SUPPORTING SERVING AND FORMER MEMBERS OF THE ARMED FORCES, EMERGENCY SERVICES AND FAMILIES

Guiding Principles For The Delivery Of Veterans' And Service Families' Mental Health Care

The aim of these principles are to help ensure that organisations which provide mental health care (in any form) for Veterans and their families or the families of still serving personnel do so in a manner which is safe, does no harm and allows the Veteran to make properly informed decisions about the care they might receive. Agreeing to abide by these principles does not confirm that a particular treatment will be effective, or that the organisations which do so, or their employees, are exemplars. However organisations which follow the principles will have demonstrated that they have taken reasonable steps to assure that they provide a safe and reasonable service and do no harm.

A) General Practitioner

Ensure that they communicate with the **Veterans' GP** about any initial assessment and then at regular periods during the follow up and at the end of any course of therapy/treatment. Where a Veteran does not have a GP, the provider will assist them to get one prior to, or at the very least alongside, beginning treatment. Veterans may, where services provide the facility, self-refer directly to the provider without having to use the GP as a 'gate keeper'. However, the Veteran's GP will be informed of, and where appropriate consulted about, any assessment undertaken and any care plan that is decided upon.

B) Initial assessment of need and risk

Only commence any treatment once a formal **broad-based initial assessment of need and risk** has been undertaken by an appropriately qualified and experienced person/clinician/professional. This assessment will often require a degree of communication with other healthcare professionals (likely to include but not limited to the Veteran's GP) and with other appropriate individuals (e.g. family member, social services etc.). Given that substance misuse is a specific problem for Veterans, the presence, and extent, of this problem should always be assessed and opportunities for intervention should be discussed with service users (either directly or through communication with another appropriately competent provider).

C) Access evidence based and NICE approved therapies

Ensure that Veterans are encouraged to access evidence based and NICE approved therapies before discussing other possible interventions (unless they are part of a well constructed and ethically approved trial). Veterans should not be urged to commence inappropriate therapeutic options just because they are in crisis; Veterans in crisis should be supported to take actions to ameliorate the crisis and pay due regard to any risks. Once the crisis has eased then discussions of the most

appropriate therapeutic option can proceed.

D) Transparency in using the terms routine, experimental and untested

Discuss possible interventions in three broad ways:

i. NICE approved and evidence based (routine)
ii. Approaches which have a sound theoretical background and are being tested as part of a well-constructed and ethically approved trial (experimental) and
iii. Interventions which currently have no strong evidence (published in respected peer reviewed journals, ones that have some sort of impact factor) but which are working towards gathering it (untested).

Organisations will be transparent in using the terms routine, experimental and untested with all service users and families. Veterans will be encouraged to discuss their treatment options with people they trust prior to deciding what option they wish to choose. Where possible written information should be made available to the Veteran after assessment so they can share it with people they trust.

E) Registration and CPD

Ensure that all therapists/clinicians have an in-date registration with an appropriate professional body, will access supervision and CPD regularly in accordance with their respective professional bodies codes of practice and keep evidence of having done so.

All therapists/clinicians will keep appropriate contemporaneous clinical notes securely (summaries of which will be sent to GP's periodically as above.

F) Codes of professional practice

Ensure that all clinicians/therapists will abide by their respective codes of professional practice which will at a minimum include displaying an understanding of boundaries, responsibilities of dealing with confidentiality and the need to have appropriate supervision and governance; and interact with other statutory bodies (e.g. social services, safeguarding boards, the Police etc.) and professionals (e.g. social workers or other clinicians/professionals).

G) 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 user's presentation. Risk assessment will include consideration of risks to self, others and also adult and child safeguarding and protection concerns. All providers will have procedures in place to act upon and communicate concerns commensurate with risks to the appropriate agencies in a timely fashion whilst paying due regard to confidentiality.

H) Safeguarding and child protection

Ensure that all clinical/therapeutic staff will have appropriate training in safeguarding and child protection as well as discussing these matters with their clinical supervisors (who will also be appropriately trained and experienced so they can provide the effective and safe clinical supervision). Update training on these topics will be undertaken in accordance with good professional practice and national guidance.

I) Complaints and compliments

Have a complaints and compliments policy/procedure which will be objective and rigorous. Service providers will also undertake a structured Serious Events Analysis (SEA) should a serious event occur in order to learn for such incidents. The results of SEA's should be communicated appropriately (e.g. with the person affected, their GP or to a professional body where appropriate).

J) Post-care support

Ensure that no service user (or their families) will be put under any pressure to provide financial or other support (e.g. media interaction, fund raising, etc.) to the organisations that are providing them with care. Any service user who, completely voluntarily, wishes to and has made an informed decision to provide a 'good news story' will be assessed as to their suitability to do so and will be appropriately supported (e.g. given informed advice about interacting with the media).

K) Outcome measures

Ensure that services carry out clinical audit and use appropriate outcome measures (e.g. the core set of measures recommended by NHS England Veterans Mental Health Network) and are transparent about their outcome data. Services should also work with other organisations, and coordinating bodies (e.g. NHS England) to pool data for the benefit of all, whilst paying due regard to confidentiality and data protection.

L) 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. This is so as not to adversely influence vulnerable users and their carers, or unduly promote a service in which they have an interest, or denigrate another except where there is clear evidence to demonstrate risk and appropriate reporting action has been taken.