



Suicide Prevention Inquiry

Health, Social Care and Sport committee – National Assembly for Wales

The Royal British Legion written evidence

1.0 About us

1.1 The Royal British Legion is at the heart of a national network that supports our Armed Forces community through thick and thin – ensuring that their unique contribution is never forgotten. We were created as a unifying force for the military charity sector at the end of the First World War, and still remain one of the UK's largest membership organisations. The Legion is the largest welfare provider in the Armed Forces charity sector, helping veterans young and old transition into civilian life. We help with employment, financial issues, respite and recovery, through to lifelong care and independent living.

For further information, please visit www.britishlegion.org.uk

Mae'r Llog Brydeinig Frenhinol wrth galon rhwydwaith cenedlaethol sy'n cefnogi ein cymuned lluoedd Arfog doed a ddelo – gan sicrhau nad yw eu cyfraniad unigryw fyth yn cael ei anghofio. Fe'n crëwyd i uno'r sector elusennau milwrol ar ddiwedd y Rhyfel Byd Cyntaf, ac rydym yn parhau yn un o'r sefydliadau uchaf ei aelodaeth yn y DU. Y Llog yw'r darparwr lles mwyaf yn sector elusennau'r Lluoedd Arfog, gan helpu cyn-filwyr, yn hen ac yn ifanc, i symud yn ôl i fywyd fel sifiliad. Rydym yn helpu gyda chyflogaeth, materion ariannol, seibiant a gwella, hyd at ofal am oes a byw'n annibynnol. Yn 2015/16, fe wnaethom ymateb i dros filiwn o geisiadau am help – mwy nac erioed o'r blaen.

Am wybodaeth bellach, ewch i www.britishlegion.org.uk

2.0 General comments

2.1 The Legion is pleased to have the opportunity to provide written evidence to the Health, Social Care and Sport Committee's inquiry into suicide prevention. Our evidence is focused on the research available for members of the Armed Forces community and our welfare delivery and experience working across Wales.

2.2 The Legion believes that it is important at the outset of this submission to highlight that the majority of people who serve in the Armed Forces go on to transition well into civilian society, enjoying comparatively good health compared to the general population. Furthermore, the overall incidence of suicide and self-harm in the UK Armed Forces is lower than in the general population, and evidence suggests that

the longer an individual stays in the military, the lower the suicide risk. However, some members of the Armed Forces community do experience issues that can lead to suicide and self-harm, and for the most serious cases it is imperative that all providers are working in collaboration to provide a safety net for those in crisis.

2.3 The Legion does not provide a crisis service for those experiencing suicidal ideation or intention. However, the Legion does encounter beneficiaries who are facing such serious issues and we do all we can to ensure these people get the vital support they need. The Legion works closely with a number of crisis support organisations such as Samaritans and the Emergency Services and provides timely and appropriate signposting to these, in the event of someone experiencing suicidal ideation or intention. Where appropriate, urgent referrals are also provided to the Legion's Outreach Service which delivers ongoing welfare support to beneficiaries and who will undertake detailed risk assessments of the beneficiary.

2.4 The Legion's Outreach Service supports vulnerable beneficiaries and their families to find practical and sustainable ways to make positive changes, achieve their potential and lead fulfilling lives. The Legion's Outreach Officer in Wales works closely with both the beneficiary and any identified specialist services or organisations that can assist beneficiaries at traumatic times such as local authority crisis teams. The Outreach Officer will also engage with other Legion staff and specialists to identify issues that may be causing stress and seek to tackle these through targeted interventions.

2.5 The Legion's Contact Centre who deliver our Advice and Information Line, has policies and procedures in place for situations where an individual presents themselves as at risk, and where there are safeguarding issues. Callers to the Contact Centre are informed as part of the welcome message that calls will remain confidential unless there is a risk to themselves or others or where they disclose involvement in a crime.

2.6 Full training is provided to Contact Centre staff, who may be in a situation where at risk or safeguarding calls are presented to them. Contact Centre staff are also provided with supporting documentation as a tool for dealing with at risk calls, advising them on what action they should take.

2.7 The Legion Contact Centre's *Child & Vulnerable Adult Protection Policy* aims to ensure that arrangements are in place for the prevention, management of and immediate response to allegations about harm and/or abuse. Where a staff member hears something that indicates abuse or harm may occur they must ensure that they:

- Have correct and up to date details for the enquirer;
- Check that the reason for concern is explored as fully as possible;
- Remind the individual of the possible need to break confidentiality;
- Ensure that the individual is getting support from the correct organisation;
- Raise their concerns with their immediate line manager or other senior manager at the end of the call. Staff should never see a concern as too minor to raise.

2.8 The Legion provides Welfare staff with mental health first aid training which incorporates suicide and self-harm. More broadly, Legion staff guidance regarding incidents of risk/safeguarding outlines the need to urgently escalate crisis cases (such as suicidal ideation or intention) to the appropriate level of senior staff or management. In addition, frontline welfare staff in Wales have undertaken suicide intervention training.

Case study 1

Mr. X is a 30-year-old Army veteran with PTSD. He approached the Legion for support in early 2018 as he was struggling with his mental health and he was homeless. Mr. X was in a desperate situation and stated that he had been homeless for almost two years and couldn't cope any longer.

Mr. X was dealt with initially by the Contact Centre advisor where he disclosed suicidal thoughts and a plan to hang himself that evening if he had to sleep on the streets again. Mr. X has a history of suicidal thoughts and had been in and out of hospital. The call resulted in the Contact Centre advisor keeping Mr. X on the phone whilst the emergency services were called to his location. Mr. X was safe when found by the police but had a ligature around his neck and was taken to hospital for a psychiatric assessment.

The following day Mr. X was discharged and contact was made with him. The Legion made numerous referrals to Alabare, the Wallich and Shelter to see what support could be offered to Mr. X in regards to his housing situation. The Legion made contact with Housing Options in order to advise them of Mr. X situation to relieve some of the stress on Mr. X having to go over his story again in order for to be assessed.

A referral to our Regional Outreach service was made to support Mr. X with his engagement with the local authority and other agencies. As a result of our engagement, Mr. X was offered specialist support and appropriate accommodation was sourced through SSAFA. Contact was maintained throughout the whole process until Mr X was safely housed.

Mr. X continued working with SSAFA in regard to his rent arrears with the local authority, and assistance was provided to support Mr. X in completing a PIP application.

Case study 2

Mr. Y called the Legion's helpline displaying signs of emotional breakdown and stating he was contemplating taking his own life and that it was difficult to gain any understanding of his current predicament. A referral was made to the Legion's Outreach Service.

Contact was made immediately with the client. Outreach Officer engaged with Mr. Y, allowing him to discuss his problems and feelings. Outreach Officer explained the role of the service, ways support could be offered, self-help tools and treatment options. Mr. Y was attempting to access mental health services and was also in the criminal justice system following an offence. This was causing Mr. Y extreme worry and distress. Mr. Y had no support networks he felt he could rely on.

Outreach Officer met with Mr. Y and jointly formulated a plan to take forward together. Outreach Officer contacted local authority housing to register client as homeless and seek support. Mr. Y was also registered with the RFEA and Poppy factory to seek employment support. Outreach Officer also contacted Veterans NHS Wales.

In the following period, the Outreach Officer attended the housing appointment with the local authority to support the client. An application for assistance was made with private rented housing via the Legion's Case Officer. Appointment with RFEA was attended by Mr. Y and Outreach Officer. Client also accessed Veterans NHS Wales treatment.

Throughout all this interaction with Mr. Y, the Outreach Officer was able to build trust and rapport with him, offering support and practical assistance at all stages.

Mr. Y, his wife and child are living in a new area, more conducive to a stable life. Mr. Y is in full-time work and attending therapist appointments, dealing with issues in a positive way. He has coping strategies in place and has an action plan for stressful situations, which includes a Mindfulness app on his smartphone which he uses every day.

3.0 Talk to me 2. Suicide and Self Harm Prevention Strategy for Wales 2015-2020.

- 3.1 The Legion commends the overall aims of the *Suicide and Self Harm Prevention Strategy for Wales*, and the key objectives underpinning it that aim to improve awareness, knowledge and understanding of suicide and self-harm amongst the public; to deliver appropriate responses to suicide and self-harm; to provide information and support for those bereaved or affected by suicide and self-harm; to support the media in responsible reporting and portrayal of suicide and suicidal behaviour; to reduce access to means of suicide; and to continue to improve understanding of suicide and self-harm in Wales and guide action.
- 3.2 While the Legion welcomes the inclusion of Armed Forces personnel in the strategy, we note that this reference is in the context of the Armed Force's role as priority care providers. While this remains a key responsibility for Armed Forces personnel, the Legion has noted that this is the sole reference to the Armed Forces community in the strategy.
- 3.3 The Legion recommends that reference to the Armed Forces in the strategy should be extended to veterans, and not focus solely on care providers. This is in light of the inclusion of veterans as a priority group in the *Together For Mental Health Delivery Plan*, as outlined in section 4 below. This, coupled with the evidence around suicide and self-harm in the Armed Forces outlined in sections 5 – 8 of this paper, highlights that the Armed Forces community would benefit from tailored support for these issues. We recommend the inclusion of the Armed Forces community, including veterans, as a specific population to support in the *Suicide and Self Harm Prevention Strategy for Wales*.

4.0 Together for Mental Health: Delivery Plan: 2016-19

- 4.1 In April 2016, the Legion provided a response to the Welsh Government's *Together for Mental Health: Delivery Plan: 2016-19*. In the response, the Legion commended the overall aim of the delivery plan and the principles underpinning it.
- 4.2 In particular, the Legion highly commended the Welsh Government's support of Veterans' NHS Wales (VNHSW), through its commitment to increase funding. Subsequent investment in the service – as called for in the Legion's 2016 Assembly election manifesto – is to be welcomed along with the inclusion of embedded peer mentors within the service, something the Legion called for in 2016.¹

VNHSW reports that approximately 46% of all new veterans describe having suicidal ideation in recent weeks at their initial assessment. A minority will also have thought

¹ Together for mental health Delivery plan 2016-2019 – The Royal British Legion response, April 2016

of a plan on how they could commit suicide. VNHSW is not a crisis service and will refer veterans to their local NHS crisis teams or Community Mental Health Teams if they require additional support above what VNHSW is currently funded for.

4.3 The Legion is pleased to note that funding to Veterans NHS Wales was further extended at the start of 2018, to a total of £900,000.²

4.4 The Legion also commended the inclusion of the priority goal for veterans in the Delivery Plan in point 7.7: ***“To ensure mental health services for veterans in Wales who are experiencing mental health problems are sustainable and able to meet that populations needs in a timely and appropriate manner.”***

4.5 However, the Legion was disappointed that the service delivery goals and key actions related to veteran mental health provision were particularly limited in the Delivery Plan. In its response, the Legion recommended the creation of a mental health service delivery plan for the Armed Forces community (to use in tandem with the main delivery plan), or at the very least, an extension of the priority goal relating to veterans.

4.6 Other recommendations included:

- Service delivery plan to be specific about the health needs of veterans and their families.
- Service delivery plan to provide specific action points that address veterans and Armed Forces families' mental health treatment provision.
- Service delivery plan to target those in the Armed Forces community at risk of mental health problems and the least likely to seek help.
- Inclusion of performance measures on 1) What statutory services identify veterans in their data capture, to ensure that members of the Armed Forces community are identified and therefore able to receive the services to which they are entitled, as called for in the Legion's Wales Manifesto in 2016³, and 2) How often priority treatment is being used in healthcare referral processes.
- Inclusion of an action point for the Welsh Government to issue guidance on priority treatment, with good practice examples. The Legion gratefully recognises the Welsh Government's recent dissemination of a health circular on priority treatment for veterans⁴, however we also believe that there is more to be done on the promotion and implementation of priority treatment in practice.
- Inclusion of an action point to specifically publicise information on mental health services available to Welsh veterans and their families, including UK wide services.

5.0 Suicide rates in-Service

5.1 For the twenty-year period 1998-2017, a total of 309 suicides and open verdicts occurred among UK Regular Armed Forces personnel⁵. This is broken down as 215

² <http://www.bbc.co.uk/news/uk-wales-42570492>

³ [The Royal British Legion, 2016. Building A Better Future For The Armed Forces Community In Wales.](#)

⁴ [Welsh Health Circular: Armed Forces Covenant - Healthcare Priority for Veterans](#)

⁵Ministry of Defence. Suicide and Open Verdict Deaths in the UK Regular Armed Forces: Annual Summary and Trends Over Time 1 January 1984 to 31 December 2017.

male and 13 female suicides, and 77 male and 4 female open verdicts. There were four coroner-confirmed suicides among UK Regular Armed Forces in 2017, with an additional 12 awaiting verdicts that may result in a suicide verdict once Coroner Inquests are held.

- 5.2 Suicide rates across all three Services have fallen since the 1990s. However, rates among Army personnel remained higher than the other Services throughout the majority of the period. Naval Service rates increased in the period 2008 to 2013, however the number of deaths each year remains small and the increased rate was the result of a changing structure of the Naval Service population and not an increase in the annual number of suicides. Suicide remains a rare event in the UK regular Armed Forces and the overall rate in each of the Services is low. For the twenty-year period 1998-2017, there was no significant difference in suicide rates between the three Services.
- 5.3 The UK Regular Armed Forces have seen a declining trend in male suicide rates since the 1990s. For the twenty-year period 1998-2017, the male suicide rate for the UK Regular Armed Forces was statistically significantly lower than the UK general population⁶.
- 5.4 Historically, Army males aged 20 years and under were the only group with a statistically significant increased risk of suicide, compared to the UK general population. However, for the last twenty-year period, the rate of suicide in young Army males was the same for males of the same age in the UK general population. The suicide rate among males aged 16-59 years in the UK general population in 2016 (latest data available and used as a proxy for 2017) was 18 per 100,000 compared to a UK Armed Forces rate of 8 per 100,000 in 2017.
- 5.5 Suicide rates for females in the Armed Forces are too low for statistical analysis. The proportion of male suicides in the UK general population increased in 2016 and has remained at approximately 75% of all suicides in the UK general population since the early 1990s⁷, suggesting that male suicide rates are generally higher across the UK.
- 5.6 In 2016, rates of suicide in the UK general population were higher among middle-aged men compared to other age groups⁸. Unemployment and economic hardship in middle-aged men within the UK general population may explain the higher rate of suicide in these age groups, whereas UK regular Armed Forces personnel are in employment with a regular income, and so may be protected against these risk factors.
- 5.7 A number of other factors specific to Service life may also play a role in reducing the risk of suicide in the UK regular Armed Forces compared to the UK general population. This may include the strong group loyalty, bonding and mutual dependence encouraged at all levels in the Services, particularly in small combat units.
- 5.8 The overall rate for the UK Regular Armed Forces and the rates presented for each Service may change when outstanding coroner verdicts are returned on deaths that have occurred since 2013, potentially resulting in increased or decreased suicide rates.

⁶ Ministry of Defence. Suicide and Open Verdict Deaths in the UK Regular Armed Forces: Annual Summary and Trends Over Time 1 January 1984 to 31 December 2017.

⁷ Office for National Statistics, 2017. Suicides in Great Britain: 2016 registrations

⁸ Ibid

5.9 Furthermore, data collected on suicide among Serving personnel excludes data on Reservists, amongst others⁹, as Defence Statistics do not receive routine notifications of all deaths among Reservists and non-Regulars. Evidence has indicated there is an increased prevalence of probable PTSD and common mental health disorders amongst deployed Reservists compared to Regular personnel and non-deployed Reservists¹⁰. Given the increased likelihood of mental health issues among deployed Reservists, it may be worthwhile to collect data on suicide rates within this group, to explore whether there is increased incidence of suicide or self-harm.

6.0 Suicide methods in-Service

6.1 The most common methods used to commit suicide in the UK regular Armed Forces are¹¹:

- Hanging, strangulations and suffocations (52%)
- Firearms and explosives (17%)
- Poisoning by gases and vapours (7%)

6.2 This finding is broadly consistent with the most common methods of suicide in the male UK general population for 2016, where hanging, strangulation and suffocation accounted for 59% and poisonings accounted for 18% of all male suicides. The most common method of suicide amongst females in the UK Regular Armed Forces was also hanging, strangulation and suffocation accounting for 11 out of 17 (65%) suicides between 1998 and 2017 - comparable with females in the UK general population. UK Armed Forces suicides using firearms and explosives are not comparable with the UK general population due to UK laws restricting access to firearms.

6.3 The likelihood of committing suicide is related to access to and knowledge of effective methods. The use of 'poisoning by gases and vapours' was the most common method of suicide in the UK Armed Forces until UK legislation was changed in 1993 to fit catalytic converters to vehicles. Following this there was a steep decline in the rate of suicide by gases and vapours. The change in policy in the mid-1990s restricting access to weapons in the Army also resulted in a fall in the rate of suicides by 'firearms and explosives'.

7.0 Suicide after leaving the Armed Forces

7.1 The MOD does not currently collect information on suicide rates among veterans. However, in terms of post-operational rates of suicide, the MOD has found no excess

⁹ Data on suicide excludes the Home Service of the Royal Irish Regiment, full time Reservists, Army Reserves and Naval Activated Reservists who were not deployed on operations at the time of their death, as Defence Statistics do not receive routine notifications of all deaths among Reservists and non-Regulars, and because reliable denominator data to produce interpretable statistics were not available.

¹⁰ Fear et al., 2010. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study, *The Lancet*.

¹¹ Ministry of Defence, 2018. Suicide and Open Verdict Deaths in the UK Regular Armed Forces: Annual Summary and Trends Over Time 1 January 1984 to 31 December 2017.

of suicide rates in veterans of the 1990/91 Gulf War¹² and the 1982 Falklands campaign¹³, along with lower rates compared to the UK general population.

7.2 In response to a written question in 2016 about the rate of suicide among personnel who had seen active service in Afghanistan and Iraq, the Ministry of Defence said the suicide rate among those deployed was lower than those who had not deployed:

“For the period 1 August 2002 to 31 December 2015, the rate of coroner confirmed suicides and open verdict deaths amongst those who had previously deployed to either Iraq or Afghanistan and were still in Service at the time of their death was 0.9 per 1,000. This compared to a rate of 1.6 per 1,000 for those UK service personnel who have not been identified as having deployed to either Iraq or Afghanistan prior to their death.”¹⁴

7.3 In 2009, Kapur and colleagues at Manchester University examined the rate, timing, and risk factors for suicide in all those who had left the UK Armed Forces between 1996 and 2005¹⁵. The risk of suicide in men aged 24 years and younger was approximately two to three times higher than the risk for the same age groups in the UK general population. However, the risk of suicide for veterans aged 30-49 years was lower than that in the general population. Overall, the rate of suicide was not greater when compared to the general population.

7.4 Risk of suicide was greatest in males, those who had served in the Army, those with a short length of service, and those of lower rank. The majority of suicide victims had not been in contact with specialist mental health beforehand. The rate of contact with specialist mental health was also lowest in the age groups at greatest risk of suicide. Risk of suicide was persistent, but may have been at its highest in the two years following discharge.

7.5 Causes of increased risk for suicide could not be proved, but the authors suggest three main possibilities: stress of transition to civilian life, exposure to adverse experiences during Service, or pre-existing vulnerabilities prior to Service. Evidence appeared to somewhat support the notion of pre-existing vulnerabilities, as findings indicated that untrained personnel with short lengths of service had a particularly high risk of dying by suicide after leaving the military.

7.6 Further research has examined the mental health among post-National Service veterans aged 16-64 and found for females, a significant association between veterans status and having suicidal thoughts. Early Service Leavers were more likely to be heavy drinkers, to have suicidal thoughts and to have self harmed than longer serving veterans¹⁶.

7.7 The studies cited above are almost 10 years old and may merit repeating. Furthermore, in light of stabilising suicide rates among young Serving males, it is worth exploring whether changes to mental health care in the military are impacting on self-harm and suicide during and after Service.

¹² Ministry of Defence, 2016. 1990/1991 Gulf Conflict UK Gulf Veterans Mortality Data: Causes of Death.

¹³ Ministry of Defence, 2014. Ministry of Defence, A study of deaths among UK armed forces personnel deployed to the 1982 Falklands campaign: 1982 to 2013, 2014

¹⁴ [HL3467](#) [on Armed Forces: Suicide], 30 November 2016

¹⁵ Kapur et al., 2009. Suicide after leaving the UK Armed Forces – A Cohort Study, *PLoS Medicine*.

¹⁶ Woodhead et al., 2010. Mental health and health service use among post-national service veterans: results from the 2007 Adult Psychiatric Morbidity Survey of England, *Psychological Medicine*.

8.0 Self-harm in the Armed Forces

8.1 Rates of deliberate self-harm among UK Armed Forces personnel as whole were low in 2016/17, at 2.8 per 1,000 personnel (0.3% of all personnel)¹⁷. However, this reflects a statistically significant increase of 26% in the rate of reported self-harm since the start of reporting in 2010/11. It is not clear whether this is a true rise in self-harming rates, or is due to improved reporting. However, this increase is in line with mental health referrals of personnel to a specialist clinician at a MOD Department of Community Mental Health (DCMH).

8.2 Groups in-Service at highest risk of self-harm between 2010/11 and 2016/17 were:

- Army personnel
- Female personnel
- 'Other' ranks
- Personnel aged under 24
- Untrained personnel (in five of the seven years presented)

8.3 Female and young personnel risk groups are broadly similar to the general population, as these groups have been found to be at greatest risk of presentation at a hospital with a self-harm episode¹⁸. Previous research with the Army¹⁹ and Navy²⁰ has also found increased risk of self-harm behaviour amongst females.

8.4 Research into intentional self-harm (self-harm and attempted suicide) amongst Serving and veteran UK Armed Forces personnel has found associations between intentional self-harm and: being young, having a shorter term of service, increased childhood adversity, and a range of other health outcomes - including PTSD²¹.

8.5 In the same study, ex-Service personnel reported lifetime prevalence of intentional self-harm more than double that of Serving personnel (10.5% vs 4.2%, respectively). However, the study did not establish whether episodes reported by ex-Service personnel took place before, during or after Service. Among this group, the possibility of reverse causation must be considered: self-harm acts may be an indirect trigger to leaving Service, thereby increasing the apparent prevalence.

8.6 Further research into the higher risk groups of Army personnel, untrained personnel, younger personnel, and ex-Service personnel may be merited, in order to identify vulnerabilities that may lead to increased incidence of self-harm.

8.7 True self-harm rates are difficult to establish due to under-reporting and associated stigma. Consequences of self-harm can also be managed by an individual at home and may not be reported to a medical professional²². In addition, UK Armed Forces

¹⁷ Ministry of Defence, 2018. Deliberate Self Harm (DSH) in the UK Armed Forces 1 April 2010 – 31 March 2017.

¹⁸ Skegg, 2005. Self-harm. *The Lancet*.

¹⁹ Blatchley et al., 2005. Deliberate self-harm in the regular army: A report on available data. Defence Analytical Services Agency.

²⁰ Slaven and Sharpley, 2002. Audit of deliberate self-harm cases in the Naval Service 1999–2001. Institute of Naval Medicine.

²¹ Pinder et al., 2011. Self harm and attempted suicide among UK Armed Forces personnel: Results of a cross-sectional survey. *International Journal of Social Psychiatry*.

²² McAllister, 2003. Multiple meanings of self harm: A critical review. *International journal of mental health nursing*.

personnel may report to an NHS Accident and Emergency facility following a self-harm episode and may not come to the attention of the military primary healthcare community or the Chain of Command. As such, it is likely that self-harm rates amongst the Armed Forces are higher than reported.

8.8 Furthermore, the ONS does not collect data on rates of self-harm in the UK general population, making comparisons of UK Armed Forces self-harm rates with the UK general population difficult and reliant upon small location based studies. However, available evidence suggests that the Armed Forces population appears healthier, with a lower lifetime prevalence of attempted suicide and self-harm, within the range of general population estimates.

9.0 Policy background

9.1 The Ministry of Defence has in recent years paid greater focus to the mental health of Regular and Reserve personnel and it is now a priority for the Department under the *Defence People Mental Health and Wellbeing Strategy 2017 to 2022*. Suicide and self-harm is one of the four core areas of the Mental Health Steering Group, along with stigma reduction; occupational stress; culture and behaviours.

9.2 The Strategy does not specify explicit suicide prevention tactics. However, it does identify measures designed to prevent the onset of mental health illnesses. These include pre-deployment training to develop resilience to situations faced, pre- and post-deployment briefings and post-operational decompression, resilience training throughout Service life with specific training for those in command, peer to peer support, and welfare and chaplaincy support.

9.3 Externally, the MOD also supports various initiatives targeting mental health, including the recent launch of a 24-hour mental health helpline for Serving personnel and veterans. Other external initiatives include NHS England's Veterans' Mental Health Complex Treatment Service (VMH CTS) - an enhanced local community based service for ex-Service personnel who have military attributable complex mental health problems that have not been resolved earlier in the care pathway.

For further information about this submission, please contact the Legion's Public Affairs and Public Policy team XXX