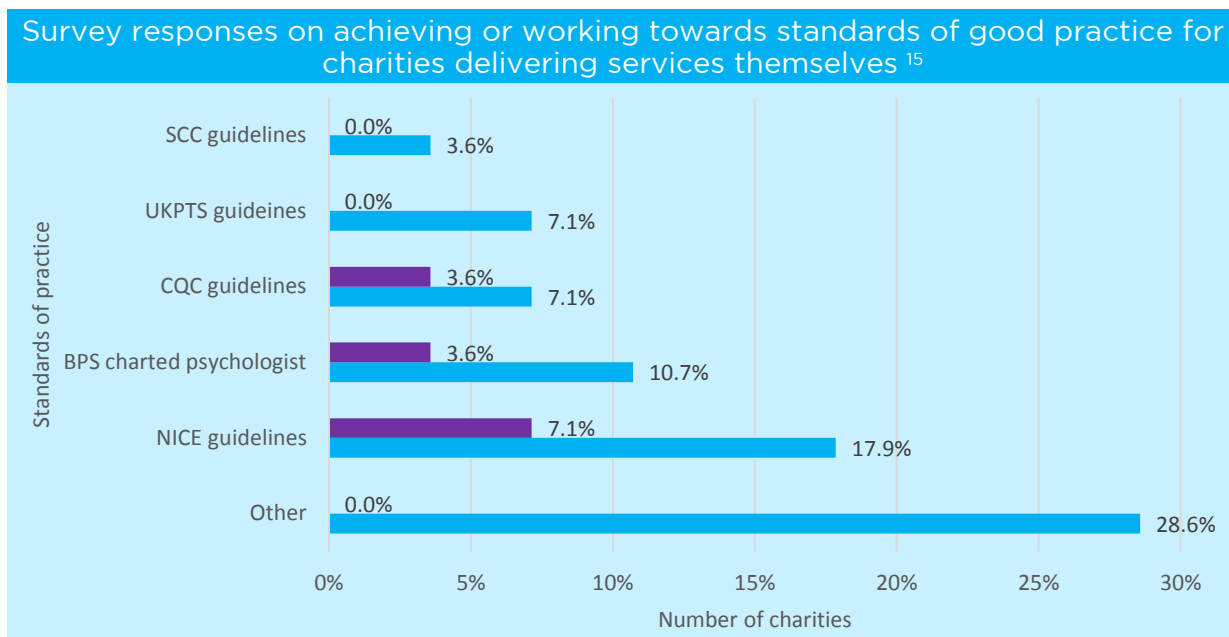
Both Care Quality Commission (CQC) guidelines and UK Psychological Trauma Society (UKPTS) guidelines were each reported to be undertaken by 7.1% of charities respectively. Only one charity has implemented Scottish Commission for Care (SCC) guidelines, and three charities currently adhere to UKPTS guidelines.

Other standards accounted for over one-quarter (28.6%) of respondents, which includes standards such as registration with the British Association for Counselling and Psychotherapy (BACP); staff qualified in mental health first aid; staff members who are trained therapists and mentors; staff registered with the Health and Care Professions Council (HCPC) and UK Council for Psychotherapy (UKCP). ‘Other’ also included academic qualifications and research professionals.

<sup>14</sup> Categories are not mutually exclusive and percentages therefore do not sum to 100%.



Figure 16



It should be noted that figure 16 does not provide a comprehensive picture of accreditation, which is often specialised to the provision being made and therefore challenging to aggregate. Nor should the reader infer that this data highlights deficiency in accreditation standards, as this data is taken from survey responses and does not cover the entire spectrum of professional standards. However, the data does provide an indication of the most common forms of professional standards that charities are working towards or achieving.

## Guidance and guidelines

The following case study outlines the efforts of Cobseo in applying the Medical Advisory Committee (MAC) *Guiding Principles for Delivery of Veterans' and Service Families' Mental Health Care*, developed by Professor Neil Greenberg, of King's College London.

### CASE STUDY: APPLYING STANDARDS OF PRACTICE

Cobseo, The Confederation of Service Charities, provides a single point of contact for interaction with the government, including both local governments and devolved administrations; the Royal Household, the private sector and members of the armed forces community. Cobseo members are able to co-operate and collaborate with others to ensure the best level of support for their respected beneficiaries.

As part of their membership with Cobseo, all potential new member charities which provide mental health services are required to meet a set standard of practice guidelines to ensure that Service personnel, veterans and their families receive advice and treatment which is in their best interests. This set of practice guidelines is known as the *Guiding Principles for Delivery of Veterans' and Service Families' Mental Health Care*. This was developed for Cobseo by Professor Neil Greenberg, of King's College London's Academic Department of Military Mental Health. In the guidelines there are 12 principles which set out the required support for the armed forces community.

<sup>15</sup> CQC: Care Quality Commission; SCC: Scottish Commission for Care; NICE: National Institute for Health and Care Excellence; BPS: British Psychological Society; UKPTS: UK Psychological Trauma Society. Categories are not

mutually exclusive – charities may undertake more than one of the above categories. Data presented in figure 17 represents survey responses only for charities which deliver services themselves (N=28).

The 12 principles are as follows:

- General practitioner – Communicate with the veteran's GP about any initial assessment, at regular periods during follow-up and at the end of any treatment. If the veteran does not have a GP, the provider will assist in providing a GP.
- Initial assessment of need and risk – Any treatment can only commence once a formal broad-based initial assessment of need and risk has taken place by an appropriately qualified and experienced professional.
- Access evidence-based and NICE-approved therapies – Ensure veterans are encouraged to access evidence-based and National Institute for Health and Clinical Excellence (NICE) approved therapies before discussing other possible interventions.
- Transparency in using the terms routine, experimental and untested – Discuss possible interventions in three broad ways;
  - Routine – NICE-approved and evidence-based,
  - Experimental – Approaches have a sound theoretical background and are being tested as part of a well-constructed and ethically approved trial;
  - Untested – Interventions which currently have no strong evidence, but which are working towards gathering it.
- Registration and CPD – Ensure that all therapists/clinicians have an in-date registration with an appropriate professional body; will access supervision and will regularly take part in Continued Professional Development (CPD) in accordance with their respected professional body.
- Codes of professional practice – Ensure that all clinicians/therapists will abide by their respective codes of professional practice.
- Risk assessment as a core element – Mandate that risk assessment will be a core element of all clinical/therapeutic interventions. The degree of risk assessment undertaken will be dynamically assessed and will be appropriate to the service users' presentation.
- Safeguarding and child protection – Ensure that all clinical/therapeutic staff will have appropriate skills in safeguarding and child protection, as well as discussing these matters with clinical supervisors.
- Complaints and compliments – Have a complaints and compliments policy/procedure which will be objective and rigorous.
- Post-care support – Ensure that no service user, or their families, will be put under any pressure to provide financial or other support to the organisations that are providing their care.
- Outcome measures – Ensure that services carry out a clinical audit, use appropriate outcome measures and are transparent about their outcome data. Services should also work with other organisations and co-ordinating bodies to pool data for the benefit of all.
- Offering choice – Mandate that all their staff behave in an ethical way when offering choice and/or recommending or referring to other providers of care.

Cobseo is currently applying the MAC principles to its application for membership process for charities which are providing direct mental health support to beneficiaries in order to ensure that members of Cobseo that deliver such mental health services are doing so in accordance with MAC guidelines. Cobseo is only applying such conditions to new applicants for membership, and is retrospectively applying it to all existing members. The confederation hopes to extend regular self-reporting against MAC principles.

Veterans Scotland takes a slightly different approach than Cobseo, which is uniquely suited to the way in which Veterans Scotland operates.

## CASE STUDY - ENCOURAGING STANDARDS OF PRACTICE

Established in 2002, Veterans Scotland is a membership organisation, which aims to enhance the welfare of the veteran community in Scotland by acting as the prime vehicle for joint working between its member charities, dissemination of information to its members and the coordination of joint approaches to UK and Scottish Governments, local authorities and other organisations whose business is of benefit to veterans. Its membership is drawn from both public and third sector organisations.

As part of its strategy, Veterans Scotland has four membership pillars; Health and Wellbeing, Housing, Employment and Support, and Comradeship. Each pillar operates to develop co-operation, collaboration, communication and new initiatives among its pillar members. Pillars operate on a collegiate basis, and each is chaired by a representative from one of the charities within the pillar. Examples of member organisations include: Veterans 1<sup>st</sup> Point, Blesma, Combat Stress, Scottish War Blinded, Help for Heroes, Legion Scotland and Poppyscotland.

The Health and Wellbeing pillar operates with its membership to:

- Improve communication, together with cooperative and collaborative working, to multiply impact, close provision gaps and reduce duplication.
- Identify and work with the MOD and Scottish Government, in the field of health and wellbeing provision to veterans;
- Review current health and wellbeing provision against veterans needs identifying both shortfalls and duplications;
- Lead on lobbying over adequate funding for health and wellbeing.

Veterans Scotland also operates and maintains the Veterans Assist website ([www.veterans-assist.org](http://www.veterans-assist.org)), which functions as a signposting facility providing a comprehensive range of information and resources for the veteran community in Scotland.

The Veterans Scotland Health and Wellbeing pillar has developed on a collegiate basis a 'Values and Standards' statement, developed and endorsed by its members, which states clearly standards to be met and replicates closely Cobseo's practice guidelines. It is also developing a matrix to promote cross-referral of veterans to the resource best suited to meet their health needs.

In addition, the pillar is working with the Scottish Government's health department to develop improved communication and expectation management with veterans regarding the terms of priority treatment.

## PROVISION FOR PTSD

The NHS defines PTSD as ‘an anxiety disorder caused by very stressful, frightening or distressing events’ (NHS 2017). PTSD remains a somewhat contested and controversial label, as it is difficult to determine exactly what constitutes a traumatic event. It is generally agreed that PTSD stems from exposure to stressors outside the range of normal human experience. However, distinguishing between ordinary and traumatic stressors is a difficult task in itself (Greenberg et al 2015). As a result, academic and medical definitions of PTSD vary and are constantly evolving.

Certain individuals are at increased risk of developing PTSD due to the hazardous nature of their occupation, such as Blue Light Services and armed forces personnel. Overall rates of PTSD within the military are relatively low at 4%. However, slightly higher rates of PTSD have been observed among combat troops and reserve forces (Murphy et al 2016).

Symptoms of PTSD in military personnel have been associated with a high burden of impairment across a range of psychological, functional and social exclusion measures (Iversen et al 2011). Common symptom clusters include:

- Re-experiencing (involuntary reliving traumatic events such as flashbacks and nightmares)
- Avoidance and emotional numbing (often leads to isolation and social withdrawal)
- Hyperarousal (heightened anxiety, anger, lack of concentration)

Comorbidity has been widely documented between PTSD and other mental health problems (for example, depression, anxiety and dissociation) and substance misuse (particularly alcohol) (Murphy et al 2015).

### Support from charities

DSC found 57 charities undertaking work which includes supporting those suffering from PTSD. This represents three-quarters (75.0%) of all charities represented in this report. Table 3 shows the split of Primary and Secondary providers by provision of clinical and non-clinical service delivery. A total of 13 (22.8%) charities provide a clinical service. In contrast, 44 (77.2%) charities deliver a non-clinical service.

A total of 27 (47.4%) charities were Secondary providers delivering a non-clinical service. Primary providers delivering a clinical service accounted for just four (7.0%) charities.

Table 3

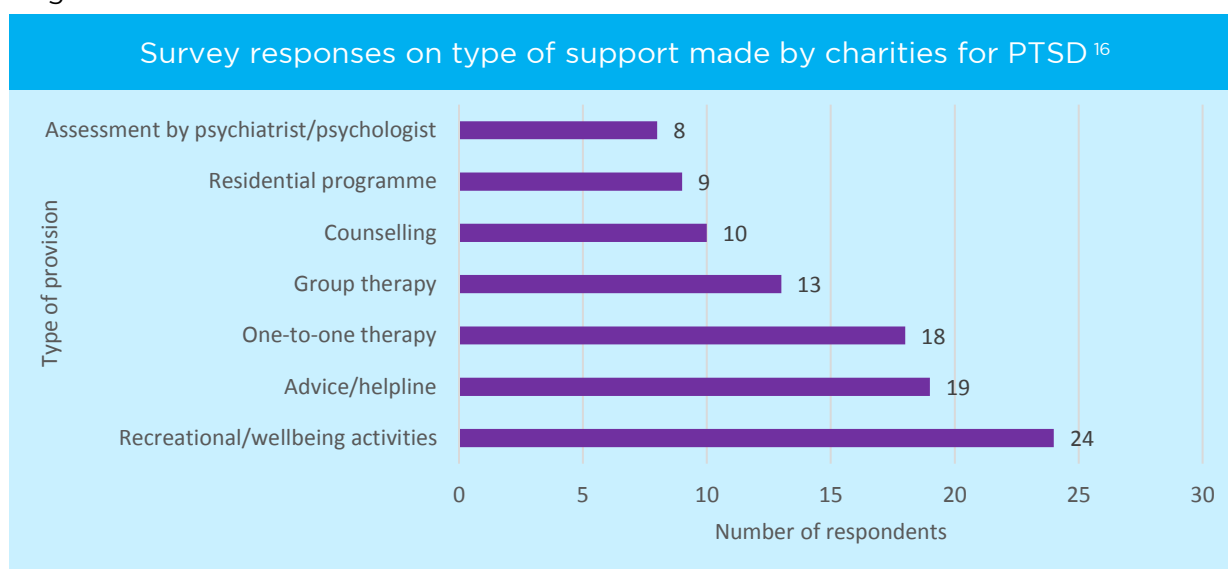
Primary and Secondary charities providing clinical and non-clinical PTSD services			
	Clinical	Non-clinical	Total
Primary	4	17	21
Secondary	9	27	36
Total	13	44	57

## Type of provision

Of those charities who responded to DSC's survey, 37 (82.2%) reported making provision for PTSD. Figure 17 shows the type of support made by charities for PTSD. The most common support for PTSD was in the form of recreational/wellbeing activities, for which 24 (64.9%) of the surveyed charities making provision for PTSD reported as being part of their support.

In total, 19 charities (51.3%) reported providing advice/helpline support, with 18 charities (48.7%) providing one-to-one therapy for PTSD.

Figure 17



## Delivery of provision

Figure 18 provides a more detailed split of clinical and non-clinical providers of PTSD support and highlights differences in provision made by charities across both types of support.

Provision from clinical providers for one-to-one therapy is much higher (100%) than from non-clinical providers (24.0%). This distinction can also be clearly seen for counselling, which is more commonly provided by clinical providers (66.7%) than from non-clinical providers (8.0%).

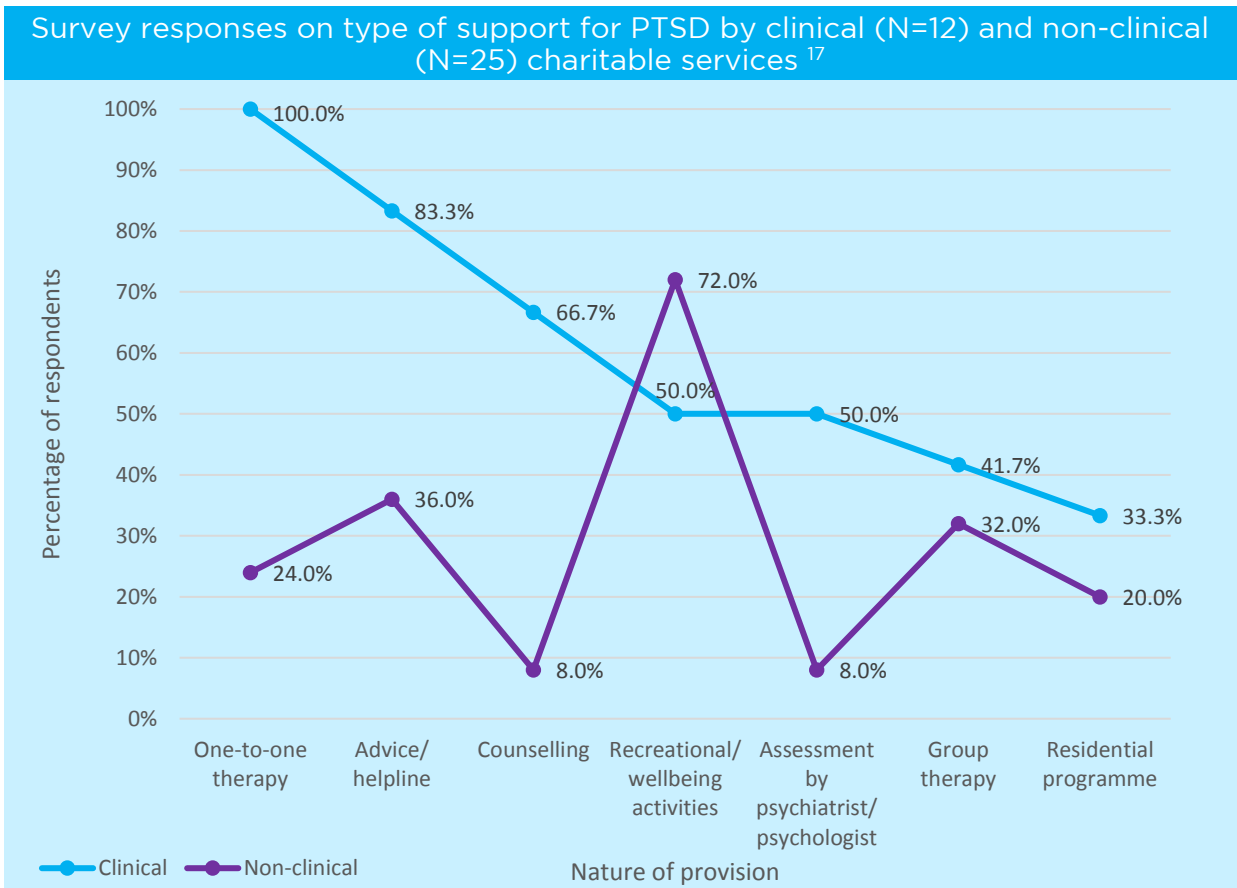
Support in the form of assessment by a psychiatrist/psychologist is also as one would expect; more common from clinical providers (50.0%) than non-clinical providers (8.0%). Advice/helpline support is also noticeably higher for clinical providers (83.3%) when compared to non-clinical providers (36.0%).

Recreational/wellbeing activities was the only form of provision reported by survey respondents to be higher for non-clinical service providers (72.0%) than their clinical counterparts (50.0%).

Figure 18 shows a clear trend in the percentage of clinical providers being more likely to provide services, with the exception of recreational/wellbeing activities, for which non-clinical providers are noticeably more likely to provide for their beneficiaries than clinical providers.

<sup>16</sup> Respondents can choose more than one answer, therefore categories presented are not mutually exclusive

Figure 18

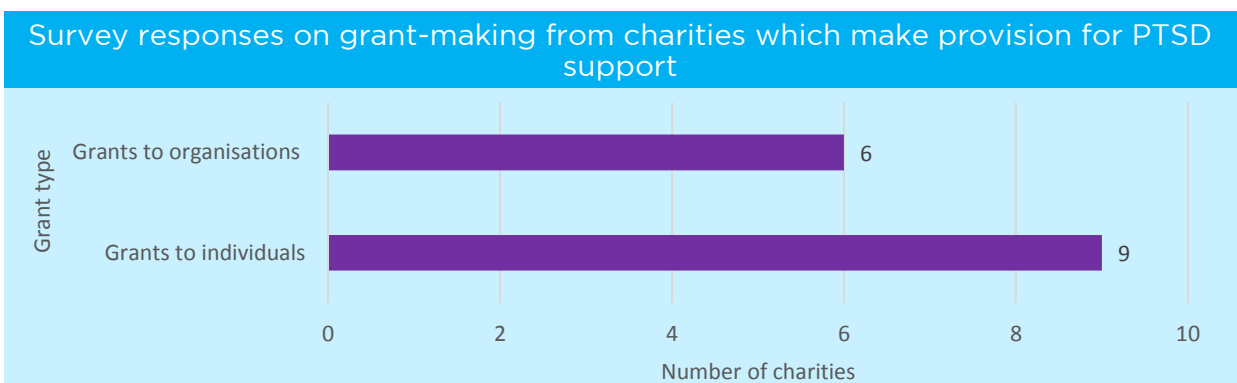


### Grant-making

DSC survey results provided in figure 19 show that of the 37 charities which make provision for PTSD support, nine charities (24.3%) reported providing grants to individuals as part of their PTSD provision.

Survey results also showed that a total of six charities (16.2%) provide grants to organisations for 'projects and programmes' as provision for PTSD support.

Figure 19



<sup>17</sup> Categories are not mutually exclusive and percentages therefore do not sum to 100%.

## PROVISION FOR DEPRESSION AND ANXIETY

Common mental disorders (CMD) is an umbrella term encompassing a range of commonly occurring mental health disorders such as depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder and social anxiety disorder (NICE 2011). This chapter will focus on depression and anxiety provision from charities.

A study of patients accessing IAPT (Improved Access to Psychological Therapies) services found that depression and anxiety was the second most common reason for veterans seeking help after PTSD (28.8% against 34% respectively) (Giebel et al 2014). However, the prevalence of depression and anxiety varies significantly among sub-groups within the veteran population.

Physically disabled veterans are twice as likely to suffer from depression and anxiety (24% disabled veterans, 12% non-disabled). Substance misusers have also been identified as being at increased risk. Conversely, depression and anxiety is marginally less prevalent in military personnel with a higher educational attainment and rank in the military (Goodwin 2015).

Data on those presenting at MOD-run mental health services further indicates that personnel previously deployed to Iraq and Afghanistan experienced higher rates of CMDs (MOD 2016). For that reason, there exists a need to identify vulnerable individuals and tailor treatment methods accordingly.

CMDs comprise different types of depression and anxiety. They cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition (Stansfeld et al 2014). Ranging in severity from mild to severe, CMDs can often have a detrimental impact on sufferers' physical health and social interactions. They can cause physical impairment, problems with social and occupational functioning, and are a significant source of distress to individuals and those around them (Stansfeld et al 2014). Depression and anxiety can prove difficult to diagnose. However, if left untreated, it is likely that it will lead to long-term physical, social and occupational disabilities and premature mortality (Zivin et al 2015).

### Support from charities

DSC found 43 charities that make provision for those suffering from depression and anxiety. This represents over half (56.6%) of all charities in this report.

Table 4 shows a total of 12 (27.9%) charities making provision for depression and anxiety were providing a clinical service, in contrast to the 31 (72.1%) charities who were delivering a non-clinical service. The most commonly represented charities making provision for depression and anxiety, were Secondary providers, delivering a non-clinical service, which accounts for 21 charities (48.8%). Conversely, the least common charity category is those Primary charities delivering a clinical service, which accounted for just three charities (7.0%).

Table 4

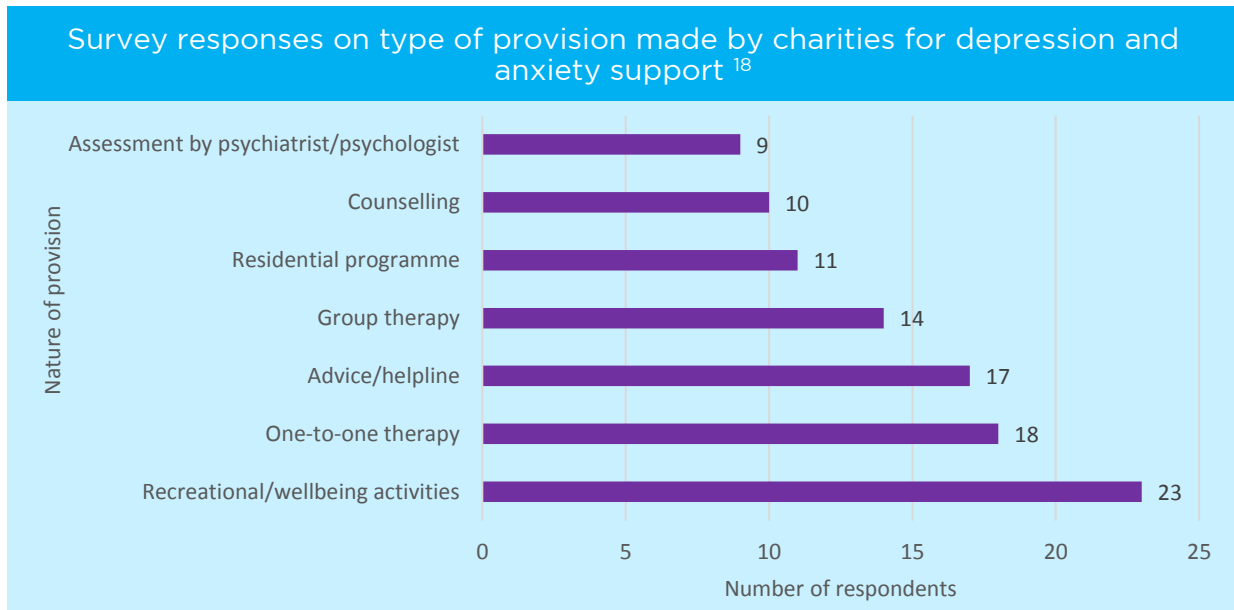
Primary and Secondary providers of clinical and non-clinical support for depression and anxiety			
	Clinical	Non-clinical	Total
Primary	3	10	13
Secondary	9	21	30
Total	12	31	43

## Type of provision

DSC undertook a survey of forces charities that make provision for mental health, the data from which is shown in figure 20. In total, 36 (80.0%) of those surveyed reported that they make provision for depression and anxiety.

The most common support provided was in the form of recreational/wellbeing activities, with a total of 23 (63.9%) of surveyed charities reported making such provision for beneficiaries suffering from depression and anxiety. In contrast, the least common provision was assessment by psychiatrist/psychologist, with nine (25.0%) charities reported making this support available.

Figure 20



## Delivery of provision

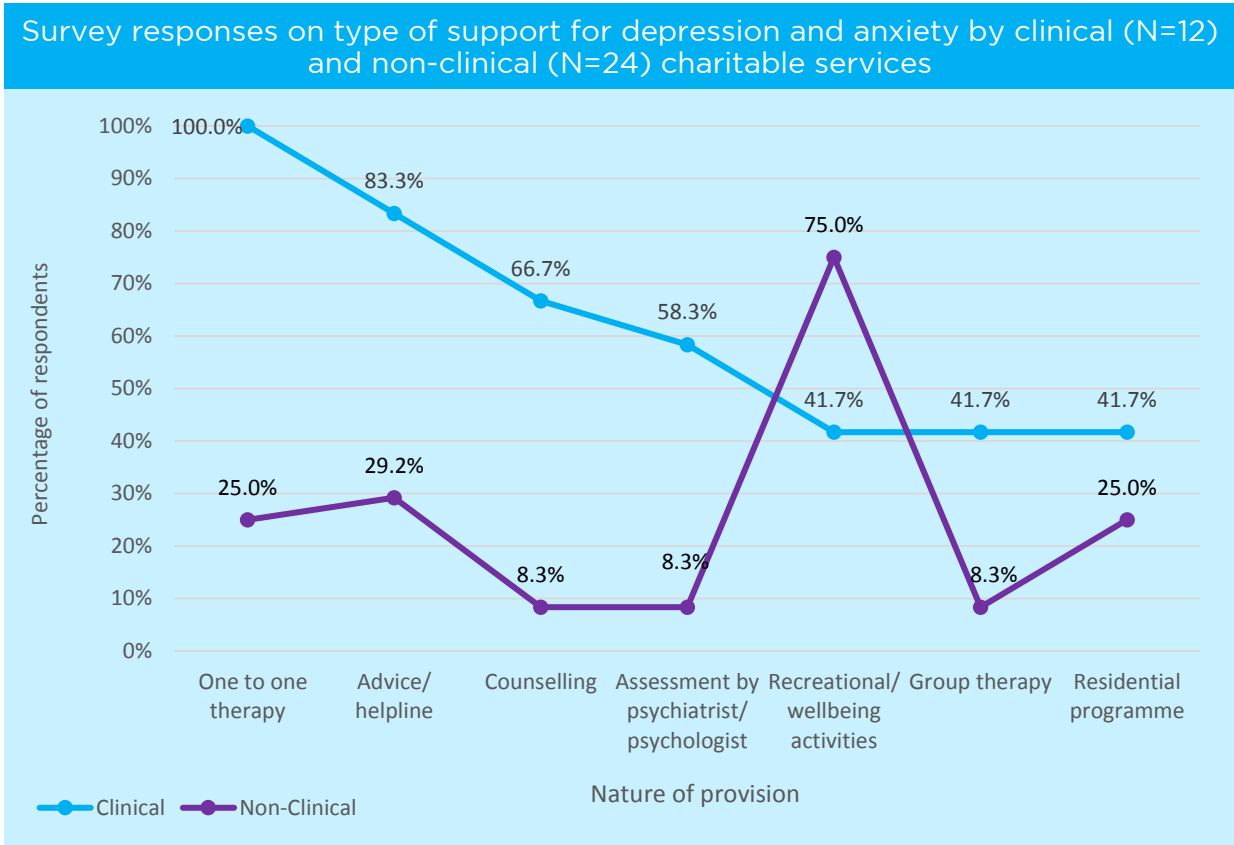
Figure 21 shows survey responses from respondents who provide support for depression and anxiety. One-to-one therapy is much higher (100%) among respondents providing a clinical service than from non-clinical providers (25.0%). This distinction can also be clearly seen for advice/helpline support, which is also noticeably higher for clinical providers (83.3%) than non-clinical providers (29.2%).

Similarly, counselling is more commonly provided by clinical providers (66.7%) than from non-clinical providers (8.3%); with provision in the form of assessment by a psychiatrist/psychologist, as one would expect, being more common from clinical providers (58.3%) than non-clinical providers (8.3%). Recreational/wellbeing activities was the only form of provision which was more commonly associated with non-clinical respondents (75.0%) than clinical respondents (41.7%).

<sup>18</sup> Respondents can choose more than one answer, therefore categories presented are not mutually exclusive.



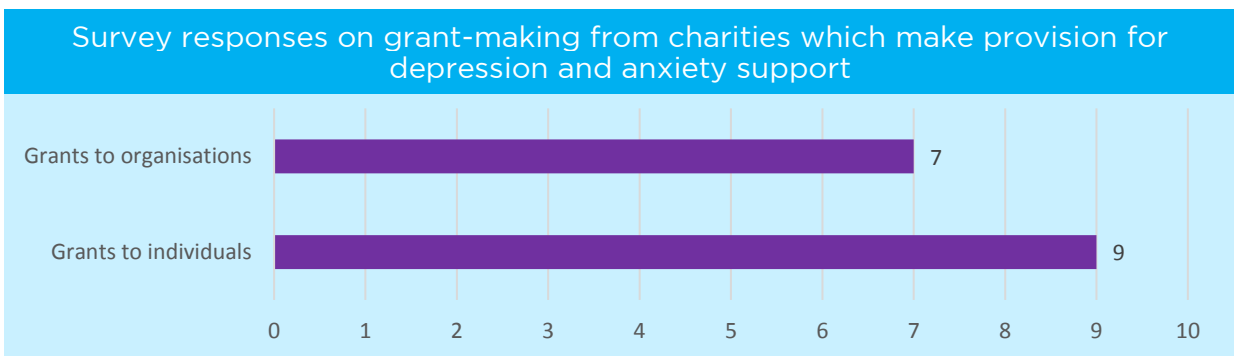
Figure 21



### Grant-making

Survey results presented in figure 22 showed that of the 36 charities which provide support for depression and anxiety, nine charities (25.0%) reported providing grants to individuals as part of their provision. Survey results also showed that a total of seven charities (19.4%) provide grants to organisations for projects and programmes as provision for depression and anxiety support.

Figure 22



## PROVISION FOR SUBSTANCE MISUSE

The World Health Organization defines substance misuse as 'the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs' (World Health Organization 2017). The NHS defines alcohol misuse as 'drinking excessively - more than the lower-risk limits of alcohol consumption' (NHS 2016). Within the UK, both men and women are advised to limit alcohol consumption to fewer than 14 units of alcohol per week.

Excessive alcohol consumption has long been a fixed feature of military life, with soldiers traditionally being administered alcohol before battle in a tradition that extended until World War II; a practice largely endorsed by health professionals (Jones and Fear 2011). Today, medical discourse typically focuses on the negative health implications, detrimental strategic performance, and patterns of long-term dependency caused by alcohol misuse. Nevertheless, alcohol misuse and dependency is significantly more prevalent within the Service personnel population across all age and gender groups. A 2007 survey of armed forces personnel found that 67% of men and 49% of women engaged in hazardous drinking compared to 38% of men and 16% of women in the general population (Fear et al 2007). A comprehensive survey of 9,990 UK Service personnel undertaken in 2010, found a 13% rate of alcohol misuse (Fear et al 2010).

Comorbidity (the presence a disorder which presents in addition to the primary disorder) of PTSD and substance misuse (particularly alcohol) has been well established (Head et al 2016). In a recent study undertaken by King's College London, 44.9% of participants with PTSD reported alcohol misuse, while 13.6% of those reporting alcohol misuse, also met the criteria for PTSD (Aguire et al (2013).

A zero-tolerance policy on illicit drug consumption is uniformly enforced across all branches of UK military forces. Despite this, the results of MOD compulsory drug testing reveal evidence of drug misuse by a small proportion of serving personnel. The most recently available statistics reveal that in 2012, 575 serving personnel failed drugs tests, which accounts for only 0.41% of personnel who underwent testing (MOD 2012). When compared to an estimated 8.9% of the general UK population who declared drug misuse in 2012, drug misuse appears significantly less prevalent within the serving armed forces population (Home Office 2012).

The extent of drug misuse by the UK veteran population is relatively unknown. The charity Combat Stress has identified alcohol misuse as more typical than illicit drug misuse, although the latter is more common among younger veterans (National Institute for Clinical Excellence 2005). A 2011 study of the health needs of veterans living in Wales found that illicit drug use among the veterans surveyed was comparable with or lower than rates in the general population (Wood et al 2011).

According to the World Health Organization, alcohol consumption is a causal factor in more than 200 disease and injury conditions. In particular, alcohol is associated with mental and behavioural disorders, including alcohol dependence, major non communicable diseases, cancers and cardiovascular diseases. It also increases the risk of injuries resulting from violence and road crashes and collisions (World Health Organization 2017).

## Support from charities

DSC found 33 charities making provision for beneficiaries suffering from substance misuse, which represents over two-fifths (43.4%) of all charities in this report. A total of ten (30.3%) charities making provision for substance misuse were providing a clinical service, in contrast to the 23 (69.7%) charities who deliver non-clinical services. Of this majority, 19 (57.6%) charities which make provision for substance misuse were Secondary providers delivering a non-clinical service. Charities delivering a clinical service which are Primary providers, accounted for just three charities (9.1%).

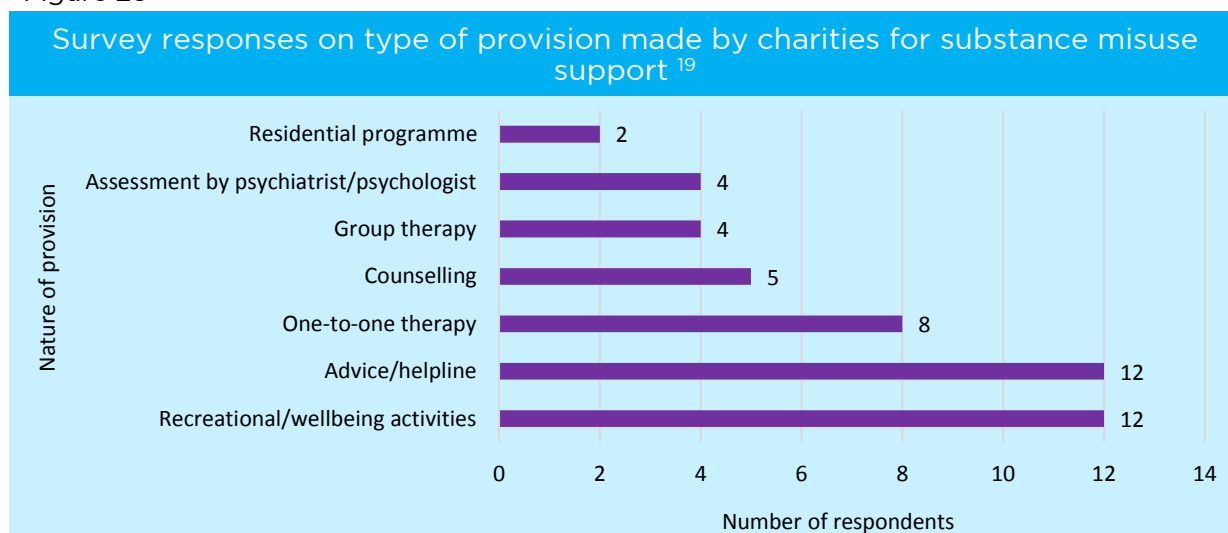
Table 5

Split of clinical and non-clinical providers by Primary and Secondary providers of support for substance misuse (N=33)			
	Clinical	Non-clinical	Total
Primary	3	4	7
Secondary	7	19	26
Total	10	23	33

## Type of provision

DSC undertook a survey of forces charities that make provision for mental health, of which a total of 23 (51.1%) of those surveyed reported that they make provision for substance misuse. Figure 23 shows that the most common provision was for recreational/wellbeing activities, with 13 (54.2%) charities making provision for substance misuse. The least common provision was residential programmes with three (12.5%) charities stating they made this type of provision. A total of nine charities (37.5%) stated they provided one-to-one therapy for substance misuse, compared to five charities (20.8%) which offered group therapy. Counselling was also provided by five charities (20.8%) as part of their substance misuse provision.

Figure 23



<sup>19</sup> Respondents can choose more than one answer, therefore categories presented are not mutually exclusive.

## Delivery of provision

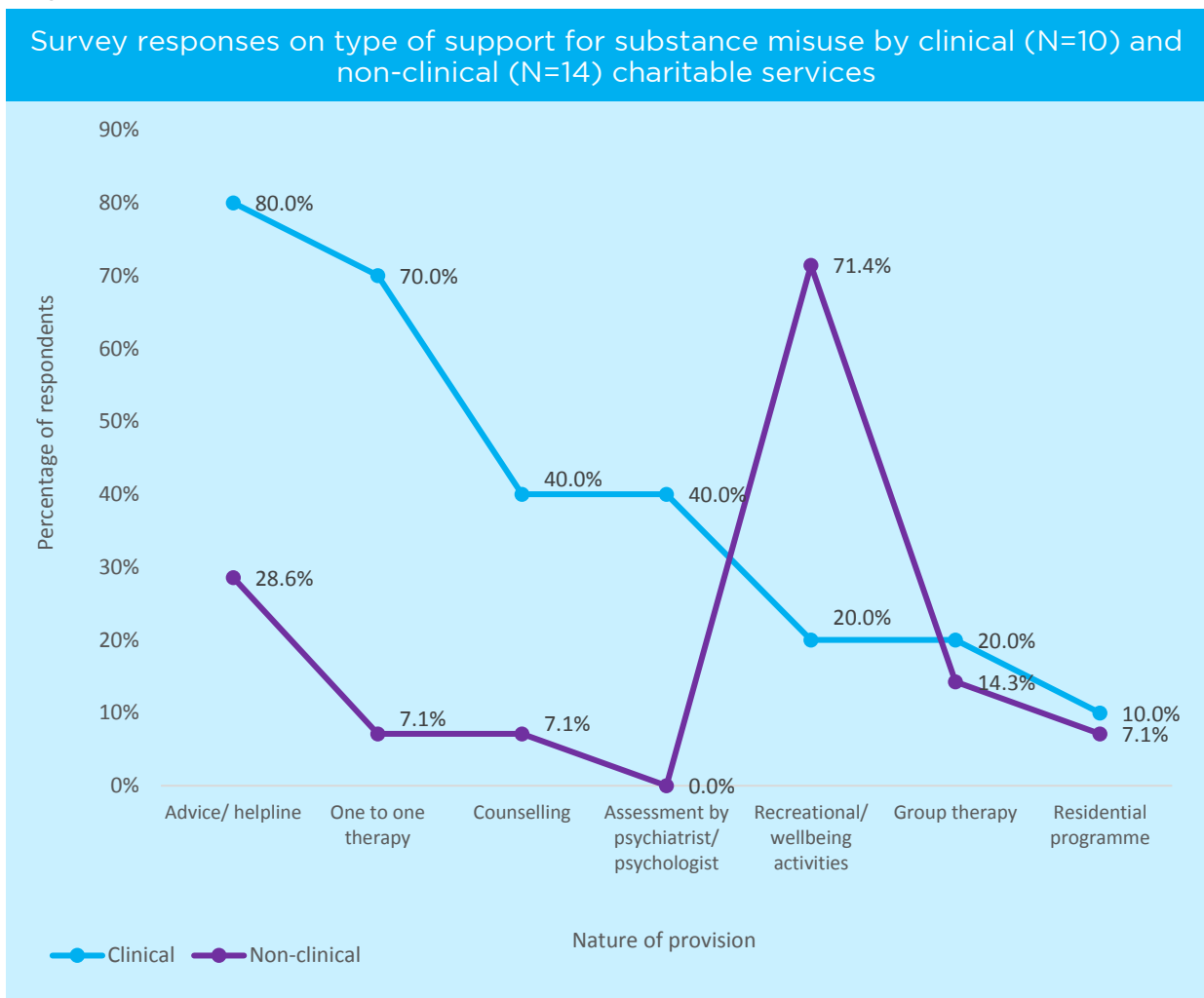
Figure 24 provides a more detailed split of clinical and non-clinical providers of substance misuse support and highlights differences in provision.

The most common response (80.0%) was from clinical providers for advice/helpline provision, which is considerably higher than for non-clinical providers (28.6%). This distinction can also be seen for one-to-one therapy as it is more common among clinical providers (70.0%) than non-clinical providers (7.1%).

A similar difference can be seen for counselling provision, which is more commonly provided by clinical providers (40.0%) than from non-clinical providers (7.1%). Provision for group therapy and residential programmes shows little difference between clinical and non-clinical providers.

In contrast to the above, recreational/wellbeing activities is the second most common form of support, with 71.4% of non-clinical providers reporting that they make such provision in noticeable contrast to 20.0% of clinical providers.

Figure 24

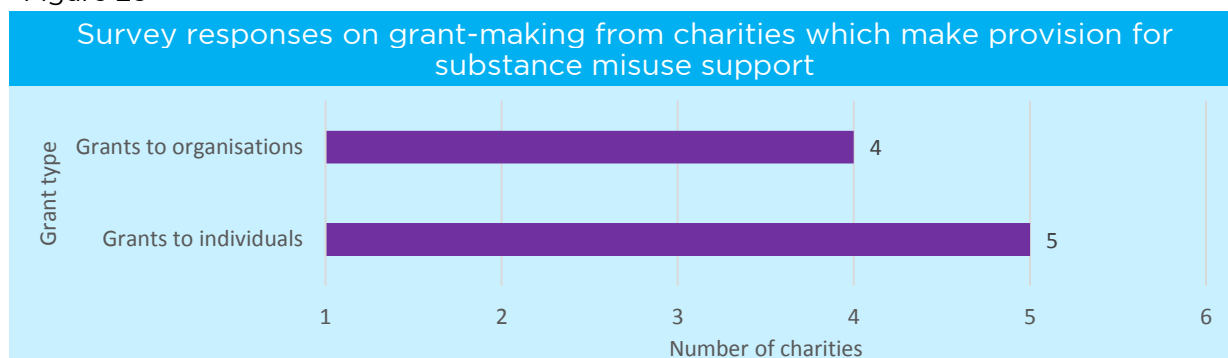


## Grant-making

Survey results presented in figure 25 showed that of the 24 charities which make provision for substance misuse support, five charities (20.8%) reported providing grants to individuals as part of their substance misuse provision.

Survey results also showed that a total of four charities (16.7%) provide grants to organisations for projects and programmes as provision for substance misuse support.

Figure 25



## CHAPTER TWO SUMMARY

### Service delivery

Three-quarters of charities offer support for PTSD, and over half make provision for depression and anxiety. Over two-fifths offer support for substance misuse, while one-third provide support for other mental health areas.

Counselling was the most common service, offered by over two-fifths of charities; followed by advice/helpline from almost two-fifths of charities and therapy provision from one-third of charities. Residential programmes were the least common treatment provided, offered by just over one-fifth of charities. It should be noted that figures for service provision vary noticeably between Primary/Secondary and clinical/non-clinical providers.

### Clinical and non-clinical

Close to one-fifth of charities within the dataset offer clinical provision (treatments administered via an accredited medical professional). The remaining four-fifths of charities within the dataset offer non-clinical provision.

### Standards of practice

DSC surveyed armed forces charities regarding standards of practice for their mental health service delivery. A total of nine charities reported following NICE guidelines for mental health care, an additional six are working towards adopting these guidelines. There were six charities currently following the CQC guidelines when delivering mental health support, while four charities are aiming to put these into practice in the near future.

A total of four charities currently employ staff members or volunteers who are chartered psychologists (accredited by the British Psychological Society), and one charity has a member of staff who is actively working towards achieving this qualification. A further one charity has implemented SCC guidelines, and three charities currently adhere to UKPTS guidelines.

### Provision for PTSD support

DSC found 57 charities making provision which includes supporting persons suffering from PTSD. This represents over three-quarters of all charities represented in this report.

Over four-fifths of survey respondents reported making provision for PTSD. The most common provision was for recreational/wellbeing activities, for which over two-thirds reported making such provision for beneficiaries suffering from the effects of PTSD.

Survey responses showed that provision for one-to-one therapy, counselling, advice/helplines and assessment by a psychiatrist/psychologist was more common from clinical providers. Recreational/wellbeing activities was the only form of provision reported to be higher for non-clinical service providers.

Survey results showed that of the charities providing PTSD support, nine charities provide grants to individuals and six charities provide grants to organisations.

## Provision for depression and anxiety support

DSC found 43 charities making provision which includes supporting persons suffering from depression and anxiety. This represents over half of all charities represented in this report.

Four-fifths of survey respondents reported making provision for depression and anxiety, the most common support provided was for recreational/wellbeing activities.

Survey responses showed that one-to-one therapy, advice/helplines, counselling, and assessment by a psychiatrist/psychologist was more common among charities providing a clinical service. Recreational/wellbeing activities was the only form of provision more commonly associated with non-clinical respondents.

Survey results showed that of the charities providing depression and anxiety support, nine charities provide grants to individuals and seven charities provide grants to organisations.

## Provision for substance misuse support

DSC found 33 charities making provision for beneficiaries suffering from substance misuse, which represents over two-fifths of all charities represented in this report. Over half of survey respondents reported making provision for recreational/wellbeing activities to beneficiaries suffering from substance misuse.

Survey responses showed that advice/helpline, one-to-one therapy, and counselling are the most common among respondents providing a clinical service. However, group therapy and residential programmes showed little difference between the percentage of clinical and non-clinical providers. Recreational/wellbeing activities is the second most common form of support, which is noticeably more common among non-clinical providers.

## CHAPTER THREE

# The last word: conclusions and recommendations

This chapter provides conclusions and recommendations from the research presented in this report. At the beginning of this research, DSC's objective was to provide an account of the provision being made by armed forces charities to beneficiaries with mental health needs. To address this remit, DSC devised the following research questions:

- How many forces charities provide mental health support?
- Which mental health areas are supported?
- How are mental health services delivered to beneficiaries?
- What standards of practice, collaboration and evaluation exist?

### HOW MANY FORCES CHARITIES PROVIDE MENTAL HEALTH SUPPORT?

DSC identified 76 armed forces charities which make provision for mental health support. This represents around 7% of the approximately 1,100 UK armed forces charities population. It is often said that there are too many armed forces charities or that veterans are overwhelmed by the number of mental health charities. However, the number of charities in this report is relatively small as a percentage of the wider charities supporting the armed forces community.

When examined in regards to charities who are solely concerned with mental health support (Primary providers) or those which make provision for mental health as part of their wider remit (Secondary providers), Primary providers accounted for only 26 charities and Secondary providers accounted for 50.

Many charities deliver multiple services and therefore may outsource some provision while delivering other services themselves. In total 85.5% of Primary providers deliver mental health services themselves compared to 74.0% of Secondary providers. A total of 19.2% of Primary providers deliver services via another organisation, compared to 56.0% of Secondary providers who outsource provision through another organisation.

The actual amount of charities in this report, when split by Primary and Secondary provision and by service delivery, starts to become much smaller and arguably more specialist to particular types of mental health issues. Therefore in regards to the perception that there are too many armed forces charities, and too many providing mental health support, this report provides evidence to counter any such misconception.

### WHICH MENTAL HEALTH AREAS ARE SUPPORTED?

In respect to types of provision and charities providing particular services across differing mental health topics, DSC found that three-quarters (75.0%) of charities make provision to support the needs of beneficiaries suffering from PTSD. This equates to only 57 charities. DSC also found that over half (56.6%) of charities identified make provision for depression and anxiety support, and substance misuse accounted for just over two-fifths (43.4%) of charities. Other forms of provision, including acupuncture, equine therapy, and funding research into mental health accounted for less than a third of charities (30.3%).

Again, this figure can also be divided between Primary and Secondary providers. PTSD accounted for more than any other provision type made by Primary providers. It is also

the only mental health area where Primary providers (80.8%) outnumbered Secondary providers (72.0%).

Interestingly, DSC also found that Secondary providers were almost twice as likely to make provision for substance misuse as Primary providers, such provision was most commonly in the form of recreational and wellbeing activities and tended to be non-clinical in nature. Findings such as this further highlight the distinctions in the type of provision and forms of services being delivered by charities to their beneficiaries.

## HOW ARE MENTAL HEALTH SERVICES DELIVERED TO BENEFICIARIES?

DSC collected data on types of services/interventions which beneficiaries can access. The most common form of service was counselling, which accounted for 44.7% of all support. Therapies accounted for 30.3% of services available to beneficiaries, while the least common type of service delivery was in the form of residential programmes (22.4%). DSC also found that support in the form of advice/helplines, and recreational/wellbeing activities each accounted for 39.5% respectively.

When service delivery was split by Primary and Secondary providers, Primary providers were the most common providers for counselling (53.8%) compared to Secondary providers (40.0%). Services for recreational/wellbeing activities was noticeably higher for Primary providers (34.6%) when compared to Secondary providers (42.0%).

Secondary providers were more commonly associated with delivery of advice/helplines (46.0%) than Primary providers (26.9%), which would be consistent with Secondary charities which are providing a signposting service, grants or help and advice to beneficiaries, rather than delivering specialist services themselves. Therapy was also more commonly associated with Secondary providers (34.0%) than with Primary providers (23.1%). Again, this may be due to Secondary providers being equipped to offer therapeutic services which cover a wide range of both clinical and non-clinical interventions.

DSC collected data on provision which was deemed to be 'clinical' and 'non-clinical'. Clinical charities accounted for under one-fifth (18.4%) of charities represented in this report, with non-clinical charities accounting for the remaining four-fifths (81.6%) of charities. This figure also contributes to addressing the misperception that there are too many charities delivering mental health support, as clinical charities, which deliver services through a registered health professional accounted for just 14 charities, of which only four are Primary providers.

The most common form of provision from clinical providers is for PTSD support (92.2%, 71.0% non-clinical), with depression and anxiety support being the second most commonly associated with clinical providers (85.7% clinical, 50.0% non-clinical). Substance misuse was also more commonly associated with clinical providers (71.4%) than non-clinical providers (37.1%).

Clinical provision was also much more common (71.4%) for advice/helpline support than for non-clinical providers (38.7%). A similar distinction was also observed across counselling provision, and therapy provision. The difference was far less pronounced for recreation/wellbeing activities delivered by clinical providers (42.9%) compared to non-clinical providers (38.7%).

Due to the relative population sizes of clinical providers (N=14) to non-clinical providers (N=62), data was aggregated in to percentages and therefore the number of charities delivering such services are not fully represented in percentage data. However, the data does show the trends in service delivery across both groups of charities.

## PTSD

PTSD is often accused of being overrepresented as a topic of mental health need among the armed forces community. DSC found that PTSD was the most commonly reported form of provision, and as discussed earlier, the number of UK armed forces charities providing support for PTSD is relatively small. DSC found 57 charities make provision which includes supporting persons suffering from PTSD. This represents over three-



quarters (76.0%) of all charities featured in this report and represents only 5% of all UK armed forces charities.

Over four-fifths (82.2%) of survey respondents (N=45) reported making provision for PTSD. The most common provision was for recreational/wellbeing activities, for which over two-thirds reported making such provision for beneficiaries suffering from the effects of PTSD. Recreational/wellbeing activities was the only form of provision reported to be higher for non-clinical service providers, highlighting the specialist, clinical nature of support required for PTSD. The recreation and wellbeing support offered by non-clinical charities takes many forms, but often includes support which is designed to decrease social exclusion, a prevalent symptom of PTSD.

## Depression and anxiety

DSC found 43 charities make provision which includes support for persons suffering from depression and anxiety. This represents over half (56.6%) of all charities featured in this report. Four-fifths (80.0%) of survey respondents reported making provision for depression and anxiety, with the most common support being recreational/wellbeing activities.

Recreational/wellbeing activities was, as seen with PTSD support, the only form of provision which was more commonly associated with non-clinical respondents. Again, this highlights the specialist clinical interventions associated with CMDs (common mental disorders), but the support of charities in the form of recreational/wellbeing activities may assist with secondary symptoms of CMDs such as decline in physical health and reduced social interaction.

## Substance misuse

DSC found 33 charities making provision for beneficiaries suffering from substance misuse, which represents over two-fifths (43.4%) of all charities featured in this report. Support for substance misuse was the least available form of provision across clinical and non-clinical providers, and across both Primary and Secondary providers.

Over half (53.3%) of survey respondents reported making provision for recreational/wellbeing activities to beneficiaries suffering from substance misuse. Clinical providers' most commonly made provision was in the form of advice/helplines (80%), and one-to-one therapy (70%). As seen with both PTSD and depression and anxiety provision, it was recreational/wellbeing activities that was the form most commonly associated with Secondary providers.

The overall prevalence among Secondary provider survey respondents for recreational/wellbeing activities may be due to such activities addressing similar secondary and associated symptoms of all three mental health areas. Recreational/wellbeing activities made available from Secondary charities may be relevant to a multitude of individuals across a range of mental health topics, rather than one specific topic. Furthermore, as these forms of provision are not mutually exclusive, it is expected that many individuals will access numerous forms of support across a number of charities and may therefore be accessing both clinical and non-clinical, Primary and Secondary support.

## Charitable expenditure

Using survey respondent data, DSC was able to calculate an approximate figure for annual expenditure on mental health for charities who responded to the question on estimating the percentage of total expenditure on mental health in the past year. A total of 40 respondents provided a figure, which is estimated to be in the region of £28,640,000 per year in charitable mental health expenditure.

Primary provider respondents (N=12) spent approximately £17,450,000 on mental health provision in the past year. Secondary provider respondents (N=28) spent approximately £11,200,000 on mental health provision in the past year.

Primary provider figures are significantly affected by the addition of the charity Combat Stress, which provided in the region of £16,600,000 in mental health expenditure in one

year. The above figures represent only survey data and therefore the reader is urged to refer to the above amounts as an indication of expenditure across a sample of charities only.

In regards to grant-making, DSC found that close to one-fifth (18.4%) of charities make grants to individuals, slightly more (23.7%) make grants to organisations. However, previous research by DSC has found that typically only 10% of charities which state they make grants actually do so <sup>20</sup>. Figures relating to the amount spent on grants per year were not available on a level to provide a reliable figure for annual expenditure on grant-making by charities.

## WHAT STANDARDS OF PRACTICE, COLLABORATION AND EVALUATION EXIST?

Survey data suggests that a relatively low number of charities which deliver services themselves are working towards or currently achieving standards of practice such as NICE or CQC guidelines. However, this may be due to a number of factors, such as the data being based on a small sample of respondents (N=28).

Another factor may be that only 14 charities are in fact providing a clinical service and would be more likely to be following such professional standards. A larger number of charities (29%) provided other examples of professional accreditation and standards, which are applicable to the type of provision being made. It is therefore recommended that future research explores charities meeting the MAC (Medical Advisory Committee) principles, as set out by Cobseo; however, this work will need to be undertaken once the MAC principles are more deeply ingrained in mental health charities' reporting and membership practices.

Partnership with other charities is the most common form of collaboration, with 52 charities, reporting working in partnership. The least common type of partnership was found in partnership with private health organisations with just four charities using this form of collaboration.

Survey data (N=46) shows that randomised control trials (RCTs) have been undertaken by five charities. An additional six charities plan to undertake RCTs in the future while 11 stated that RCTs were not relevant to their work. Twelve survey respondents stated that their charity's services had been independently evaluated by a university and five charities had undergone evaluation by a local health authority.

## RECOMMENDATIONS

### Transparency and following Cobseo's and Veterans Scotland's lead

Although a number of charities provided excellent information on their websites, including downloadable information, annual reports and accounts, this was not consistently undertaken by a large number of charities. When collecting data for this report, DSC noticed a lack of available data from many charities communicating what the charity does in relation to mental health.

When DSC researchers attempted to find evidence of charities meeting professional standards for mental health provision, there was hardly any available information from many charities. With the exception of a small number of charities which provided excellent quality of information on treatment methods and standards of practice, DSC would urge charities making provision for mental health to provide more detailed information. Their websites should include information on the provision offered, the method of service delivery, and (where applicable) refer to MAC principles being met.

<sup>20</sup> This situation is not specific to the armed forces charity sector. Earlier research by DSC published in *UK Grant-making Trusts and Foundations* revealed that many more charities in general state in their objects that they make grants than do in practice.

This has obvious implications for researchers, but it is potentially the public or other charities that require more transparency. Information on work undertaken and provision made would provide information to potential beneficiaries, who in turn could be more confident in approaching services provided by charities.

Increasing transparency by providing more detailed information would also allow for more potential collaboration and sharing of good practice. It would provide statutory health professionals with more information from which they may be able to signpost service users.

Currently Cobseo clearly states that it is beginning to apply MAC principles to new member applicants stating that they deliver mental health services. This is an excellent example of a membership organisation providing a mark of quality, which can be recognised by beneficiaries, other charities and statutory health-care professionals. Similarly, Veterans Scotland is also taking steps to encourage its members to adopt its 'Values and Standards' statement which is based on similar criteria to Cobseo's MAC principles. Members of both Cobseo and Veterans Scotland are, for the reasons outlined above, urged to state on their websites that they are meeting or working towards such standards/principles. In turn, this would hopefully encourage other charities (both member and non-member charities) to follow their lead in information sharing and wider transparency on mental health provision.

DSC therefore recommend that both Cobseo and non-Cobseo members involved in mental health service delivery, work towards and communicate the extent to which they adhere to the *Guiding Principles for Delivery of Veterans' and Service Families' Mental Health Care* (MAC principles), developed for Cobseo by forces mental health expert Professor Neil Greenberg, of King's College London.

It is also hoped that Veterans Scotland members work towards adopting the 'Values and Standards' as developed by Veterans Scotland's Health and Wellbeing pillar. Veterans Scotland's collegiate approach to encouragement and collaboration among members is an excellent example of shared support in both developing standards and communicating good practice.

Such standardised approaches undertaken by Cobseo and Veterans Scotland could, as they develop, provide a mark of quality for charities to display. A logo or other mark to show that a charity is meeting the standards or principles promoted by their member organisation would be of use to beneficiaries, other charities, health professionals and government agencies alike, in order to provide increased confidence in the charity sector's provision for mental health.

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