

**SCOPING REVIEW:
A Needs-Based Assessment and
Epidemiological Community-Based
Survey of Ex-Service Personnel and their
Families in Scotland**



FINAL REPORT

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ABBREVIATIONS AND ACRONYMS

ACDMH	Academic Centre for Defence Mental Health
ACTR	Aberdeen Centre for Trauma Research
AFCS	Armed Forces Compensation Scheme
AFP	Armed Forces Project
AFPPA	Armed Forces Personnel Administration Agency
AFPRABS	Armed Forces Pension and Research Attributable Benefits Scheme
AFPRB	Armed Forces Pay Review Body
AFPS	Armed Forces Pension Scheme
AMG	Agency Management Group
APC	Army Personnel Centre
APMS	Adult Psychiatric Morbidity Survey
ASOs	Administration Support Officers
AUDIT	Alcohol Use Disorders Identification Test
BLESMA	British Limbless Ex Service Men's Association
CABx	Citizens Advice Bureau
CAC	Central Advisory Committee
CAD	Citizens Advice Direct
CEA	Continuity of Education Allowance
CHI	Community Health Index
CHP	Centre for Housing Policy
CHR	Combined Housing Register
CI	Confidence Intervals
CIDI	Composite International Diagnostic Interview
CISD	Critical Incident Stress Debriefing
CLG	Communities and Local Government
CMO	Chief Medical Officer
COB	Contingency Operating Base
COBSEO	Confederation of British Service and ex-Service Organisations
CoSLA	Convention of Scottish Local Authorities
CPNs	Community Psychiatric Nurses
CPSR	Centre for Psychological Services Research
CRAU	Complex Rehabilitation and Amputee Unit
CSO	Chief Scientist Office
CTAs	Civilian Training Attachments
CTP	Career Transition Partnership
DASA	Defence Analytical Services Agency
DCMHs	Departments of Community Mental Health
DDS	Defence Dental Services
DEE	Department for Education and Employment
DHP	Defence Health Programme
DMCP	Defence Medical Capability Programme
DMDC	Defence Manpower Data Center
DMETA	Defence Medical Education and Training Agency

DMHTs	Deployed Mental Health Teams
DMPD	Defence Medical Postgraduate Deanery
DMRC	Defence Medical Rehabilitation Centre
DMS	Defence Medical Services
DMSD	Defence Medical Services Department
DMTC	Defence Medical Training Centre
DoE	Department of Education
DoH	Department of Health
DRP	Defence Rehabilitation Plan
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4 th edition
DSS	Department of Social Security
DWP	Department for Work and Pensions
EHFS	Earl Haig Fund Scotland
EMDR	Eye Movement Desensitisation and Reprocessing
ERG	External Reference Group
ESAG	Ex-Service Action Group
ESP	Employment Support Programme
ESRC	Economic and Social Research Council
ETS	Educational and Training Services
FMHTs	Field Mental Health Teams
FRP	Full Resettlement Programme
FTRS	Fulltime Regular Service
GHN	Glasgow Homeless Network
GHQ-28	General Health Questionnaire-28
GIP	Guaranteed Income Payment
GMC	General Medical Council
GP	General Practitioner
GRT	Graduated Resettlement Time
GVMAP	Gulf Veterans Medical Assessment Programme
HASCAS	Health and Social Care Advisory Service
HIC	Housing Information Centre
HLS	Howard League Scotland
HMG	Homelessness Monitoring Group
HMS	Her Majesty's Ship
HTF	Homelessness Task Force
IA	Insurance Allowance
IAPT	Improving Access to Psychological Therapies
ICD-10	International Classification of Diseases and Related Health Problems Version 10
IERO	Individual Education and Resettlement Officer
IMEG	Independent Medical Group
IPPH	Ilford Park Polish Home
IRTC	Individual Resettlement Training Costs
IRTs	Incident Response Teams
ISG	Independent Scrutiny Group
JCCC	Joint Casualty and Compassionate Centre

JPA	Joint Personnel Administration
JSHAO	Joint Service Housing Advisory Office
KCL	King's College London
KCMHR	Kings Centre for Military Health Research
LAs	Local Authorities
MAP	Medical Assessment Programme
MCTC	Military Corrective Training Centre
MDHUs	MoD Hospital Units
MHPs	Mental Health Practitioners
MoD	Ministry of Defence
MQR	Medical Quinquennial Review
MRR	Mortality Ratio
MRS	Medical Reception Station
MSI	Multiple Symptom Illness
NAO	National Audit Office
NAPO	National Association of Probation Officers
NBI	Non Battlefield Injury
NHS	National Health Service
NHSCR	National Health Service Central Register
NICE	National Institute for Clinical Excellence
NISHS	Northern Ireland Study of Health and Stress
NSFAMH	National Service Framework for Adult Mental Health
ODPM	Office of the Deputy Prime Minister
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
ONS	Office for National Statistics
PCL	PTSD Checklist
PCTs	Primary Care Trusts
PHQ	Patient Health Questionnaire
PIR	Prison-In-Reach
PRTT	Police Rehabilitation Training Trust
PSNI	Police Service of Northern Ireland
PTSD	Post Traumatic Stress Disorder
PVR	Premature Voluntary Release
RAF	Royal Air Force
RAMP	Reception Arrangements for Military Personnel
RAuxAF	Royal Auxiliary Air Force
RCDM	Royal Centre for Defence Medicine
RDPH	Regional Director of Public Health
REDA	Removal Expenses and Disturbance Allowance
RFPS	Reserve Forces Pension Scheme
RHQ	Regimental Home Headquarters
RMHP	Reserves Mental Health Programme
RMR	Royal Marine Reserve
RN	Royal Navy
RNR	Royal Navy Reserve
ROCR	Review of Central Returns

RRU	Regional Rehabilitation Unit
RWOs	Regional Welfare Officers
SaBRE	Supporting Britain's Reservists and Employers
SACRO	Safeguarding Communities and Reducing Offending
SAM	Sickness Absence Management
SchARR	School of Health and Related Research
SCJS	Scottish Crime and Justice Survey
SCSH	Scottish Council for Single Homeless
SFA	Service Family Accommodation
SHAs	Strategic Health Authorities
SHeS	Scottish Health Survey
SHS	Scottish Household Survey
SLS	Scottish Longitudinal Survey
SMR	Standardised Mortality Ratios
SPACES	Single Persons Accommodation Centre for Ex-Services
SPCP	Service Personnel Command Paper
SPS	Scottish Prison Service
SPVA	Service Personnel and Veterans Agency
SSAFA	Soldiers, Sailors, Airmen and Families Association
SSSFT	South Staffordshire and Shropshire Healthcare NHS Foundation Trust
TA	Territorial Army
TBI	Traumatic Brain Injury
TM-CBT	Trauma-Focused Cognitive Behavioural Therapy
TRiM	Trauma Risk Management
UHBFT	University of Hospital's Birmingham Foundation Trust
UK	United Kingdom
US	United States
UWO	Unit Welfare Officer
VA	Veterans Agency
V1P	Veterans First Point
VPU	Veterans Policy Unit
VWS	Veterans Welfare Service
WAG	Welsh Assembly Government
WASAS	Work & Social Adjustment Scale
WHO	World Health Organisation
WMH	World Mental Health
WPC	War Pensions Committee
WPS	War Pensions Scheme
WPWS	War Pensioner's Welfare Service
WWII	World War II

EXECUTIVE SUMMARY

1. BACKGROUND

- 1.1 The deployment of the UK Armed Forces to Iraq and Afghanistan has engendered a broad political imperative and increased the academic interest in the health and wellbeing of both Service and ex-Service personnel.
- 1.2 Each year in the UK, approximately 25,000 men and women leave the UK Armed Forces (Fletcher, 2007) and return to civilian life for a miscellany of reasons and in a variety of different circumstances including medical discharge (Iversen *et al*, 2005). Whilst some have completed lengthy terms of service, over 5 million individuals have served at least one day in the Armed Forces (in accordance with the broadest definition of a "Veteran"). Currently, however, the average length of military service is four years.
- 1.3 Little is known about what happens to ex-Service personnel when they leave the UK Armed Forces, although much has been reported about Veterans from other countries (e.g., US Armed Forces). Currently, within the UK most findings derive from studies conducted by the King's Centre for Military Health Research using existing data from their original military cohort established in 1995 (e.g., Dandeker *et al*, 2003; Iversen *et al*, 2005; Iversen *et al*, 2005, van Staden *et al*, 2007). These findings confirm that, although the majority who leave the UK Armed Forces benefit from their experiences and are successful in their transition to civilian life, there is a significant minority who fare less well due to a variety of factors including mental health problems and pre-enlistment vulnerabilities.
- 1.4 Issues relating to Veterans, continue in the main, to be reserved issues to the Westminster Government with responsibility for Veterans falling to the Ministry of Defence (MoD). However, by virtue of the fact that, when men and women leave the UK Armed Forces and return to civilian life, civilian authorities and service providers take on the responsibility for meeting the needs and aspirations of the 600,000 Veterans that currently reside in Scotland.
- 1.5 The Scottish Government has certain devolved responsibility over a wide range of services that can be accessed by

Veterans, such as healthcare, housing, social care, education and skills training, and employability. Responsibility for the co-ordination of Veterans' issues across the Scottish Government falls under the remit of the Social Inclusion Division. In a concerted endeavour to meet this responsibility, the Scottish Government has undertaken various actions to support Veterans in recognition of the fact that Scotland owes a debt to its service personnel and to her Veterans. To complement the Scottish Government's consultation paper on the wellbeing and welfare of the UK Armed Forces and Veterans in Scotland (26 June 2008), the Scottish Government's contribution to the MoD Command Paper "*The Nation's Commitment: Cross Government Support to our Armed Forces, their Families and Veterans*" (17 July 2008), sets out its commitment to assist Service personnel and Veterans across Scotland.

- 1.6 This report is based on the outcome of a Scoping Review, the principal aim of which was to identify to what extent a population-based survey is required to inform the national commitment to meeting the health and wellbeing needs of ex-Service personnel and their families in Scotland.

2. APPROACH

- 2.1 The methodological framework and analytic strategy for this scoping review derived from that suggested by Arksey & O'Malley (2005) in order to ensure a comprehensive but selective coverage of current knowledge, practice, service provision and the emergent evidence- and eminence-base given the extensive nature of this field of enquiry.
- 2.2 The work undertaken focussed on fulfilling five specific objectives (*project deliverables*) to:
 - (i) review extant knowledge, practice, and service provision in respect of meeting the health and wellbeing needs of ex-Service personnel and their families;
 - (ii) identify existing gaps in the implementation of the Veterans Initiative at the policy, health systems, provider practice and community behaviour levels, which may compromise its effectiveness in fulfilling its strategic outcomes;
 - (iii) review relevant research activity to identify outcomes and gaps in the emergent eminence- and evidence-base;
 - (iv) identify possible methods for conducting a robustly designed population-based survey in Scotland with

- particular reference to the implications for comparative analyses, and
- (v) provide indicative costs and timescales associated with the methods identified.

3. ESTABLISHING THE CONTEXT

- 3.1 An overview of the evolution of Veteran-related policy and strategy in the UK (following the launch of the Veterans Initiative in March 2001) was undertaken. Its purpose was to understand the historical and contemporary context in which cross-Government policy on the provision of health and welfare support to the UK Armed Forces community has developed and to identify the key drivers of Veteran-related policy and strategy.
- 3.2 Subsequent commitments made by UK Government and the Devolved Administrations in respect of providing health and welfare support for the UK Armed Forces community were mapped chronologically based on the publication date of relevant 15 key strategy and policy-related papers and reports.

4. OVERVIEW OF THE CURRENT STATUS OF HEALTH AND WELFARE SUPPORT

- 4.1 An overview of the current status of health and welfare support provision for the UK Armed Forces community was considered in terms of its organisation and delivery.
- 4.2 Key factors that have led to substantive shifts in strategic thinking with regards to the development, organisation, and delivery of health and welfare support services and which have consequently been influential in shaping current service provision were identified.
- 4.3 Particular consideration was given to those factors associated with the risk of social exclusion in vulnerable subgroups of the ex-Service population given the wider political agenda.

5. OUTCOME OF THE CONSULTATION PROCESS

- 5.1 The views of a wide range of stakeholders were sought on key issues relating to meeting the health and wellbeing needs of ex-Service personnel and their families in Scotland.
- 5.2 These included representatives from the statutory and voluntary services, priority groups, and related agencies,

military, clinical, and academic experts in the relevant domains, and key political figures informed in Veteran affairs. In addition to engaging with those user groups with established links, the consultation process also included those that have not engaged with formal initiatives in order to identify gaps which need to be addressed.

- 5.3 Key issues associated with pre-Service factors, Service-related factors, transition-related factors, and post-Service factors were categorised in accordance with the Needs Map generated by the Veterans Agency.
- 5.4 The issues highlighted were those identified by those consulted as being of particular importance and were grouped according to general themes within each of the categories.

6. OUTCOME OF THE DESK-BASED RESEARCH

- 6.1 A critical and selective analysis of three main sources of data was undertaken in relation to:
 - (i) MoD and Government commissioned reviews;
 - (ii) surveys commissioned by charities and agencies affiliated to the provision of the Veterans Initiative, and
 - (iii) academic-based research reported in the peer review literature.
- 6.2 In line with the terms of reference for the scoping study, this review reflected a UK focus with specific reference to data that would inform the national commitment to meeting the health and wellbeing needs of ex-Service personnel and their families in Scotland.
- 6.3 The objective of the analysis was to establish the current status of knowledge based on evidence and eminence-based practice in meeting the health and wellbeing needs of the Veterans' community, and (ii) identify in-progress research in this domain.

7. SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

- 7.1 *The following key issues and suggestions emerged from the interviews conducted with stakeholders and Veterans.*
 - Pre-enlistment vulnerabilities play a major factor in determining those who fare least well on leaving Service and who are at an increased risk of social exclusion.

- Paradoxically, whilst military life offers a number of positive benefits in terms of providing structure, security, a sense of identity and an esprit de corps, these benefits may exact a penalty on demobilisation and the transition to civilian life including the risk of fostering a “dependency culture”.
- Those who enlist in the Army and of a lower rank experience the greatest problems in adjusting to civilian life.
- The prevailing culture/ethos of “machismo” and “toughness” does not readily accommodate the need to report mental health problems and seek help. It also was also suggested as being a major reason why the heavy use of alcohol is a common feature of military life.
- Stigma is a prevailing issue in relation to mental health problems and help seeking.
- Support for partners of Service personnel is lacking, particularly for those of Reservists.
- Significant advances in military prehospital care and trauma management have generated a new major challenge in terms of the long term physical and emotional adjustment for severely injured personnel.
- Efforts by the Services to facilitate the transition from military to civilian life are inadequate, particularly for those who are most vulnerable to transition difficulties such as Early Service Leavers and those discharged on medical grounds.
- Differences in need exist between older and younger Veterans.
- A number of barriers to provision of mental health care for Veterans exist including:
 - attitudes and behaviours of the individual (e.g., fear of stigma, denial, excessive alcohol use);
 - attitudes and behaviour of others (e.g., employers, healthcare professionals, GPs), and
 - delivery of mental health services for Veterans (e.g., lack of specialist trauma services, conflict of interest between voluntary and statutory agencies, lack of integration among agencies).
- For some, the transition from military to civilian life includes a number of social and environmental problems in terms of employment, housing, finance, support for partners, and social exclusion

7.2 *The following key findings emerged from the review of eminence- and evidence-based literature.*

- Overall, the evidence suggests that military life is beneficial for the majority who serve and that their transition to civilian life is successful. However, there is a significant minority who fare badly, particularly Early Service Leavers (i.e., those who have completed fewer than four years of Service) and those who have served time at the Military Correctional Training Centre (MCTC) prior to discharge. Both of these groups are more likely to have had a previous history of childhood anti-social behaviour than their Serving counterparts.
- Military personnel with mental health problems are more likely to leave Service early and have an increased risk of ongoing social exclusion and ongoing ill-health.
- Pre-enlistment factors known to affect the risk of adverse health and wellbeing outcomes include: childhood traumatic experiences; socio-economic adversity; previous psychiatric history; personality, and coping style.
- Single males, of lower rank, with lower educational status and who have served in the Army are most likely to have experienced these adverse vulnerability factors in childhood. To what extent, however, this association would be significantly different from a similar age-matched group in the general population has yet to be established. Moreover, it is not known to what extent these findings would generalise to women.
- Recent KCMHR studies of Veterans report a prevalence rate of 4% for “probable” PTSD, 19.7% for symptoms of common mental health problems and 13% for alcohol misuse.
- Reports from the charitable sector suggest that presentation with combat-related mental health problems can be as long as 14 years post-discharge. There is however no evidence to suggest that ex-Service personnel are no more or less likely to seek help than people who have never served.
- Compared with their Regular counterparts, Reserve UK Armed Forces personnel (particularly medical reservists) have an increased risk of experiencing mental health problems as a consequence of deployment to Iraq and Afghanistan. However, the evidence suggests that this finding is more likely due to family issues prior to deployment, support to families during deployment, and experiences of home-coming than events in theatre.
- Relative to the general population, both serving and ex-Service personnel report higher levels of alcohol consumption (but only in younger age groups). Alcohol

misuse has also been identified as a problem affecting Service women.

- The overall rate of suicide is no greater among UK ex-Service personnel than in the general population. However, for men aged 24 years and less who have left the UK Armed Forces the risk of suicide is approximately two to three times higher than that of the same age group in both the general and serving populations.

7.3 *The following key research gaps in the evidence were identified.*

- Whilst a considerable body of literature exists on the health and wellbeing outcomes in respect of serving military personnel, few studies are specifically dedicated to those who have left the UK Armed Forces.
- Most of the literature relating to ex-Service personnel in this domain derives from the US. The extent to which the findings from such studies are generalisable to ex-Service personnel in the UK is limited.
- To inform service provision and the development of appropriate interventions it is imperative to establish the extent to which the Veteran population differ from those in the general population. Whilst there have been two studies in the UK that have adopted this approach, one in England (Woodhead *et al*, 2010), and one in Wales (Wood *et al*, in press), comparisons between the two are limited due to variations in the design, sampling strategies, and method of diagnostic assessments used.
- There is a paucity of robust epidemiological data about the health and wellbeing, views, expectations, and needs of ex-Service personnel and their families in Scotland, and how these compare with the general population. The current evidence-base is therefore not sufficient to design specific health strategies or develop new services—within or outside the conventional health care system—particularly in order to reach non-treatment seeking ex-Service personnel who suffer from mental health problems and are at risk of social exclusion.
- Although the number of Service women has gradually increased in line with the implementation of equal opportunities policies by the MoD, there is a paucity of research about their specific health and wellbeing needs, particularly post-Service.
- Given the evidence that military service has a positive impact for the majority of UK Armed Forces personnel, it is necessary to understand what factors facilitate and enable those with the same vulnerabilities to fare well by using

appropriate comparison groups. Such an approach would enable the UK Armed Forces to identify what could be done to improve the life chances of young people with pre-enlistment vulnerabilities in preparation for leaving military service.

- Although evidence suggests a link between areas of high social deprivation and offending behaviour, it is not known for example whether recruitment into the UK Armed Forces from such areas has a positive or negative impact on the risk of subsequent offending and incarceration of those particular recruits on leaving military service and to what extent there is regional variation.
- Relatively little is known about the health and wellbeing outcomes in the longer term for ex-Service personnel due to the paucity of large prospective longitudinal studies. Well-designed cohort studies offer a number of advantages in respect of identifying the longer term implications of military service.
- Given the increasing numbers of injured combat troops returning from Iraq and Afghanistan with complex trauma injuries there is a particular need for research to understand the longitudinal course of post-traumatic reactions and to assess the factors which may affect psychosocial adjustment. The post-acute clinical management of such cases in rehabilitation and primary care settings has not been adequately addressed in the literature.
- Very little is known about the impact of military and ex-Service life on partners and families.
- An increase in the deployment of reservists in the UK Armed Forces and concerns about poorer health outcomes following deployment highlights the need for a greater understanding of the impact of the additional challenges facing families of Reservists compared to the family members of Regular personnel.
- There remain gaps in the evidence with regards to determining the effectiveness of health and welfare interventions including establishing whether recommended treatments (e.g., for PTSD) are best delivered in specialist Veterans' mental health facilities or in the mainstream NHS (Fossey, 2010).

7.4 The outcome of the review confirmed the need to undertake a population-based survey in order to inform the national commitment to meeting the health and wellbeing needs of ex-Service personnel and their families in Scotland.

8. *The following design and funding recommendations were made.*

- Possible options for the design of a population based survey to inform policy development in meeting the health and wellbeing needs of ex-Service personnel and their families in Scotland need to take into consideration the following challenges.
 - Identification and tracking of Scottish Veterans and their families to permit a representative sampling frame and strategy.
 - Adequate sample size(s) to ensure sufficient power to detect statistically significant differences thereby maximising the generalisability of findings.
 - Recruitment and retention mechanisms to maximise compliance rates and minimise loss at follow-up thereby enhancing the representativeness of the sample(s).
 - Reliable and valid assessments.
 - Identification of index and comparison groups against which different sub-samples of the Veteran population (e.g., those who are at risk of social exclusion) could be meaningfully contrasted.
 - Data protection and ethical requirements (including identifying mechanisms to ensure the safety of research personnel involved in the recruitment and assessment of participants).
 - Costing requirements associated with possible approaches according to:
 - a realistic and feasible timeframe, and
 - a realistic estimation of the resources required (i.e., research personnel, travel, subsistence, equipment, consumables, consultancy, data entry and analysis).
- The design should be ambitious in terms of sample size to allow for detailed sub-group analysis and to take into account the potential effects of attrition due to the nature of the target population.
- Commitment should be sought for funding for at least 3 years but preferably longer to ensure that the long term value of the resource is fully realised.
- A mixed methods approach should be used to allow for the in-depth understanding of key issues (e.g., barriers to help seeking).
- The design must be founded on the rigorous application of population-based research methods to:
 - assess a broad range of health and wellbeing needs;
 - accurately identify those individuals who require health and social care services;

- reliably evaluate the use and perceived effectiveness of health and social support and clinical care currently available, and
 - identify factors conducive to recovery, wellbeing, and psychosocial adjustment.
- Given the likely scale of a population-based survey in Scotland and the range of interests it is likely to serve, a form of collaborative funding is recommended.

SECTION 1: Introduction

1.1 BACKGROUND TO THE SCOPING REVIEW

- Civilian authorities and service providers have the responsibility for meeting the needs and aspirations of Veterans and their families who currently reside in Scotland.
- The Scottish Government has certain devolved responsibility over a wide range of services that can be accessed by Veterans, such as healthcare, housing, social care, education and skills training, and employability.
- Responsibility for the co-ordination of Veterans' issues across the Scottish Government falls within the remit of the Mental Health Division of the Directorate of Primary & Community Care and the Social Inclusion Division.
- In a concerted endeavour to meet this responsibility, the Scottish Government has instigated a variety of initiatives designed to support Veterans in recognition of the fact that Scotland owes a debt to its service personnel and Veterans. To complement the Scottish Government's consultation paper on the wellbeing and welfare of the UK Armed Forces and Veterans in Scotland (26 June 2008), the Scottish Government's contribution to the MoD Command Paper "*The Nation's Commitment: Cross Government Support to our UK Armed Forces, their Families and Veterans*" (17 July 2008), set out its commitment to assist Service personnel and Veterans across Scotland. These included the launch of a new dedicated fund, the Scottish Veteran Fund, which marked for the first time direct investment from the Scottish Government in Veteran service provision and was designed to run as a complementary programme to the MoD administered Veteran's Challenge Fund. In addition, NHS priority treatment was extended to all Veterans (CEL 8, 2008), and the Scottish Government invested £930,000 in a pilot scheme dedicated to a community-based, one-stop-shop for Veterans' mental healthcare in an endeavour to provide them with effective support and comprising a partnership involving the NHS, *Combat Stress*, Veterans' organisations and others to deliver alternative approaches to care.

1.2 TERMS OF REFERENCE

- Following a meeting at St Andrew's House (Scottish Government, Edinburgh) on 11 February 2009, Mr Geoff Huggins (Head of Mental Health, Directorate of Primary & Community Care,

Scottish Government) commissioned the Aberdeen Centre for Trauma Research (ACTR, Robert Gordon University) to undertake a 6-week Scoping Review in collaboration with Wing Commander Walter Busuttill (Director of Medical Services, *Combat Stress*).

- In accordance with the grant conditions set out in Annex A of the Letter of Award from Mr Huggins (dated 24 April 2009), it was agreed that the grant not exceeding the sum of £13,215 for the purpose of a 6-week Scoping Review to examine the issues and possible methodological approaches to conducting a robustly designed population based survey of Scottish Veterans and their families. Based on an estimated start date of 4 May 2009, the expected outcomes were agreed as follows.
 - To use the data derived from the methods and work plan set out in the original proposal to define possible methodological approaches to conducting a robustly designed population based survey; including identification of cost requirements associated with the possible approaches.
 - To present the outcomes within agreed timescales to a core group of Scottish Trauma experts; and the Scottish Government, to inform next steps.
- This report presents the findings of that scoping review, the key aspects of which were presented to the Core Group of Scottish Trauma Experts on 17 June 2009 at St Andrews House (Scottish Government, Edinburgh). In addition, it provides a wide ranging examination of the policy context and how initiatives for meeting the health and wellbeing needs of ex-Service personnel and their families have developed along side key government themes and policy drivers. In acknowledgement of the breadth of the remit, the length of the review has been substantially extended and updated to provide a contemporary evaluation as a basis on which to move the agenda forward.

1.2.1 Aim

- The principal aim of this scoping review was to identify to what extent a population-based survey is required to inform the national commitment to meeting the health and wellbeing¹ needs of ex-Service personnel and their families in Scotland.

¹ Refers to the three main dimensions of emotional, social, and psychological wellbeing as defined in the consultation paper "*Towards a Mentally Flourishing Scotland: The Future of Mental Health Improvement in Scotland 2009-2011*".

1.2.2 Objectives

- In furtherance of this principal aim, the work undertaken focussed on fulfilling five specific objectives (*project deliverables*) to:
 - (i) review extant knowledge, practice, and service provision in respect of meeting the health and wellbeing needs of ex-Service personnel and their families;
 - (ii) identify existing gaps in the implementation of the Veterans Initiative at the policy, health systems, provider practice and community behaviour levels, which may compromise its effectiveness in fulfilling its strategic outcomes;
 - (iii) review relevant research activity to identify outcomes and gaps in the emergent evidence- and evidence-base;
 - (iv) identify possible methods for conducting a robustly designed population-based survey in Scotland with particular reference to the implications for comparative analyses, and
 - (v) provide indicative costs and timescales associated with the methods identified.

1.2.3 Parameters of the Scoping Review

- For the purpose of the scoping review, a holistic definition of health was used according to the World Health Organisation (WHO)²:
 - “*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*”.
- The most inclusive definition of the term “Veteran” has been used in line with MoD and UK Government policy and strategy. Unless otherwise specified, all references to “Veteran(s)” refers to all military personnel who have served more than one day (together with widows/ widowers and their dependents) in the UK Armed Forces (both Regular and Reserve personnel).
- For the purpose of this report, the term “UK Armed Forces community” includes:
 - Service personnel (i.e. **current** serving members of the UK Armed Forces – including the UK Reserve Forces);
 - Ex-Service personnel/ Veterans (i.e. **former** members of the UK Armed Forces), and

² Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

- Families (i.e. the **immediate** family members of either Service or ex-Service personnel/ Veterans)

1.2.4 Methodological Framework and Analytic Strategy

- The methodological framework for this scoping review derived from that suggested by Arksey & O'Malley (2005). As such, the methods used throughout the different stages were conducted in accordance with the views upheld by proponents of systematic reviews (Mays *et al*, 2001), although it should be noted that a scoping study is by definition a non-systematic review of the literature (Anderson *et al*, 2008a). The rationale for choosing this method was to ensure a comprehensive but selective coverage of current knowledge, practice, service provision and the emergent evidence- and eminence-base given the extensive nature of this field of enquiry. The work was subdivided into three inter-related phases based on what was deemed to be achievable within the short time-frame and budgetary constraints of this scoping review. The activities assigned to each phase are described below.
- *Phase I: compilation of a database*
This involved desk-based research to compile a database comprising the following three elements:
 - (i) *policy mapping* – to identify key papers that have shaped the policy context within which the Veteran care initiative has been developed.
 - (ii) *conceptual mapping* - to establish how particular terms are used in what context, by whom, and for what purpose given that it is recognised as an important element within broader literature mapping exercises (Anderson *et al*, 2008a).
 - (iii) *literature mapping* - to identify gaps in the emergent evidence base by conducting a selective and critical analysis of seminal studies and relevant reviews, which derive predominantly from the UK.
- *Phase II: consultation process*
This comprised both telephone and face-to-face interviews³ with a range of individuals within policy, practice, and academia. Their views and recommendations were specifically sought in order to provide: (i) valuable insights about key issues that may not be apparent from the literature, (ii) additional references to include in the review, and (iii) additional themes to inform the search process. The importance of consulting with key stakeholders is well

³ The mixed method used to conduct the interviews was adopted for pragmatic reasons to accommodate the short time-frame and modest budget.

recognised (Oliver, 2001) as are the techniques for doing so (Anderson *et al*, 2008a).

- *Phase III: synthesis of data*

This was dedicated to synthesising the data derived from *Phases I* and *II* in order to address the five specific objectives detailed above.

1.3 FORMAT OF THE REPORT

- The remainder of this report comprises the following broad outline.
 - *Section 2* is dedicated to understanding the context (both historical and contemporary) in which cross-Government policy on the provision of health and welfare support to the UK Armed Forces community has developed and to identify the key drivers of Veteran-related policy and strategy.
 - *Section 3* provides an overview of the current status of health and welfare support provision for the UK Armed Forces community in terms of its organisation and delivery.
 - *Section 4* summarises the views of those key informants who participated in the consultation process.
 - *Section 5* presents the outcome of the desk-based research undertaken in *Phase I* of the review, which comprises a critical and selective analysis of three main sources of data in order to: (i) establish the current status of knowledge based on evidence- and eminence-based practice in meeting the health and wellbeing needs of the Veterans' community, and (ii) identify in-progress research in this domain.
 - *Section 6* concludes by summarising the key evidence that has emerged from the scoping review and considers the case for undertaking a methodologically robust needs-based assessment and population-based survey of Veterans and their families in Scotland. In so doing, the extent to which similar studies conducted elsewhere might offer a valid blueprint for such a study is explored and potential models of funding and delivery are also addressed.

SECTION 2: Veteran-Related Policy, Strategy, and Commitments

2.1 PREFACE

The purpose of this section is twofold. First, it provides an overview of the evolution of Veteran-related policy and strategy in the UK following the launch of the Veterans Initiative in March 2001. Second, it describes the subsequent commitments made by UK Government and the Devolved Administrations in respect of providing health and welfare support for the UK Armed Forces community. In so doing, this section follows a chronological structure determined by the publication date of the relevant key papers and reports identified as part of this review (as shown in *Table 1*). To set the context within which these developments and commitments to advancing Veterans' affairs are considered, this section begins with providing some background information on the: (i) role, composition, and ethos of the UK Armed Forces, (ii) Scotland's contribution to the UK Armed Forces; (iii) composition of the Veterans community, and (iv) key drivers deemed to have had significant influence with regards to the evolution of the Veteran-related policy and strategy and the fundamental principles on which it is based.

Table 1. Key Strategy and Policy-Related Papers and Reports

Year	Title and Source
2003	<i>"Strategy for Veterans"</i> (MoD)
2003	<i>"Improving the Delivery of Departmental Support and Services for Veterans"</i> (Dandeker <i>et al</i> , Joint Report of the Department of War Studies and the Institute of Psychiatry, King's College London)
2008	<i>"Report of Inquiry into National Recognition of our Armed Forces"</i> (Report to the PM)
2008	<i>"Scotland's Veterans and Forces' Communities: Meeting their Well-being and Welfare Needs"</i> (Scottish Government Consultation Paper)
2008	<i>"The Nation's Commitment: Cross-government Support to our Armed Forces, their Families and Veterans"</i> (Command Paper 7424)
2008	<i>"Scotland's Veterans and Forces' Communities: Meeting our Commitment"</i> . (Scottish Government)
2008	<i>"The Government's Response to the Report of Inquiry into</i>

2009	<i>National Recognition of our Armed Forces</i> "The Nation's Commitment to the Armed Forces Community: Consistent and Enduring Support" (MoD Consultation Paper Cm7674)
2009	"The Nation's Commitment. Cross-Government Support to our Armed Forces, their Families and Veterans" (First Annual Report) (UK Government)
2009	"Annual Report on Scottish Government Support for our Armed Forces and Veterans Community" (Scottish Government)
2010	"Fighting Fit. A Mental Health Plan for Servicemen and Veterans" (Murrison, UK Government)
2010	"Across the Wire. Veterans, Mental Health and Vulnerability" (Fossey, Centre for Mental Health)
2010	"Report of the Task Force on the Military Covenant" (Strachan et al)
2012	"Our Commitments. Scottish Government Support for the Armed Forces Community in Scotland" (Scottish Government)
2012	"The Armed Forces Covenant Annual Report" (First Annual Report; MoD)

2.2 ROLE, COMPOSITION, AND ETHOS OF THE UK ARMED FORCES

- The UK Armed Forces enable the UK Government to fulfil its most important responsibility of providing security for the nation and for its citizens⁴. Approximately 187,880 service men and women (QMR, 2012) are employed by the Ministry of Defence (MoD) to "...protect and safeguard the United Kingdom and its overseas territories and to support the Government's foreign policy"⁵. In addition, the UK Armed Forces employ approximately 83,100 civilian staff who predominantly work alongside their respective uniformed counterparts, both in the UK and abroad (QMR, 2011). Overall, 17,610 are women employed in the UK Armed Forces (i.e., 9.7%), of whom 3,830 are officers as of 1 January 2012 (QMR, 2012).
- The UK Armed Forces is a hierarchical organisation that comprises the three services of the Army, Royal Navy [RN], and

⁴ 'The National Security Strategy of the United Kingdom: Update 2009. Security for the Next Generation, June 2009;

<http://www.cabinetoffice.gov.uk/media/216734/nss2009v2.pdf>

⁵ 'The Nation's Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans, July 2008; <http://www.mod.uk/NR/rdonlyres/415BB952-6850-45D0-B82D-C221CD0F6252/0/Cm7424.pdf>

Royal Air Force [RAF]). In accordance with its Diversity Vision, the MoD seeks to recruit “*a workforce that is drawn from the breadth of the society we defend*”, which is manifested in policies to recruit from a broad section of society including from deprived areas with high levels of unemployment and low levels of educational attainment. Recruits to the RAF and the RN however typically have more technical skills than their Army counterparts which may be in part due to differences in socio-economic status. The recruitment of sufficient, motivated people of the right calibre is regarded as critical to the maintenance of operational effectiveness. Whilst each of the individual Services has its own ethos and attracts recruits in accordance with single-services preferences, the Tri-Service Armed Forces Careers Offices were created in the 1990s to facilitate tri-Service harmonisation and promote the sharing of best practice among the Services.

- The Army represents the largest service with a full time trained strength⁶ of 99,670 Regular soldiers compared with the 38,930 personnel in the RAF and 34,430 personnel in the RN (QMR, 2012). Approximately 87% of service personnel are located in the UK. Of the 24,230 service personnel who are based overseas, 77% are stationed in Germany, Belgium and the Netherlands. Currently the UK Armed Forces have around 9,500 troops serving in Afghanistan⁷, as part of a coalition force comprising more than 100,000 western troops, 65,000 of whom are US military.
- To sustain its defence capability, the MoD has previously maintained that it would need to recruit approximately 20,000 men and women per year to the UK Armed Forces. The last intake in 2010/2011, however, was down to 12,800 in total reflecting the outcome of the 2010 Strategic Defence and Security Review (which sets out how the Government will deliver the priorities identified in the National Security Strategy), which proposed reductions in manpower over the next five years across all three Services and the civilians in Defence.
- Fundamental to ensuring the provision of the UK’s defence capability are the Reserve Forces, which comprise both Volunteer⁸ and Regular Reservists⁹. Among the tri-Services, the

⁶ Full-time strengths include UK Regulars, Trained Gurkhas and fulltime Regular Service (FTRS).

⁷ The British Prime Minister, Gordon Brown MP, announced plans in October 2009 to raise troop numbers in Afghanistan by 500 to 9,500.

⁸ Dedicate their spare time to train and have a liability to be called up and deployed alongside their Regular counterparts. The minimum commitment is 27 days training per annum (or 19 days for some specialist units). They are paid an annual bounty (a tax free lump sum bonus for meeting their training commitment) and are paid per day or part day for training that they complete in addition to expenses. On mobilisation, they effectively

nature and strength of the Reserve Force vary and there are several different types of Reserve service. However, all are subject to the Reserve Forces Act 1996 (RFA96). Prior to the late 1990s, the Reserve Forces were only used at times when the vital interests of the nation were under threat¹⁰. Since 2003, in excess of 18,000 Reservists have been deployed along with their Regular counterparts. Over the past five years, there has been a strategic shift in respect of their contribution as a part-time professional force to operations. In announcing the Strategic Defence and Security Review on 19 October 2010, the Prime Minister commissioned an independent review of the Reserve Forces, to ensure that their skills, experiences and capabilities are used to maximum efficiency by the MoD. The Commission's final report, *Future Reserves 2020* (FR20), recommended that Defence should adopt the Whole Force Concept (i.e., "*Defence is supported by the most sustainable, effective, integrated and affordable balance of Regular military personnel, Reservists, Ministry of Defence civilians and contractors*"). To effectively implement such a concept requires a substantial increase in the overall proportion of Reservists in the UK Armed Forces structure. By 2015, FR20 recommends increased manning levels across all Reserve Forces to be: Territorial Army (TA; from 20,000 to 30,000), Royal Navy Reserve/ Royal Marine Reserve (RNR/RMR; from 1,900 to 3,100) and Royal Auxiliary Air Force (RAuxAF; from 1,180 to 1,800).

- Although historically women have played a vital role in the UK Armed Forces¹¹, it was not until the early 1990's that a significant change in the peacetime duties of women military personnel was effected and their roles were fully integrated resulting in the abolition of the separate Women's Services in the Army and Naval Service. In 1997, the Secretary of State for Defence announced plans to extend opportunities for the employment of women in the UK Armed Forces. Since 1998, women have been able to serve in front line positions on naval vessels, as pilots of combat aircraft, and in combat support roles in the Royal Artillery and the Royal Engineers along side their male counterparts without restriction on deployment unless they are pregnant or where the primary duty is "*...to close with and kill the enemy*". Thus, women can serve in administrative and

become Regulars paid at full time rates according to rank. Should their civilian salary be higher than that accorded to their military rank, additional remuneration is paid and legislation is in place to protect their civilian jobs (Report on the Strategic Review of Reserves, 2009).

⁹ Former members of the Regular Forces who have liability for mobilisation.

¹⁰ Report on the Strategic Review of Reserves, MoD, 2009

¹¹ For example, during WWII women were employed in a wide variety of roles, some of which (e.g., pilots) exposed them directly to the dangers of front line combat.

supportive roles in the Royal Marines General Service, the Household Cavalry, the Royal Armoured Corps, the Infantry, and the Royal Air Force Regiment, otherwise they are debarred from serving in these units.

- In order for the MoD to meet its recruitment targets and hence operational commitments, the Service also needs to attract those who are under the age of 18 years in order to compete effectively in an increasingly competitive employment market. Whilst previous MoD intake figures to the UK Regular Forces (UKDS, 2007/2008) confirm that over half of the 21,325 new recruits were aged between 16 and 19 years, there are no data available in respect of age distribution for the 12,800 intake reported by UKDS 2010/2011. However, in the Army, potential recruits tend to be aged between 16.9 and 33 years¹². The MoD take the view that, by recruiting from this age group, the UK Armed Forces provides a valuable and constructive training and employment to many young people who might otherwise encounter difficulties in obtaining employment in civil life had they not joined up. It is also the case however that, given the very different nature of Service life and commitment, the MoD is keen to recruit individuals before they have made other lifestyle choices (*"Government's Response to the House of Commons Defence Committee's Third Report of Session 2004-05, on Duty of Care"*, July 2005).
- On joining up, all recruits are required to undergo intensive training that is both physically and mentally demanding. Furthermore, all recruits must be medically and physically fit for world-wide deployment. A culture of discipline, reliance on others, and acceptance of others is instilled by the tri-Services to equip their personnel with the necessary skills and attitudes for the full spectrum of military operations (including engagement in combat). There is a clear chain of command¹³ through which orders are issued and problems are dealt with. Commanding Officers are therefore responsible for the care of all Service personnel under their command. Moreover, a strong sense of camaraderie prevails among unit members, which is fostered through shared experiences, hardships and deprivations in training. Such camaraderie therefore is regarded as essential

¹² The exception to this is for those who apply for the position of junior soldier when the age limits are from 15.7 to 17.1 years.

¹³ The chain of command is the line of authority and responsibility along which orders are passed within a military unit and between different units. Orders are transmitted down the chain of command from the higher ranks to the lower ranks until it is received by those expected to execute it. In general, military personnel give orders only to those directly below them in the chain of command and receive orders only from those directly above them. The UK Armed Forces regard the chain of command as the "backbone" that enables them to work effectively.

to ensuring that each unit possesses a good *esprit de corps*. The traditions and honour of a military unit or corps also play a significant part in ensuring a sense of pride, belonging and inheritance by its members.

- Although recruits are required to forsake a few of the freedoms they enjoyed as civilians to adapt to military life and ethos, military life is considered to be “a great leveller” which provides a positive experience for the majority (Dandeker *et al*, 2003). To this end, most of those who leave the UK Armed Forces suffer no ill effects from being in the military and achieve a successful transition to civilian life. However, understanding the background of recruits is regarded as a key factor when determining how military life may impact on later life. Recruiting grounds have traditionally been areas of economic and social deprivation (Fossey, 2010).

2.3 SCOTLAND’S CONTRIBUTION TO THE UK ARMED FORCES

- Scottish military links and heritage play an important role in its national identity¹⁴ historically with respect to the famous Scottish Regiments (now amalgamated into the Royal Regiment of Scotland). Furthermore, Scotland makes a significant contribution to UK defence both at home and abroad with an estimated 12,000 service personnel¹⁵, 5,000 volunteer reservists and 10,000 cadets as well as 10 University Squadrons and Corps. The tri-Services have a substantial presence at approximately 400 sites located across Scotland.
- The MoD contributes on average £600 million per year to the Scottish economy. In addition to the 20,000 personnel employed by the MoD and UK Armed Forces, approximately 11,000 Scottish jobs are directly dependent on Defence contracts within industry such as those relating to the production of ships and equipment to support operations.

2.4 COMPOSITION OF THE VETERAN COMMUNITY

- The official classification of a “Veteran” pertains to all military personnel who leave the UK Armed Forces (whether Regular or Reserve) having received one day’s pay from the MoD (KCMHR,

¹⁴ For example, a number of navy ships and submarines have strong links with local towns and cities that bear their names including HMS Edinburgh and HMS Montrose.

¹⁵ Located in five of the 15 Local Authority areas, *viz*, Argyll and Bute, Moray, Fife, and the City of Edinburgh.

2006)¹⁶. Between 2010 and 2011 the outflow from UK Regular Forces for all three Services was 18,150 (UKDS, 2011). Because personnel leave the Service following different lengths of service and at various stages of their career the Veteran population comprises individuals who require differing levels of support.

- The widows/ widowers and dependants of Veterans are recognised as being part of the Veteran community thereby constituting an extensive and disparate population. Consequently, to obtain accurate estimates of its size in the UK and in Scotland is a key challenge, the reasons and implications of which will be addressed in Section 6. However, the UK Government in devising its Veteran-related policy and strategy have relied on the estimates which originally derived from a Research Surveys of Great Britain (RSGB) omnibus survey of 2005 commissioned by the *Royal British Legion*.
- The *Royal British Legion* commissioned-research involved a nationally representative sample of 6,200 UK adults aged 16 years and above living in private residential households, of which 1,200 respondents were in the adult Veteran community. Based on the outcome of that survey, the size of the UK Veteran community (i.e., Veterans and dependents) was estimated to be around 10.5 million people, which equates to 18% (or one in six) of the total UK population. Of these, approximately 4.8 million people were Veterans. The average age of the adult Veteran community was 63 years (compared with 47 years in the general adult population), and were predominantly white. Eighty four per cent of Veterans were men and 94% of adult dependants were women. Veterans typically served with the UK Armed Forces for six years and were discharged from Service over 40 years ago.
- Of the 10.17 million estimated to be living in private residential households in the UK, the *Royal British Legion* proposed that around 10% reside in Scotland (2005). On this basis, in their 2005 report into the needs of Veterans living in Scotland, *Poppyscotland* calculated that the total ex-Service community for Scotland would comprise 1.017 million living in private residential households with the remaining 0.4 million residing in communal establishments (e.g., residential homes and hostels). Because the *Royal British Legion* omnibus survey did not include the latter, *Poppy Scotland* used the 1.017 million as the basis for estimating the size of the Veteran community in Scotland of which 480,000 were Veterans. The age profile for the Veterans'

¹⁶ The term "Veteran" can also, exceptionally, include those members of the Merchant Navy who have contributed to military operations.

community in Scotland was generated using the same assumptions. To this end, *Poppyscotland* estimated that 75% of the adult Veterans' community would be 55 years or more with only 8% falling below 35 years of age.

- In a 2006 publication entitled "*Future profile and welfare needs of the ex-Service community*", the *Royal British Legion* predicted that the Veteran population will reduce in size from 4.8 million to 3.1 million by 2020. A more recent estimate of the Veteran population in England based on data from the 2007 Adult Psychiatric Morbidity Survey (APMS) suggested that the 3.8 million Veterans residing in private households would be expected to halve over the next 20 years as the proportion of National Service Veterans reduces with time (Woodhead *et al*, 2009).

2.5 KEY DRIVERS OF VETERAN-RELATED POLICY AND STRATEGY

- According to Downey (1977), the defence policy of a nation is essentially a reconciliation of the following three inter-related factors.
 - (i) How the nation assesses threat to its security or its policies.
 - (ii) To what extent it sees a military response as necessary and justified.
 - (iii) What manpower, equipment and military organisation can be provided with the money and other resources allocated.
- Historically, however, the human personnel contribution to defence has tended to be sublimated by a focus on strategic and technological issues (Dandeker *et al*, 2003). Indeed, it is only since the end of the Cold War that human resource issues have assumed a higher priority in forming part of a coherent strategic approach intended to address the provision of health and welfare support in respect of the UK Armed Forces community.
- In 1998, the Secretary of State for Defence, the Rt Hon George Robertson MP, presented to Parliament the White Paper "*Strategic Defence Review*" (MoD, 1998), which detailed a radical agenda for change to reshape and modernise the UK Armed Forces in an endeavour to meet the challenges of the 21st Century. For the first time, a "*Policy for People*" was included which sought to acknowledge the unique operational demands made on those who serve in the UK Armed Forces and their civilian counterparts (as well as the impact on their

dependents). In particular, it emphasised the need for the implementation of a number of initiatives which would address key issues relating to the recruitment and retention of personnel including problems associated with undermanning, overstretch, and training wastage. Although some attention was devoted to identifying ways of improving operational welfare provision for Service personnel and their families, the underlying rationale for the initiatives proposed inclined more towards addressing the needs of the military (e.g., enhancing manpower requirements and ensuring a better return on the investment in training) rather than addressing the specific needs of serving personnel and their dependents.

- In February 2002, however, the publication of the first UK Armed Forces Overarching Personnel Strategy (MoD, 2002/2003) document established the broad principles of the UK Armed Forces approach to Service and ex-Service personnel policy by including a theme entitled “*Remember*” to address the need to provide ex-Service personnel and their dependants with help and support, particularly with regard to resettlement back into civilian life.
- In July 2003, the publication of a joint report of the Department of War Studies and the Institute of Psychiatry (King’s College London [KCL]) entitled “*Improving the Delivery of Cross Departmental Support and Services for Veterans*” (Dandeker *et al*, 2003) identified five strategic themes as being fundamental to shaping the Veterans Initiative, *viz*, identity, communication, care, recognition and education. *Table 2* summarises the objectives for each theme and its associated benefits in enhancing the overall status of Veterans in accordance with that proposed by the KCL team. The development of a more effective partnership between the UK Government and Veterans’ organisations was also highlighted as being crucial to achieving these objectives. The underlying rationale for the strategic themes has been attributed largely to those moral, economic, and political factors, which impact on the status of Veterans in civic society and determine the extent to which there is public support for the UK Armed Forces community (Dandeker *et al*, 2003). A summary of the nature and implications of each of these three factors is provided below.

Table 2. Summary of Strategic Themes, Objectives and Potential Benefits

Themes	Objectives	Potential Benefits
<i>Identity</i>	<ul style="list-style-type: none"> ➤ Increase self worth ➤ Establish acceptance in civilian society. 	<ul style="list-style-type: none"> ➤ Enhance recruitment and retention for Regular and Reserve forces.
<i>Communication</i>	<ul style="list-style-type: none"> ➤ Enable two way interaction between MoD and Veterans. 	<ul style="list-style-type: none"> ➤ Facilitate the monitoring of health and social welfare. ➤ Target resources to those most in need.
<i>Care</i>	<ul style="list-style-type: none"> ➤ Observe “duty of care”. ➤ Provide appropriate care. ➤ Facilitate integration into civilian society. 	<ul style="list-style-type: none"> ➤ Reduce prevalence of psychological and social problems. ➤ Enhance positive perception of the UK Armed Forces by the public.
<i>Recognition</i>	<ul style="list-style-type: none"> ➤ Increase understanding of Veterans’ achievements and issues. 	<ul style="list-style-type: none"> ➤ Enhance the media portrayal of the UK Armed Forces and its personnel (Serving and ex-Service) ➤ Improve the image of the UK Armed Forces community. ➤ Garner public support.
<i>Education</i>	<ul style="list-style-type: none"> ➤ Improve civil-military understanding. ➤ Engender appreciation for the sacrifices made on behalf of the nation. 	<ul style="list-style-type: none"> ➤ Obtain public approval for the investment in Veterans.

2.6 MORAL AND SOCIAL FACTORS

2.6.1 Recognition of Sacrifice

- By joining military service, personnel agree to sacrifice certain civil liberties and to follow orders including those which put their lives at risk in defence of others. Deployment to support UK national interests or to strengthen international peace and security operations may arise unexpectedly and for indeterminate periods of time. As part of a fighting force, this also exposes those deployed on operational duties to dangerous and potentially life threatening situations, which carry a risk of physical and psychiatric injury. In return for that sacrifice there was a reciprocal promise that the Nation will help and support the UK Armed Forces and their families, particularly in respect of those who have been damaged in military service.
- Acknowledged by all three Services, this mutual promise was enshrined in the "Military Covenant"; a term coined in 2000¹⁷ to describe an inherent social and moral commitment that exists among the Nation, Government and Service personnel. Thus, in return for the sacrifices that Service personnel made, the State had an obligation to recognise that contribution and retain a long term duty of care toward Service personnel and their families. It embraced the expectation that the UK Government should recognise the unique demands placed on military personnel, which sets them apart from all other occupational groups who serve and protect society (e.g., police, prison officers and ambulance personnel) The responsibilities detailed therein included a lifelong duty of care to provide for the physical and psychological wellbeing of all serving and ex-Service personnel and their dependents. Dandeker *et al* (2003) suggest that one of the key benefits for the UK Government in reminding the public of the nation's moral obligation to repay its debt of gratitude is that it should help Veterans to feel valued by society thereby boosting their self-esteem and perceptions of self-worth which in turn will improve public perceptions (particularly by means of positive reporting in the media). Moreover, an enhanced understanding and appreciation of the UK Armed Forces by the public should elevate levels of recruitment and retention and support for military operations.
- In view of the fact that the Military Covenant had no statutory basis, in 2010 the Coalition Government made a commitment in their "*Programme for Government*" (May 2010) to "work to

¹⁷ Some suggest that the obligations associated with the Military Covenant were evident long before 2000 (McCartney, 2007).

rebuild the Military Covenant" using a series of "low-cost policy ideas". The Government subsequently indicated an intention to enshrine the Military Covenant in law for the first time. An independent Task Force on the Military Covenant, chaired by Professor Hew Strachan, was established in summer 2010 to support the work to "rebuild the Military Covenant" and published its Report on 8 December 2010. A number of recommendations were made by the Task Force as to how the Government could rebuild the Covenant through various local and national initiatives, such as the "Armed Forces Community Covenant", the principal aim of which was to enable central and local government, charities and society to more widely embrace and support the "Armed Forces Family"¹⁸ from "cradle to grave". Three big themes were identified, as follows.

- *Local partnerships* – to facilitate effective delivery of support to and recognition of Veterans within civilian communities.
 - *Education* – to promote greater understanding of the UK Armed Forces by the general public, and help Serving personnel to remain in Service longer and be better prepared for the transition to civilian life.
 - *Communication* – to promote a wider understanding of the UK Armed Forces, and to make Serving personnel aware of their rights and opportunities available to them.
- The Armed Forces Covenant was published in May 2011. Its core principles are based on the premise that members of the UK Armed Forces Community should not suffer disadvantage as a result of their service and that where appropriate they may receive special treatment (especially those that have been injured or bereaved). As such, it defines the following 15 themes within the scope of the Covenant.
 - Terms and Conditions of Service
 - Healthcare
 - Education
 - Housing
 - Benefits and Tax
 - Responsibility of Care
 - Deployment
 - Family Life
 - Commercial Products and Services
 - Transition

¹⁸ Defined by Strachan *et al* (2010) as consisting of: Serving personnel, Veterans, reservists and their respective families including the bereaved.

- Support After Service
 - Recognition,
 - Participation as Citizens
 - Changes in Defence and Recourse
- The principles of the Armed Forces Covenant were subsequently enshrined in law for the first time after the Armed Forces Bill received Royal Assent on 3 November 2011. The new Armed Forces Act 2011 creates the requirement for an annual Armed Forces Covenant report to Parliament each year by the Secretary of State for Defence. The first Armed Forces Covenant Annual Report was published on 6 December 2012 to summarise achievements since the interim report last year (e.g., introduction of the Community Covenant with a £30m grant scheme to support it) and planned initiatives and commitments to address the disadvantages that remain (e.g., obtain funding for a study into support for the bereaved and the families of those who have been injured).

2.6.2 “Duty of Care”

- In response to the exceptional demands of military service¹⁹, Service personnel have a right to expect the MoD to fulfil not only its legal obligations as an employer but also its moral ones as part of its “duty of care”. In so doing, the demands placed on both Service personnel and their families should be *reasonable* in order to mitigate the stresses and difficulties associated with Service life. Part of the conditions of their employment, as stated in The Armed Forces Overarching Personnel Strategy is that, where circumstances permit, the MOD will “*take steps to minimise risks to life or health, and where appropriate, provide treatment, rehabilitation and after care*” (MoD, 02/03, p.10). In undertaking such steps, Dandeker *et al* (2003) argued that improvements in the provision of health and social welfare support of Service personnel and Veterans will reduce the likelihood of damaging media coverage thereby helping to increase public support for the UK Armed Forces community.

2.6.3 No Disadvantage

- Strategic thinking on Veterans’ issues has been underpinned in particular by the fundamental principle that those who serve in the UK Armed Forces should not suffer any disadvantage by virtue of their Service commitment to protecting the security of

¹⁹ These include the fact that war can cause psychological and physical damage, which in some cases may be long term or even permanent (Alexander & Klein, 2008).

the nation and its citizens, particularly in terms of that which is incurred as a result of the Service mobility requirement. Such thinking is based on the moral obligation by the UK Government to ensure fair treatment and to implement appropriate measures to ensure that special provision is rapidly made available and in accordance with need.

2.7 ECONOMIC FACTORS

2.7.1 Recruitment

- To sustain a sufficient war-fighting capability in accordance with the UK Government's strategic objectives, it is estimated that the UK Armed Forces requires approximately 18,000 personnel to join the trained strengths having successfully completed basic training; a target which typically demands around 25,000 new recruits per year (Armed Forces Overarching Personnel Strategy, MoD, 2002/2003). The recruitment and retention of personnel however represents an ongoing challenge for the MoD as numbers fluctuate by virtue of changes in the socio-economic climate. When national economic conditions are favourable, the UK Armed Forces have fewer recruits thereby restricting choice during selection. In times of economic adversity, the number of recruits increases as does the choice for selection whilst fewer leave military service prematurely (Fossey, 2010).
- Public perception of the military and its appeal as a career are also considered important factors in affecting recruitment rates as evidenced by the recruitment policy cited in the Armed Forces Overarching Personnel Strategy which declares that one of the key principles of recruitment is to "*...project the Armed Forces as careers of first choice for all people*" (MoD, 2002/2003).

2.7.2 Retention

- Overstretch in the UK Armed Forces has been heralded as a common and complex problem due to the extent to which the two major combat operations in Iraq (OpTELIC) and Afghanistan (OpHERRICK) have exacted a substantial toll and will continue to do so for the foreseeable future. Despite the fact that operations have since ceased in Iraq, it could take a considerable number of years to resume normal operating tempo particularly given that operational demands in Afghanistan may negate any gains achieved from the withdrawal of troops from Iraq. To sustain the high demand for troops²⁰ has required that many serve for

²⁰ According to MoD figures, 12,000 Service personnel were involved in operations in Iraq and Afghanistan.

longer periods and on a more frequent basis in theatre; a circumstance which is exacerbated by the six month deployment policy that requires massive redeployment twice a year. A gap of one year between operational deployments is therefore not uncommon. Moreover, troops may spend a significant proportion of time prior to deployment away from home to undertake essential training and preparation. During 2008, approximately 10.3% of the Army were in breach of the Harmony Guidelines²¹ (particularly the infantry among whom 30% of all soldiers exceeded the separated allowance guidelines), and 6.2% of RAF personnel were deployed in excess of 280 days.

- The direct link that exists between overstretch and manpower requirements means fewer Service personnel available to deal with the rise in operational demands. A previous report by the National Audit Office (HC 1633, 2005-06) found that deployment spent on overseas operations and time away from home represent key reasons for leaving the UK Armed Forces. However whilst financial incentives²² used by the MoD as a means to improve recruitment and retention may be successful in the short term, a House of Commons Committee of Public Accounts Report (HC 43, 2007) suggest that key reasons for leaving (e.g., inability to plan ahead in life outside work and the impact of Service life on family life) have not been addressed adequately.

2.7.3 Litigation

- The circumstances under which military personnel might sue the Crown in respect of personal injury suffered in a theatre of combat is an issue with which the MoD has had to contend since the suspension of statutory immunity in 1987 (Rowley, 2004).
- The class action brought against the MoD by Veterans suffering from Post Traumatic Stress Disorder (PTSD) has since served to

²¹ All three Services have agreed Harmony Guidelines to allow members of the UK Armed Forces to have sufficient time to recover from operations; for unit, formation and personal training and development; and to spend more time at home with their families. The RN guidelines determine that personnel spend, on Defence (2008), in 2007 around average, 60 % of their time deployed and 40 % alongside in their home port during a three-year period. The maximum individual threshold (separated service) is 660 days away from their normal place of work in the same three year period. The Army guidelines determine that soldiers can be deployed for one six-month tour in every 30 months (6 on, 24 off) and during that 30 month period a soldier should not expect to be away from his or her normal place of work for more than a total of 415 days. The RAF guidelines determine that personnel should not spend more than 280 days in every 24 months away from their normal place of duty.

²² In recognition of the challenges associated with being deployed on operational tours in conflict areas, the MOD introduced, in October 2006, a £2,240 tax free allowance for all Service personnel deployed to Bosnia, Iraq and Afghanistan.

highlight the potential financial costs of failing to implement policies²³ to protect Service personnel from psychological injury.

- Although the judgement handed down in May 2003 was in generic favour of the MoD²⁴, the judgement contained a number of criticisms of the MoD in respect of prevention, training, detection and treatment. Two important mental health initiatives were set up by the MoD in response to that judgement. The first was an Overarching Review of Operational Stress Management and the second was the establishment of the Mental Well Being Steering Group (MWBSG) which considered policy and practice on suicide, deliberate self harm, and stress in the workplace, including the application of the new Health and Safety Executive stress management standards.

2.8 POLITICAL FACTORS

2.8.1 Public Support

- A public understanding of the military and recognition of their role is considered fundamental in determining the climate within which the military can effectively recruit and the willingness of the taxpayer to finance the UK Armed Forces²⁵. Yet, there is an increasing concern that civil-military relations are being compromised due to a substantial reduction in the visibility of the military²⁶ (Strachan, 2003).
- Dandeker *et al* (2003) provide a comprehensive review of the mitigating circumstances deemed responsible for the divide that exists increasingly between the military and civic society. One of the key reasons for the diminishing military footprint is the fact that, since 1914, the proportion of the British population who have either had direct experience of the UK Armed Forces or who have a family member with such experience has substantially decreased. Hence, the number of those who directly experienced the legacy of the First and Second World Wars which included a "...sense of righteous struggle, an

²³ The Veterans alleged that the UK Armed Forces had failed to support, train and prevent them from developing psychological injury and then to detect it and to provide appropriate treatment. All had served during the period 1979-1994, the majority in Northern Ireland, the Falklands or the Gulf.

²⁴ Twelve out of the 16 cases were found in favour of the MoD. The remaining four cases that lost the judgement pertained to individual issues rather than institutional failure (Over-Archiving Review of Operational Stress Management: Phase 2-Training and Communication Strategies; 28 April 2005).

²⁵ The prevailing controversy over defence policy and operations in respect of the Iraq invasion and, increasingly the campaign in Afghanistan, highlights the extent to which public support plays an important role in terms of determining military success from a moral, political, and economic perspective (Chalmers, 2009).

²⁶ A phenomenon commonly referred to as the "military footprint".

affirmed nationalism, and a pride in military achievement" (Black, 2004, p.10) are rapidly becoming a minority²⁷.

- More recently, as challenges to the security of the nation become increasingly focused on the threat of terrorism (particularly on an international level), a number of changes in military practice have resulted in a substantial restriction on; (i) the wearing of uniforms by military personnel in public²⁸; (ii) access by the public to military installations (exacerbated also by health and safety" regulations), and (iii) military displays and Open Days.

2.8.2 Social Exclusion

- By virtue of a wider political agenda, the UK Government have sought to address the needs of those vulnerable groups who are most at risk of social exclusion²⁹, particularly in respect of people with mental health problems (e.g., the National Social Inclusion Programme, 2004).
- In addition to the moral case for helping those in need, Dandeker *et al* (2003) have also highlighted the financial gains for the UK Government in enabling their citizens to make a productive contribution to society. Whilst the evidence suggests that the majority of Veterans effect a positive adjustment to civilian life following demobilisation, there are a significant minority who, for a variety of reasons (including service-induced ill health and/ or injury) are at risk of social exclusion. To this end, the case for assisting Veterans may pertain more to the fact that they are entitled to effective support from the UK Government because they fall within the socially excluded category rather than because of their unique and deserving social status as a Veteran *per se*.
- Furthermore, it has also been argued that this particular issue has been instrumental in determining the UK Government's decision to adopt the most inclusive definition of the term "Veteran" in developing a Veteran-related policy and strategy³⁰.

²⁷ The longest-lived founding member of the RAF and the only remaining First World War Veteran, Henry Allingham, died in 2009 aged 113.

²⁸ Restrictions on military wearing uniforms in public were originally imposed following the IRA threats of the 1970s and 1980s.

²⁹ The concept of social exclusion originated in the UK in the critical social policy of the 1980s (Levitas, 2006). It has become increasingly prominent in association with discussions pertaining to disadvantage which extend beyond material deprivation and encompass the notion of participation in mainstream social, cultural, economic and political activities (Morgan *et al*, 2007).

³⁰ The inclusive definition of the term "Veteran" pertains to all military personnel who have served more than one day (together with widows/ widowers and their dependents) as well

2.9 EVOLUTION OF VETERANS POLICY AND STRATEGY

- In March 2001, the Veterans Initiative (which subsequently became known as the Veterans Programme) was launched to raise awareness of the role and contribution of Veterans in society and to address specific issues of concern to the Veteran community. A Minister for Veterans (Rt Hon Don Touhig MP) was appointed by the Prime Minister to provide a UK Government focus for Veterans' issues to ensure that they were approached in a systematic fashion cross government. In addition, the Minister for Veterans is responsible for helping the country to understand and celebrate the achievements of its Veterans as well as chairing the Veterans Task Force, the Veterans Forum and the Veterans Plenary³¹.
- In March 2003, the Strategy for Veterans was launched based on framework that comprised three key "pillars", as summarised in *Table 3*. Communication, research and adequate sources of funding were regarded as essential to underpinning the success of the work undertaken in affiliation with the three work streams. In adopting the so-called "through life" approach the Strategy for Veterans recognised the need for an "evolutionary" approach to accommodate any changes that ensued over time with respect to the nature, size and requirements of the Veteran community. On this basis, the strategy also sought to target Service personnel (on the grounds that they represent future Veterans); ex-Service organisations (given that they represent Veteran groups); the public (with particular emphasis on the younger generation), and service providers. A structured plan of action was also formulated to enhance service delivery in respect of those Veterans presenting with specific needs that are distinct from those civilians who have not served in the UK Armed Forces. The primary nature of the roles of each of the key partners along with examples of their designated responsibilities is provided in *Appendix A*.

as those members of the Merchant Navy in recognition of their vital contribution to supporting military operations.

³¹ This is an annual meeting attended by a wide range of representatives from the Veterans community and Government. Its objective is to enable the Minister for Veterans to deliver the strategic priorities of the Veterans Initiative and to provide updates on progress achieved.

Table 3. Summary of Key Components of the Strategy for Veterans

Objectives of Key Pillars	Focus of Pillar-related Work Streams	Intended Activities
<i>"To ensure excellent preparation for the transition of Service personnel back to civilian life"</i>	Transition	(i) In-Service improvement of: <ul style="list-style-type: none"> ▪ training regimes ▪ healthcare (treatment and rehabilitation) ▪ educational opportunities, personal development, qualifications (ii) High quality pension schemes and no fault compensation schemes for Service-induced injury and illness (iii) Improved identification of and response to the needs of vulnerable Service leavers.
<i>"To provide advice and support for those Veterans who require it"</i>	Support	(i) Provision of information and practical assistance to war pensioner and widow(er)s (ii) Working in partnership with those responsible for the delivery of the programme to ensure: <ul style="list-style-type: none"> ▪ needs are reflected in wider public policy and support arrangements. ▪ problems associated with social exclusion are adequately addressed. ▪ awareness of health issues and special needs are raised with civilian healthcare providers.
<i>"To ensure that the nation recognises, understands and commemorates Veterans' contribution in society."</i>	Recognition	(i) To promote: <ul style="list-style-type: none"> ▪ public awareness of the contribution of the UK Armed Forces ▪ the contribution of Veterans to society. ▪ commemorative events and projects including an annual Veterans Day.

- A subsequent review of the Strategy for Veterans was undertaken to establish whether a change of direction was necessary on the basis of progress achieved. The outcome of this review was presented by the Minister for Veterans (Rt Hon Don Touhig MP) in the form of the revised Strategy for Veterans. Although the review confirmed that the broad approach of the original strategy remained pertinent (thereby endorsing retention of the three key pillars of the strategy, *viz*, transition, support, and recognition), it also proposed some specific changes which were associated with the importance attributed to:
 - recognising the importance of feeding back appropriate lessons learned into the MoD policies;
 - reinforcing the importance of research (as evidenced by the intention to instigate a separate Veterans Research Strategy);
 - raising awareness among the general public, service deliverers and Veterans themselves about issues that affect Veterans and the help available to them;
 - improving communication among those responsible for the delivery of services and policies for Veterans (given that this particular element is regarded as being pivotal to the success of the Veterans Programme);
 - exploring ways to improve service delivery, and
 - setting clear and measurable objectives to demonstrate real improvements in the lives of Veterans.

- In 2004, the Veterans Policy Unit (VPU) was formed from the merger of the Gulf Veteran's Illnesses Unit and the Veterans Affairs Secretariat. The role of the VPU is to provide support to the Minister for Veterans and Under Secretary of State for Defence. Comprising both military and civilian personnel, the VPU covers a wide range of policy issues and Veteran-related projects in accordance with the remit of the Strategy for Veterans.

- Commissioned by the Prime Minister (Rt Hon Gordon Brown MP), the first ever cross-Government strategy for supporting the UK Armed Forces community was originally announced by the Minister of State for the UK Armed Forces (Rt Hon Bob Ainsworth MP) on the 8 November 2007.

- In December 2007, the Prime Minister, Rt Hon Gordon Brown MP (with support from the Secretary of State for Defence)

requested an independent inquiry³² into the relationship between the UK Armed Forces and the rest of society based on evidence derived from 300 serving members across all ranks in the three Services and a substantive consultation with a wide range of stakeholders and persons of influence in respect of military matters.³³ Views were also sought from personnel in USA, France and Canada, by virtue of the experience of these three democratic countries in regularly deploying their forces in combat operations. The rationale for this Report of Inquiry was based on concerns about a decrease in public support due to the anticipated erosion of their familiarity and understanding of the UK Armed Forces (as described in Section 2). In line with a public opinion survey conducted by the MoD, the evidence taken from serving military personnel suggested that civilians lacked an understanding of them, their way of life, and their career choice. In an endeavour to address these concerns, a series of practical recommendations ("*...that would involve minimum diversion of scarce Defence resources...*") were directed predominantly at the UK Government with a view to:

- increasing visibility
- improving contact
- building understanding
- encouraging support

The UK Government's response to that Report was announced in a Written Ministerial Statement on 19 May 2008³⁴ by the Rt Hon Bob Ainsworth MP followed by a paper detailing the nature of response ("*Report of Inquiry into National Recognition of our Armed Forces*", October 2008). The UK Government accepted the majority of recommendations (albeit with qualification or modification in some cases). Where appropriate, the Devolved Administrations were responsible for progressing recommendations in co-operation with the MoD and the UK Armed Forces in Scotland, Wales and Northern Ireland.)

- Following an extensive consultation³⁵ and liaison with other UK Government Departments and the Devolved Administrations, the Secretary of State for Defence (Rt Hon Des Browne MP) presented to Parliament the first cross-Government strategy on

³² Although the enquiry ran in parallel to the production of the Service Personnel Command Paper on sustaining and harmonising cross-Government support for the UK Armed Forces community, it was commissioned as an independent endeavour.

³³ Royal family; Government; House of Lords; Members of Parliament; Devolved Assemblies and Civic Leaders; MoD; Armed Forces support organisations and charities; Religious leaders; Service museums; Business and sport; City of London Livery Companies; Media.

³⁴ Hansard 19 May 2008: Column 3WS.

³⁵ A team comprising personnel from all three Services of the UK Armed Forces and MoD civil servants consulted with current and former Service personnel, their families, Service charities and Service Families Federations.

the 12 July 2008. Commonly known as the "*Service Personnel Command Paper*" (SPCP), the cross-Government strategy retained the two key principles³⁶ that underpinned the revised Strategy for Veterans. On this basis, the strategy sought to:

- put an end to any disadvantage experienced by Service personnel and their families (particularly in respect of the requirement of mobility both nationally and internationally).
 - address the provision of support and recognition for those military personnel who have been injured in Service.
- In an endeavour to redress any potential disadvantage incurred by Service personnel during the course of duty, the SPCP endorsed the need to ensure that the following key aspects were embraced on an enduring basis.
 - "*As much lifestyle choice as any citizen*" - to facilitate a balance between the demands of Service life (including mobility), personal development, and family stability.
 - "*Continuity of public service*" - regardless of the location of Service and whenever Service mobility is required.
 - "*Proper return for sacrifice*" - based on a "through life" provision of treatment and welfare support.
 - "*The Armed Forces community matters*" - in respect of policy or legislative proposals.
 - On this basis, the UK Government made a pledge to undertake 47 specific commitments in respect of the nine areas listed below.
 - Compensation
 - Health
 - Housing
 - Education and skills
 - Transport
 - Support for families
 - Benefits
 - Building careers
 - Foreign and Commonwealth Service personnel

An outline of the measures associated with the commitments by the UK Government in respect of each of these nine areas is provided in *Appendix B*.

- To complement the steps undertaken by Whitehall, the Scottish Government undertook a consultation³⁷ with key stakeholders

³⁶ The first principle is that the Armed Forces should not be disadvantaged by a military career and associated lifestyle. The second principle is that, where appropriate, special treatment should be provided for those serving and ex-Service personnel who have been injured in course of duty).

³⁷ The consultation process was closed on 29th August 2008.

on its approach to the delivery of services to the UK Armed Forces community residing in Scotland. The purpose of that consultation was set out by the Scottish Government in the April 2008 Consultation paper "*Scotland's Veterans and Force's Communities: meeting their well-being and welfare needs*". Scottish Ministers subsequently detailed their commitment to the UK Armed Forces community in a paper entitled "*Scotland's Veterans and Forces' Communities: meeting our commitment*", the publication of which was in parallel to the SPCP of July 2008. The commitment pledged by the Scottish Government comprised the following six areas.

- Healthcare
- Housing
- Transport
- Education
- Employment and employability
- Local co-operation

An outline of the measures associated with the commitments by the Scottish Government in respect of each of the six areas is provided in *Appendix C*.

- In order to build on the commitments and practical measures proposed in the Service Personnel Command Paper, the MoD published a Green Paper in July 2009 entitled "*The Nation's Commitment to the Armed Forces Community: Consistent and Enduring Support*". Its purpose was to launch a consultation process to identify ways to improve the health and welfare support given to the UK Armed Forces community using a consistent and enduring approach which would uphold the principles of the SPCP across all levels of UK Government. A number of broad and wide ranging options were proposed, which included the creation of a Charter for the UK Armed Forces Community; exploration of the value of a legal duty being imposed on public bodies, and the availability of a UK Armed Forces hotline to enable complaints to be made in the event of dissatisfaction with service provision. Linked to these options were 29 consultation questions, the responses to which were to be used to inform UK Government thinking on how "*...to ensure that the principles of no disadvantage and special treatment where appropriate are recognised, understood and upheld at all levels of administration, from policy formulation right through to service delivery*" (p.5). The public consultation was closed on the 31st October 2009.
- In November 2009, the first annual report of the evaluation of the UK-wide commitment was published. Undertaken by an

External Reference Group (ERG)³⁸, the report addressed what has been delivered, the extent of progress made, and the impact of that progress, in respect of each of the 47 specific commitments made in July 2008³⁹. On this basis, the ERG concluded that:

- work dedicated to raising the profile of the needs of the UK Armed Forces community and in fostering support across the UK Government should continue to remain high on the political agenda.
- time is required to assess the improvements made in respect of specific deliverables where measurement is more difficult such as those pertaining to Veterans' health needs.
- empirical evidence is lacking in some areas thereby hampering the extent to which progress can be demonstrated.
- communication remains a substantial challenge as a key factor in ensuring success at the point of service delivery, raising awareness in the UK Armed Forces community, and countering the scepticism as to whether the commitments will effect a real difference for their dependents.

In order to build on the initial progress made and to maintain the momentum achieved thus far, particular emphasis was placed on further work to be undertaken with a particular focus on the key area of communication and the development of suitable measures⁴⁰.

- The Scottish Government published a parallel report comprising an evaluation of achievements and progress made in respect of the Scottish commitment (a summary of which is presented in *Appendix D*). In terms of the measures detailed in that report, mention was made of only two empirically-based initiatives, *viz*, the Veterans First Point (V1P) pilot project and research commissioned by *Poppyscotland* to identify the employment needs of disabled and vulnerable Veterans in Scotland (Hurley *et al*, 2009). Moreover, in addressing what steps should be taken to build on that which has been achieved to date in Scotland, no

³⁸ A product of the Service Personnel Command Paper, the ERG was set up to oversee the implementation of the work and to provide a mechanism which would remind Government and the Devolved Administrations of the issues to be addressed in respect of their commitment to the UK Armed Forces. It comprises a wide range of perspectives including senior officials (Whitehall Departments, the Scottish Government and Welsh Assembly Government), and representatives from the major Service charities, the Service Families Federation, and academia.

³⁹ Overall, it concluded that 15 of the 47 original commitments have been fully completed during the period up to 31 July 2009. A further 13 UK-wide commitments were anticipated to be fully completed within the subsequent 12 month period.

⁴⁰ Two aspects were highlighted in terms of: (i) mechanisms to measure impact at ground level, and (ii) scope for the development of specific measures.

mention was made of the need to address the paucity of empirical evidence to ascertain the effectiveness of measures implemented despite the fact that research activity forms a significant part of the Veteran-related policy and strategy. Only two statements appeared in the section dedicated to presenting the “next steps”. The first endorsed the need for more time for the work to be delivered. The second referred to the intention of the Scottish Government to play a “full part” in addressing the emerging issues reported in July 2009 (MoD Consultation Paper Cm7674 “*The Nation’s Commitment to the Armed Forces Community: Consistent and Enduring Support*”) to ensure that the implications for Scotland are considered and that their implementation fulfils the needs of the target population in Scotland.

- To complement the values set out in the Armed Forces Covenant (UK Government, June 2011), the Scottish Government has increased its efforts to ensure that no member of the UK Armed Forces community in Scotland faces disadvantage when accessing services and support. In September 2012, the Scottish Government published a document entitled “*Our Commitments. Scottish Government Support for the Armed Forces Community in Scotland*” to illustrate what it has achieved by working with strategic partners in the statutory and voluntary sectors and through the *Firm Base Forum*⁴¹ in terms of providing appropriate public and support services within the domains of health, housing, education and justice. In addition, it provides a summary of specific initiatives for future implementation, which take into consideration the harsh economic climate and the anticipated increase in the military footprint in Scotland⁴².

⁴¹ The Firm Base Forum is an advisory group and, as such, is not generally responsible for policy making. It’s remit is bound by working practices and scope of the Concordat between the Scottish Ministers and the Secretary of State for Defence, Membership comprises Hd AFVIT, 1 Star representatives from the 3 Services (currently NRCSNI, Comd 51 (Sc) Bde and AOS), Chairman ‘Veterans Scotland’, CEs HRFCA and LRFCA and Secretariat.

⁴²This anticipated increase originates from the announcement to the House of Commons by the then Defence Secretary, Dr Liam Fox, on 18 July 2011 that more than 2,000 extra Service personnel will be based in Scotland despite the closure of RAF Leuchars.

SECTION 3: Provision of Healthcare and Welfare Support

3.1 PREFACE

The following section is predominantly dedicated to establishing the current status of health and welfare support provision for the UK Armed Forces community in terms of its organisation and delivery. In so doing, key factors have been addressed that have led to substantive shifts in strategic thinking with regards to the development, organisation, and delivery of health and welfare support services and which have consequently been influential in shaping current service provision. Particular consideration has been given to those factors associated with the risk of social exclusion in vulnerable subgroups of the ex-Service population given the wider political agenda as highlighted in the previous section.

3.2 DEFENCE HEALTHCARE

3.2.1 Military Medical Care Policy and Strategy

- The 1991 Gulf war has been advanced by Wessely and Dandeker (KCMHR, 2006) as “...perhaps the most important driver” (p.5) of the increasing interest in the health of Service personnel in the UK Armed Forces. In response to the concerns and controversies of the so-called “Gulf War Syndrome” The MoD set up the Gulf Veterans Medical Assessment Programme (GVMAP) to investigate claims of ill health among Gulf War Veterans, which began to emerge in the 1990s. The remit of the GVMAP was subsequently extended to former Porton Down volunteers and to Veterans of Operation TELIC (the 2003 Iraqi campaign). Its role is to diagnose presenting conditions, recommend appropriate management, and collate data for research purposes to identify trends.
- Two fundamental principles underpin the Defence Health Strategy as specified in “*The Armed Forces Overarching Personnel Strategy*” (MoD, 2002/2003). The first pertains to the fact that a prerequisite of military service is the maintenance of an effective operational force comprising Service personnel who are “*fit for task*” to ensure that the UK Government can fulfil its most important responsibility of providing security for the nation and for its citizens⁴³. To sustain morale and physical capability however requires contemporary and effective medical support.

⁴³ (“The National Security Strategy of the United Kingdom”: Update 2009. Security for the Next Generation, June 2009; <http://www.cabinetoffice.gov.uk/media/216734/nss2009v2.pdf>.)

Thus, a fundamental element of the UK's military capabilities is the availability of medical personnel who are suitably trained in accordance with the requirements of the relevant professional bodies and whose clinical skills can be maintained to the requisite standard⁴⁴. The second is associated with the Military Covenant and pertains to the need for recognition of the exceptional demands of military service. As such, Service personnel also have a right to expect the MoD to fulfil its "duty of care" in order to mitigate the inherent risk to life and health and the stresses associated with the special circumstances encountered by Service families (as discussed in *Section 2*).

- The vehicle for the delivery of the Health Strategy is the Defence Health Programme (DHP) 2007-2011. It comprises a statement of intent to continue to improve the quality of medical provision by the Defence Medical Services (DMS) "...to improve the operational capability of the Armed Forces and the confidence in healthcare, by promotion, provision and maintenance of all elements that impact on the health of Service Personnel and, where appropriate, their dependent families." By working through the chain of command, the DHP seeks to minimise those risks to health and to provide a holistic treatment capability that includes rehabilitation and aftercare services. This includes the effective collection of data and information flow processes to improve "through life" patient outcomes, which have been facilitated since 2007 by the rollout of the Defence Medical Capability Programme (DMCP).

3.2.2 Responsibility for the Delivery of UK Armed Forces Medical Care

- The DMS is responsible for providing healthcare to approximately 258,000 Service personnel (serving in the UK and overseas), their family dependants, and entitled civilians. It includes primary healthcare, dental care, hospital care, rehabilitation, occupational medicine, community mental healthcare, and specialist medical care. The DMS therefore provide healthcare in a wide range of facilities including regional rehabilitation units and field hospitals. The cost of medical care provision as a result of military operations was recently

⁴⁴ The White Paper ("*Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*") of February 2007 set out a programme of reform to the UK's system for the regulation of health professionals based on consultation on the two reviews of professional regulation published in July 2006 ("*Good Doctors, Safer Patients*") by the Chief Medical Officer (CMO) for England and the DoH's ("*The Regulation of the Non-Medical Healthcare Professions*"). It is complemented by the Government's response to the recommendations of the Fifth Report of the Shipman Inquiry and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries ("*Safeguarding Patients*"), which sets out a range of measures to improve and enhance clinical governance in the NHS.

estimated to be £71 million in 2008-2009 (National Audit Office, HC294, 10 February, 2010).

- Each of the three Services has an individual responsibility for delivering primary healthcare and the requisite medical support whilst on operations. The Surgeon-General and the Deputy Chief of the Defence Staff (Health) determine medical policy for the three Services⁴⁵ and jointly oversee the work of the following three organisations.
 - The Defence Medical Services Department (DMSD) – the administrative headquarters of the DMS responsible for strategy.
 - The Defence Medical Education and Training Agency (DMETA)⁴⁶ – a tri-Service organisation responsible for: (i) providing personnel to meet the secondary care requirements of operational deployments, and (ii) education and training of medical personnel.
 - Defence Dental Services (DDS) – a tri-Service organisation responsible for the provision of dental services in the UK and on operations.

- The relationship between the DMS and the National Health Service⁴⁷ is founded on a Concordat⁴⁸ between the Department of Health⁴⁹ (DoH) and the MoD to confirm their joint intention to renew and strengthen the partnership between the defence and the civil healthcare services at national level. As a crosscutting partnership its fundamental aims are to:
 - enable the DMS and NHS to collaborate with and support each other;
 - provide value for money for the taxpayer;
 - maintain high standards of care for patients, and
 - promote the effective defence of the nation.

- The NHS/ MoD Partnership Board is responsible for overseeing the Concordat at official levels and to identify innovative

⁴⁵ The three Services are directly responsible to the Service Chiefs of Staff.

⁴⁶ DMETA has command and control over: MoD Hospital Units; The Royal Centre for Defence Medicine (RCDM); The Defence Medical Rehabilitation Centre (DMRC) at Headley Court; The Defence Medical Training Centre (DMTC) at Keogh Barracks, and The Defence Medical Postgraduate Deanery (DMPD)

⁴⁷ On the basis of the NHS Plan, the NHS provides a universal health service, which is available to all citizens of the UK based on their clinical need and not their ability to pay. Funded nationally, the provision of service must be responsive to the different needs of different populations.

⁴⁸ The Concordat is an overarching agreement between the MoD and the DoH, which was signed on the 19th September 2002 by the respective Parliamentary Under-Secretary of State. It originated from the recommendation by the MoD Medical Quinquennial Review (MQR) to reinforce the relationship between the DMS and the NHS by a formal agreement between the DoH and the MoD.

⁴⁹ The DoH is responsible for funding, directing and supporting the NHS.

methods of delivering healthcare to both civilian and military patients.

3.2.3 Trauma Care Provision for Severe Operational Injuries

- DMS personnel are employed on operations on a tri-Service basis to deliver medical care in theatre such as Operation TELIC (Iraq)⁵⁰ and Operation HERRICK (Afghanistan)⁵¹. Between October 2001 and October 2009, a total of 522 personnel have been seriously injured⁵² as a result of deployment on both of these operations (National Audit Office, HC294, 10 February, 2010). The Reserve Forces (which comprise both Volunteer⁵³ and Regular Reservists⁵⁴) provides a fundamental contribution to the treatment of operational casualties⁵⁵, in particular with regards to deployed hospital care and specialist roles. Delivery of treatment is undertaken by medical staff designated to either: (i) Incident Response Teams (IRTs),⁵⁶ (ii) Deployed Rehabilitation Teams (DRTs), or (iii) Deployed Mental Health Teams (DMHTs).⁵⁷
- Typically, casualties⁵⁸ defined as “seriously injured” are initially treated and stabilised by medical personnel in theatre prior to being aeromedically evacuated⁵⁹ (i.e., transported by air under medical supervision) to appropriate facilities in the UK⁶⁰. A total of 6,900 personnel have been aeromedically evacuated back to the UK from Iraq and Afghanistan since 2003 for serious injuries

⁵⁰ Prior to the UK Armed Forces withdrawal from Iraq in 2009, medical care was provided by approximately 280 UK medical staff at the main base in Basra Air Station (National Audit Office, 2010)

⁵¹ The UK medical group in Afghanistan in the Summer of 2009 constituted approximately 360 staff who provided treatment and rehabilitation at the field hospital in Bastion in Helmand Province (the main site of operations for the UK Armed Forces). (National Audit Office, 2010)

⁵² This figure comprises categories the Department refer to as “*very seriously injured*” and “*seriously injured*” Service personnel.

⁵³ Dedicate their spare time to train and have a liability to be called up and deployed alongside their Regular counterparts. The minimum commitment is 27 days training per annum (or 19 days for some specialist units).

⁵⁴ Regular Reservists are former members of the Regular Forces who have liability for mobilisation.

⁵⁵ Between October 2001 and the end of October 2009, a total of 522 military personnel have been seriously injured on operations in Iraq and Afghanistan (National Audit Office, 2010).

⁵⁶ Their role is to provide the assessment and immediate treatment of all casualties (whether injured in combat or otherwise).

⁵⁷ Both of these teams are responsible for the provision of first line treatment and guidance on the need for further treatment or referral.

⁵⁸ Severe injuries include multiple fractures, amputations, loss of sight or hearing, brain injury or sometimes a combination of all of these.

⁵⁹ The decision to evacuate is a clinical one.

⁶⁰ However, an increase in the number of clinical staff deployed to field hospitals has resulted in more extensive treatment of operational casualties in theatre than was previously the case.

as well as for a range of other medical conditions (National Audit Office, HC294, 10 February, 2010).

- Since 2001, the main receiving unit for such casualties has been the Royal Centre for Defence Medicine (RCDM) located at the University of Hospital Birmingham Foundation Trust⁶¹ (UHBFT) which includes five specialist hospitals including Selly Oak Hospital (the main treatment facility for the more common types of injuries sustained due to polytrauma). Forty eight per cent of evacuated personnel receive their first treatment in a secondary care facility at either the RCDM or the five MOD Hospital Units embedded in NHS hospitals (National Audit Office, HC294, 10 February, 2010).
- According to the Medical Care for the Armed Forces 7th Report of Session 2007-08, the decision taken by the MoD to use the UHBFT as a centre for treating operational casualties derived from the MoD's view that "*...the medical needs of the Armed Forces are best served through access to facilities and training in a busy acute care hospital that is managing severe trauma on a daily basis.*" In addition, treatment is further facilitated by a good link between Selly Oak Hospital and RAF Brize Norton, which is the main point of arrival for operational casualties.
- The RCDM has introduced measures to promote a military atmosphere in response to meeting the needs of those Service personnel who feel the loss of a military environment, which include the following.
 - Most Service personnel are treated together in the same trauma ward (depending on the type of treatment required).
 - Military liaison officers provide regular visits to deal with day-to-day needs of Service personnel and to maintain links with the patients' units.
- In recognition of the fact that arrangements for the provision of NHS care were not originally set up to accommodate the casualties of war, the "*Joint Casualty Reporting and Reception Plan*" (JCRRP) was devised to enable the NHS to become involved in the treatment of mass casualties. In 2002, the JCRRP was subsequently refined and is now known as the "*Reception Arrangements of Military Personnel*" (RAMP). According to the findings of the recent National Audit Office Report (HC 294, 10

⁶¹ First introduced in April 2004, Foundation Trusts are a new type of NHS hospital run by local managers, staff and members of the public to meet the needs of the local population. They represent the Government's de-centralisation of public services and are accorded more financial and operational freedom than other NHS Trusts although they remain within the NHS. As such they are subject to the NHS performance inspection system.

February 2010), the increase in casualty numbers arising from military operations however inevitably impacted on the demand for services provided by Selly Oak. When military casualties peaked in July 2009, a third of the 90 trauma and orthopaedic ward beds were occupied as a result, and 80% capacity was reached in respect of the military-managed ward.

- In June 2010, the new £545 million Queen Elizabeth Hospital (QEH) Birmingham brought further improvements to the care of military patients. Situated in the Edgbaston area of Birmingham, this NHS hospital has replaced the previous Queen Elizabeth Hospital and Selly Oak Hospital. It has 1,213 patient beds, 30 operating theatres, and has the largest single-floor critical care unit in the world, with 100 beds. UK Armed Forces personnel are treated in single rooms or four-bed bays in a 32-bed trauma and orthopaedics ward in order to cater for their specific requirements and to help create a military environment conducive to their recovery. It has more staff (both military and civilian) than a normal NHS ward, a quiet room for relatives and a communal space for patients to gather. A dedicated physiotherapy suite is available close to the ward for military patients. University Hospitals Birmingham has also become the home of a £20 million national trauma research centre, which brings together military and civilian trauma surgeons and scientists to share medical innovations and advances in battlefield treatment and will play a key role in gathering scientific evidence from injuries sustained in both military and civilian environments.

3.2.4 Illnesses and Non Battlefield Injury (NBI)

- A significant number of Service personnel require treatment for illnesses such as gastrointestinal disorders and for injuries caused by non-conflict related military events (e.g., road traffic incidents or training). Since 2006, Service personnel deployed on Operations Helic and Telic have attended medical facilities in theatre a total of 125,000 times for minor injury and illness. Rates in Afghanistan have almost doubled from 4% to 7% of deployed personnel per week between 2006 and 2009 (particularly around the six-monthly rotations of deployed units), which represents a cost of £0.7million and a small reduction in operational capability of 6,700 days lost. Should these rates continue to increase, there is the potential risk that operational capability will be further reduced. Factors attributed to this increase have been identified in the recent National Audit Office report of "*Treating Injury and Illness arising on Military Operations*" (HC294, 10 February 2010) as:

- basic living conditions at some forward operating bases
- operational intensity
- improved reporting

3.2.5 MoD Hospital Units: Secondary Care and Training

- Following the 1990 review of Defence secondary care in the UK as part of “*Options for Change*”⁶², a number of “*stand-alone*” military hospitals were closed due to insufficient numbers of patients. Moreover, the small number of clinical cases seen imposed severe restrictions on opportunities for adequate training and maintenance of medical skills of staff. In an endeavour to address these issues, the MoD took the decision to establish MoD Hospital Units (MDHUs) within host NHS facilities. In so doing, the MoD held the view that this would not only facilitate the maintenance of training and skills for Defence medical staff by working alongside their civilian clinical counterparts, but it would also enable some secondary care provision for Service personnel in an environment with a military milieu.
- Currently there are five MDHUs in England that are tri-Service in composition and are embedded in host NHS Acute Trusts⁶³, viz, Portsmouth, South Tees, Frimley Park, Plymouth and Peterborough. Their primary function is to be fully integrated throughout each host NHS Trust for the dual benefit of assisting Service personnel with the development and maintenance of their medical skills whilst making a contribution to overall NHS capacity and capability. In addition, they serve a key purpose in ensuring the provision of personnel who are at “*full readiness for deployment*” as required including a substantial number of Reserve medical personnel (Medical Care for the Armed Forces (7th Report of Session 2007-08), House of Commons Defence Committee 18th February 2008). Whilst the potential benefits of this arrangement cannot be disputed in principle, in practice there are a number of issues which have surfaced following the realignment of medical care, a summary of which will be provided in Section 5 as part of the commentary on the evaluation of progress made since the implementation of the Veterans Initiative in March 2001.

⁶² This was the first major post-Cold War review of UK military requirements.

⁶³ Acute Trusts are responsible for managing NHS hospitals to ensure that they provide high-quality healthcare and that they are cost efficient. They employ a large part of the NHS workforce. Acute Trusts can be regional or national centres for specialised care. Some are attached to universities and help to train health professionals. Acute Trusts can also provide services in the community through health centres, clinics, or in patient’s homes.

- The priority of treatment of injured Service personnel is intended to return them as quickly as possible to operational effectiveness. The DMS employs two mechanisms to fulfil this objective, viz, “fast track programming” and “accelerated access”. The former pertains to the system whereby Service personnel can receive fast access to treatment (in the main for musculo-skeletal disorders) that extends beyond the arrangements with the MHDUs. As such fast track treatment is provided either in the MHDU host Trusts, in other NHS Trusts, or in the independent sector. “Accelerated access” refers to treatment that Service personnel receive within MHDUs.

3.2.6 Rehabilitation and Aftercare

- To meet the Defence strategic intent on health, the provision of effective rehabilitation and aftercare constitutes another major element of the work undertaken by the DMS under the aegis of the Defence Rehabilitation Plan (DRP). The DRP is based on a tiered approach comprising three elements (see *Appendix E*). In order to fulfil the aim of restoring function as efficiently and effectively as possible (particularly in respect of enabling a return to active military duties), the approach taken by the DMS with regards to the treatment of musculo-skeletal injuries incorporates the following underlying principles.
 - Local provision of care (where possible)
 - Best use of physiotherapy and rehabilitation (as opposed to surgical intervention)
 - Reduction of waiting time for assessment and treatment
- In the same way that capacity at Selly Oak was challenged due to increasing levels of military casualties, the Defence Medical Rehabilitation Centre (DMRC) at Headley Court faces similar pressures in meeting the rehabilitation needs of Service personnel. On average, seriously injured patients receive four periods of rehabilitation at Headley Court, a figure which equates to 89 days in rehabilitation over a 187 day period. Thus rehabilitation is an ongoing process for most patients. Since 2006, the number of complex trauma patients has increased two fold although the number of neurological patients has remained constant. Between 2006 and 2008, the number of staff increased by 23% and ward beds by 83% in 2007 to 2008. Over the course of 2009, the number of operational patients at Headley Court exceeded the 28 beds originally dedicated to complex trauma (although this was not the case in terms of overall bed numbers).
- In the event that casualties from Afghanistan persist at the 2009 level, analysis undertaken by the National Audit Office (HC294,

10 February 2010) suggests that seriously injured patients will occupy 86% of all ward beds by April 2010. To this end capacity at Headley Court will be exceeded unless other categories of ward patients reduce or alternative treatment facilities are identified. In currently reviewing its contingency plan with the DoH, the MoD intends to expand the provision of rehabilitation for seriously injured personnel by providing Headley Court-led services in other existing rehabilitation centres and building additional ward space (National Audit Office Report, HC 294, 10 February 2010).

3.2.7 Mental Healthcare for Service Personnel

- The mental healthcare provision for Service personnel underwent a reconfiguration based on the outcome of the Medical Quinquennial Review, which was published by the MoD in 2002. This constituted the delivery of an occupational mental health and community-based service through 20 Departments of Community Mental Health (DCMHs)⁶⁴. Together with primary care the DCMHs provide most of the mental health service delivery to military personnel in the UK and abroad⁶⁵. By virtue of the MoD's principal aim to provide out-patient treatment for the majority (where possible), the DCMHs are staffed by multidisciplinary mental health teams⁶⁶ accordingly. For Service personnel who are on operations abroad, Field Mental Health Teams (FMHTs) comprising mental health professionals visit all operations to liaise with unit commanders and to attend to those in need of mental health support. Since, 2006, a total of 1,700 Service personnel have attended a medical facility during recent operations in Iraq and Afghanistan due to a mental health condition (National Audit Office, HC294, 10 February, 2010). A much smaller percentage however are referred for treatment by the FMHTs while on operations. Between 2008 and 2009, 0.2% of those deployed in Afghanistan and 0.8% of those deployed in Iraq received referrals.
- The provision of in-patient mental healthcare has also been subject to changes following the closure of the Duchess of Kent Psychiatric Hospital at Catterick in April 2003. This led to an interim arrangement being signed with the Priory Group commencing in December 2003 for the delivery of inpatient

⁶⁴ The DCMHs are embedded within 15 Service units in the UK, 4 Service units in the British Forces Germany and 1 Service unit in Cyprus. The 15 UK-based Service units are: (Aldershot, Brize Norton, Catterick, Colchester, Cranwell, Donnington, Kinloss, Leuchars, Marham, Faslane, Plymouth, Portsmouth, Tidworth, Belfast, Woolwich).

⁶⁵ Including Cyprus, Germany and Gibraltar.

⁶⁶ The DCMH mental health teams comprise psychiatrists, mental health nurses, clinical psychologists, and mental health social workers.

services on the grounds that it would permit patients to receive treatment at closer proximity to their parent units than was previously possible. The Priory Group subsequently became the default provider of in-service mental health provision when the full contract with the MoD was signed on the 1st April 2004. Due to increasing concerns⁶⁷, however, about the extent to which the quality of inpatient care provided by the Priory Group was being compromised the contract was subjected to a review, the outcome of which resulted in it being duly terminated.

- On the 18th November 2008, the Under Secretary of State for Defence (Rt Hon Kevan Jones MP) announced that the MoD had awarded a contract to provide in-patient mental health care to Service personnel across the UK to a partnership comprising an initial network of seven NHS trusts⁶⁸, the lead for which is the South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT). All seven trusts were selected because of their Healthcare Commission ratings for clinical quality and resource management in addition to their geographical proximity to the 15 Departments of Community Mental Health (DCMH) located within the UK. Thus, this new scheme ensures that treatment is offered close to the patient's home or parent unit by using the facilities at each of the participating trusts to ensure national coverage and to build on MoD's partnership with the NHS. Moreover, the development of a network of NHS hospitals to provide care on this basis has been heralded as a first for the NHS.

- As stated in its Annual Report 2009/10, the vision of this unique NHS Inpatient Network is to:
 - improve clinical outcomes;
 - minimise inpatient stay in accordance with clinical need;
 - align the Network to the cultural needs of the MoD;
 - provide culturally sensitive, evidence-based high quality mental health care;
 - ensure services are dedicated to returning individuals to return to work as soon as is clinically possible, refine services to enhance patient experience;

⁶⁷ For example, in the Medical Care for the Armed Forces (7th Report of Session 2007-08), House of Commons Defence Committee 18th February 2008. HC327, in providing evidence as a witness on the 11th October 2007, Dr Christopher Freeman was cited as saying that he was "...not convinced that the Priory's clinicians had the relevant expertise, and that they lacked the ability to relate to the experience of Service personnel." (p.29). Furthermore, he expressed concerns about the financial benefits derived by the private sector in delaying the discharge of patients, which resulted in a tension between the NHS and the private sector.

⁶⁸ South Staffordshire and Shropshire Healthcare NHS Foundation Trust, Cambridge and Peterborough NHS Foundation Trust, NHS Grampian, Hampshire Partnership NHS Trust, Lincolnshire Partnership NHS Foundation Trust, Somerset NHS Foundation Trust and Tees, and Esk and Wear Valleys NHS Foundation Trust).

- provide services in response to the developing requirements of the MoD;
 - audit all aspects of the service;
 - promote education, training and conference events across the Network and in partnership with the MoD, and
 - refine services to enhance patient experience.

- Since the contract commenced on 12 January 2009 with SSSFT and subsequently the other partners on the 9 February 2009, NHS Greater Glasgow and Clyde was incorporated into the Network with a specific remit to provide services to DCMH Faslane thereby resulting in a total of eight NHS mental health providers and the second one to be based in Scotland along with NHS Grampian. In addition, the Inpatient Network increased its core bed capacity in three Trusts (Hampshire, Somerset and Tees, Esk and Wear Valleys), resulting in an overall increase of 14% with 25 beds available across the Network. Two per cent of those Service personnel who are aeromedically evacuated from Iraq and Afghanistan receive their first treatment at either the inpatient care provided by the this network of NHS Mental Health Trusts or outpatient care provided by the 15 DCMHs (National Audit Office Report, HC 294, 10 February 2010).

- On 31st May 2011, SSSFT hosted an Academic Seminar entitled "*Military Mental Health & Associated Issues*" at St George's Hospital, Stafford. MoD inpatient performance and activity figures reported at that seminar from 1st January 2009 to 27th May 2011 included the following.
 - Total number of referrals received (n=559)
 - Total internal Network transfers (n=3)
 - Total re-admissions within the Network (n=80)
 - Total number of admissions for NHS Grampian (n=21; 3.76%)
 - Total number of admissions for NHS Greater Glasgow and Clyde (n=13; 2.33%)
 - Total number of referrals by Service:
 - Army (n=370; 66.19%)
 - RAF (n=92; 16.46%)
 - Royal Marines (n=16; 2.86%)
 - Royal Navy (n=79; 14.31%)
 - TA (n=2; 0.36%)
 - The number of admissions per year per service has decreased.
 - In 2011, the average length of stay for NHS Grampian was 28 days compared with 43 days for NHS Greater Glasgow and Clyde.

- The rank order of the top 10 diagnostic codes over the contract period was:
 - alcohol dependence (28.77%)
 - adjustment disorder (23.65%)
 - moderate depressive episode (21.65%)
 - post traumatic stress disorder (9.69%)
 - severe depressive episode without psychotic symptoms (4.94%)
 - acute stress reaction (3.13%)
 - severe depressive episode with psychotic symptoms (3.13%)
 - adjustment reaction (2.56%)
 - harmful use (1.12%)
 - paranoid schizophrenia (1.14%)

3.3 OPERATIONAL STRESS MANAGEMENT POLICY AND STRATEGY

- The judgement handed down by Lord Owen in May 2003 in respect of the 2002/03 PTSD class action (Mr Justice Owen - Multiple Claimants v. MoD, 2003) highlighted the need for the MoD to address their failure to provide Service personnel employed on operational duty with adequate training and support, and to detect and treat those suffering from operational stress.⁶⁹ In December 2003, the Service Personnel Board (SPB) agreed to address the actions identified in their initial paper (SPB 21/03 dated 16th December 2003). This was followed by a second paper (SPB 22/03 dated 22nd December 2003), which sought to principally endorse the Terms of Reference for an Overarching Review of Operational Stress Management.
- In February 2004, a Steering Group comprising both general and medical staff (including psychological experts) was established to undertake the necessary action. This included the implementation of a tri-Service review to ensure that Service personnel (and MoD employed civilians) are protected (as far as possible) against the effects of operationally induced stress. It comprised two phases. The first phase was dedicated to devising a tri-Service policy for the management of operational stress (SPEG paper 19/04 dated 29th September 2004). The second phase pertained to proposing a strategy for: (i) training commanders in the delivery of the policy, and (ii) communicating the policy across Services. A key message to be

⁶⁹ The bespoke MoD definition of "operational stress" is "...an individual or group reaction to stressors relating to the operational context which, if not managed, may result in impaired performance and possible effects on health". (p.8, Overarching Review of Operational Stress Management; Phase 2 Training and Communication Strategies)

conveyed in communicating the policy was that the effects of operationally induced stress are uncommon, unpredictable, but amenable to treatment (in the same way as a physical injury).

- Development of the second phase strategies was reported in “*Over-Archiving Review of Operational Stress Management – Phase 2 Training and Communication Strategies*” (28th April 2005) in the form of nine recommendations. In summary their purpose was identified as being to:
 - focus on existing training and communication initiatives to deal with operational stress,
 - review existing training measures to identify gaps in provision which need to be addressed to improve the mental wellbeing of those exposed to stress on operational duty, and
 - review the communications strategy to deliver advice on operational stress management and to make sure that action is taken to resolve any deficiencies.

3.4 PREVENTION AND MANAGEMENT OF PSYCHOLOGICAL TRAUMA

3.4.1 Screening

- Lord Owen’s judgement on the PTSD Class Action (Mr Justice Owen - *Multiple Claimants v. MoD*, 2003) proclaimed that pre-deployment screening, with current levels of knowledge, would offer no significant protection against the development of PTSD occasioned by combat.
- Much of that knowledge derives from the King’s Centre for Military Health Research (KCMHR) and is based on evaluations of the practical implications of mental health screening in the context of the Iraq deployment. Jones and Wessely (2005) highlight the extent to which screening out those who may be particularly vulnerable to the stresses of combat is fraught with difficulty. Moreover, papers by Rona *et al* (2005) and Gilbody *et al* (2006) outline the reasons as to why screening post-deployment does not provide an effective means to reduce trauma-related psychopathology either in the military or the civilian sectors. On the basis of the conclusion reached by KCMHR that screening is not an effective preventative measure, the DCMHs do not routinely screen personnel on return from operations. Consequently, there is a considerable reliance on personnel themselves seeking help and the non-medical stress management processes introduced by the MoD for Service personnel both during and after deployment such as Trauma

Risk Management (TRiM) and the “decompression” technique, both of which are described below.

- According to the recent National Audit Office report (HC 294, 10 February 2010) this situation is further aggravated by the inconsistent access to non-medical stress management programmes on return to the UK for Reserve Forces personnel (who typically deploy individually rather than as part of a unit) and those Service personnel who move units following deployment. The MoD is currently developing its stress management programme to address this issue.

3.4.2 Trauma Risk Management (TRiM)

- This is a relatively new approach pioneered by the Royal Marines as an alternative to the previously espoused Critical Incident Stress Debriefing (CISD)⁷⁰, which is now being adopted by the three Services. TRiM is conducted by trained military personnel within the unit itself rather than by mental health professionals (e.g., psychiatrists or counsellors).
- It therefore builds on the peer support and “buddy system” which has long standing favour with the military (Keller *et al*, 2005) to ensure a better “fit” with military culture.
- TRiM practitioners are peers and colleagues from each unit who receive brief training to:
 - offer a point of contact and support (particularly in the aftermath of a traumatic event),
 - identify those at risk, and
 - arrange for further help in accordance with individual need.
- TRiM formalises the unit’s responsibility to routinely check on those who have experienced a traumatic incident at one, three, and six months intervals. In line with the UK Armed Force’s mental well-being policy, the work of TRiM is also intended to reduce stigma in the military by seeking to change military culture in order to encourage those with mental health problems to seek help without fear of discrimination.
- In making it more acceptable for Service personnel to report experiencing psychological distress without fear of discrimination

⁷⁰ CISD was enthusiastically embraced in the late 1980s and 1990s as a suitable means of relieving distress and preventing the onset of PTSD particularly for the military and the emergency services (e.g., Mitchell & Everly, 1995). Subsequent evaluations (including a Cochrane Review [Rose *et al*, 2009]), however, provided evidence to suggest that mandatory, one-off CISD sessions increase the risk of making some individuals feel worse, probably through “retraumatizing” them (Alexander & Klein, 2008).

and reprisals (e.g., losing their job), it is also intended that this will also help to increase treatment compliance (KCMHR, 2006, 2010).

- KCMHR conducted a randomised controlled trial (RCT) to evaluate the effectiveness of TRiM as a means of providing immediate intervention. Whilst there was no evidence to suggest that TRiM reduced traumatic stress, it has since been rolled out across the three Services by virtue of the fact that it has not shown to cause harm, it encourages military personnel to talk about problems experienced as a result of exposure to traumatic stress, and it is perceived as being helpful (Greenberg *et al*, 2010).

3.4.3 Decompression

- This is a technique used to help Service personnel who are returning from front-line duty to recover from their experience and to facilitate their return home. It involves a unit spending approximately 36 hours together between leaving the combat zone and heading home. Given that the time required to reach and return from combat zones has been substantially reduced from what was previously the case, decompression is intended to provide the opportunity to reflect on and talk about their experiences should individuals wish to do so in a relaxing military environment.
- Since 2006, all Service personnel returning from operations spend 36 hours in Cyprus on their way home (Deahl *et al*, 2011). A recent study by Jones *et al* (2011) reported that only 50% of Service personnel want to undergo decompression compared with 90% who report finding it helpful having experienced it, although further research is required to determine how best to facilitate adjustment on return home from operational duty (Hacker Hughes *et al*, 2008).

3.4.4 Medical Assessment Programme (MAP)

- This programme was established in 1994 by the MoD on a national basis to offer expert mental health assessments to any Veteran with operationally induced mental health problems who has been deployed on operations since 1982 (including the Falkland's conflict).

- Based at Guys and St Thomas Hospital in London, MAP is run by Professor Ian Palmer (a Consultant Psychiatrist and a Professor of Military Psychiatry who served in the Army for 25 years).
- Veterans can either be referred through their NHS General Practitioner (GP) or can contact MAP directly. Furthermore, carers of Veterans who have concerns about their mental health can also contact MAP.
- The assessment (which comprises a review of NHS and service medical records followed by a consultation with the Veteran) results in a diagnosis, treatment plan, and liaison with the medical and mental health team involved in the Veteran's care. In addition, the Veteran is provided with a written document outlining his/her situation.

3.4.5 Reservists Mental Health Programme (RMHP)

- In response to concerns raised about the mental health of members of Reservists who had been deployed on military operations (e.g., National Audit Office, HC 964 Session 2005-2006, 31 March 2006) and the empirical evidence to support those concerns (e.g., Hotopf *et al*, 2006), the MoD announced its intention in November 2006 to initiate the RMHP to meet the mental health needs of Reserve personnel.
- The DMS in partnership with the NHS subsequently launched the RMHP to offer assessment and out-patient treatment (where appropriate) by DMS personnel to eligible Reservists⁷¹ for mental health problems associated with operational deployment. Eighty one patients were seen between December 2006-2008, of whom 70% were diagnosed with a combat-related mental health problem.
- Although GP referral is considered to be the predominant mechanism by which individuals gain access to the RMHP, according to the recent National Audit Office report (HC 294, 10 February 2010) only 12% accessed the programme through their GP in 2008.
- Referrals from civilian psychiatric services are also accepted (subject to the GP being kept informed). In exceptional circumstances self-referral is accepted for an initial assessment.

⁷¹ The criteria for entry into the RMHP are restricted to current and former members of the Reserve Services who must have been demobilised since January 2003 (following overseas operational deployment) and whose mental health problems resulted primarily as a result of their operational service as a Reservist.

- The assessment conducted by DMS mental health practitioners' results in out-patient treatment being provided only for those who have suffered from an operationally related mental health problem that is amenable to that which is available through the RMHP. In the event that acute care is required, the DMS provides access to NHS in-patient treatment.
- On completion of the RMHP treatment patients are referred back to their GP for further care. Re-referral for further assessment (if required) is available providing a minimum of six months has elapsed since the previous discharge.
- Regardless of whether or not the individual is eligible for treatment under the aegis of the RMHP, all those assessed are provided with a personal management plan which details the nature of their key problems and how these might be addressed.

3.4.6 Evidence-Based Treatment for Combat-Related Disorders

- A relatively small number of Service personnel require treatment for combat-related psychiatric disorders (although these may not surface until many years after they have left the military).
- Although PTSD commonly adopts centre stage (a myth commonly fuelled by the media), as a condition it is neither the sole psychopathology to emerge post-trauma nor does it most commonly occur in isolation from other co-morbid conditions (e.g., anxiety, depression and substance abuse) (Klein & Alexander, 2009).
- The National Institute for Clinical Excellence⁷² (NICE) 2005 guidelines state that individuals suffering from psychological conditions should be offered an evidence-based psychological therapy as the first line of treatment rather than pharmacological treatments. For example, based on the outcome of a systematic review of clinical treatment trials for PTSD, the NICE guidelines (2005) recommend two psychological treatments, *viz*, Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR). The use of medication is also acknowledged as an appropriate treatment, particularly when there are legitimate

⁷² NICE is an independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. The guidance is developed using the expertise of the NHS and the wider healthcare community including NHS staff, healthcare professionals, patients and carers, industry and academics.

reasons for not pursuing a psychological approach.⁷³ Two antidepressants, namely, paroxetine and mirtazapine are recommended for use by non mental health specialists (e.g., GPs), and amitriptyline and phenelzine are recommended for use by mental health specialists.

3.5 MEDICAL DISCHARGE

- All Service leavers who leave the UK Armed Forces through medical discharge are required to attend a Medical Board.
- It is the responsibility of the Medical Board to make the decision about whether an individual is medically unfit for any form of military service.
- Not all those who appear before the Medical Board will be recommended for medical discharge as it depends on which of the following medical grades is received as shown in *Table 4*.

Table 4. Medical Discharge Grades and Fitness Levels

Medical Grade	Fitness Level
P2	<i>Fit for combat</i>
P3	<i>Fit for light duties (applied in the case of a medical condition which would prevent the individual from undertaking the full range of military duties, but is capable of performing useful duties in barracks)</i>
P4	<i>Pregnancy/maternity</i>
P7	<i>Fit for limited duties (applied when an individual can perform useful duties within the limits of his/her disabilities. This may also require the provision of regular, continued medical care or supervision, and may require regular long-term medication)</i>
P8	<i>Medically unfit for any form of military service</i>
P0	<i>Unfit for duty but under medical care (a return to duty is likely within a total period of 12 months)</i>

- Referral to the Medical Board is made by either the individual's doctor, unit, or the Sickness Absence Management team (SAM). In the Army, typically the Medical Board comprises three experienced Army or ex-Army doctors and the chairman is a

⁷³ These reasons include a lack of suitably trained personnel; a failure to respond to a psychological therapy, and the patient's aversion to psychological treatments.

consultant in occupational medicine. Their assessment of each individual's case comprises a:

- review of medical notes,
- discussion with the individual about his/her presenting medical condition, and
- physical examination (if required).

Allocation of the medical grade will also take into consideration the views of the unit chain of command in respect of future Service employment.

- The findings of the Medical Board can take up to two weeks. There is a possibility, however, that the SO1 Occupational Medicine Army Personnel Centre (APC) will not accept the conclusion reached by the Medical Board. For this reason, individuals who are found by the Medical Board to be medically unfit for any form of military service in the Army are advised to make provision for this pending confirmation from their unit or the APC Medical Discharge Cell before committing themselves to any future arrangements. Confirmation of a P8 grading indicates that the individual has fallen below retention standard and is either medically discharged or medically retired, the effects of which vary according to military status and whether or not the individual is trained or in training as a new recruit.
- The medical discharge procedures are complicated and require the individual to complete a number of administrative activities with the appropriate departments. Medical documents should be automatically forwarded to the Service Personnel and Veterans Agency (SPVA) for assessment to determine eligibility for pension/ compensation. Whilst the case is being assessed, it is left up to the individual to keep the SPVA informed of any change of address within the first few months after discharge. The Veterans Welfare Service (VWS) is notified of all medical discharges, and a letter is sent to all those who are medically discharged to inform them of VWS services. Further details about the roles of the SPVA and the VWS are provided later on in this section under the heading of "Welfare".
- Medical discharge data is compiled from two sources, *viz*, FMED23 (Medical Board Report) and pay and personnel systems. Although they are subject to quality and completeness checks, it is important to be aware that statistics based on medical discharges do not represent measures of true morbidity or pathology. Within a medical and occupational health context their purpose is to provide an employability recommendation, which is subsequently translated into a chain of command decision on manning requirements. At best they indicate a

“minimum burden” of ill health in the UK Armed Forces. In addition, the number and diversity of processes involved with administering a medical discharge introduce a series of time lags, as well as impact on the quality of data recorded.

- The UK National Statistics 2009 present the medical discharges for all three Service personnel by Service, year and the principal cause leading to discharge between 2004 and 2008 (i.e., the period for which the Defence Analytical Services Agency [DASA] have validated the data). The International Classification of Diseases and Related Health Problems Version 10 (ICD 10) is used to classify the primary cause leading to medical discharge. A summary of the causes of medical discharge for each of the three Services in relation to musculo-skeletal disorders, mental behavioural disorders, and nervous system diseases is provided in *Table 5*. However, in interpreting these data it is important to note that comparisons between the single Service statistics are not valid because medical discharge rates differ in each Service to meet specific requirements in respect of the:
 - fitness level required by each Service
 - employment policy of each Service

- Whilst the medical discharge rates for mental and behavioural disorders have decreased over the five year period for Regular UK RAF personnel and Regular UK Naval Service personnel, there has been an increase for Regular Army UK personnel. Whereas in 2004, mental and behavioural disorders were recorded as the primary cause of medical discharge for 121 Regular Army UK personnel, in 2008 there were 137 cases despite a decrease of cases in 2007 to 114. Overall, however, the most prevalent primary cause of medical discharge for all three Services pertains to physical disorders rather than mental disorders.

Table 5. Medical Discharges for Tri-Services

Cause of Medical Discharge	Regular UK Army Personnel		Regular UK RAF Personnel		Regular UK Naval Service Personnel	
	<i>N</i>	%*	<i>n</i>	%*	<i>n</i>	%*
Musculo-skeletal disorders	3,109	65	413	44	974	63
Mental and behavioural disorders	602	13	271	29	185	12
Nervous system diseases	192	4	74	8	92	6

Note: * Percentage of all cause coded medical discharges during the five year period

Source: DASA (Health Information)

3.6 SERVICE FAMILY HEALTHCARE PROVISION

- In addition to its responsibility for meeting the healthcare needs of its Service personnel, the MoD is also required to deliver healthcare to those Service families who are posted overseas. Should it be the case that there are insufficient MoD resources available to fulfil that requirement this is met by contracts with local healthcare providers in the host country as well as UK-based NHS Trust hospitals.
- Although the healthcare of Service families in the UK is the responsibility of the NHS, the MoD has a role to play in supporting Service families following the termination of an overseas posting to facilitate the transition to NHS healthcare provision (Medical Care for the Armed Forces (7th Report of Session 2007-08), House of Commons Defence Committee 18th February 2008).

3.7 VETERAN HEALTHCARE POLICY AND STRATEGY

- In terms of meeting Veterans' health needs, the SPCP outlined a commitment to:
 - improve information about how Veterans' health needs differ from those of the general population,

- establish whether more has to be done to assess the healthcare needs of Veterans, and
 - raise awareness among healthcare professionals about the healthcare needs of Veterans.
- In meeting that commitment, however, two different problems have been identified with regards to assessing the healthcare needs of Veterans.
 - The first problem pertains to obtaining a clear understanding of the nature, extent and distribution of physical and mental injury among Veterans in the UK. Although some of the needs of Veterans who have sustained physical injury are well recognised (e.g., with regards to the long term management and rehabilitation of amputees), controversy remains in respect of health needs where the diagnosis of certain conditions has been subject to dispute (e.g., Gulf War Syndrome). Furthermore, to define the special mental health needs of Veterans is problematic due to the diverse nature of psychological injury.
 - The second problem is concerned with assessing the availability and quality of current health service provision for Veterans to establish whether the healthcare needs of Veterans are being met effectively. Anecdotal reports suggest that some Veterans perceive their health care needs to be qualitatively different to civilian patients and that to receive treatment alongside them in the NHS is unsatisfactory. The validity of these claims, and the implications for future healthcare provision, require an empirically based evaluation.
- Two papers presented to the Partnership Board formed the basis of the discussion as to how the evidence base could be amalgamated effectively to inform commissioners of the healthcare needs of Veterans. The first paper was prepared by MoD/DoH officials and entitled "*Veterans' Health Needs Assessment – Options for a Way Ahead*". The second paper entitled "*Veterans' Health and Healthcare Needs*" was prepared by John Newton (RDPH South Central, Department of Health) for presentation to the Working Group 2: Policy, Strategy and Veterans dated the 26 September 2008. Both of these papers highlighted the importance of identifying and building on the existing and emerging evidence. In respect of the latter, the second paper suggested an approach to achieve this requirement, an outline of which is provided in *Table 6*.

Table 6. Outline of Partnership Board Approach

Approach	Purpose	Proposed methods
<i>Conduct of a formal epidemiological needs assessment</i>	<p>To obtain qualitative data on:</p> <ul style="list-style-type: none"> ▪ frequency of specific conditions ▪ risk factors ▪ lifestyle and behaviour patterns 	<ul style="list-style-type: none"> ▪ Case-control studies (Veterans vs non-Veterans) based on representative groups and appropriate controls. ▪ Large scale prospective cohort study based on a clearly defined target population
<i>Assessment of the quality of service provision for Veterans</i>	<p>To obtain qualitative data on the NHS treatment experiences of Veterans and their families</p>	<ul style="list-style-type: none"> ▪ Interviews ▪ Focus groups
<i>Identification of factors to enable Service improvement</i>	<p>A pragmatic approach to identify current strengths and weaknesses of a service from referral to the completion of an initial course of treatment</p>	<ul style="list-style-type: none"> ▪ Experience-based Design Model ▪ Formulation of Stakeholder Group (including Veterans) to provide a source of external advice on service improvement

- In order to take further this approach, it was proposed that the Partnership Board should request the DH Policy Research Programme to commission a suitable academic group to: (i) conduct a literature review of existing evidence on the physical and mental health needs of Veterans, and (ii) use the outcome of that literature review along with other relevant sources of information to develop a robust research proposal for one or more studies. By this means, it was proposed that additional

qualitative and quantitative data on the healthcare needs of “recent” Veterans in the UK (including prognostic indicators of health risk) could be generated. It was also proposed that the NHS Institute for Innovation and Improvement should be invited to support the Experience-based Design work using a selection of NHS services that provide healthcare to Veterans (e.g., inpatient facilities at Selly Oak) at an estimated £20,000 per unit for a six month project.

- A subsequent Discussion Paper for the MoD/UK Departments of Health Partnership Board meeting on 10 February 2009 entitled “*Assessing Whether More Needs to be Done to Assess the Healthcare Needs of Veterans*” provided an update on progress towards meeting this particular commitment of the SPCP. It endorsed further the importance of obtaining robust epidemiological data that would provide the necessary evidence to determine whether Veterans’ healthcare needs differ from the general population. In addition, it highlighted the need for commissioners to identify the numbers of Veterans within their region as part of their local needs assessment, particularly in view of the increasing number of younger Veterans who have been deployed on more recent operations (e.g., the Gulf War, the Balkan conflict, Iraq, and Afghanistan). The paper also proposed a “staged approach” to meeting this commitment, which would incorporate five stages to:
 - (i) identify current knowledge and practice relating to the healthcare needs of Veterans;
 - (ii) identify research already in progress;
 - (iii) synthesise the outcome of (i) and (ii) to identify gaps;
 - (iv) commission projects to address gaps in service provision, and
 - (v) produce guidance for commissioners subject to requirements.

- In addition to addressing the first two stages (which will be included in Section 5), this paper also proposed an approach for undertaking the other three stages. In terms of stage (iii), the Partnership Board was asked to approve a proposal to commission a scoping review to inform further work on “*assessing the healthcare needs of recent forces Veterans*”, which was subsequently awarded to KCMHR. The specification of that review will be considered in Section 5. In considering what more might be done to meet this commitment, the paper proposed the need for further research to:
 - obtain more in-depth and robust data on Veterans’ experience of and satisfaction with NHS services.

- ascertain whether the help-seeking behaviour of Veterans is different when compared to the general population.
- Finally, it suggested that the MoD investigate the extent to which the data obtained on medical discharges by DASA on the previous 10 years could be analysed for future benefit.
- Most recently, the Coalition Government commissioned Dr Andrew Murrison MP to examine the relationship between the MoD and the NHS in respect of addressing mental health problems (Murrison, 2010). The report entitled "*Fighting Fit*" included the following four key recommendations.
 - (i) Examination of the MoDs current systems of assessment for and evaluation of mental health problems.
 - (ii) Increase in the numbers of mental health professionals to enhance outreach provision for Veterans.
 - (iii) Introduction of a Veteran's Information Service (VIS) for access 12 months post-service.
 - (iv) Pilot of an online early intervention service for Serving and ex-Service personnel.

3.8 CURRENT ORGANISATION AND DELIVERY OF VETERAN HEALTHCARE

- On leaving the UK Armed Forces, the healthcare of Service personnel transfers from the military to the NHS. To facilitate the transition of care all departing Service personnel have a discharge medical, the purpose of which is to:
 - provide an opportunity to document any harm that has occurred and that could be attributable to service (e.g., high-tone hearing loss in gunners),
 - ensure that there are no outstanding matters to be addressed, and
 - prepare a summary⁷⁴ for the NHS GP along with instructions on where service medical records⁷⁵ can be obtained.
- It is the responsibility of the individual to register with an NHS GP practice and handover the summary as soon as possible on discharge. The NHS GP practice can subsequently apply to the

⁷⁴ This summary of the individual's Service medical history (form Fmed 133) is a two page document which comprises five parts. Part 1 is addressed to the civilian GP; Part 2 is to be completed by the individual; Part 3 is only to be used in cases of medical discharge; Part 4 provides Service vaccination history, and Part 5 is to be completed by the President of the Medical Board/ Unit Medical Officer. It includes details of disabilities, immunisations, clinical conditions and any other significant treatments received.

⁷⁵ For MoD personnel, all medical records are contained in form Fmed4, which is archived by the three Services.

relevant Service repository to obtain a copy of the Veteran's full medical record (with his/her written consent). This applies whether or not the Veteran has left service because of a medical discharge. Because some GPs, however, have reported problems in accessing past service records for discharged members of the UK Armed Forces, the Partnership Board, DMCP and Connecting for Health are currently working together to develop a range of proposals to ensure better connectivity between the MoD and the NHS. These include:

- improving the transfer of records between the MoD and the NHS
- making referrals into the NHS by means of Choose and Book
- accessing summary care information

As an interim measure, a DoH guidance letter was issued to SHA Chief Executives in June 2008 to notify GPs of contact points for accessing records should any difficulty be encountered. In addition, the standard Family Doctor Services Registration Form (GMS1) used by NHS GP practices now asks individuals who are registering with a GP practice to declare whether they have left military service and, if so, to provide their: (i) address prior to enlisting, (ii) service or personnel number, and (iii) date of enlistment.

- For Service personnel discharged with significant health problems, the MoD typically liaises with the local Primary Care Trusts⁷⁶ (PCTs) and affiliated providers of health and social care in the event of ongoing health needs. A military social worker provides support for up to 12 months to enable access to the appropriate NHS services. Responsible Commissioner Guidance covers issues associated with continuity of care for those leaving the UK Armed Forces.
- In 1953, hospitals run by the Ministry of Pensions for the treatment of war pensioners⁷⁷ was transferred to the NHS. The UK Government gave an undertaking that there should be priority out-patient and in-patient examination and treatment for war pensioners in NHS hospitals for the condition or conditions for which war pensioners received a pension or gratuity unless there was an emergency case or another case which demanded clinical priority (Priority Treatment for War Pensioners,

⁷⁶ PCTs are local organisations at the centre of the NHS which work with Local Authorities and other agencies to ensure that the health and social care needs of the local community are met.

⁷⁷ Originally, the term "war pensioner" embraced Veterans who were injured or disabled as a result of service in the UK Armed Forces either before the First World War or between 21st October 1921 and 2nd September 1939. The definition of a war pensioner has been extended over time to include Veterans of more recent operations.

HSG(97)31, dated 18th June 1997). Current guidance on this is set out in Priority Treatment for War Pensioners – HDL (2006) 16 which states that GPs and NHS Hospitals should give priority treatment to war pensioners (both in-patient and out-patient), for examination or treatment which relates to the condition(s) for which they receive a pension or gratuity, unless there is an emergency case or another case demands clinical priority. Veterans should not be given priority treatment for conditions unrelated to service in the UK Armed Forces.

- Updated DoH guidance⁷⁸ for access to health services for military Veterans issued on the 12 September 2007 (HSG) extended the guidance of HSG(97)31 based on that implemented by Hull Teaching PCT whereby priority access to the NHS was made available to all military Veterans for Service-related conditions⁷⁹. In addition, entitlement of priority access to NHS treatment based on clinical need is no longer contingent on eligibility to receive a war pension. (By the same token, Veterans who are eligible to receive priority treatment does not necessarily mean that they are entitled to a war pension.) Although it is for clinicians to decide whether it is likely that a condition is related to service, this updated guidance states that *"...it is not appropriate for secondary care staff systematically to ask patients where they are Veterans suffering from a condition that they believe is related to their military service"*. Thus, it is solely dependent on Veterans to be willing and to take the initiative to inform clinical staff accordingly that priority access may be forthcoming (should the clinician decide that it is appropriate). The Service-related conditions identified as being most likely to benefit from priority treatment provision were:
 - hearing loss,
 - orthopaedic injuries, and
 - mental health conditions.
- As of 1 January 2008⁸⁰, GPs were requested to implement the extension of priority treatment in making new⁸¹ referrals for diagnosis or treatment. In the event that the GP considers that severe disability has resulted from a condition due to service,

⁷⁸ The updated guidance was issued by the Chief Executive of the NHS in England (David Nicholson CBE) to the Chief Executives of the PCTs, NHS Acute and Mental Health Trusts and the NHS Foundation Trusts.

⁷⁹ This also included cases where a health professional suspects that a Veteran's condition may be associated with his/her military service.

⁸⁰ The extension of priority treatment to Veterans in Scotland applied to new GP referrals from 29 February 2008.

⁸¹ The restriction placed on "new" GP referrals from the 1st January 2008 was to avoid incommoding other NHS patients who had already received dates for appointments. Only in exceptional circumstances would there be a justification for priority treatment despite having either been referred to treatment or undergoing treatment before this date.

then he/she “could suggest” to the Veteran to apply for a war pension given that they may also be entitled to claim a pension or gratuity or receive benefits (e.g., a free prescription).⁸² As is the case with war pensioners, all Veterans have use of the NHS complaints system should they encounter any problems in respect of access to priority treatment. The updated guidance also highlighted the implications for service provision (particularly in the future) resulting from anticipated changes in the profile of the UK Armed Forces. Due to increasing recognition by the UK Armed Forces of the need for active equal opportunity policies⁸³, the proportion of women as well as those from the ethnic minorities who join the military service is likely to increase. To this end the healthcare needs of Veterans will also change accordingly.

- On the 13 February 2008, the Healthcare Policy and Strategy Directorate (Scottish Government) also provided updated and extended guidance on HDL (2006) 16. From 29 February 2008, all Veterans (including those who have served as Reservists) should receive priority access to NHS primary, secondary and tertiary care for any conditions likely to be Service-related. This also applied to those Veterans who are not in receipt of a war pension. NHS Boards were tasked with the responsibility to ensure that GPs, heads of service in secondary care, and all relevant hospital staff were aware of the current priority treatment provisions. Recipients of CEL 8 (2008) were also advised that monitoring arrangements would be required to evaluate impact on those services that are most likely to be accessed by Service personnel (e.g., mental health, audiology, and orthopaedic services). To minimise any potential confusion that may arise when Veterans interpret “priority treatment” as “preferential treatment” the Scottish Government and the MoD have worked together in providing Veterans organisation in Scotland and CAS with information to clarify this issue. Finally, CEL 8 (2008) outlined the process involved in obtaining the medical history of Service personnel on their release from the UK Armed Forces.

⁸² Access to free prescriptions is currently restricted to war pensioners.

⁸³ For example, the “diversity” policy incorporated within the Armed Forces Overarching Personnel Strategy (MoD, 2002/2003)

3.9 DEVELOPMENT OF A COMMUNITY-BASED MENTAL HEALTH SERVICE FOR VETERANS

- From 1948 successive governments have intended that the NHS should be the main provider of mental healthcare for Veterans. In addition to the NHS, the MoD also relies on the services of *Combat Stress*⁸⁴ to supplement the provision of mental healthcare available to Veterans on a UK-wide basis including Scotland. As an independent charity founded in 1919, it has a long-standing reputation for its work with Veterans, the original focus of which pertained to the occupational rehabilitation for Great War Veterans who returned from hospitals such as Craiglockhart. In more recent times, their charitable work has been dedicated to providing residential care for Veterans with mental health problems at one of their three treatment centres⁸⁵ run by the Society. In addition to providing a rehabilitative function, *Combat Stress* provides its clients with social opportunities within a “secure military haven” which also facilitates the re-establishment of contact with old acquaintances (“*A Community Based Mental Health Service for Veterans: a Core Briefing Paper*”, MoD & SPVA, 2008). A network of Regional Welfare Officers (RWOs) operates to offer support within client’s homes and to instigate the process of assessment for Veterans who would potentially benefit from a residential stay at one of the *Combat Stress* centres. In addition, *Combat Stress* operates a national network of Community Outreach teams comprising RWOs, Community Psychiatric Nurses (CPNs), Mental Health Practitioners (MHPs) and Administration Support Officers (ASOs).
- The RWO is usually the first face-to-face contact a Veteran will have with a member of *Combat Stress*. Together the team can provide a wide range of practical support and advice in the Veterans own home, as well as community-based clinical care provided by the CPN and MHP.
- With the emergence of NICE-recommended treatments for mental health conditions, there has been increasing focus on the need for mental health service providers to ensure the provision of effective treatments for those who require them. To this end, the MoD co-operates with the DoH and *Combat Stress* accordingly. Changes to NHS procedures and commissioning arrangements, along with concerns expressed about the

⁸⁴ Also known as the “Ex-Services Mental Welfare Society”.

⁸⁵ The Combat Stress Treatment Centres are Tyrwhitt House (Leatherhead), Audley Court (Shropshire) and Hollybush House (Ayrshire), which are situated in the catchment areas of the Surrey and Borders Partnership NHS Trust (South East Coast SHA), Shropshire County PCT (West Midlands SHA) and Ayrshire and Arran NHS Trust respectively.

prevailing milieu within the *Combat Stress* treatment centres, resulted in agreement being sought from *Combat Stress* in 2004 to undertake an independent review of its work⁸⁶.

- In spring 2005, a review was conducted by the Health and Social Care Advisory Service (HASCAS)⁸⁷ to evaluate the treatment programmes provided by *Combat Stress* in respect of clinical arrangements (including staffing, training, and cost effectiveness). Whilst confirming the enthusiasm, commitment and motivation of the *Combat Stress* staff, it highlighted areas of improvement to ensure that the programme incorporated best practice⁸⁸. Furthermore, it called for wider improvements in mental health service provision which extended beyond that already provided by *Combat Stress* in order to meet the mental healthcare needs of all Veterans in the community (i.e., not just war pensioners). On this basis, a key feature of the HASCAS Review pertained to work (that commenced in the autumn of 2006) to develop this new community based model for mental health services for Veterans, which placed NHS Primary Care services and GP services at its core. Officials from the MoD, the four UK Health Departments, *Combat Stress*, and the HASCAS were instrumental in devising the framework for the structure of this new initiative, which also incorporated the advice of leading UK clinicians (including the UK Trauma Group).
- In January 2007, the outline of that service model and the proposed pilot projects was presented in a HASCAS briefing paper ("*A Community Based Mental Health Service for Veterans: Outline of Service Model and Pilot Projects*"). This was followed in April 2007⁸⁹ by the core briefing paper ("*A Community Based Mental Health Service for Veterans: A Core Briefing Paper*"), a primary objective of which was to present the firm proposals upon which the model would be based. These were as follows.
 - As an NHS led service it would reflect NHS best practice and procedure.

⁸⁶ Over the past five years, *Combat Stress* has routinely collected clinical audit data on new patients admitted to all three of their treatment centres.

⁸⁷ The HASCAS Review was led by Professor John Hall and advised by the Health Care Commission and the Mental Health Care Commission.

⁸⁸ This was based on evidence derived from *Combat Stress* data which demonstrated that despite the increasing number of Veterans requesting help for mental health problems, the figures failed to "...reflect the heterogeneity of diagnoses seen in clients nor their differing support needs." It also established that some of those presenting to *Combat Stress* had a mental health need that could be adequately managed by NHS GPs or other specialist community-based services. In the case of those with complex problems of a severe and enduring nature, issues were raised regarding the accessibility and acceptability of treatment centres.

⁸⁹ Issued by the MoD Service Personnel and Veterans Agency (SPVA), this core briefing paper was updated to May 2008.

- Access to the service would be predominantly client and GP centred.
 - Cases would be managed by means of an evidence-based step care approach as encouraged by NHS policy.
 - Evidence-based treatment would be provided in accordance with the condition-specific guidance issued by NICE.
 - In seeking to identify the specific clinical and social needs of Veterans, the service would also be in line with the 1999 National Service Framework for Adult Mental Health (NSFAMH).
 - Regionally based clinical networks comprising NHS clinicians, mental health specialists from the DCMHs, academic and UK Trauma Trust⁹⁰ clinicians in order to facilitate the conjoint sharing of training, information and expertise.
- A total of eight service elements were identified with a view to ensuring the provision of:
 - general and specific information regarding local “Veteran-sensitive” and accessible services – for both Veterans and agencies;
 - clinical guidance for primary care – to encourage early presentation, case identification and assessment;
 - access to a “Veterans Champion” at PCT level – to assist and support the retention of Veterans in primary care services by assuring them of an understanding of the military;
 - parallel welfare support and advocacy for Veterans – to address their needs and concerns regarding a broad range of matters;
 - local Veterans’ mental health clinical networks – to promote and facilitate the sharing of knowledge, skills, and expertise;
 - access to a “Community Veterans Mental Health Therapist” at Mental Health Trust level - to improve the assessment, treatment, and support of Veterans with identified Service-related severe or complex mental health needs;
 - identification of key workers for at-risk Veterans who may require intervention – to ensure a co-ordinated approach by all agencies concerned, and
 - appropriate residential settings – to enable the: (i) provision of respite care, (ii) stabilisation of severely

⁹⁰ The UK Trauma Trust in Hull Humber and East Yorkshire has a special interest in Veterans because of the relatively high numbers who reside in this region. It is the base for the National Gulf Veterans and Families Association and the mental health charity, MIND, has a sponsored self-help group for Veterans with mental health problems in Leeds.

disturbed Veterans, and (iii) delivery of evidence-based interventions.

- Responsibility for the provision of a local enhanced service varied according to the nature of the service element. For example, the MoD would be responsible for ensuring the standard provision of general information on a national basis, whereas it would fall to the local services to ensure that Veterans and relevant agencies were furnished with the information about local “Veteran-sensitive” and accessible services. In terms of commissioning the mental health services for Veterans, the provision of specialist treatment for the small number of “vulnerable” Veterans were intended to be accommodated within the existing NHS arrangements for commissioning specialised services.
- The underlying rationale for accommodating Veterans healthcare needs within existing NHS services derives from the view that a Veteran-dedicated service model would not be:
 - in line with the long established UK social welfare arrangements,
 - justified due to insufficient demand (particularly as the Second World War generation diminishes), and
 - supportive of social inclusion.
- The military and the Veterans’ community, however, have expressed concerns about the accessibility and acceptability of a community-based mental health service. In particular, these concerns derive from the view that Veterans’ exposure to military culture and related experience means that they have different healthcare needs to those of the civilian population that cannot be met satisfactorily in an NHS setting with civilian medical staff. Proposed barriers to obtaining appropriate and timely help for Veterans include the:
 - stigma attached to mental health problems. (Although this is not unique to the military, this issue may be compounded when Service personnel are exposed to a culture that reflects machismo ideals and which commends those individuals who are resilient, stoic, and self-sufficient in the face of adversity.)
 - configuration of NHS mental health services to prioritise severe enduring mental illness.
 - problems for Veterans in engaging with treatment services that have little understanding of military culture or combat-related psychological trauma.

- Whilst most of these concerns are based on anecdotal reports rather than empirical evidence, there is evidence to suggest that Veterans frequently present to mental health services for treatment many years after they have experienced combat (Creamer & Forbes, 2004). This is further substantiated by reports from *Combat Stress* that, on average, the time between discharge from service and first contact with *Combat Stress* is 14.1 years (Fletcher, 2007; Busuttil, 2010). However, the ongoing rise in the number of referrals to *Combat Stress* resulting from the most recent operations, viz, Op TELIC and Op HERRICK suggests that delayed help-seeking is more likely in older Veterans than the younger ones. Hart & Lyons (2007) state that the time between discharge and referral of nine months for the 167 referrals received from Op TELIC is substantially less compared to that of the *Combat Stress*-wide average delay of 13 years⁹¹. To establish whether there is a causal link however between the accessibility and acceptability of service provision (particularly with regards to the mental health services) and a delay in seeking appropriate help has yet to be established.
- In addition, the HASCAS Review brought to the fore two key factors widely considered as *sine qua non* when planning a new service⁹². The first factor is concerned with ensuring that there is likely to be a demand for the proposed service. Evidence for that demand should be informed by robust epidemiological data to confirm the range of needs to be met and the extent of the conditions that require intervention (as indicated by their prevalence⁹³ and incidence⁹⁴ rates). The second factor is concerned with ensuring the availability of sufficient resources to fulfil requirements (both in terms of the extent of the problem and the range of needs identified).
- As evidenced by their December 2006 paper ("*Piloting the Implementation of a Community Mental Health Service for Veterans*")⁹⁵, however, the absence of robust epidemiological data on the incidence and prevalence rates pertaining to

⁹¹ This figure is subject to variation depending on when the clinical audit data was obtained. Hence, the discrepancy between the figure cited by Hart & Lyons (2007) and the figure cited by Fletcher (2007) reported in Section 3.

⁹² Epidemiological data are widely recognised as a prerequisite for the identification of deficits and problems in health care systems and for offering guidance on service planning and resource allocation (Jenkins *et al*, 2003).

⁹³ The term "prevalence" refers to the total number of cases at a single point in time.

⁹⁴ The term "incidence" refers to the total number of new cases which arise over a period of time [typically in one year]

⁹⁵ This paper was based on the outcome of a HASCAS meeting of the 3rd August 2006 at the MoD, which was subsequently detailed in the HASCAS paper of July 2006 ("*Mental Health Services for Veterans: a Proposed Service Model*").

Veterans with significant mental health problems substantially undermined the extent to which it was possible to adequately address these two factors. Moreover, there were no data available to inform the extent to which the needs of this target population were being met by the NHS and affiliated civilian agencies, particularly with regards to “vulnerable” subgroups⁹⁶ with concomitant social problems (thereby increasing substantially their risk of social exclusion).

3.10 PILOTING THE IMPLEMENTATION OF A COMMUNITY-BASED MENTAL HEALTH SERVICE FOR VETERANS

- In an endeavour to obtain the necessary epidemiological data to inform the UK wide roll-out of the community based mental health service for Veterans, the MoD and the DoH announced in 2007 that six pilot schemes would be conducted predominantly over a two year period in the following sites:
 - London (based in Camden & Islington)
 - Shropshire & Stafford
 - Cardiff
 - St Austell (based in Bodmin)
 - Newcastle upon Tyne
 - Edinburgh
- Other active partners in these projects are the long-standing service for Veterans in Hull⁹⁷, the RMHP programme at Chilwell (Nottinghamshire), and *Combat Stress*. Service developments in Northern Ireland are included as part of this initiative with involvement from the Police Rehabilitation Training Trust (PRTT), which was originally established in 1999 to assist retired RUC officers and those planning to leave service. As the primary provider of psychological services to serving officers and police staff on referral from the Police Service of Northern Ireland (PSNI) Occupational Health and Welfare Unit, it has since expanded to provide a service to Service personnel from the Irish Regiments.
- Intended as one aspect of improving mental health services for Veterans across the UK, the structure of the pilot schemes has been designed to be consistent with current NHS policies,

⁹⁶ These included those Veterans who had: (i) severe and chronic mental health problems; (ii) long standing physical illness and injuries (the majority of whom were considered to be the older Veterans); (iii) encountered the Criminal Justice System (some of whom may also have served a custodial sentence); (iv) homelessness, and (v) unemployment.

⁹⁷ As part of the Humber Mental Health Teaching NHS Trust Service a specialised psychological trauma service has existed for some time in Hull and the East Riding of Yorkshire. As the only trauma service in the UK Trauma Centre network that refers to having a special interest in Veterans it provides them with a direct referral service from GPs in the region.

structures and procedures, including that of quality assurance. A Clinical Expert Group has produced guidance on referral criteria, the design of person assessment, the range of interventions to be provided, a service specification, and information on core staff training. The "*Mental Health Services for Veterans: A Proposed Service Model*" paper presented a three dimensional scheme to classify the mental health problems of participants as follows.

- *Dimension 1*: severity (mild/moderate/severe)
 - *Dimension 2*: complexity (simple/complex)
 - *Dimension 3*: relationship to military service (not at all/to some extent/ considerably)
- As the purpose of these pilot schemes is to: (i) encourage early presentation; (ii) offer appropriate interventions in the community to those who would potentially benefit, and (iii) involve existing and new cases (although priority would be for new referrals), all six sites are co-terminous with the catchment area of a Mental Health Provider Trust or equivalent (e.g., a Care Trust or PCT). In addition, sites were chosen to permit comparisons based on the following factors.
 - Sites which include a *Combat Stress* Treatment Centre (e.g., Stafford) and those which do not (e.g., St Austell)
 - Sites based in England (e.g., London) with those based in another home nation (e.g., Cardiff and Edinburgh)
 - Comparator sites where there is no change of service (i.e., the RMHP, *Combat Stress*, the Hull Psychological Trauma Service and the PRTT).
 - In the December 2006, the HASCAS paper ("*Piloting the Implementation of a Community Mental Health Service for Veterans*") estimated that the total costs for the pilot schemes would range from £470,000 to £582,000. The implementation of the pilot schemes started from late 2007 in Camden & Islington, Shropshire & Stafford, and Cardiff. The Edinburgh based pilot scheme known as "Veterans First Point" (VIP) was launched in April 2009 to run over three years. VIP was developed by a Veterans Advisory Group, which was established by the Rivers Centre for Traumatic Stress (Royal Edinburgh Hospital) and which included Veterans and representatives from a wide range of Veteran organisations. Funded by the MoD (£70,000), NHS Lothian (£220,000), and the Scottish Government (£640,000), VIP was officially opened by the Public Health Minister, Shona Robinson. Staffed by peer support workers with military backgrounds, it provides a dedicated "one-stop-shop" service to offer information and advice on a wide range of health and welfare support services. At a meeting of the Scottish Parliament

Cross Party Group on Supporting Veterans (held at Whitefoord House on 28 April 2009), it was noted that the Scottish pilot scheme was different to the other pilot projects currently underway in England and Wales although the evaluation of all projects would be used to inform subsequent decisions on the roll-out of a community-based mental health service for Veterans in Scotland.

- In addition to the implementation of an audit protocol, comprising specified outcome measures, an integral part of these pilot projects is the conduct of a full independent evaluation, the tender for which was awarded to Professor Michael Barkham (Director of the Centre for Psychological Services Research [CPSR]⁹⁸, University of Sheffield). A key aspect in determining the nature of that evaluation was reaching agreement on a minimum core data set by the Expert Group. In April 2008, the paper entitled "*Veterans Mental Health Project: A Minimum Data Set for Community Based Mental Health Services for Veterans*" led to an agreement that the minimum data set should comprise two categories of core information comprising: (i) routine clinical data and (ii) pilot specific data based on patient descriptor information (including details on the client, service history, and medical/ social history) and the administration of two standardised measures (Patient Health Questionnaire [PHQ9] and the Work & Social Adjustment Scale [WASAS]) for completion on every occasion the service user attended. Other clinical measures were also used where clinically appropriate, and other facets of the services were captured by interviews with service users in accordance with the NHS Ethical Protocol Agreement.
- The outcome of the pilot scheme evaluation intended to: (i) generate data that would inform the provision of local services within the designated pilot regions, and (ii) establish whether the community-based model for mental health services for Veterans would be sufficiently robust to warrant its implementation across the UK. The findings from the evaluation of the Edinburgh pilot scheme were presented to a selected audience on the 21 April 2010 at a conference organised by VIP. The evidence from the Final Report "*An evaluation of six Community Mental Health Pilots for Veterans of the Armed Forces*" (CTLBC-405, 15 December 2010) is summarised in *Section 5*.

⁹⁸ The CPSR is an interdisciplinary collaboration between the University of Sheffield's School of Health and Related Research (SchARR) and the Department of Psychology. Officially launched on the 9 November 2007, the aim of the CPSR is to improve decision-making, and the quality and outcome of services for the treatment of psychological problems.

3.11 IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT)

- An important aspect of conducting the pilot studies is to link these in with the IAPT programme to access psychological therapies in common mental health conditions. The goal of the IAPT programme is to deliver a new state-of-the-art psychological therapy service in the UK which would “...*not only demonstrate a paradigm shift in meeting the health needs of a large group of people, but also show that the NHS can deliver innovative new services valued by the wider population*”. On securing additional targeted funding in the Comprehensive Spending Review (CSR07), the national roll-out of the IAPT programme commenced in order to enable PCTs to implement the NICE guidelines for people suffering from depression and/ or anxiety disorders. Publication in February 2008 of the policy document entitled “*Improving Access to Psychological Therapies. Implementation Plan: National Guidelines for Regional Delivery*” (Gateway Ref: 9427) provided Strategic Health Authorities (SHAs), PCTs, training providers and service providers with clarity about the form and nature of the services to be established and an overview of training⁹⁹ and commissioning requirements for the implementation of IAPT. The NHS Operating Framework 2008/09 highlighted the need for PCTs to conduct a needs assessment of their local population as the first step in planning how they will implement a stepped-care psychological therapies service.
- Guidance on performance indicators, service standards and outcomes monitoring was subsequently provided in the IAPT Outcomes Framework 2008/09. The standard set of performance indicators developed by SHAs to support regional performance monitoring¹⁰⁰ of each IAPT service are collated nationally to produce averages which are published to permit benchmarking (subject to Review of Central Returns [ROCR] approval). Service-level performance indicators are based on an outcomes framework. Subject to discussions with the SHAs and ROCR, outcomes are monitored in respect of the following performance areas:

⁹⁹ Funding from the Comprehensive Spending Review 2007 was secured to pay for the major training programme to enable the availability of sufficient suitably trained therapists in accordance with the progressive expansion of the IAPT. By 2010/11 it is intended that 3,600 new mental health therapists will have received training under the aegis of the IAPT.

¹⁰⁰ Regional performance indicators are used to establish PCT coverage, capacity building of a skilled workforce, and extending access to NICE-compliant services.

- accessibility – to ensure that waiting times and the range of interventions provided across the stepped care model are appropriate;
 - equity of access – to ensure access to all members of the community (established by means of a local equality impact assessment);
 - population coverage – to demonstrate improvements in those receiving psychological therapies;
 - effectiveness – to: (i) obtain pre- and post-treatment health and wellbeing outcome data (for at least 90% of those treated), (ii) demonstrate symptom reduction, and (iii) demonstrate social inclusion and employment status, and
 - acceptability and quality – to monitor: (i) satisfaction and choice of IAPT service users’ and (ii) supervision of trainees and experienced staff.

- In March 2009, the Veterans Positive Practice Guide on IAPT (DoH, 2009) highlighted the need for commissioners to:
 - understand the demographic profile of their local populations (including Veterans) to provide IAPT services that are appropriate;
 - include Veterans as part of needs assessment;
 - ensure the effectiveness of IAPT services for Veterans from a range of circumstances (particularly those who present with complex and problems distinct from the general population given their vulnerability to social exclusion);
 - improve access as a way to remove barriers which prevent Veterans from accessing psychological therapy services);
 - engage with Veterans’ organisations and groups and those with existing expertise in working with Veterans [e.g., MAP, *Combat Stress*, UK Trauma Group]);
 - encourage Veterans to engage with services by providing a conducive location that provides some form of anonymity;
 - recruit, develop and retain a workforce that delivers high quality services to meet all needs including those of Veterans, and
 - understand military culture.

- An approach has also been made to see whether Veteran mental health can be part of work undertaken by NICE to provide additional guidance for specific at-risk groups.

3.12 HEALTHCARE PROVISION FOR VETERANS WHO ENCOUNTER THE CRIMINAL JUSTICE SYSTEM

- The NHS is responsible with the Prison Service for providing healthcare to those Veterans who are in prisons along with their civilian counterparts. It is the aim of the Prison Healthcare Policy Unit at the NHS¹⁰¹ to provide the same quality of health service to prisoners as it does for the general public.
- Evidence that the prison population in the UK suffers from a relatively high rate of mental health problems¹⁰² has been instrumental in informing UK Government policy¹⁰³ to improve mental health services for prisoners. In line with that policy, "*Changing the Outlook: A Strategy for Modernising Mental Health Services in Prisons*" proposed how a multidisciplinary health team system could provide In-reach services in order to ensure that all prisoners with severe and enduring mental health illness (including Veterans) could receive comprehensive care. To this end, the first Mental Health In-reach Services were commissioned from local Mental Health NHS Trusts in 2001-02 to offer prisoners the same type of specialist care and treatment they would receive in the community from Community Health Teams. In January 2004, an evaluation of the success of the PIR services in England and Wales commenced the details of which is presented in *Section 5*.
- Despite these initiatives to enhance mental healthcare provision for prisoners, there is a growing consensus that prison may not always be an appropriate environment for those with severe and enduring mental illness. Indeed, many harbour concerns that the experience of being in custody can exacerbate mental ill health, increase vulnerability and elevate the risk of self-harm and suicide. Furthermore, in light of substantial increases in the prison population¹⁰⁴, there has been an imperative to address this issue at a time when the UK Government contemplates the need for larger capacity prisons as a means of alleviating the increasing pressure on the prison system. Thus, in December

¹⁰¹ The Prison Healthcare Policy Unit at the NHS has replaced the former directorate of Health Care for Prisons at the Home Office.

¹⁰² The ONS Survey of Psychiatric Morbidity among prisoners in England and Wales was carried out in 1997 on behalf of the DoH (Singleton *et al*, 1998). Key findings from that survey showed that over 90 % of prisoners suffered one or more of the five psychiatric disorders assessed, *viz*, psychosis, neurosis, personality disorder, hazardous drinking and drug dependence.

¹⁰³ The National Service Framework for Mental Health recommends better mental health assessment for prisoners. The Department of Health's NHS Plan calls for more comprehensive mental health services in prison.

¹⁰⁴ Since June 1995, the prison population in England and Wales has increased by 60 % (Ministry of Justice, 2007, Lord Carter's review of prisons: Securing the future: Proposals for the efficient and sustainable use of custody in England and Wales).

2007, the Secretary of State for Justice asked Lord Bradley (former Home Office Minister) to undertake a six month¹⁰⁵ independent review to determine the: extent to which offenders with mental health problems or learning disabilities can be diverted from prison to other services, and (ii) nature of the barriers which may prohibit such a diversion¹⁰⁶.

- In February 2009, Lord Bradley presented the outcome of his review to the UK Government followed by the publication of "*The Bradley Report*" in April 2009. It proposed the implementation of a number of recommendations over varying timescales. A crucial first step in their implementation pertained to the need to establish the governance arrangements at a national, regional and local level to provide a framework as a basis for the work to progress. Consistent implementation across the country and the strategic working of key organisations to deliver the agenda was considered to be of paramount importance in developing appropriate services to meet the diverse and complex needs of the target population. Particular emphasis was placed on the existence of "good early identification" and "assessment of problems" which can inform how and where offenders are most appropriately treated to ensure their effective management. The establishment of Criminal Justice Mental Health Teams was considered to be a vital component in ensuring that prisoners can receive targeted and effective care during their custody. The momentum of the work would be contingent on measuring progress with regular reports to Parliament. By this means, the wider stakeholders and the public would be kept advised of any subsequent changes and of their effectiveness.
- Publication of the HMIP Thematic Report ("*Out of Sight – Severe and Enduring Mental Health Problems in Scotland’s Prisons*") in December 2008 presented 20 recommendations for the Scottish Prison Service (SPS) in respect of the current arrangements and challenges for managing prisoners suffering from severe and enduring mental health problems. The inspection focussed on six specific areas relating to mental health issues in Scotland’s prisons in respect of:
 - the scale of severe and enduring mental health problems in Scotland;

¹⁰⁵ To ensure a comprehensive consideration of the "offender pathway" and the associated mental health services, agreement was obtained to extend the review period to 12 months.

¹⁰⁶ The term "diversion" refers to "...a process whereby people are assessed and their needs identified as early as possible in the offender pathway (including prevention and early intervention), thus informing subsequent decisions about where an individual is best placed to receive treatment, taking into account public safety, safety of the individual and punishment of an offence." (p.16, *The Bradley Report*, April 2009).

- the processes involved;
- the impact on the prison;
- prison-based and community interventions;
- issue for release, and
- reasons for use of prison for people suffering from severe mental health problems.

The findings relating to each of these six areas will be presented in *Section 5*. However the main finding from the Thematic Inspection was that: *“The use of imprisonment is inappropriate for people with severe and enduring mental health problems. Their primary need is mental health and the appropriate place to address that is hospital.”*

- The Howard League Scotland (HLS) has focused on problems of the Scottish courts and the legal system, liaising with and influencing Scottish Ministers, civil servants, the Judiciary and the SPS in respect of the wider criminal justice system in Scotland. It is particularly interested in the:
 - rehabilitation of offenders and the effectiveness of interventions;
 - improving prison regimes;
 - relationships between drug and alcohol abuse and crime;
 - early intervention and prevention;
 - reducing the unnecessary use of imprisonment, and
 - links between poverty and crime.

The HLS are of the opinion that it is time for criminal justice policy and systems to adopt a different direction that would rely more extensively on community approaches to reducing crime and dealing with criminality. HLS is a fully independent body that seeks to promote effective pathways to achieving this goal; the success of which would help to address the capacity issues facing the prison service across the UK.

3.13 WELFARE AND SUPPORT

3.13.1 Organisation of Welfare and Support Provision

- From the 7 April 2007 the Armed Forces Personnel Administration Agency (AFPAA) and the Veterans Agency (VA) were amalgamated into the Service Personnel and Veterans Agency (SPVA) to provide an integrated and efficient “through life” personnel service to both Serving personnel and Veterans under the new brand for services to Veterans “*Veterans UK*”. As a single banner covering a variety of different Veterans’ services provided by a range of different organisations, its purpose was to form a single point for accessing information. From 2 April 2007 a new Veterans’ portal website (www.veterans-uk.info)

replaced the previous VA website as a focal point for accessing information on Veterans' services provided by the MoD, other UK Government departments and voluntary agencies.

- The SPVA works in partnership with EDS (Defence) Ltd for pension payments and Atos Origen for medical support to pension awards. It also has commercial relationships with Paymaster (1836) Ltd for pension payments and Atos Origen, SPVA has responsibility for the delivery of a tri-Service administration system known as the Joint Personnel Administration (JPA); the remit of which is to harmonise and simplify personnel and pay administration across the Services to ensure a joined up service.
- The day-to-day business of the SPVA is managed at the highest level by the Agency Management Group (AMG), which comprises both MoD and EDS directors. It also has an Executive Board to complement the role of the AMG and to address commercially sensitive and funding issues for managing the Partnering Agreement. The strategic intent of the SPVA is: *"Dynamic delivery of high quality comprehensive and responsive through life services to the Serving and Veterans Community"*. Its mission is to: *"...deliver reliable, trusted and efficient personnel services to the Serving and Veterans communities"*.
- The core functions of the SPVA are to administer the:
 - pay¹⁰⁷ and allowances to the UK Armed Forces through the Joint Personnel Administration (JPA);
 - Armed Forces Pension Scheme (AFPS) 75 and 05;
 - AFCS and the WPS in accordance with relevant legislation, and
 - award and delivery of campaign medals and the Veterans badge.
- In addition, the SPVA provides:
 - administrative support for casualties and the repatriation of compassionate cases through the Joint Casualty and Compassionate Centre (JCCC)¹⁰⁸;
 - quality welfare services and support to war disablement pensioners, war widow(er)s, their dependants and carers;
 - ex-Service beneficiaries of the AFCS;

¹⁰⁷ The UK Armed Forces Pay Review Body (AFPRB) is responsible for undertaking an independent review to establish pay for Service personnel, the recommendations for which have been fully implemented by the MoD in the last 10 years.

¹⁰⁸ The JCCC was officially launched on 11 April 2005 by the MoD to administer in-Service casualty and compassionate case by facilitating and co-ordinating support, advice, and payment to bereaved families.

- a managerial role for the Ilford Park Polish Home (IPPH)¹⁰⁹;
 - the ex-gratia payment scheme for former prisoners of the Japanese in World War II¹¹⁰ (in accordance with UK Government policy), and
 - administrative support to the Central Advisory Committee (CAC) on war pensions and the War Pensions Committee (WPC).
- To reflect the unified service to Veterans under Veterans-UK, the Welfare Service was also subjected to rebranding such that the War Pensioner's Welfare Service (WPWS) was given the new name of the "Veterans Welfare Service" (VWS). The main role of the VWS is to provide advice, guidance and practical assistance to war disabled pensioners and war widow(er)s. It also provides assistance to individuals who are in the process of claiming under the WPS or the AFCS. Assistance provided by the VWS is available to deal with all Veterans' concerns regardless of whether they are directly related to disablement or Service. Regional Welfare Managers throughout the UK are responsible for ensuring the welfare managers provide the services required. Administrative staff and a network of volunteer visitors provide support for each regional office. The VWS has a close working relationship with the Regimental Home Headquarters (RHQ)¹¹¹ and all of the main ex-Service organisations to ensure that Veterans and their dependants have ready access to a wide range of advice and help on welfare issues.

3.13.2 UK Armed Forces Welfare Policy and Provision

- As part of its "duty of care", the MoD has a responsibility to secure the well-being of its Service personnel and their dependents both in the UK and overseas; a responsibility which is enshrined in the UK Armed Forces Welfare Policy (PSG 18). This policy is underpinned by seven principles that pertain to the provision of operational and non-operational welfare support as a means of meeting that responsibility.

¹⁰⁹ The IPPH provides residential and nursing care to people who qualify for admission under the 1947 Polish Resettlement Act.

¹¹⁰ The "Japanese Asset Scheme" was launched in the 1950s to distribute former liquidated assets to Far Eastern Prisoners of War. Eligibility was extended in March 2001 to provide the £10,000 ex gratia payment to those prisoners of war who had a birth link with the UK followed by an announcement in March 2005 that 500 additional ex gratia payments would include former prisoners of Japan who had resided in the UK for at least 20 years since WWII as at November 2000 when the scheme was first launched. The Veterans Agency paid totals of £3.21 million in 2003/04 and £1.8 million in 2004/05.

¹¹¹ The RHQ in the UK are responsible for the aftercare of Service personnel on leaving the Army. The level of welfare assistance provided is dependent on individual's circumstances. However, they provide a "gateway" to a large number of ex-Service welfare organisations.

- Although the three Services share many components of their duty of care, the welfare and support structures vary among Services and among establishments. A tri-Service review of the provision of welfare support to the greater Service community was completed in December 2005. Its purpose was to:
 - undertake a gap analysis to identify shortfalls and opportunities for rationalisation particularly with regards to the accessibility of welfare support;
 - examine the possible harmonisation of welfare provision across the three Services;
 - ensure the adoption of best practice, and
 - determine the most efficient use of welfare resources.

- Welfare fora provide the opportunity for frequent discussion on welfare issues. Units are required to provide the MoD with information on the frequency of meetings, the attendance of key figures (e.g., the Commanding Officer) and any changes in the frequency or arrangements for meetings.

- The Defence Select Committee's Report "Duty of Care" (Third Report of Session 2004-05) raised concerns about the role of Empowered Officers in providing welfare support to recruits on the grounds that "*...recruits are reluctant to discuss their concerns with the chain of command. Recruits who are not comfortable talking to an NCO may be even less inclined to seek out an officer*" (Paragraph 176). The recommendation was therefore made to the MoD to review the possibility of Soldiers, Sailors, Airmen and Families Association (SSAFA) Forces Help or similar qualified civilian staff providing an alternative to the Empowered Officer. By having a position equivalent to the Empowered Officer, the civilian would have direct access to the welfare services within a unit and authority to make "binding recommendations". In its subsequent response, the MoD conceded that the "*...Empowered Officer concept is not working perfectly at the moment*", but because it had only been in operation for a year felt that it was too early to introduce new arrangements.

- Traditionally the role of the chaplains¹¹² within the UK Armed Forces has been to provide guidance and advice to Service personnel and their dependents in respect of spiritual, moral and pastoral needs. To this end, chaplains are regarded as an

¹¹² Chaplains are addressed both officially and otherwise by their ecclesiastical title or official appointment, not by their relative rank or military title. They are known as "padre" by all ranks. When dressed in combat uniform, chaplains are distinguishable by the sign of the cross on the collar and the title "padre" on their name badges.

integral part of welfare support provision. The nature of the military chaplaincy is also proactive in the sense that chaplains are required to share the experience of Service personnel such as being on exercise and taking part in physical training. However, chaplains do not have a command role and do not assess training performance. This reflects the ethos of the welfare service provision in the UK Armed Forces, which is not under the control of the chain of command of those who seek its assistance. Its purpose is predominantly to work in partnership with the MoD in order to ensure that both the requirements of Service and the needs of serving soldiers and their families are fulfilled. Welfare Officers are mainly serving personnel who are professionally trained and equipped with the necessary skills and knowledge to provide welfare support.

- According to the Defence Select Committee's Report "Duty of Care" (Third Report of Session 2004-05) the provision of non-uniform welfare services varies considerably at different units and was subject, in part, to the Commanding Officer's support and interest. Furthermore concern was expressed about the extent to which Commanding Officers "*...may be tempted to "tick the box" of welfare provision merely on the basis that an organisation is present within an establishment and not give that provision the importance it very much deserves*" (Paragraph 196). In response, the MoD confirmed that the welfare review had been mapping the different services and organisations that provide welfare services to the UK Armed Forces. On this basis, the review would seek to assess the welfare contribution that each organisation provides to Commanding Officers in order to:
 - (i) identify the nature of the gaps and overlaps in provision, and
 - (ii) review the interface between organisations and Commanding Officers.

- A National Audit Office report on the Reserve Forces in 2006 reported that Reservists and their families make little or no use of the Defence Welfare Services until they are deployed. On this basis, it was recommended that the MoD should focus its attention and resources on those welfare services which are most used by Reservists and their families to ensure that:
 - information supplied to Reservists' families is written in plain English;
 - Reservists in all three Services have access to adequate dedicated provision of welfare support, and
 - welfare support provision is improved for families of deployed Volunteer Reservists who do not live in close proximity to the Reserve Unit with which they train and those Regular Reservists who have no unit.

- In 2009, the Report on the Strategic Review of Reserves (MoD) presented seven recommendations with respect to providing welfare support to serving members of the Reserve Forces. These included the need for:
 - consideration of a long-term strategy for the improvement of Reservist welfare support;
 - steps to be implemented by the MoD to enhance the understanding of Reservists, *viz*, their entitled welfare support and benefits at all stages of service and for their dependents;
 - potential for providing a single point of entry for welfare support;
 - a review of the current provision and eligibility criteria for the Reserve Forces in each service to access all welfare provision and organisations, and
 - further research and surveys to be conducted by the MoD to ascertain attitudes towards welfare provision.

3.14 ORGANISATION AND NATURE OF RESETTLEMENT PROVISION

- In providing a framework for all aspects of the Service personnel policy agenda, a key theme of the Armed Forces Overarching Personnel Strategy (MoD, 2002/03) is to provide Veterans and their dependants with *"...a robust and effective system of resettlement provision"*. As part of its "whole life" strategy, this system is viewed by the MoD as *"...a fundamental pillar of support and a tangible manifestation of the UK Armed Forces commitment to be an employer of first choice"* (National Audit Office, *Leaving the Services*, 24 June 2007). Whilst it is ultimately considered the responsibility of the individual Service leaver to effect a successful return to civilian life by making good use of the MoD's resettlement provision, it is the responsibility of the MoD to ensure that military personnel are secure in their knowledge that they will receive assistance to prepare them for civilian life and future employment.
- As part of the military covenant between the MoD and its personnel the resettlement provision is dedicated to ensure:
 - access to timely and accurate resettlement advice and information to all Service personnel;
 - modern resettlement provision based on best civilian outplacement practice which would meet the needs of eligible Service personnel;

- resettlement assistance on a graduated basis (both in terms of provision and time available according to length of service);
 - responsive and effective contracted resettlement services (including advice, workshops, training and job finding);
 - resettlement assistance to as many Service personnel as possible, and
 - appropriate resettlement allowances to assist Service leavers.
- Service leavers are typically classified into the following three categories.
 - *Normal service leavers*: those who are discharged from the trained strength either on: (i) completion of their engagement, (ii) having submitted their notice to leave, or (iii) having been given notice of discharge under redundancy.
 - *Medically discharged service leavers*: those who are discharged from the trained strength due to a medical condition which has been graded by a Medical Board as being a P8 (i.e., medically unfit for any form of military service).
 - *Early Service leavers*: those who are either compulsorily discharged from trained strength or untrained strength or who leave voluntarily from trained strength or untrained strength with less than four years service.
- The resettlement provision is tri-Service with a central MoD Directorate determining policy and administering the third tier of support, the Career Transition Partnership (CTP) described below. The first two tiers of support are provided by the individual Services.
 - *First line unit resettlement information and administration*: provided in an interview with the Unit Welfare Officer (UWO)¹¹³.
 - *Second line educational and training services (ETS) resettlement advice*: provided in an interview with the Individual Education and Resettlement Officer (IERO).
 - *Third line CTP¹¹⁴ outplacement service*: provided through a contract partnership that exists between MoD's Directorate of Resettlement and Right Management Ltd.

¹¹³ Each unit with an overall strength of 25 personnel or more has a UWO.

¹¹⁴ Formed in 1998, the CTP contract was renewed for a further 10 years in 2005. It incorporates nine Regional Resettlement Centres (RRCs) in the UK, one in Germany, and one in Nepal. The core RRC is based in Aldershot, but all offices are linked to a central database of service leavers, employers and jobs. CTP staff who understand the military way of life and the challenges facing those making the transition from service to civilian life. Although primarily focussed on helping Service leavers to find suitable employment in

- In accordance with the Tri Service Resettlement Manual (JSP 534) resettlement from the UK Armed Forces often begins within two years of the "exit" day when leavers officially become civilians. Since the introduction of an initiative to give support to Early Service leavers in April 2004¹¹⁵, all Service personnel have access to some assistance in making their transition from military to civilian life. The level of resettlement support provided to Service leavers is dependant upon length of service (to aid retention) and is not dependent on their rank, as follows.
 - *All Service personnel*: Entitled to access resettlement advice via their respective single Service Resettlement Advisers (including finance, housing briefs) at any stage of their career.
 - *Early Service leavers*: Generally have no access to CTP services, but receive a mandatory resettlement brief and interview by a suitably qualified interviewer prior to discharge.
 - *Service leavers who have completed a minimum of four years*: Entitled to access a range of services provided by the CTP including the Employment Support Programme (ESP).¹¹⁶
 - *Service leavers who have completed a minimum of six years (five years if enlisted prior to September 2002)*: Entitled to the CTP Full Resettlement Programme (FRP).¹¹⁷
 - *Service leavers who have been medically discharged*: Entitled to the FRP.

- For normal and medically discharged Service leavers resettlement is received under the terms of Graduated Resettlement Time (GRT), which aims to reward length of service and provides full flexibility in how pre-release settlement time is spent. Hence, those who have less than one year of service and are medically discharged are entitled to FRP but are restricted to 10 working days GRT, whereas those who have more than 16 years of service are entitled to FRP and 35 working days GRT.

a second career, the service also assists those who plan to retire or who are seeking full time education. The CTP seeks to administer a high quality, no cost recruitment service for employers seeking the best. This includes an online vacancy database, employment fairs around the UK, and a team of employment consultants available to advise and assist with employer's recruitment needs.

¹¹⁵ The Early Service leavers initiative derives from one of the recommendations made in the Dandeker *et al* (2003) report to broaden the CRP arrangements to include more vulnerable service leavers.

¹¹⁶ The ESP comprises an interview with a Career Consultant or one-day workshop, and thereafter a job finding service with access to an Employment Consultant for up to two years post-discharge.

¹¹⁷ The CTP Full Resettlement Programme builds on the ESP through providing access to vocational training, coaching in job interview technique, CV writing, and dedicated career consultancy support aimed at improving Service leaver's employment opportunities.

- Resettlement arrangements are designed to be sufficiently flexible to permit both deferred and transferred resettlement. The full rules governing these arrangements are laid down in JSP 534. For those entitled to the FRP, the CTP delivers support from the start of the resettlement up to two years post-discharge. In addition, these personnel are entitled to claim an Individual Resettlement Training Costs (IRTC) Grant to assist with the cost of training with external civilian college or firms. Civilian Training Attachments (CTAs) and CTP sponsored courses can be supported by IRTC. With the exception of Service personnel whose service is terminated prematurely for misconduct, all other personnel are also granted terminal leave on completion of their commission of engagement to assist with their resettlement, based on one day's terminal leave for each completed month of service. The maximum allocation is 20 working days.

- JSP 752 Tri Service Regulation for Allowances specifies the entitlement of Final Tour of Duty Provision (FToD) for normal and medically discharged Service leavers. The purpose of FToD is to assist personnel in their final tour to resettle themselves and their family in the area of the UK in which they intend to retire should the Service be unable to assign them to a duty station within 50 miles of their chosen retirement location. It includes the following:
 - *Removal expenses and disturbance allowance (REDA)*: Provided at public expense under FToD provision,
 - *Insurance allowance (IA)*: To meet the average cost of transit insurance purchased by Service personnel when they are required to move their personal effects, but are not entitled to claim REDA, and
 - *Continuity of education allowance (CEA)*: Concessions available for those who are medically retired/ discharged.

- For the purpose of informing Service personnel of their entitlement on discharge the MoD provides an abundance of information in the form of booklets, manuals, and websites. The "*Transition to Civilian Life. A Welfare Guide*" (dated 21 January 2008) was developed specifically for issue to those leaving the Army who intend to settle in the UK¹¹⁸. Its purpose is to explain some of the procedures and actions that those Service leavers are required to take in effecting their transition from the military

¹¹⁸ Service leavers who have served overseas and wish to be discharged and settle in the country in which they have served are advised to seek advice on matters relating to that country. Service leavers leaving the Army from the UK and returning to their country of origin are advised of the same.

to civilian life. Comprising 14 sections, it covers resettlement, housing, leave and pensions as well as explaining the related administrative procedures.

- In recognition that those not eligible for FRP may be at risk of social exclusion, and as a consequence may encounter health and welfare problems on leaving the UK Armed Forces, further initiatives have been undertaken to identify how best to help vulnerable Service leavers. This now includes the pilot of a “voluntary light touch mentoring scheme” which was sponsored by Pensions and Veterans and provided by the VWS and volunteers from the SSAFA Forces Help. Based at Catterick Garrison, the focus of this telephone-based service was on signposting clients to appropriate sources of support. Clients were followed-up for a six month period after which a brief evaluation was undertaken on housing arrangements, employment, alcohol use and relationships. Initially, the pilot evaluated Service leavers undergoing training with subsequent recruitment of Early Service leavers (i.e., with less than four years service) who recently returned from deployment. However, the provision of additional assistance by means of this system proved to be ineffective, predominantly due to low take-up rates and the conclusion that current welfare assistance provision (e.g., JobCentre Plus) was sufficient (Braidwood & Williams, 2009). Fossey (2010) suggests that such an outcome may in part be due to “*maturity, stigma or ignorance, especially if mental health problems had not been identified at the time of discharge*” p.15.

3.15 PENSIONS PROVISION

- All Service personnel automatically become a member of the Armed Forces Pension Scheme (AFPS) on joining the UK Armed Forces. As an occupational pension scheme, it provides pension and invaliding benefits to members. Although it is based on a non-contributory scheme pension benefits are taken into consideration with regards to pay assessments. Within the Army there are three pension schemes (AFPS 75, AFPS 05, and the Reserve Forces Pension Scheme [RFPS]). Under current arrangements, all Service leavers should receive a Service Leaver’s Pack from the Termination Cell, Service Personnel and Veterans Agency (G) approximately nine months prior to their termination date or as soon as possible after the notification of discharge (if less than nine months). Its purpose is to provide guidance and advice before and after leaving Regular service. To avoid a delay in receiving their Termination benefits and pension, eligible Service personnel are required to complete an

SPVA Pension Form 1 (no earlier than six months and no later than six weeks before last day of service). Completion of this form is a legal requirement.

- The End of Service Benefits and Pensions Policy contained within the Armed Forces Overarching Personnel Strategy (MoD, 2002/03) refers to a package that comprises pensions and ill health, injury and death benefits, the award of which is subject to revision by virtue of developing manning requirements. In particular, this policy is designed to support the career patterns of Service personnel and to maximise retention rates at particular stages.

3.15.1 War Pensions Provision

- Any disablement arising from a Service-related cause can lead to the award of a war pension, the administration of which has been subject to a number of changes. In June 2001, the War Pensions Agency (WPA) became an Executive Agency of the MoD following the reorganisation of the Department of Social Security (DSS)¹¹⁹ into the Department for Work and Pensions (DWP)¹²⁰. The WPA subsequently changed its name in 2003 to the Veterans Agency (VA) to provide a single point of contact within the MoD for providing information, help and advice on a wide range of subjects including benefits and welfare issues, pensions and benefits by means of a free Helpline, welfare service and website. Its core functions were to administer the:
 - War Pensions Scheme (WPS) which provided financial support to war pensioners and war widow(er)s living in over 100 countries worldwide (although most were resident in the UK), and
 - Armed Forces Compensation Scheme (AFCS).
- On 6 April 2005, the AFCS replaced the arrangements for compensation paid under the WPS and the Armed Forces Pension and Research Attributable Benefit Schemes (AFPRABS). The AFCS covered all Regular (Gurkhas included), ex-Regular, Reserve and ex-Reserve personnel whose significant injury, illness or death by service occurred on or after the 6 April 2005. It is no-fault, non-contributory and separate from compensation for common law claims. Benefits included a tax-free lump sum awarded for pain or suffering. The AFCS was particularly

¹¹⁹ The DSS was established in 1988 following the split of the Department of Health and Social Security (DHSS) into separate departments for health (DoH) and social security (DSS).

¹²⁰ The DWP was formed from the DSS to absorb the employment functions which had previously been the responsibility of the Department for Education and Employment (DEE) since the dissolution of the Department of Education (DoE) in 1995.

significant in that, for the first time, it permitted injured Service personnel (men and women) to claim compensation whilst still in Service. A tariff system comprising 15 levels was used to determine the amount of the award based on severity of injury.¹²¹ In addition, since its inception the AFCS ensured that those who sustained the more serious injuries (i.e., tariff levels 1 to 11) received compensation for life on leaving the Services by means of regular tax-free and index-linked payments known as the Guaranteed Income Payment (GIP). The purpose of GIP was to make up for the deficit in pensions and earnings due to a decrease in the amounts such personnel were likely to earn post-injury. A total of seven principles underpinned the AFCS, which were: (i) fairness; (ii) simplicity; (iii) modernity; (iv) security; (v) employability; (vi) human rights, and (vii) affordability.

- In July 2007, the Under Secretary for State for Defence and Minister for Veterans (Rt Hon Derek Twigg MP) commissioned a review of the AFCS to assess whether the rules relating to multiple injuries arising from one incident continued to meet the Scheme's original intent of focussing on the most severely injured. Having taken into consideration the comments received during the consultation undertaken between October and November 2007, the review concluded in January 2008. It recognised that a specific rule in the Scheme that calculates the lump sum award where more than one injury is sustained in one incident was not originally intended for the type of serious multiple injuries being sustained in contemporary conflicts. Far more of those who sustain such injuries survive because of significant advances in the medical care provided in theatre. Measures duly implemented in respect of this review included an increase in the lump sum payment for Service personnel with the most serious injuries to £570,000 and provide an increase for all awards ranging from 10% to 100%. Furthermore, these increases were applied to all claimants of the AFCS since 2005. The amending Statutory Instrument was laid on the 16 January 2008 and the changes came into force on 8 February 2008 (*"Armed Forces and Reserve Forces Compensation Scheme: The Ministry of Defence's Proposals for Changes to the Rules on More than One Injury Sustained in One Incident. Summary of Responses"*, February 2008, MoD: London).
- Originally it was intended that a full review of the AFCS would not be conducted until after five years of operation in order to allow sufficient cases to support any evidence-based analysis.

¹²¹ The compensation award for tariff level 1 (i.e., the most serious injuries) was £285,000.

On 29 July 2009, however, the Secretary of State for Defence (Rt Hon Bob Ainsworth MP) brought forward the planned review of the AFCS to 2010 to ensure further that Service personnel were not being disadvantaged by inadequate compensation for injuries sustained in Service. Members of the public and Service personnel were invited to submit their views on the AFCS during the public and service engagement period from the 22 October to 19 November 2009. The terms of reference ("*Armed Forces Compensation Scheme Review*" [Hansard Column 66 WS, 22 October 2009]) for the review was to consider the AFCS in its entirety with regards to:

- establishing the validity of underlying principles,
 - evaluating the effectiveness of the AFCS (in its current form) in effecting these principles, and
 - making recommendations on the need for modifications to ensure that the AFCS is "fit for purpose".
- Under the aegis of the MoD, the Admiral the Lord Boyce led the review as independent chairman with support from:
 - a MoD team comprising both military and civilian members
 - an Independent Scrutiny Group (ISG) which included:
 - medical and legal experts in injury¹²² and compensation issues.
 - representatives from the Confederation of British Service and ex-Service Organisations (COBSEO), the Royal British Legion (RBL), Service Family Federations, War Widows and an injured soldier who had received compensation from the AFCS.
- In undertaking the review, comments were obtained from over 200 individuals and groups and the Review Team undertook visits to serving personnel of all three Services in their bases and at Headley Court. The Admiral the Lord Boyce also conversed with Ministers, the Chief of the Defence Staff and the heads of the three Services and the judiciary.
- In February 2010, the Secretary of State for Defence presented to Parliament the outcome of Admiral the Lord Boyce's Review, which comprised findings in respect of eight areas related to the terms of reference above. Although the underlying principles were considered by the Review Team to remain "broadly right", they recommended changes to the wording in order to enhance comprehensibility and to effectively convey how the: (i) tariff system operates in terms of level of award, and (ii) compensation scheme links in with the availability of other UK Government welfare support. It also acknowledged that the

¹²² The use of this term also included service-related illness or death.

AFCS enhanced the provision of compensation awards compared with its predecessor, the WPS. Recommendations were made however to improve certain aspects of the AFCS, the implementation of which received full approval from Defence Ministers. On this basis, the AFCS will be revised to increase the:

- GIP – to reflect the enduring effects of more severe injuries on potential for promotion and the ability to continue in work to the age of 65 years;
 - tariffs levels 3 to 15 by 50%;
 - maximum award for mental illness, and
 - time limits for claims and appeals.
- Improvements were also recommended in respect of the:
 - burden of proof arrangements for claimants who have poorly maintained clinical records, and
 - communicating effectively to Service personnel and their families the:
 - nature of the scheme,
 - entitlement to payments, and
 - rationale for the calculations on which payments are determined.

New additions to the AFCS pertained to the:

- formation of an expert medical body to advise on compensation regarding specific illnesses and injuries (e.g., mental health, injury to genitalia, loss of hearing).
 - introduction of a rapid interim payment prior to the full award to assist those who have been injured.
- *“The Review of the Armed Forces Compensation Scheme – One Year On”* (MOD, February 2011) describes the progress which took place over the past year. For example, the creation of the recommended Independent Medical Group (IMEG) to advise Ministers on the medical aspects of the Scheme was established in early 2010 and comprised senior consultants from relevant specialties including trauma, orthopaedics, neurology, occupational medicine, and mental health. IMEG also had three lay members to represent the Services and ex-Service organisations. The initial brief was for IMEG to consider specific topics from the Lord Boyce Review, *viz*, the compensation for mental disorders and hearing loss. In addition, consideration was given to a number of potential anomalies identified in the Review which meant that the Scheme was not delivering the horizontal and vertical equity on which it was founded. These included: loss of the use of a limb, injury to genitalia, spinal cord injury and brain injury. Due to the complexity of these topics and the diversity of opinion, more time has been given to enable in-depth consideration. In September 2010, the Minister for

Defence Personnel, Welfare and Veterans extended IMEG in its present form to March 2012, with a review of its future in September 2011 to enable further work in this domain. Thus, some of the recommendations have been more complex to implement than others because of the need for detailed analysis and legislative work. However, all of the recommended legislative changes to the Scheme have now been undertaken and the new legislation was laid before Parliament on 28 February 2011.

3.15.2 Benefits Provision

- The impact of Service life can adversely impact on the ability of:
 - spouses and civil partners to obtain paid employment and maintain a National Insurance contribution record the implication of which may be twofold. First, it may adversely affect their contribution record for basic State Pension along with their access to contribution-based working-age benefits. Second, it may result in unfair treatment in respect of the assessment for eligibility to certain entitlements in the UK, and
 - accompanying family members to obtain paid employment by virtue of the mobility requirement.
- To tackle any disadvantages associated with entitlement to benefits, the UK-side commitment sought to implement a number of measures which included use of the Service medical board evidence in place of the face-to-face medical assessment by the DWP to establish eligibility for Employment and Support Allowance (which replaced Incapacity Benefit as of October 2008). This allowance is paid weekly to sick and disabled people under State Pension age who are unable to work.
- Benefits in respect of transport concessions for Service personnel and Veterans who were seriously injured in Service and entitlements for severely disabled Veterans have also been addressed as part of a UK-wide commitment. The measures undertaken in Scotland are outlined in *Appendix C*, and the progress made since their implementation in July 2008 is summarised in *Appendix D*.

3.16 HOUSING PROVISION

- When a Service occupant of Service Family Accommodation (SFA) is due to leave the UK Armed Forces on discharge, it is the responsibility of the individual's administrative unit to inform DE Ops (Housing) Housing Information Centre (HIC) four months pre-discharge. Thereafter, HIC issues a period of notice to

individuals to vacate SFA subject to the nature of their exit from Service, as follows.

- *Normal discharge/ Premature Voluntary Release (PVR):* 93 days Notice to Vacate timed to expire on the last day of service.
 - *Medical discharge:* 93 days continued use and occupancy of the SFA after the date of discharge. Thereafter, extensions of up to 93 days may be granted on compassionate grounds¹²³.
 - *Compulsorily discharge:* A minimum of 28 days notice is given in cases of discharge on disciplinary grounds or misconduct.
- A crucial element to enable Service personnel to effect a smooth transition from military to civilian life is the provision of advice on and assistance with housing. The July 2008 SPCP contained 10 housing-related commitments which sought to remove any housing disadvantage that the UK Armed Forces community may suffer as a result of:
 - the mobility requirements of service (nationally and internationally), and
 - injury sustained in service.
 - Measures were proposed to redress the potential disadvantage that Service personnel face in terms of not being able to get on the housing ladder because of their obligation to be mobile throughout service. These included the following.
 - *Affordable homes:* The Key Worker status will be extended to enable Service leavers to access the Key Worker Living scheme 12 months after discharge. Scottish Ministers agreed to extend access to their affordable housing schemes to Service leavers 12 months after discharge. (paragraph 2.13)
 - *Adaptable affordable homes:* Low cost initiative for First Time buyers in Scotland may also be eligible for a grant from the Local Authority (LAs) to cover the cost of any necessary adaptations. (paragraph 2.16)
 - Similarly, measures were proposed to assist seriously injured ex-Service personnel in obtaining suitable accommodation. These were as follows.
 - *Adapted social housing:* In view of the fact that seriously injured service personnel can face delays in obtaining suitable adapted housing where they are not given sufficient priority, it was proposed that seriously injured

¹²³ Entitlement for an extension on compassionate grounds is at the discretion of HIC in consultation with the appropriate Local Service Commander at non-entitled SFA charges.

personnel in England and Wales should be given “additional preference” (i.e., high priority for social housing). Scottish Ministers were required to remind landlords of existing high priority that seriously injured personnel in Scotland receive for adapted social housing. (paragraph 2.15)

- *Disabled Facilities Grant Means Test:* AFCS and WPS payments for most seriously disabled were to be disregarded in the means test for DFG in England and Wales. In Scotland this means test was to be considered for discontinuation. (paragraph 2.17)

- The allocation issues identified as part of the Scottish Government’s commitment to support Veterans and Service personnel living in Scotland were addressed in “Paper 3 – Veterans” for discussion at a meeting of the Allocations Policy Review Advisory Group on 27 February 2009. The paper was prepared at the request of Scottish Ministers as part of the wider review of social housing allocations policy. The paper first referred to the legislative context within which this policy operates to highlight the following.
 - On leaving the UK Armed Forces, ex-Service personnel have the same rights to social housing as any other civilian.
 - The Housing (Scotland) Act 1987¹²⁴ states that anyone who is 16 years or older must be admitted to a housing list.
 - Social landlords¹²⁵ must act in accordance with those factors specified by the Housing (Scotland) Act 1987 that determine the allocation of social housing. Beyond that which is specified, social landlords have discretion to develop allocations and letting policies in line with local priorities.
 - Because social landlords are legally bound to allocate their houses in accordance with housing need, seriously injured ex-Service personnel should already be considered as a high priority in this regard.

- Paper 3 also outlined the steps taken to implement the Scottish Government commitment on seriously injured Service personnel. These included the production of a revised Housing Circular on housing for people leaving the UK Armed Forces by the Scottish Government in consultation with Convention of Scottish Local Authorities (CoSLA) and the MoD. The key aspects highlighted in respect of meeting the housing needs of seriously injured ex-Service personnel in Scotland are as follows.

¹²⁴ As amended by the Housing (Scotland) Act 2001.

¹²⁵ The term “social landlords” includes Local Authorities and registered social landlords.

- Access to adapted social housing – to accommodate the nature of the injury and/or disability sustained.
 - Special consideration by social landlords of housing applications pertaining to ex-Service personnel who left service under medical discharge.¹²⁶
 - Rapid assessment of housing applications - to minimise delays in the allocation and arrangements of suitably adapted accommodation.
 - Social landlords to liaise with other relevant housing and service providers (including Veterans' services) - to ensure that all aspects of need are considered and appropriate support (including housing) is provided.
- In order to establish what has been achieved to date in terms of meeting the housing needs of the UK Armed Forces community in Scotland, *Appendix D* provides an overview of the specific measures undertaken as part of the Scottish Government commitment in relation to housing and the progress that has since been achieved.

¹²⁶ Those leaving under medical discharge may normally remain in Service families' accommodation for 3 months after discharge.

3.17 HOMELESSNESS INITIATIVES

- As part of its obligation to the UK Armed Forces community, the MoD has sought to tackle homelessness¹²⁷ by putting preventative measures in place for “vulnerable” Veterans who are at risk of experiencing social exclusion. For example, in the financial year 2002-03, the MoD committed £285,000¹²⁸ to preventative programmes to assist with the re-housing of ex-Service personnel. In recognition of the need to measure the impact of these programmes in order to provide evidence for future policy decisions in respect of homelessness, the MoD together with the Office of the Deputy Prime Minister, the Devolved Administrations and the Ex-Service Action Group (ESAG)¹²⁹ commissioned KCMHR to conduct a feasibility study of the extent, causes, impact and costs of rough sleeping and homelessness amongst Veterans in a sample of Local Authorities in England. The findings of this study and the recommendations that derived therefrom will be addressed in *Section 5* along with the other research studies that have been conducted in this domain.
- In July 2008, the UK Government pledged a further £400,000 to provide new supported housing for Service leavers in England to enable them to make a successful transition to civilian life. This initiative was to be delivered by the Department for Communities and Local Government (CLG) in collaboration with the Housing Corporation with support from MoD gifted land. Opportunities were to be explored with Scottish Ministers and ex-Service charities on housing ventures that would meet the accommodation needs of Veterans in Scotland.

¹²⁷ In Scotland the Housing (Scotland) Act 1987 amended by the Housing (Scotland) Act 2001, states that people are homeless if there is no accommodation they are entitled to occupy. Entitlement means having either: (i) an interest in it [i.e., by virtue of being either the owner or the tenant]; (ii) a right or permission, or an implied right or permission to occupy, or (iii) some other enactment or rule of law giving the right to remain in occupation or restricting the right of another person to recover possession. Furthermore, in Scotland a person is also considered to be legally homeless if they have accommodation but: (i) they cannot secure entry to it; (ii) they have nowhere they entitled to place it and live in it (e.g., a caravan); (iii) it is probable that occupation will lead to violence, or threats of violence which are likely to be carried out, or (iv) it is overcrowded and may endanger the health of the occupants.

¹²⁸ These funds supported the programmes run by the Joint Service Housing Advisory Office (JSHAO) costing £140,000 per annum; the Single Persons Accommodation Centre for Ex-Service (SPACES) costing £110,000 per annum, and the Shelter Armed Forces Project (AFP) at a cost of £35,000 per annum.

¹²⁹ ESAG was established in 1997 following concerns about the number of ex-Service personnel who experience homelessness and the implications for their welfare.

3.17.1 Homelessness Legislation, Policy and Strategy in Scotland

- A number of steps have also been taken to improve homelessness legislation in Scotland which derives originally from the Housing (Homeless Persons) Act 1977 (consolidated in the Housing [Scotland] Act 1987). As such it was the first act to place specific and comprehensive duties on the 32 Local Authorities (LAs) for dealing with homelessness in their area. It was limited in scope, however, by virtue of the fact that a number of hurdles needed to be overcome even if an applicant was found to be homeless. These hurdles were:
 - “*priority need*” – to ensure that where supply of LA accommodation was limited, families with children and the most vulnerable would have priority access.
 - “*intentionality*” – to counter the concerns that households would deliberately give up their homes in the belief that the homelessness route would lead to superior accommodation.
 - “*local connection*¹³⁰” – to prevent “magnet cities” from becoming inundated with homeless people from outwith the area.

- The appointment of the Homelessness Task Force (HTF) by the Scottish Executive in August 1999 provided the catalyst for initiating a homelessness action plan with the following terms of reference:

“To review the causes and nature of homelessness in Scotland; to examine current practice in dealing with cases of homelessness; and to make recommendations on how homelessness in Scotland can best be prevented and, where it does occur, tackled effectively” (p.1. Scottish Executive, 2002).

- The first report of the HTF, published in April 2000, focused on amendments to the homelessness legislation. It formed the basis for what was enacted by the Scottish Parliament as Section 1 of the Housing (Scotland) Act 2001, which required LAs to carry out an assessment of homelessness in their area and to prepare and submit a strategy for preventing and alleviating homelessness in their area by 1 April 2003. The production of a homelessness strategy is designed to enable LAs to adopt a holistic approach to tackling and preventing homelessness (including rough sleeping), which requires the LAs

¹³⁰ To establish a local connection means that individuals must have close family ties within the area, or the individual or member of his/ her family has either resided in the area prior to enlistment or has obtained permanent, civilian employment in the region.

engaging in partnerships with housing associations, health boards, voluntary organisations and employability/training organisations to enable the development of sustainable solutions to homelessness, with the individual at the core. In taking this approach, concomitant problems, which may serve to exacerbate the likelihood of repeat homelessness are dealt with such as health service access to address substance misuse problems. In addition, the LAs homelessness strategies should also identify actions to facilitate early and effective interventions to support those at risk of becoming homeless, which may include:

- arrangements for the early identification of individuals experiencing housing difficulties across the full range of tenures and landlords,
 - access to advice and support for at risk individuals, and
 - availability and access to the appropriate services to tackle specific issues (e.g., family and relationship counselling, mediation, and debt advisors).
- It is the legal duty of LAs to secure some form of temporary accommodation. Those accepted as homeless should automatically be placed on the housing register (or waiting list), which would entitle a “reasonable preference” (i.e., priority) for a permanent tenancy. A recently revised Code of Guidance on Homelessness provides LAs with guidance on how to operate their homelessness functions. Whilst all LAs must “have regard to” the Code in their policies and practice according to the Scottish Council for Single Homeless (SCSH) its implementation is variable across Scotland. Moreover, whilst families with children and certain categories of vulnerability (e.g., old age) are well addressed by the legislation, it is not clear to what extent other groups (including vulnerable ex-Service personnel) face different policies in different parts of Scotland. Communities Scotland is the organisation responsible for regulating LAs homeless functions and was established by the Housing (Scotland) Act 2001 to ensure that LAs implement their homelessness duties correctly.
 - In February 2002, the HTF final report¹³¹ made a further 59 recommendations for improving the legislative framework which were endorsed by the Scottish Parliament on 7 March 2002. In respect of Service leavers who either return to or who were already residing in Scotland, the HTF in its final report made the following recommendations.

¹³¹ That report was founded on a review of the causes and nature of homelessness in Scotland, the data for which derived from 13 research projects commissioned by HTF.

- LAs should take full account of the needs of those leaving the UK Armed Forces for whatever reason (including dependents) as part of their homelessness strategies. To this end, LAs should engage with Veterans' organisations, and their strategies should incorporate the findings of the Resettlement Working Group of the Veterans Task Force.
 - Guidance to LAs should emphasise that Service leavers should be classified as threatened with homelessness in the event of cases where their licence to occupy Service accommodation is due to expire and no other accommodation is available.
 - LAs and other bodies (including the Scottish Prison Service) who may encounter individuals who are homeless or at risk of homelessness should have procedures in place to identify Veterans and to sign post the support services available to them.

- The Homelessness Monitoring Group (HMG) was established in 2002 to oversee the implementation of the HTF recommendations¹³², and the Homelessness etc. (Scotland) Act 2003 provides the necessary legislation to take them forward. HTF regard their implementation as being fundamental to defining the rights of those affected by homelessness (including Veterans) and the duties and obligations, which LAs and others have towards them¹³³. Following the commencement of section 1 of the Homelessness etc. (Scotland) Act 2003, the definition of priority need has been expanded. From 30 January 2004, LAs have a legal duty to assist a member of a household who is vulnerable as a result of having been discharged from the Regular UK Armed Forces¹³⁴. By means of the Homelessness etc. (Scotland) Act 2003, however, it is intended that the requirement to establishment "priority need" will be phased out over a 10 year period, the law will be updated, and the "local connection" provision will be suspended.

- The benefits system is also considered by the HTF as having an important role to play in helping individuals through the crisis of homelessness given that the most significant aspect of the social security system is the SCSH benefit system. As it is means

¹³² The HMG meets approximately quarterly and submits a report to the Scottish Parliament on an annual basis.

¹³³ According to the Scottish Council for Single Homeless, the Homelessness etc. (Scotland) Act 2003 is one of the most "progressive pieces of legislation in Europe". In particular, it introduces a cultural shift in how LAs can respond effectively to homelessness in the 21st Century such that the focus is placed on available resources on re-housing homeless individuals successfully as opposed to investigating how best to ration them out of the system (http://www.scsch.co.uk/information/features/homelessness_policy.htm)

¹³⁴ This represents an amendment of section 25 of the Housing (Scotland) Act 1987 (c.26). Section 25 refers to "persons having priority need for accommodation".

tested, housing benefit can meet up to 100% of the rent. However, it cannot be used to provide a deposit on a rented property and housing benefit for privately rented accommodation is subject to restrictions. The administration of housing benefit has become increasingly complex and some LAs may take longer than 14 days¹³⁵ to process a claim. Although there are other benefits such as the Social Fund (which offers further financial assistance) and Community Care Grants¹³⁶, in Scotland benefit matters are reserved and therefore outwith the scope of the Scottish Parliament and Government. Moreover, a main limitation of all of these funds is that they are cash limited (i.e., once the budget allocated to a specific area has been used up there is no further financial assistance available) and their implementation is subject to geographical variation. For this reason the HTF highlighted the general need for more information about the operation of the benefits system in Scotland and for research into the impact of benefits policy on homeless people in Scotland including Veterans.

3.18 WELFARE PROVISION FOR VETERANS WHO ENCOUNTER THE CRIMINAL JUSTICE SYSTEM

- The link between homelessness and offending and imprisonment is well established. In Scotland, approximately 3,000 ex-prisoners submit homelessness applications each year (Pawson, Davidson & Netto, 2007). Once imprisoned, individuals are at an increased risk of losing any accommodation that they might have previously had due to a number of mitigating factors including housing benefit restrictions and a lack of information regarding how to retain their tenancies (McIvor & Taylor, 2000). There is the suggestion that private landlords may discriminate against those with criminal convictions who are trying to access accommodation. Furthermore, because family bonds may be weakened by periods of imprisonment, this can mean that ex-prisoners are unable to return to and remain in their original family home (Hickey, 2002). Scottish prison statistics suggest that between 3,600 and 8,550 individuals may have encountered homelessness following release from prison in 2006 (Scottish Executive, 2006).
- Concern has been expressed over a number of years by those voluntary organisations that help ex-Service personnel to adjust to civilian life that a number may end up in the Criminal Justice System. In an endeavour to improve in-reach prison services,

¹³⁵ The 14 day administration period pertains to Regulation 91(1) of the Housing Benefit (General) Regulations 1987.

¹³⁶

the MoD leads a working group that brings together Government, the Prison Services and organisations from the voluntary sector. As a non-executive body, it helps to ensure a partnership approach to undertaking in-reach activities. Prison-In-Reach (PIR) is an initiative that aims to ensure all Veterans that are prisoners or probation offenders and their families as well as those responsible for resettlement services are fully informed of the types of support available to them from the SPVA¹³⁷ and ex-Service charities¹³⁸. This includes both pre- and post-discharge welfare provision. The work of PIR is designed to contribute to the wider UK Government goals of reducing the risk of re-offending.

- In Scotland, the MoD has been working in partnership with the Scottish Prison Service, Families Outside, and a number of Scottish ex-Service organisations to improve knowledge and support available to ex-Service prisoners and their families. In 2006, a PIR pilot was undertaken in HMP Edinburgh, which aimed to raise awareness among resettlement and welfare staff as well as other voluntary organisations. This work was supported with a poster, leaflet and advice wallet that contained contact details of those providing advice, guidance and practical assistance. Following evaluation, the PIR project was rolled out to all 17 prisons in Scotland.
- Discussions have also taken place with Safeguarding Communities and Reducing Offending (SACRO)¹³⁹ with the aim of ensuring project partners become closely involved in the services offered through its developing Community Links Centre (aims to provide advice, guidance, and assistance to prisoners and discharged prisoners including the extensive support that can be provided by ex-Service organisations for Veterans in prison).

3.19 EDUCATION AND SKILLS TRAINING PROVISION

¹³⁷ This includes availability of the SPVA Veterans UK website to prison staff via computer systems to enable details of the help provided to all Veterans by the SPVA and other service providers to be shared with ex-Service offenders.

¹³⁸ The *Royal British Legion*, *SSAFA Forces Help* and *Combat Stress* all provide welfare visits to Veterans in prison and support to their families. These visits do not count against an offenders personal visit allowance.

¹³⁹ SACRO is a voluntary organisation with the mission to reduce conflict and offending through the provision of a range of Community Mediation, Youth Justice and Criminal Justice Services. In respect of the last named, the aim is to contribute to community safety by addressing the risk of re-offending among service users. SACRO also has a strategic objective to engage in research in order to evaluate and provide evidence on the impact of its services through the analysis of conviction data.

- While Service personnel can enjoy a long and fulfilling career in the UK Armed Forces, the majority leave service at least 25 years before the national retirement age. For most this requires the need to pursue a second career on leaving service (National Audit Office, HC 618 Session 2006-2007, 27 July 2007). Many who join the UK Armed Forces do so at a young age (particularly those who are recruited by the Army), and typically commit to a military career before taking advantage of any opportunities in further and higher education. Indeed, this is one of the reasons why the MoD is reluctant to raise the recruitment age of all three Services to 18 years.

- Once individuals attain that age of 18 years, they are more likely to have continued in academic study to pursue other career aspirations not related to the military thereby making it more difficult to attract them to a career in the UK Armed Forces (Cm6620, July 2005). To address this potential disadvantage, however, the SPCP pledged a commitment to put measures in place which would assist those Veterans who wish to pursue further education and training. *Appendix C* provides an overview of the specific measures undertaken as part of the Scottish Government commitment in relation to education and skills training and the progress that has since been achieved. (It also provides a summary of the measures implemented to address the potential educational disadvantage experienced by Service children due to the mobility requirement.)

3.20 EMPLOYMENT PROVISION

- In accordance with the UK-wide commitment to help Veterans to enhance their chances of success in obtaining employment in civilian life, the Scottish Government pledged to implement five specific measures as summarised in *Appendix C*. On the basis of the first annual report, as provided in *Appendix D*, the following measures have since been implemented.
 - Improved signposting in respect of the availability of public sector jobs.
 - Statement of Employer Support issued by SaBRE (Supporting Britain's Reservists and Employers) has been endorsed by the First Minister.
 - Establishment of standards and outcomes as part of the Supported Employment Framework for those who encounter particular difficulty in gaining access to the labour market. (A package of support tailored to meet specific needs in this regard will be provided to facilitate employment prospects.)

- Obtaining and retaining suitable employment is a challenge for those with mental health problems. The Social Exclusion Unit project sought to establish: (i) how best to assist Veterans with mental health problems to enter and retain employment, and (ii) what more can be done to provide them with opportunities for social participation and access to services. Links were also established with the DWP and the Pathways to Work team to conduct a series of rehabilitation pilot schemes to address employment skills and attitudes. The Welfare to Work Strategy is founded on the premise that work is good for health and that everyone (including those with disabilities) should have the opportunity to work.

- Following a 12 month pilot scheme conducted in London, Project Compass was established by the MoD along with a number of partner organisations¹⁴⁰ to help ex-Service personnel who: (i) want to be employed; (ii) have no current substance misuse or mental health problems; (iii) have been living a relatively stable life in the previous 6 months, and (iv) are homeless or at risk of homelessness. In order to help Veterans obtain suitable training, experience and the opportunity to secure sustained employment in their chosen career, it provides:
 - bespoke training, careers advice and employment support;
 - two day Ready for Work pre-employment training programmes to enhance self-esteem and communication skills;
 - two week work placements with companies¹⁴¹;
 - job coaches, and
 - referrals to other support agencies (including *Combat Stress*).

¹⁴⁰ The partner organisations are: KPGM; Business in the Community; *The Royal British Legion*; Sir Oswald Stoll Foundation, and Barclays Bank.

¹⁴¹ The companies providing placements and job coaches include: Bain & Co; Barclays Bank, Chelsea Football Club; Freshfields; KPMG; S2 Securities, and the Royal Mail.

SECTION 4: Outcome of the Consultation Process

4.1 PREFACE

The purpose of this section is to present the outcome of the consultation process, which was structured to identify issues associated with pre-Service factors, Service-related factors, transition-related factors, and post-Service factors in accordance with the Needs Map generated by the Veterans Agency¹⁴². The issues highlighted here are those identified by those consulted as being of particular importance and are grouped according to general themes within each of the categories, although inevitably there is some overlap across these broad themes.

4.2 METHOD

- An important aspect of the consultation process was to obtain the views of a range of stakeholders on key issues relating to meeting the health and wellbeing needs of ex-Service personnel and their families in Scotland. These included representatives from the statutory and voluntary services, priority groups, and related agencies, military, clinical, and academic experts in the relevant domains, and key political figures informed in Veteran affairs. In addition to engaging with those user groups with established links, the consultation process also included those that have not engaged with formal initiatives in order to identify gaps which need to be addressed. A list of those who participated is provided in *Appendix F*.

4.3 PRE-SERVICE FACTORS

4.3.1 Pre-Enlistment Vulnerabilities

- It was generally felt that those who fared least well on leaving Service were those individuals from disadvantaged backgrounds who were recruited to the infantry and joined the UK Armed Forces in an endeavour to escape from life problems. For this minority group, military service was considered to have been successful in containing delinquent behaviour. On discharge, however, these individuals were regarded as being at high risk of social exclusion.

¹⁴² http://www.Veterans-uk.info/pdfs/publications/misc/needs_map.pdf

4.4 SERVICE-RELATED FACTORS

4.4.1 Military Culture/Ethos

- Military life may represent a surrogate family in which close-knit bonds are forged, especially in operational units such as those in the Infantry. Whilst this, and the *esprit de corps*, represents a positive feature of military life, the extent to which the Services cater for almost every need of these personnel, in a highly ordered and structured environment, may foster unintendedly a dependency and a lack of self-determination. These outcomes may exact a penalty on demobilisation when ex-Service personnel lose that security and structure.
- The pursuit of the *machismo* ideal permeates military life. The participants emphasised that the Services (and, perhaps, the Infantry most of all) encourage denial of fear, emotional expression, and physical problems, including discomfort and fatigue. On the other hand, some individuals, it was reported, become masters of "throwing a sickie".
- "Toughness" is the prevailing ethic which is not one that readily accommodates the need to report mental health problems. This may be one of the reasons why the heavy use of alcohol is a common feature of military life. Particularly in Scotland, "being able to hold your drink" is associated with manliness. Also, alcohol may be used as a self-medication against emotional problems and fear. This dual role of alcohol is a likely source of many problems on demobilisation.
- To the military, to turn to their peer group is an acceptable source of support, hence the interest in TRiM and Battleminds. The participants did not challenge this use of peer support, but were concerned about the stigma that prevails in the UK Armed Forces concerning mental health problems and help seeking, which has resulted in the excessive shunning of mental health provision both within the military and the NHS.
- Concerns were also expressed about the lack of support for the partners of Service personnel whilst they were still serving, particularly in the case of those who were posted on an individual basis rather than as a unit.

4.4.2 Inter-Service Differences

- It was widely held that the Army personnel fare worst on demobilisation than do the personnel from the other two arms. This may be attributable to a number of factors. First, the RAF

and the Navy may provide more opportunities for the development of skills and experience which are transferable to the civilian domain. Second, it may be that the Army is least likely to develop the capacity to think for oneself and to take responsibility for one's own actions, including self care.

- The Navy, in particular, has demonstrated a more realistic attitude to emotional matters and seems to be less dominated by the *machismo* philosophy. This is borne out by their enthusiasm to initiate and to develop TRiM. Naval personnel also seem to be keen on reunions and on the maintenance of contacts with former comrades through "Navy News" and "Rum and Ration", although the Army also has an informal system of tracking Veterans through "Facebook" and "Rumour".

4.4.3 Rank Differences

- There was widespread agreement that officers adjusted more successfully to their re-entry into civilian life than other ranks. Possible reasons for this were consistently identified: better education and training; higher levels of income; more rigorous selection for military service, and better social supports.

4.4.4 Gender Differences

- About 10% of the Armed Forces are female but very few participants spontaneously mentioned anything to do with female Veterans. However, inter-Service differences were noted. In the Navy, serving men and women are faced with the same issues on board Naval vessels. They enjoy the same level of seniority as do their male colleagues, and may be allocated the same duties as men. In the Army, however, females tend to be allocated duties in non-combat areas. (Although it was accepted that: (i) the "combat zone" can comprise a shifting matrix of engagements; (ii) female medics may be close to the areas of direct engagement, and (iii) there are female helicopter pilots who do fly in combat zones.) It was claimed that females and males in the RAF present with the same emotional problems with one exception, namely, males are more likely to suffer from post-traumatic stress (presumably related to the different levels of direct combat exposure). There was uncertainty, however, as to whether this picture was sustained in the longer term.

4.4.5 Operational Exposure

- Combat experience is widely acknowledged to be disturbing for most individuals, including "medics" (who have only about six

weeks' training), as it entails (real or perceived) threat to life and exposure to gruesome sights and experiences.

- Significant advances in military prehospital care and trauma management have resulted in higher survival rates for severely injured personnel. Whilst this is a positive gain, it also generates a new major challenge in terms of long term physical and emotional adjustment for these survivors.
- In relation to service in Northern Ireland, a distinction was drawn between those who were local personnel and those who came from the mainland. It was argued that the psychological demands on the former were considerably greater because of various factors, including the fact that they had no respite from unremitting threats of violence to themselves and their families, and were required to live a life in a climate of fear and uncertainty.
- Peacekeeping was also identified as a difficult role because of its psychological demands, particularly where there has been inadequate training and if the rules of engagement and their operational roles have not been sufficiently defined. It was also reported to be difficult to cope with situations even when the rules of engagement were defined if they prevented troops from fulfilling what they felt was their primary role, namely the protection of others (as was the case in Rwanda).
- It was emphasised by some that, whilst combat exposure could be psychologically damaging, military life in general and combat in particular could be exciting and rewarding. However, this may lead to a "sensation hunger" on return to the more banal civilian existence. It may encourage them, for example, to be low in harm avoidance and to seek out ventures and experiences which are emotionally stimulating and exciting.

4.4.6 Mental Health Screening

- Currently, there is no mental health screening in the UK Armed Forces. There is a reliance on "health surveillance" and "psychoeducation". Participants acknowledge the problems associated with screening but were sympathetic to it in principle because they were not convinced that the current strategy was effective, particularly because of the influence of *machismo* and because individuals, neither in Service nor after demobilisation, show a willingness to present themselves for appropriate help for psychological problems.

4.5 RESETTLEMENT AND TRANSITION

- Dissatisfaction with the efforts by the Services to facilitate the transition from military to civilian life was commonly reported. Some help and advice is provided, often in the fashion of voluminous documents. It was believed that these were commonly ignored as their relevance was not recognised at the time of their distribution.
- Some commented that the focus was not on forthcoming demobilisation but on current military duties and commitments. Time was not made sufficiently available to reflect on transition issues and to benefit from a full resettlement package.
- In particular, interviewees commented on the lack of preparation for dealing with emotional issues and conflict in civilian life: in relation to transitional issues, the military seemed to be principally concerned about employment issues.
- About 20,000 (about 10% of the full military complement) leave the Services annually. Early leavers and those discharged on medical grounds were considered to be among the most vulnerable to transition difficulties. To counter this circumstance, Dr Anne Braidwood, PCV-Medical Advisor, established a mentoring project for Early Service Leavers (Braidwood & Williams, 2009).

4.6 POST-SERVICE FACTORS

4.6.1 Time Out of the Services

- Differences between older and younger Veterans were identified. Older Veterans required more assistance with practical matters (such as mobility aids), and they made more use of the Regimental Associations. In addition, they were noted to have better social networks. On the other hand, unrealistic expectations regarding the availability of resources and ease of adjustment were more often reported among younger Veterans.
- It was felt that those who had served for only a short period (NB: about four and a half years is the current average of service) may be more vulnerable if they have failed to develop a sense of personal discipline and responsibility.

4.6.2 Barriers to Care

- Participants identified many barriers to the provision of mental health care for Veterans. Whilst not mutually exclusive, there are several sub-headings under which these can be presented.
 - *Attitudes and behaviour of the individual*
 - Once again, participants pointed to the extent to which stigma deters individuals from revealing their emotional difficulties. Because of their delay in seeking help, their problems become more entrenched and complex. Commonly, they seek help only when they reach a major crisis and/or when they are at their nadir in terms of resilience and ability to function. Prior to that, they use denial, alcohol and "relationship-hopping" as a means of coping.
 - Denial may be so profound that the individuals genuinely do not recognise they have a problem. Others in their lives may also collude in the same deception.
 - Alcohol, it was generally agreed, was a major problem. It masks the underlying problems and pathologies, but only temporarily. In the longer term, excessive alcohol use becomes a significant issue in its own right as it becomes associated with health, social, financial and behavioural difficulties (including criminality).
 - A frequent theme was that some ex-Service personnel, who harbour much anger, may be overly keen to avoid taking responsibility, preferring to blame the Services, and their Service experience, for their misfortunes and health problems. Because of their hostility towards their former employers, they divorce themselves from the opportunities for help which the military have provided.
 - Reports were commonly made of high rates of non-attendance and non-compliance with treatment.
 - An interesting assertion was made by some interviewees to the effect that some personnel (ranging from about 10-30%) who present allegedly with Service-related problems have never been a member of the Armed Forces. This phenomenon has also been reported in Vietnam Veterans, and, thereby, has contaminated some research findings and policies based thereon.
 - Some individuals emphasised the need to improve screening, especially by using former front line ex-Servicemen (as is the case with *Veterans First Point*).
 - *Attitudes and behaviour of others*

- It was reported that some Veterans have difficulty in getting time off work to attend appointments with the mental health services.
- Those who deliver such services do not necessarily regard ex-Service personnel as having any priority. Thus, priority of care for Veterans is not implemented consistently across the country.
- Certain interviewees allege that some GPs do not ask, or even want to know about, the military records of their patients. As a result, casenotes are incomplete records of the individuals' histories. Even if GPs do display an interest in their patient's military histories, they cannot easily access the appropriate medical and work records. The lack of information was also regarded as a problem for others involved in helping ex-Service personnel, including charities and Regimental Associations.

➤ *Delivery of mental health services for Veterans*

- A common assertion was that Scotland generally suffered from a lack of specialist trauma services which engage suitably trained personnel who could treat Service-related conditions.
- In terms of what constitutes "adequate training", it was emphasised that Veterans may pose a particular challenge: not only have they combat-related pathologies, they may have personality and adjustment problems, including those which antedate their Service duties.
- Also, it was felt that there was a lack of understanding of the interaction between mental health and physical injuries (which are generally dealt with well), including traumatic brain damage.
- Some reported that what services there are (voluntary and statutory) are sometimes in conflict with regard to what each should do to provide the most appropriate care for ex-Service personnel. *Combat Stress* was generally viewed as a treatment resource, but there were different opinions as to where and how it best fitted into an integrated system of care for Veterans.
- Even in the absence of open conflict, the various agencies do not represent an integrated system. The referral process is insufficiently consistent and, generally, there is poor communication among these agencies. Favourable references were made, however, to the individual contributions of *Combat Stress*, *Veterans First Point*, the *Veterans Agency*, and *SSAFA*.

4.6.3 Areas of Particular Difficulty

- A number of social and environmental areas of difficulty were identified. Again, these sub-headings are not intended to be mutually exclusive.
 - *Employment*
 - Many ex-Service personnel have had no experience of applying for a job: the Armed Forces have been their only employer.
 - New prospective employers and those staff at Job Centres were alleged to display a lack of understanding of mental health issues in relation to Veterans. One consequence of this was a failure to recognise the difficulties in holding down a job when suffering from a mental disorder and the need for time off to attend out-patient appointments.
 - *Housing*
 - Local authorities were accused of being unsympathetic to the plight of ex-Service personnel. It was felt that other groups, such as substance misusers and asylum seekers, were accorded a higher priority than Veterans.
 - *Finance*
 - Personal debt was reported to be a significant problem; one which often prompts contact with the Regimental Associations, who do try to help.
 - The main problem appears to be the Veterans' inability to manage their own financial affairs - no doubt another legacy of the "dependency culture" which military life may unintentionally foster.
 - *Support for partners*
 - Commonly voiced was a view that partners (mainly female) of Veterans are not given sufficient credit for their supportive role. It was thought that they tended to be the ones who deal with most of the family problems which emerge on demobilisation.
 - *Personal*
 - Participants identified a number of personal conflicts which Veterans have to face. On leaving the Forces, they have to

shed a special and valued identity: they have to re-establish themselves in a new world, one which may not wholly respect them for what they have been doing during their military service.

- What self respect and self esteem they have developed during their military careers may not translate into civilian life.
- The ordered and protective world of the military they lose, and they have to make their own decisions and take responsibility for them.
- When things do not work out, many resort merely to blaming others for their misfortunes. Others may experience shame and a sense of failure.
- Confrontation with the justice system was described by some interviewees as an expression of a "delayed delinquency".

➤ *Social exclusion*

- A significant number of Veterans become the victims of a downward social spiral. Without the structure and security of the military environment, they become subject to the misfortunes described below.
- They may develop few coping skills.
- Alcohol/drug misuse, unemployment, homelessness, debt, mental ill health, and broken relationships may all conspire to create a negative social image of them. In some cases, this may exacerbate an already negative or at least ambivalent societal view of the military due to their involvement in contemporary international conflicts, which evoke strongly conflicting opinions. Episodes of explicit stigma were exemplified by the interviewees.
- The absence of formal homecomings and victory parades, in conjunction with adverse media comment about the current role of the military internationally, may reduce the Veterans' sense of worth and achievement. It also does not represent happy closure with regard to their military careers.
- All of these factors above can lead to a sense of alienation, one which is not sufficiently counterbalanced because of their poor social network of support, in contrast to that which they enjoyed during their military life.

SECTION 5: Review of the Eminence- and Evidence-based Literature

5.1 PREFACE

The purpose of this section is to present a critical and selective review of the data which derived from the three sources of: (i) MoD and Government commissioned reviews; (ii) surveys commissioned by charities and agencies affiliated to the provision of the Veterans Initiative, and (iii) academic-based research reported in the peer review literature. In line with the terms of reference for the scoping study, this review reflects a UK focus with specific reference to data that would inform the national commitment to meeting the health and wellbeing needs of ex-Service personnel and their families in Scotland.

5.2 MoD AND GOVERNMENT COMMISSIONED REVIEWS

A summary of the documents identified is provided in *Table 7*. Analysis of the data obtained from this source was dedicated principally to identifying: (i) existing gaps in the implementation of the Veterans Initiative at the policy, health systems, provider practice and community behaviour levels, which may compromise its effectiveness in fulfilling its strategic outcomes, and (ii) outcomes and gaps in the emergent eminence- and evidence-base.

Table 7. Summary of MoD and Government Commissioned Reviews

Year	Title and Source
Delivery of Cross Departmental Support and Services for Veterans	
2003	<i>"Improving the Delivery of Cross Departmental Support and Services for Veterans"</i> (Dandeker et al, MOD)
Defence Healthcare (In-Service & Post-Service)	
2006	<i>"Review of Healthcare"</i> (Defence Committee)
2008	<i>"Review of the Defence Medical Services"</i> (Healthcare Commission)
2010	<i>"Treating Injury and Illness Arising on Military Operations"</i> (National Audit Office)
Transition	
2007	<i>"Leaving the Services"</i> (National Audit Office)
Homelessness	
2005	<i>"Homelessness Feasibility Study"</i> (Dandeker et al, MOD)
Health and Social Outcomes/ Health Service Experiences	
2009	<i>"Health and Social Outcomes and Health Service Experiences of UK Military Veterans. A Summary of the Evidence"</i> (Fear et al, Department of Health)
Community Mental Health	
2010	<i>"An Evaluation of Six Community Mental Health Pilots for Veterans of the Armed Forces"</i> (Dent-Brown et al, MOD)

5.2.1 Delivery of Cross Departmental Support and Services for Veterans

Dandeker et al (2003)

- Between July 2002 and March 2003, a multidisciplinary¹⁴³ team of researchers from King's College London (KCL) conducted the first scoping review in the UK to:
 - address the "neglected problem" of how best to identify the needs of "vulnerable" Veterans, and

¹⁴³ The expertise of the team comprised psychiatry, military sociology, anthropology and related medical and social sciences (Dandeker et al, 2003).

- identify ways to improve the delivery of cross-departmental support and services to Veterans.
- The four aims of this seminal review were to:
 - formulate a Veterans-related “needs” map in respect of those who encounter problems with social exclusion;
 - match this map against what was the current provision of services;
 - identify where the gaps are in the delivery of services, and
 - delineate a research strategy which would be commensurate with the views of key stakeholders.
- In fulfilment of these aims, its objectives were to:
 - understand the main ways in which Veterans may be at risk of social exclusion;
 - understand how military life may contribute to social exclusion;
 - propose future research directions and priorities, and
 - identify ways in which the Government might effect a difference in respect of Veteran-related service delivery.
- By means of a multimodal approach, which combined qualitative and quantitative methodologies, data were obtained from the following sources.
 - *A systematic review of the UK literature:* This was combined with a “narrative” overview of the world literature to ensure a comprehensive coverage.
 - *Stakeholder interviews:* Representatives from 14 Veterans’ organisations were interviewed using a standardised interview schedule.
 - *In-depth qualitative interviews:* Face-to-face interviews with 52 vulnerable Veterans using a structured interview schedule.
 - *Quantitative data analysis:* The quantitative data were obtained from their existing KCL military cohort to conduct a cross-sectional and longitudinal analysis of Service leavers with the primary focus on economic outcomes. This included a telephone interview of 400 “at risk” Veterans¹⁴⁴.
- Key themes to emerge from the *systematic review of the UK literature* were as follows.
 - Exposure to war and combat is a life-changing experience for those who serve.

¹⁴⁴ The sample comprised those in the KCL military cohort who: (i) had been identified as having mental health problems at two points on the earlier follow-up, and (ii) who were unemployed at the last follow-up.

- Military life for most however is considered a positive experience, particularly for those younger recruits who may have come from disadvantaged backgrounds. As such, a military career enables these individuals to embark on a more “favourable life trajectory” than might otherwise have been the case.
 - The vast majority of ex-Service personnel do not therefore experience mental health problems whilst either in Service or after leaving Service.
 - The minority who do encounter problems “fare badly” and are at an increased risk of social exclusion. Pre-Service factors are considered to play a key role in this regard by exacerbating the development of post-discharge health and welfare problems in “vulnerable” Veterans.
 - The socio-economic context of military conflict is also a major determinant of the health and economic outcomes for Service leavers.
 - Deployment on operations has a deleterious impact on family and marital relationships.

- Key themes to emerge from the *stakeholder interviews* pertained to the following.
 - Problems with resettlement can be exacerbated by the “dependency culture” of the UK Armed Forces.
 - Another major problem related to military culture is the heavy (“culturally condoned”) use of alcohol by Service personnel.
 - Media and public attention is dominated by a small number of high profile Veterans.
 - A deterioration in the understanding of the military by civic society due to has an adverse impact on Veterans who have to engage with the Local Authorities and Social Services.
 - By virtue of the “consumerist and individualistic” nature of contemporary society, younger Veterans are more likely to demand welfare assistance than older Veterans.

- The common themes to derive from the *in-depth qualitative Veteran interviews* highlighted the need to consider the following factors.
 - The blanket use of the term “Veteran” to describe those who leave Service.
 - The accessibility of the FTP.
 - Provision of training in life skills during Service and mentoring post-Service.
 - Differences between younger and older Veterans.
 - Vulnerabilities associated with medical discharge.

- The “Catch-22” that exists in respect of unemployment and housing provision for Veterans.
- In focusing on economic outcomes, the key findings in respect of the quantitative analysis of data from the existing KCL military cohort showed that:
 - in excess of 75% of Service leavers effected a successful transition and gained employment after leaving (although no information was provided as to the stability of this employment);
 - deployment on operations did not adversely affect the likelihood of securing employment post-discharge so long as individuals did not suffer from physical or mental ill health, and
 - a key predictor of employment was impoverished mental health.
- In focusing on treatment needs and experiences as well as factors that influence help-seeking behaviour, the key interim findings from the telephone follow-up survey of “at risk” Veterans showed that:
 - a significant number (50%) did not seek help for mental health problems, the most common reason for which was a sense of self-reliance;
 - of those who were in contact with clinical services, all were being managed in primary care;
 - pharmacological treatment (particularly antidepressants) was most commonly used. Few had received specialist advice or treatment, and even fewer had received psychological therapies such as CBT, and
 - poor mental health was a key predictor in respect of the few who engaged with a Service charity.
- In undertaking this work, the KCL team have been instrumental in the UK by informing Veteran-related policy and strategy (as demonstrated in *Section 2*) and to scoping the nature and extent of the challenges associated with meeting the health and wellbeing needs of the “vulnerable” Veteran population. By focussing on this subgroup who are most “at risk” of social exclusion (i.e., those who encounter problems with homelessness, unemployment, substance misuse, physical and mental health problems), the outcome of that signal scoping review has highlighted the importance of considering the following factors.
 - The relationship between military service and the subsequent development of psychopathology (combat-related or otherwise) and problems of psychosocial

adjustment post-service is highly complex due to the interplay of a number of vulnerability factors, *viz*, pre-Service, in-Service, transition, and post-Service.

- Whilst military life for many Service personnel is a great “leveller”, with many perceived positive benefits, there are aspects of military culture and ethos that may impede those who do encounter mental health problems from seeking timely and appropriate help. In addition, whilst the heavy consumption of alcohol is endorsed as an accepted part of military culture, this can cause serious problems for some Service personnel following discharge.
- There are considerable challenges in tracking those who experience social exclusion as evidenced by the response rate of 50% for the telephone follow-up survey of “at risk” Veterans. To address this problem, Dandeker *et al* (2003) advocate the use of “aggressive tracing” of non-responders in order to avoid selection bias. The challenges associated with the tracking of the Veteran population will be addressed in *Section 6*.

5.2.2 Defence Healthcare (In-Service and Post-Service)

Defence Committee Review of Healthcare (2006)

- In October 2006, the Defence Committee undertook a wide-ranging inquiry into the provision of healthcare for the UK Armed Forces. It focussed on the following six key areas.
 - (i) Treatment process and procedures involved in the care of seriously injured Service personnel from point of wounding through to treatment received following evacuation from theatre.
 - (ii) Provision of rehabilitation for those with severe musculo-skeletal or neurological injuries.
 - (iii) Delivery of healthcare in respect of the relationship between the MoD and the NHS.
 - (iv) Healthcare provision for Service families and Veterans.
 - (v) Mental healthcare provision for Service personnel and for Veterans.
 - (vi) Role of the Reserve personnel in the DMS.
- The inquiry comprised a series of visits in the UK (including to DMRC [Headley Court] and to Tyrwhitt House [*Combat Stress*]) and to overseas sites (including the deployed field hospital in the Contingency Operating Base [COB, Basra Air Station] and the Princess Mary Hospital [TPRM, RAF Akrotiri]). A visit was also made to the Regional Rehabilitation Unit (RRU) and the Medical Reception Station (MRS) at Redford Barracks in Edinburgh. Of the four evidence sessions conducted during the course of the

inquiry, one took place in Edinburgh on 11 October 2007 involving the Royal College of Psychiatrists, the St John and Red Cross Defence Medical Welfare Service and officials from the then Scottish Executive.

- On the basis of the evidence obtained from the sources above, the Defence Committee commended the:
 - provision of “world class” clinical care for seriously injured Service personnel by the DMS working alongside the NHS;
 - provision of “exceptional” rehabilitation services, particularly by the DMRC [Headley Court];
 - concept of an integrated approach to service provision by the MoD, the NHS, charities, and welfare organisations (particularly in respect of capitalising on a “...*proud tradition in the UK of linking the community with Service personnel who have been injured fighting on their behalf*” p.3);
 - soundness of the MoD’s decision to base secondary care around units embedded in NHS Trusts by virtue of the opportunities this arrangement provides for training and maintenance of skills whilst permitting the treatment of Service personnel in a quasi military environment;
 - Government’s extension of the priority access to healthcare available to Veterans;
 - DMS for progress made in respect of mental healthcare provision, particularly in adopting a preventative approach such as the intended community-based model that incorporates NHS best practice, and
 - contribution of *Combat Stress* in helping to meet the needs of Veterans with mental health problems.

- In addition, the Defence Committee identified a number of key areas for improvement, which led to the following recommendations.
 - Government and voluntary organisations to be involved in the wider public debate about which services should be provided by each sector.
 - The DMS and the NHS to work together to enhance their sharing of best practice.
 - An MoD review of how it engages with other departments and administrations.
 - The Scottish Executive to examine its procedures for engagement and co-operation (given that the Defence Committee found the co-operation in Scotland to be “inadequate”) and to examine how improvements could be effected.

- The implementation of procedures which would facilitate the identification of Veterans in respect of priority access as opposed to the MoD relying on individuals to identify themselves as Veterans.
- A more effective means of transferring medical records from military to civilian clinicians (e.g., an automatic system of transferring medical records and tracking Veterans in the NHS that incorporates an “opt out” option to provide a robust means of protecting privacy).
- Financial investment in high-quality healthcare by the MoD to complement that of the NHS.
- The systematic and robust identification and treatment of Veterans by *Combat Stress*.
- A robust method of tracking Veterans and a comprehensive understanding of their problems by the NHS.
- Public recognition of the contribution by the Reserve forces to the military and civic society.
- The MoD to ensure that the Reserve forces are not subject to overstretch whilst maintaining adequate levels of recruitment and retention.

Healthcare Commission Review of the Defence Medical Services (2008)

- In January 2008, the Surgeon General (MoD) requested the Healthcare Commission to undertake an independent review of the quality of healthcare services provided by the DMS in the UK and overseas. This was the first time that the Healthcare Commission had received such a request from the MoD in view of the fact that the services provided by the DMS were outwith the scope of the Health and Social Care Act (2003); the legal framework within which the Healthcare Commission operates. The legislation required to bring the DMS within the regulatory remit was laid before Parliament in June 2008.
- Based on *Standards for Better Health*¹⁴⁵, the overarching aim of that unique review was to promote the improvement in provision of service by the DMS by identifying good practice and areas in need of improvement. Moreover, it sought to assist the DMS to implement more “...robust governance of the quality of the care and treatment it provides.” (*March 2009, Commission for Healthcare Audit and Inspection, MOD, p.4*). The outcome of

¹⁴⁵ Set by Government and used to assess the performance of the NHS based on standards pertaining to patient safety issues, quality of healthcare provision, and the extent to which services are focused on meeting patients’ needs.

that extensive review revealed both areas of "...exceptional good practice and expertise" (e.g., trauma management in theatre, medical emergency response and rehabilitation services) as well as "...several areas where improvement is needed" (e.g., the need for a clear governance structure and system for the entirety of the DMS).

- A total of 485 commentaries about the healthcare services provided by the DMS were summarised according to four main headings: (i) "the standards of care across the DMS"; (ii) "views of those who used the service"; (iii) "areas of exemplary practice", and (iv) "areas of good practice in clinical governance". Whilst 213 of the 300 comments received pertained to Primary Care, only 10 were received in relation to community health services. In terms of the number of respondents by role, the majority comprised members of the UK Armed forces (n=215), with 52 family dependants, 20 entitled civilians and 13 professional bodies. The review was advertised through the MoD internal communication systems, and a number of options were made available for respondents to submit their comments (e.g., completing an on-line feedback form or telephoning the Healthcare Commission). What is not clear however is how this sample was selected. For this reason, it is difficult to establish to what extent the views received are generalisable, particularly when only seven respondents expressed an opinion on the community mental health services (the majority of which were positive).
- However, whilst bearing this limitation in mind, it is interesting to note the concern raised by respondents (number unknown) about the closure of military hospitals in favour of NHS and independent acute healthcare providers. The preference from that review was for dedicated military hospitals to provide treatment and care for Service personnel rather than through contracted medical services provided by the NHS; a view shared by the 113,961 individuals who signed a petition to this effect which was delivered to Downing Street in August 2008.
- In stark contrast, the Defence Committee inquiry (see above) endorsed the wisdom of the MoD's decision to base its secondary care around units embedded in the NHS Trusts. A decision which derived from a spending review and which was substantiated by evidence derived from a study conducted by Dr David Rosser (UHB Medical Director) entitled "*Military Hospitals for the Care of Military Battle Casualties*". According to that study, the average number of 36 military patients receiving treatment at UHB at any one time during 2007 to 2008 was too small a number to enable surgeons to maintain effectively their

skills. In examining the treatment provided to at least one military patient between 2005 and the first half of 2008 according to area of specialism (e.g., renal, knee and plastic surgery), UHB surgeons performed an average of 72 operations a year on NHS patients compared to four operations for military cases. The same situation was apparent in respect of hand surgery (253 civilians vs 7 military), and cardiothoracic surgery (549 civilians vs 3 military). Thus, whilst the figures clearly support the treatment of military personnel in the NHS, the views of those being treated does not necessarily correspond accordingly thereby enforcing the need to ensure that patient needs are taken into consideration in the planning and developing of services. The challenge therefore is to determine how best to meet those needs in a clinical and cost effective manner. According to the Healthcare Commission review, "... patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services based on what assessed research evidence has shown provides effective clinical outcomes." (p.95)

National Audit Office Report of MoD: Treating Injury and Illness arising on Military Operations (2007)

- The recent report by the National Audit Office (NAO) to assess the effectiveness of the MoD's provision of medical care to Service personnel who were injured or suffered health problems (mental or physical) resulting from operations in Iraq and Afghanistan focused on the:
 - level of medical care provision in terms of:
 - timeliness
 - adequacy
 - availability
 - impact of minor injuries and illness on operational capacity (as measured by "manpower days lost")
 - effectiveness of medical support provision in terms of:
 - success of treatment in saving the lives of seriously injured Service personnel;
 - speed of evacuation from theatre back to the UK;
 - capability of the field hospitals to stabilise major trauma casualties, and
 - capacity of UK-based medical care and rehabilitation provision.
- The effectiveness of mental healthcare provision was examined in terms of:

- trends in overall rates of mental health conditions during and after deployment,
 - balance of healthcare at three sites of delivery (i.e., forward bases, the field hospitals, and in the UK), and
 - mental health support for Service personnel on operations.
- To generate the necessary data pertaining to the aspects listed above, the methods underpinning the fieldwork for that report comprised the following seven elements.
 - *Review of key documents* - to identify the standards of medical care set by the MoD and to adjudge performance accordingly.
 - *Semi-structured interviews* – to enable an understanding of the delivery of treatment and rehabilitation and health protection measures.
 - *Analysis of medical data* – to permit analysis of rates of disease and injury and to create treatment pathways.
 - *Other data analysis* – to examine potential issues pertaining to capacity at medical facilities.
 - *Process mapping and modelling* – to ascertain any changes to treatment and rehabilitation and risks to capacity at Selly Oak and Headley Court.
 - *Literature review* – to compare the MoD care provision to identified good practice by analysis of the academic literature in the treatment and rehabilitation of:
 - major trauma;
 - post-trauma mental health;
 - musculoskeletal injury, and
 - gastrointestinal illnesses.
 - *Focus groups* – to solicit the patient perspective on care provided at Headley Court.
- In line with the report by the Healthcare Commission, the findings of the NAO evaluation suggested that there has been a steady increase in Service-related illness and injury rates in comparison with the data for 2001 (when the level of injury and illness rates on Operation HERRICK were at zero). In 2009, 131 Service personnel had suffered serious injuries on deployment. As the figures for Operation HERRICK have increased over time, the figures pertaining to Operation TELIC have gradually decreased from the highest rate of 46 in 2003 to the lowest rate of 1 in 2009. Both sets of figures however are likely to be an underestimate given that the data for 2009, based on recorded medical attendances on military operations, were only available up to 31 October 2009. Relative to the number of serious injuries sustained on Operation HERRICK and Operation TELIC, a considerably higher rate was reported for the total level of minor

injury and illness. In 2009, the combined rate for both operations suggested that the health of 31,687 Service personnel had been compromised to some extent, although this was less than that reported in 2007 ($n=38,419$) and 2008 ($n=47,035$).

- As has been the case with the increase in the level of serious injury, the numbers of Service personnel with mental health conditions have increased since 2006 from 45 to 380 in 2009 for those deployed on Operation HERRICK. However, although the 2009 level ($n=199$) is higher than that of the 2006 level ($n=74$), there has been a decrease when compared with the previous two years of 2007 and 2008 ($n=298$ and $n=239$ respectively).
- The quality of operational medical care was evaluated by calculating the number of “unexpected survivors” (i.e., personnel who survived even although the severity of injury would be expected to have resulted in fatality). By means of mathematical modelling, the MoD identified 144 unexpected survivors who, when pooled with cases identified by clinical peer review between April 2006 and July 2008 among casualties treated at UK-run field hospitals, increased to a total of 175 (representing 25% of all seriously injured casualties who survived). In comparing this rate with the 6% of unexpected survivors rate achieved by 81 NHS hospitals (in England and Wales) based on Trauma Audit and Research Network performance data, the evidence supports the view of the Defence Committee Review and the Healthcare Commission (Defence Medical Services: A Review of the Clinical Governance of the Defence Medical Services in the UK and Overseas, March 2009, Commission for Healthcare Audit and Inspection) that the quality of healthcare provided on military operations is not only high confirmed by the views solicited, but it can also effectively reduce the risk of mortality. However, it is important to be aware of key differences in the calculations effected between the MoD and the NHS, the reasons for which will be addressed in *Section 6*.
- The increase in casualty rates overall combined with the increase in the number of “unexpected survivors” has inevitably resulted in an increase in demand for medical treatment and care. This currently has implications for field hospitals in Afghanistan (which are currently close to capacity in coping with casualty levels), the timeliness of evacuation (both to field hospitals and to the UK), contingency plans for capacity at Selly Oak, and impact on future Regional Trauma Networks (RTNs). With regards to the last named, research in civilian healthcare

has shown an association between survival rates and the number of trauma patients seen by a clinician. The intention by the NHS to introduce RTNs (i.e., where a hospital in each region is an identified major trauma centre) requires the MoD to give careful consideration when planning new military hospital unit contracts to ensure a balance between military medical staff receiving sufficient experience of major trauma and the wider skills required for future operations and the NHS deriving benefits from that military trauma experience.

- In terms of rehabilitation, Headley Court was regarded as providing a unique facility for complex trauma, neurological injury and other complex injuries that is not currently matched by any NHS equivalent for general rehabilitation for trauma. This lack of a civilian equivalent combined with the paucity of data collated on outcomes for individual patients treated at Headley Court however means that it is currently not possible to benchmark the quality of care provided. However, there is a consensus of agreement by patients and military commanders that the quality of care provided by the mental and occupation health specialists and rehabilitation staff at Headley Court is “exemplary” as evidenced by the outcome of the independent Healthcare Commission review.
- Limitations in the data collected on operations (due in part to the difficult circumstances) mean that the MoD does not have any knowledge of how many personnel seek treatment (on demobilisation) at UK-based medical facilities for minor injuries or illness caused by military operations. To this end, it is not possible to: (i) quantify the full impact of military operations on the health of Service personnel, and (ii) accurately attribute the health burden of serving on operations. Thus, the opportunities for prevention may be severely compromised. To date, there are also no comparative data on illness and injury rates with coalition partners to assess relative performance. Because data sets are not linked, it is also not possible to monitor timelines for treatment and rehabilitation.
- Examination of the provision and use of military mental health services showed that a relatively low proportion of Service personnel are referred to specialist psychiatric support in theatre. Based on the first assessment by a mental health specialist, in 2008 the overall mental health rates for deployed and non deployed personnel who sought medical help in the UK were 16 per 1,000 of the population. The rate of PTSD assessed in the UK in previously deployed Service personnel was 1.1 per 1,000 personnel compared with 0.3 per 1,000 Service personnel

who had never been deployed. In light of evidence that suggests that it can take a number of years before help is sought for mental health problems (e.g., Creamer & Forbes, 2004; *Combat Stress*, 2007) the full extent of the mental health problems associated with Operation TELIC and Operation HERRICK may not have fully emerged. Although Headley Court routinely assesses the risk of mental health problems in seriously injured personnel, there is no routine assessment of the mental health of other UK military personnel returning from operations.

5.2.3 Transition

National Audit Office (2007)

- In 2007, the NAO undertook an examination of the resettlement support provided by the MOD to Service leavers on discharge from all three Services. This examination sought to determine to what extent the following four areas of resettlement support optimised the opportunity for the successful re-integration of Service leavers into civilian life.
 - (i) Career transition services
 - (ii) Housing services
 - (iii) Financial briefings and services for those who are being medically discharged
 - (iv) Co-ordination of transition services and the communication of their nature in a timely and effectively manner.

- Data were obtained from the following sources.
 - *A retrospective questionnaire survey* – to obtain the views of 4,997 personnel who had left the Services in the two years prior to October 2006. (In total, the survey was sent by post to 38,153 Service leavers and achieved a 13% response rate.)
 - *Semi-structured interviews* – to obtain the views of key individuals and organisations within the MoD involved with the delivery of resettlement support to Service leavers.
 - *First and second line visits to units in the three Services* - to gain: (i) a better understanding of the practical delivery of resettlement services; (ii) insight into the key issues, and (iii) views on key issues arising from the survey (which included completion of a short questionnaire by second line officers).
 - *Focus groups* – to obtain views on the main issues addressed in the survey. (These involved 10 to 15 Service leavers at the units visited and the CTP centres.)

- *Financial and statistical analysis* – to calculate the costs to the MoD of resettlement activities for 2005-06 and 2006-07. (These costs took into consideration each tier of the resettlement process, viz, outflow rates from the UK Armed Forces, CTP take-up rates and satisfaction rates, and subsequent employment statistics.)
- *Review of MoD papers* – to evaluate policy and planning related to resettlement services and accommodation, performance CTP reports, minutes of resettlement conferences, guidance manuals and promotional literature. (This also included an examination of the *Continuous Attitudes Survey* conducted by the MoD in 2007.)
- *International comparisons* – to understand how other countries (Australia, Canada, France, Germany, New Zealand and the USA) provide resettlement services. (That work benefitted from the availability of information obtained as part of the “Sustaining the Veteran” research project conducted by SCS Ltd for the UK Defence Academy.)

In addition to the above, the survey team attended some resettlement courses, workshops and briefings provided for Service leavers. The key findings pertaining to the evaluation of the effectiveness of the Career Transition Services are provided in *Table 8*.

- In interpreting those findings, however it is important to bear in mind the following.
 - *Low response rate*: For this reason, the extent to which these findings would be generalisable to the target population (i.e., Service leavers) is highly questionable. In view of the fact that it is not possible to establish the extent to which those who responded differed from those who did not, there is a potential for a response bias whereby those experiencing problems post discharge and/or those with less favourably disposed towards the resettlement services would be least likely to respond. Alternatively, the reverse could also be true such that those who were most disaffected would relish the opportunity to respond in a critical fashion. Given that most of the responses received were more positive than negative and that the response rates were skewed in favour of those of a higher educational status (as evidenced by the higher response rate achieved for officers of all three Services) and discharge because of end of engagement (rather than medical discharge or compulsory/administrative discharge), it is more likely to be the former rather than the latter. Yet it is the views of

those individuals who are most at risk of encountering problems that are particularly important in terms of helping to prevent subsequent problems of social exclusion.

- *Unweighted data*: The data were not weighted to remove known biases relating to gender, rank, Service, and ethnicity as it was not possible to weight the data for other unknown biases associated with homelessness, literacy levels and educational status. For this reason, no attempt was made to extrapolate the results of the survey across the population.
 - *Retrospective assessment*: The reliability of the responses may have been compromised by recall bias due to the fact some respondents would have left Service up to two years previously. Given the difficulties in obtaining up to date contact details this retrospective census of all personnel leaving Service during the last two years prior to October 2006 was adopted for pragmatic reasons.
- The challenge associated with tracking Service personnel once they have been discharged from the UK Armed Forces (as highlighted initially by Dandeker *et al* 2005 with regards to identification of homeless ex-Service personnel) was endorsed further. Contact details of the Service leavers who participated in the NAO survey were dependent on those held by the MoD. Given that it is the responsibility of individuals to notify the MoD of any subsequent change of address once discharged, a proportion of the contact details were found to be no longer be valid; a situation which is likely to exacerbated to a greater extent in respect of the more vulnerable Service leavers.
 - In respect of establishing overall value for money, the extent to which the NAO analysis could be performed in some areas was compromised because of the lack of pertinent information. Although the survey found that the MoD has "sound" management information on almost all aspects of performance (particularly the CTP contractor), it also reported that there is a paucity of data available for a number of aspects including the performance provided at single Service level (most notably at Army Unit level) and Service leaver's time spent on resettlement activities. Estimates were therefore calculated in respects of the following costs.
 - Cost to the MoD of time allocated to Service leavers to undertake resettlement activities by means of GRT is in excess of £78 million per year.
 - The overall cost of resettlement in 2006-07 was £115 million.

- The MoD saves approximately £40 million per year in recruitment and initial training costs for those who start the CTP resettlement programme but who subsequently decide to return to Service (although it is difficult to attribute the relative influence of the advice provided by the CTP in this respect).

Table 8. Key Findings by Domain

Domain	Key findings
Effecting a successful transition	<ul style="list-style-type: none"> ■ Approximately 75% reported that they found the return to civilian life as expected or easier. (Those who served the shorter time experienced most difficulty in making the transition.) ■ Over 50% had a job to go to on discharge. ■ Approximately 66% found military service of benefit in finding employment post-discharge. ■ Only 10% took more than four months to find a job.
Employment status post-discharge Employment stability post-discharge	<ul style="list-style-type: none"> ■ At the time of the survey, the majority of respondents were in paid fulltime work including 62% of Early Service leavers. ■ Overall, only 6% were unemployed and seeking work. ■ Approximately 33% of Service leavers had two or more jobs since leaving the services. ■ The decision to change civilian jobs was mainly due to better pay and more responsibility.
Employment area Housing	<ul style="list-style-type: none"> ■ Over 50% had a job in the public sector.
Housing	<ul style="list-style-type: none"> ■ 89% of officers owned a house prior to leaving the Services (either outright or with a mortgage) compared to 25% of the junior ranks. ■ On leaving the Services, the majority of officers and Senior Ratings resided in their own home whereas the majority of junior/other ranks were dependent on relatives for accommodation. ■ Only 5% reported occupation of Service accommodation after their final day in the UK Armed Forces.
Debt	<ul style="list-style-type: none"> ■ 11% reported problems with debt pre-discharge. ■ 13% encountered debt problems post-discharge. ■ For those who experienced debt, the level of debt for most was under £5,000 (both pre- and post-discharge).
Civilian GP registration CTP services use	<ul style="list-style-type: none"> ■ 12% were not currently registered with a civilian GP. ■ 9% of entitled Service leavers did not make use of the CTP resettlement package. The main reasons for officers not doing so pertained to the view that attendance at the CTP would not be useful or relevant to the needs of the individual and to a lack of awareness of the CTP services. ■ Those respondents who had served as NCO/Warrant Officer/ Senior Rating were most likely not to attend because they waived their entitlement in exchange for a reduced notice period.
Satisfaction with CTP services	<ul style="list-style-type: none"> ■ Of those entitled to the CTP, most were satisfied with a number of the elements of the employment support provided.

5.2.4 Homelessness

Dandeker *et al* (2005)

- As part of a wider UK study of ex-Service homelessness, the MoD and the Office of the Deputy Prime Minister (ODPM) commissioned the King's Centre for Military Health Research (KCMHR)¹⁴⁶ to undertake a feasibility study to:
 - examine and develop methods to be used in a future study regarding the extent, nature, and costs of rough sleeping and homelessness among ex-Service personnel in England.

- The UK literature review conducted by Dandeker *et al* (2005) highlighted the paucity of studies on ex-Service homelessness in the UK. Moreover, of those undertaken, almost all have been based on small sample sizes¹⁴⁷ and have been predominantly London-based. The review of the international literature confirmed that most of the international literature had emanated from the USA. To this end, it further endorsed the limitations in making direct comparisons due to major differences in the provision of:
 - health and support systems;
 - the length of time that ex-Service personnel can access services post-discharge, and
 - the type of outreach services, and the provision of medical and addiction treatment services.

- Dandeker *et al* (2005) also identified two groups who were most at risk of homelessness and other related difficulties post-discharge, as follows.
 - Group 1:* Service personnel who left Service early by virtue of either: (i) failing to pass their basic training; (ii) administrative discharge, or (iii) medical discharge.
 - Group 2:* Service personnel who served for a number of years without difficulty, but who experienced problems of adjustment in making the transition from military to civilian life.

- Comparisons undertaken between the 33 ex-Service personnel and the 22 civilians who participated in these interviews showed key differences in respect of the circumstances listed below.

¹⁴⁶ The work of KCMHR originally began as the Gulf War Illnesses Research Unit (founded in 1996). The change in name to KCMHR reflected expansion of its military-related research portfolio. Launched in 2004, KCMHR comprises a collaboration among the three parts of King's College London (KCL), *viz*, the Institute of Psychiatry (IoP), the Department of War Studies, and the Medical School (KCMHR, 2006, 2010).

¹⁴⁷ Dandeker *et al* (2005) define a small sample as being fewer than 100 participants.

- *Age* – ex-Service personnel were older.
 - *Encounters with the Criminal Justice System* – ex-Service personnel reported more arrests before the age of 15 years, but civilians were more likely to have served time in prison or a young offenders institution and to have committed more offences (including theft, possession of firearm, and robbery).
 - *Physical health problems* – ex-Service personnel were more likely to report problems although Dandeker *et al* (2005) suggest that this may be because of better access to healthcare services or a reflection of the age difference.
 - *Foster care* – civilians were more likely to report experiencing foster care. Relatedly, civilians were also more likely to report a dysfunctional family background.
 - *Substance misuse* – civilians were more likely to report problems with alcohol and drugs. However, Dandeker *et al* (2005) suggest that this may be due to enhanced access to healthcare and/ or a reflection of the age difference between the two groups. It may also however be a matter of “definition”.
- Of particular relevance to our scoping review are the two aspects of the Dandeker *et al* (2005) feasibility study that relate specifically to Scotland. The first relates to the comprehensive review of the key methodological issues that would need to be considered in the event of a larger study and the implications that these would have should a similar endeavour be commissioned in Scotland. These particular issues will be discussed in Section 6. The second pertains to the findings from the pilot interviews conducted in Scotland (presented below) to give an in-depth understanding of the unique characteristics of this particular group and to explore some of their pathways to homelessness.
 - In terms of the pilot interviews conducted in Scotland, these were based on a sample size of 15 ex-Service personnel from Edinburgh ($n=11$) and Glasgow ($n=4$). The majority of the sample were identified as having:
 - served in the Army ($n=13$);
 - seen active service ($n=10$);
 - completed their period of engagement ($n=6$);
 - not received a Resettlement Package prior to leaving service ($n=13$);
 - become homeless due to family breakdown ($n=8$), and
 - spent their first night on leaving the Service in a family member’s home ($n=8$)

- The majority (n=9) felt that their time in the military had “helped”. Only three considered that the military had “disadvantaged” them even although six had reported the reason for leaving the UK Armed Forces as either “dishonourable discharge” or “medical discharge”. The mean length of service was 7 years (range of 1-22 years). Based on qualitative data obtained from 15 ex-Service personnel, the vulnerability factors that emerged pertained to the following four circumstances, as listed on p.92.
 - *“Unstable family life, especially divorce or relationship breakdown”*
 - *“Inability to adjust to civilian life”*
 - *“Dishonourable or medical discharge”*
 - *“The belief that they had not been given sufficient support on leaving the Armed Forces”*

5.2.5 Health and Social Outcomes/ Health Services Experience

Fear *et al* (2009b)

- Commissioned by the Department of Health in England, the report by Fear *et al* (2009b) summarises the available evidence on the: (i) health and social outcomes, and (ii) health experiences of ex-Service personnel of the UK Armed Forces. As such, their focus was predominantly on those who had left Service rather than those who have been Veterans of a specific conflict or war, but who remain in Service.
- The authors of this report highlight the fact that the military-related literature uses the term “Veteran” in two different ways. Some studies use the term to refer to those military personnel who are no longer serving having left the military. Other studies use the term to refer to those military personnel who remain in Service but who have been operationally deployed in support of particular conflicts or wars (e.g., Gulf War Veterans). Relatedly, they also raise the issue of the different definitions attributed to “Service” and the extent to which it can vary among nations. A detailed explanation of the differential use of both of these terms has been addressed by Dandeker *et al* (2003, 2006).
- In extending the original review of the literature undertaken by Dandeker *et al* (2003), the more recent review focused on papers published since 2003 to provide a general overview of the national and international literature on the health and social outcomes, and health services experiences, of UK ex-Service personnel. The 76 papers selected as being of most relevance to

ex-Service personnel were categorised according to four categories, the description for which along with the number identified per category is presented in *Table 9*.

Table 9. Categorisation, Inclusion Criteria, and Numbers Identified Per Category (N=76)

Coding	Category	Inclusion Criteria	Number Identified
1	"Ex-Service personnel UK"	<ul style="list-style-type: none"> ▪ Includes some data on UK ex-Service personnel ▪ Not necessarily the focus of the paper 	24
2	"Service personnel in general (UK)"	<ul style="list-style-type: none"> ▪ Includes data on UK Service Personnel ▪ Not specific data or analyses on ex-Service personnel 	21
3	"Ex-Service personnel (non-UK)"	<ul style="list-style-type: none"> ▪ Includes data on non-ex-Service personnel ▪ Can be applied to UK ex-Service personnel 	9
4	"Service personnel in general (non-UK)"	<ul style="list-style-type: none"> ▪ Includes data on non-UK Service personnel ▪ Has relevance to UK ex-Service personnel 	22

- The key findings identified by Fear *et al* (2009b) are summarised in *Table 10* below. On the basis of those findings, a number of recommendations were made for future research endeavours to investigate issues for which questions which have yet to be addressed in respect of health and social outcomes of ex-Service personnel in the UK. These included the need for periodic review of that evidence and the need for researchers to use different study methods and designs in order to achieve the following.
 - Longitudinal, prospective studies to enable the stratified follow-up of a sample comprising ex-Service personnel. To facilitate the conduct of such studies, however, would require:
 - obtaining consent at either the time of recruitment, during military Service or on discharge;
 - planning to ensure data collection commences prior to the occurrence of adverse outcomes either whilst military personnel are still serving or after they have left Service.

- using data linkage of routinely collected data to facilitate a systematic method of data collection and collation.
- Randomised controlled trials as an evidence-based approach to determine the efficacy of interventions, including those used for screening purposes, and to facilitate the standardisation of mental health care provision.
- Qualitative studies to enable an in-depth exploration of complex issues (e.g., the transition from military to civilian life), which cannot be readily understood when relying solely on quantitative research methods.

Table 10. Key Findings According to Focus of Analysis

Focus of Analysis	Key Findings
Comparisons of UK ex-Service population with general population.	<ul style="list-style-type: none"> ▪ Similar in health status ▪ Broadly similar prevalence rates of mental disorder ▪ Similar rate of suicide (except for male ex-Service personnel aged 24 years or less, who are at increased risk compared to similarly aged males in the general population)
Comparisons of UK military personnel (Service and ex-Service) with general population. Comparisons of ex-Service personnel with members of the UK Armed Forces who are still serving.	<ul style="list-style-type: none"> ▪ Higher alcohol consumption in UK military personnel, but this difference does reduce with age ▪ Similar prevalence rates of mental disorders
Comparisons of UK military personnel affected by mental health problems with UK military personnel without mental health problems. Military personnel who leave Service with psychiatric	<ul style="list-style-type: none"> ▪ Military personnel affected by mental health problems are more likely to: <ul style="list-style-type: none"> ○ leave Service early ○ experience adverse health and social outcomes post-Service ▪ Increased risk of: <ul style="list-style-type: none"> ○ social exclusion ○ ongoing ill health

**problems
Comparisons of
early Service
leavers with longer
serving UK military
personnel.
Gulf War
deployment**

**Deployment to
Iraq/ Afghanistan**

- Early Service leavers are more likely to be at risk of:
 - developing health problems
 - engaging in risk taking behaviours
- Associated with:
 - increased mortality from non-disease-related causes (in particular road traffic incidents), but effect reduces over time such that by 7 years post-deployment it cannot be observed
- Not associated with:
 - reproductive health problems
 - an increased incidence in cancer
- Associated with adverse mental health outcomes in respect of military personnel who:
 - report pre-Service vulnerabilities
 - serve as a Reservist (when compared with their Regular counterparts)
 - report high levels of direct combat exposure
- USA data on returning US military personnel suggests an ongoing increase in mental health problems – no evidence has been found to suggest that this is the case for the UK.

5.2.6 Community-Based Mental Health

Dent-Brown *et al* 2010

- Funded by the UK MoD in collaboration with the Health Departments for England, Scotland, Wales and Northern Ireland, six regional community mental health service pilots for UK Armed Forces Veterans¹⁴⁸ were evaluated by means of a comparison with three existing services, *viz*, *Combat Stress*, Humber Traumatic Stress Service (NHS) and UDR/Royal Irish Aftercare Service. The project team was led by Dr Kim Dent-Brown of the University of Sheffield and the evaluation was supported by a number of key individuals in its design and implementation including Professor Ian Palmer (MAP) and Dr Anne Braidwood (MoD).
- The key objectives of this endeavour were to evaluate service provision in terms of identifying facilitators and barriers in order

¹⁴⁸ These comprised: South Stafford and Shropshire Healthcare NHS Foundation Trust; Cardiff and Vale University Local Health Board; Camden and Islington NHS Foundation Trust; Tees, Erk & Wear Valleys NHS Foundation Trust; Cornwall Partnership NHS Trust, and NHS Lothian.

to address the question as to “what an effective, culturally sensitive, cost effective and sustainable NHS led mental health service for Veterans would look like”. Each service differed in respect of design, availability of resources and funding, as well as the envisaged service model of care.

- A multi modal method was used to obtain data from each service in respect of:
 - clients (routinely collected and anonymised data; anonymised questionnaires);
 - lead clinicians/managers (telephone interview);
 - staff (sample diary activity), and
 - documentary evidence (annual reports and the outcome of audits).

- The extent of data collection across the pilot services varied considerably. The findings for all services were based predominantly on the questionnaires returned by a small subsample of clients with an average response rate of 8%. For this reason, statistical analysis of the data was not possible. In addition, it is important to note that the majority of respondents were aged 40 years and above and had been discharged from service between 10 to 20 years previously. Consequently, the authors emphasise that the accounts provided may not reflect the current practice in the MoD, UK Armed Forces or NHS. However, some conclusions were drawn about the more and less successful features of the pilot services, as shown in *Table 11*. (These, however, did not include an evaluation of generic services [i.e., those for non-Veterans].) As post-intervention outcome data were only collected by one service, conclusions about Veterans’ perceived acceptability of and satisfaction with services was based on qualitative data.

- Eight priority recommendations were made such as the need for a common minimum data set to be established for enabling inter-service comparisons and co-ordinated by an independent research group. This would include routine pre- and post-intervention outcome data for all clients seen. Further recommendations were made in respect of: the identification and accessibility of mental health services for Veterans; staffing and activity levels, and the need for strategic investment in enhancing data collection practices by co-ordinating computerised patient information systems with that of the NHS.

Table 11. Pilot Services Evaluation by Components

More successful features	Less successful features
<ul style="list-style-type: none"> • option of self-referrals • access to staff with experience of being a Veteran • staff with training and experience of working with Veterans • availability of group work with other Veterans • provision of multi-agency clinics to advise on health, psychosocial and financial issues • services with combined assessment and treatment to reduce waiting time • teams/buildings identified as being specifically dedicated to Veterans • conjoint agency working and sharing of information • routine access to the UK Armed Forces' service records of new referrals 	<ul style="list-style-type: none"> ▪ reliance on assessment-only services resulting in treatment in generic NHS settings ▪ clinical pathways that involve onward referral with subsequent waiting lists ▪ staff who lack training and experience with Veterans ▪ sole practitioner services resulting in discontinuity of care ▪ Veterans required to travel long distances for assessment/treatment

- The one Scottish based community pilot, Veterans' First Point (VIP), comprised a "one-stop shop" for Veterans and their families, the concept for which was established in 2007 and based on a mental health service to provide information and support on a wide range of health and social welfare issues. The model took two years to develop, and NHS Lothian applied to run the pilot with additional funding from the Scottish Government. A key feature of the service was that the core staff (three peer supporter workers and a full time Veterans Therapist) were all ex-Service personnel and all employed staff were NHS employees. The service began accepting referrals on the 23 April 2009, and during the MoD funded period, a total of 291 referrals were received of which 111 attended an appointment with a clinician. A comparison of these referrals with *Combat Stress* (and to some extent Northern Ireland) showed differences in respect of marital status, service, time served and rank, as follows.

- Higher rate of divorce for Lothian referrals of 39% compared with 27% for *Combat Stress* and 13% for Northern Ireland;
 - Smaller proportion of Army referrals (77.4%) and a higher proportion of RAF (9.7%) and Royal Marines (2.8%) for Lothian compared with *Combat Stress* (82.4%, 4.3%, and 0.3% respectively);
 - Higher proportion of Lothian referrals had served 0-4 years (30.6%) and fewer over 10 years (31.1%) than *Combat Stress* (12.7% and 48.7% respectively), and
 - Higher proportion of Lothian referrals were Privates (65.4%) than *Combat Stress* (42.6%).
- Data were obtained for 30 clients seen by V1P in respect of initial severity and outcomes, viz, the PHQ-9¹⁴⁹ and the WSAS¹⁵⁰. A comparison of intake scores for Lothian, *Combat Stress* and Northern Ireland showed that, although the WSAS scores were similar, those clients referred to the two pre-existing services reported slightly more mood disturbance symptoms than did the clients of V1P. However, no outcome measure data were available to ascertain whether scores changed post-treatment.
 - Whilst the median satisfaction score for Lothian was slightly higher than that of Northern Ireland (31.1 vs 27.5 respectively), this was based on responses received from only 13 clients out of the 160 questionnaires distributed (i.e., a response rate of 8.1%). Of the six community mental health pilots for Veterans, however, the Lothian service did receive the highest rating with regards to:
 - welcoming environment;
 - staff familiarity with UK Armed Forces culture and experience;
 - choice of support on offer, and
 - enhancement of client's situation¹⁵¹

¹⁴⁹ This is the nine item depression scale of the PRIME-MD Patient Health Questionnaire.

¹⁵⁰ The Work and Social Adjustment Scale (WSAS) is a self-report scale of functional impairment attributable to an identified problem (Mundt, 2002)

¹⁵¹ Whilst V1P scored the highest out of the six pilot services, it scored less than the Northern Ireland pre-existing service.

5.3 VETERAN-RELATED CHARITIES AND AGENCIES COMMISSIONED STUDIES

Table 12. Summary of Veteran-Related Charities and Agencies Commissioned Studies

Year	Title and Source
Veterans' Profile and Needs: UK	
2005	"Profile of the Ex-Service Community in the UK" (Compass Partnership, The Royal British Legion)
2006	"Profile and Needs: Comparisons between the Ex-Service Community and the UK Population" (Compass Partnership, The Royal British Legion)
2006	"Greatest Welfare Needs of the Ex-Service Community" (Compass Partnership, The Royal British Legion)
2006	"Profile and Needs of the Ex-Service Community 2005-2020" (Compass Partnership, The Royal British Legion)
2006	"Future Profile and Welfare Needs of the Ex-Service Community"
2011	"Health, Welfare and Social Needs of the Armed Forces Community: a Qualitative Study" (Compass Partnership, The Royal British Legion)
2011	"Legion Welfare in the 2010s: A Decade of Change" (Centre for Future Studies, The Royal British Legion)
Veterans' Profile and Needs: Scotland	
2005	"Meeting the Need. A Report into Addressing the Needs of Veterans Living in Scotland" (Poppyscotland)
Treatment Effectiveness and Client Satisfaction Evaluation	
2007	"Combat Stress: Treatment Effectiveness and Client Satisfaction" (Hart & Lyons, Combat Stress)
2009	"An Evaluation of the Gardening Leave Project for Ex-Military Personnel with PTSD and Other Combat Related Mental Health Problems" (Atkinson, The Gardening Leave)
Service Provision Evaluation	
2012	"Armed Services Advice Project Evaluation" (Bonnar Associates, Poppyscotland)
Homelessness	
2008	"The Experiences of Ex-Service Personnel in London" (Johnsen et al, The Ex-Services Action Group)
2009	"Review of Data from Scottish Government. Ex-Service Personnel Making Homeless Applications" (MRUK Research, Poppyscotland)
Employment	
2009	"Research into Good Practice in Supported Employment, and Identification of Key Resources" (Hurley & Simpson, Poppy Scotland)
2009	"Research into the Employment Needs of Disabled and

	<i>Vulnerable Veterans in Scotland</i> (Hurley <i>et al</i> , <i>Poppyscotland</i>)
Criminal Justice System	
2008	<i>"Ex-Armed Forces Personnel in the Criminal Justice System"</i> (National Association of Probation Officers [NAPO])
2009	<i>"Armed Forces in the Criminal Justice System"</i> (National Association of Probation Officers [NAPO])

5.3.1 Veterans' Profile and Needs: Scotland

Poppyscotland (2005)

- In December 2005, the Earl Haig Fund Scotland (EHFS) Board of Directors approved the implementation of the Alfred Anderson Plan¹⁵²; a 12 month strategic review which included as its first step the need to conduct research to:
 - clarify the extent of current needs in the Veterans' community in Scotland, and
 - identify which needs the EHFS should support.

- The rationale for this strategy related to the fact that because the size and nature of the Veterans' community in Scotland will change over time, it is imperative to ensure that ex-Service organisations can: (i) accommodate any change in needs, and (ii) deliver support in a way that is both efficient and cost effective. To this end, the then Chief Executive of *Poppy Scotland* (Major Jim Panton¹⁵³) referred to two significant challenges in particular facing ex-Service organisations over the next decade, *viz*, ensuring:
 - (i) effective communication of the on-going development of appropriate services, and
 - (ii) that service provision meets the current needs of the Veterans' community.

- Under the direction of Mr Gary Gray (Head of Charitable Services) the research programme comprised the following four phases.
 - *Phase 1* - interviews with over 30 ex-Service organisations to identify collective support available to the Veterans' community.
 - *Phase 2* - face-to-face interviews with Veterans and their dependents throughout Scotland (commissioned as an

¹⁵² The Alfred Anderson Plan was named after the last World War One Veteran in Scotland, who passed away in November 2005.

¹⁵³ Major Jim Panton is currently Chief Executive of *Erskine*; a charitable organisation founded in 1916 to provide nursing and medical care for Veterans in Scotland.

independent research project which was conducted by George Street Research)

- *Phase 3* – analysis of the information from individuals and organisations within the Veterans’ community.
 - *Phase 4* – formulation of recommendations for consideration by the EHFS Directors.
- The outcome from Phase 1 was the identification of a host of varying levels of activity, which included the delivery of advice to Veterans at a local level, “caseworking” and the provision of “benevolence”. A total of 15 “lead” organisations¹⁵⁴ were identified, the majority of which support the delivery of “local initiatives” ($n=12$)¹⁵⁵ and provide “benevolence” ($n=12$)¹⁵⁶. Local initiatives comprise a wide range of activities (including hospital visits) considered to play an essential role with regards to:
 - identifying those Veterans who are in greater need (e.g., due to unemployment), and
 - instigating referrals to appropriate agencies depending on the nature of their needs.
 - Reasons for support, however, were found to vary considerably and were not dependent on age (although those who were younger and older were most likely to require such support). In respect of the older generation, difficulties commonly encountered related to the physical demands in undertaking routine tasks.
 - Provision of financial support by means of “one-off benevolence grants” fell predominantly on the single-Service Benevolent Funds, EHFS, OAS and Regimental Associations. SSAFA Forces Help played a key role in negotiating with grant giving bodies to obtain financial assistance as and when required.
 - Analysis of the needs of EHFS clients over a 12 month period by means of FY03/04 based on demographic characteristics, type of support received, and cost of support provided, indicated that the majority (75%) were aged 50 years or more thereby reflecting the RBL profile of the UK Veterans’ community of November 2005. In addition, it was suggested that this finding has important implications in light of increases in life expectancy such that it may well be the case that the demand for benevolence support provided by ex-Service organisations will persist for some time to come. The population projections estimated for Scotland bear further testimony to that view. These suggest that, by 2031,

¹⁵⁴ The “lead” organisations identified were: *ABF, BLESMA, Combat Stress, EHFS, OAS, RAFA, RAFBA, RBLS, Regimental Associations, RNA, RNBT, SNIWB, SSAFA Forces Help, WPWS, WWA.*

¹⁵⁵ The three exceptions were the *ABF*, the *RNBT*, and the Regimental Associations.

¹⁵⁶ The three exceptions were the *RNA*, the *WPWS*, and the *WWA*.

there will be an 81% increase in the proportion of people aged 75 years. Those who are over 65 years of age will constitute 24% of the Scottish population (Anderson *et al*, 2008b).

- In anticipation of an increase in the number of elderly Veterans in the Scottish population¹⁵⁷, emphasis was also placed on the need for the continued provision of residential, nursing and dementia care. A key aspect of that provision, however, was the need to ensure "...*cooperation, collaboration and rationalisation that could be replicated in other areas of the Veterans Scotland arena*". (p.8) On this basis, the gradual withdrawal of some organisations in delivering this type of care (e.g., the sale of Flanders House¹⁵⁸ to Erskine by EFHS in October 2005) was considered to be a "sensible" development.
- Emphasis was placed on the need to retain services offered by ex-Service organisations not being catered for by the NHS or Social Services. *Combat Stress* was specifically mentioned in this regard. However, in view of the considerable number of organisations that provide a wide variety of support to Veterans throughout Scotland, the *Poppyscotland* report proposed rationalisation as a strategy to streamline service provision to maximise the effective use of resources. This is particularly the case where areas of duplication exist such as that found in relation to some of the functions undertaken by the RBLs Pensions Department¹⁵⁹ and the War Pensioners' Welfare Service (WPWS)¹⁶⁰. On this basis, it was suggested that the formation of stronger working practices between these two organisations may result in a better use of the WPWS as a publicly funded body.
- The following three specific factors were highlighted with regards to considering the provision of pension support by ex-Service organisations:
 - (i) *Mortality*: This has resulted in a substantial reduction in the number of war pensioners resident in Scotland (as well as the rest of the UK).
 - (ii) *State provision*: The improvements of the provision of state benefits may deter those entitled to a war pension for fear of jeopardising their state entitlement.

¹⁵⁷ *Poppyscotland* estimated that, by 2025, there will be approximately 50,000 Veterans over the age of 80 years resident in Scotland.

¹⁵⁸ Flanders House was the EHFS residential care home located in Anniesland (Glasgow). Following its sale to Erskine for a "nominal" sum, the site was used for the construction of a purpose-built home ("Erskine Glasgow") which was officially opened in October 2007.

¹⁵⁹ EHFS provide an annual grant to assist with the RBLs provision of war pensions advice.

¹⁶⁰ The WPWS and RBLs were found to be the main providers of war pensions advice to Veterans (although BLESMA and *Combat Stress* also provide such advice to their specific client groups).

(iii) *Armed Forces Compensation Scheme*: Following its introduction in April 2005 and the implementation of the recommendations from the recent Armed Forces Compensation Scheme Review (MoD, 2010), there will be an inevitable reduction in the number of applications for war pensions from new Service leavers.

- The need to ensure a co-ordinated approach across all aspects of service provision featured heavily in the *Poppyscotland* report. *Veterans Scotland*¹⁶¹ in particular was considered to have made significant progress in terms of modernising the way in which housing organisations work in partnership. As a potential model for replication elsewhere in the UK, examples of the housing initiatives implemented by *Veterans Scotland* to facilitate this partnership included the:
 - launch of a new website launched to help ex-Service people applying for Veterans' housing anywhere in Scotland.
 - development of the Combined Housing Register (CHR), which finds accommodation best suited to Veterans' needs with rent cheaper than normal rent arrangements.
 - enhancement of the application process to allow Veterans to express an interest in a suitable area by clicking on a map and browsing all properties currently available.
 - standardisation of the housing application form which is subsequently validated by *Veterans Scotland* prior to the request for accommodation being placed on the active list until suitable accommodation is found.
- Specific reference was made to the importance of addressing the issue of homelessness among ex-Service personnel in Scotland. The potential for Veterans to become homeless in Scotland was heightened by two factors in particular. First, general housing demand was considered to exceed housing supply. Second, different qualifying criterion for eligibility in terms of the 900 accommodation units was identified. On the grounds that most of that population are located in Glasgow, it was proposed that future endeavours in this regard should target that region and involve the key homelessness organisations to establish how best to proceed in the future. In addition to undertaking discussions with the *Glasgow Homelessness Network* (GHN), suggestions for possible future initiatives included the formation of a Scottish equivalent of the London-based *ESAG* and *Project Compass*. However, prior to doing so, *Poppyscotland* recognised the importance of conducting further research amongst the

¹⁶¹ Veterans Scotland is the umbrella group for ex-Service charities in Scotland, which is funded by the Veterans Challenge Fund and ex-Service charities.

homelessness in Glasgow to establish whether there would be a justified requirement for such initiatives.

- Homeless Veterans were also considered to have a greater need for enhanced employment advice and support than the majority who effect a successful transition from military to civilian life. In addition to addressing these needs, further exploration was also suggested with respect to the employment needs of disabled Veterans.
- In an endeavour to solicit empirical evidence of the needs of Veterans in Scotland, *Poppyscotland* have been responsible for commissioning a series of research projects (as summarised in *Table 11*), which followed on from research undertaken by (George Street Research) to conduct face-to-face interviews with a sample of Veterans. Although it was not possible to obtain a copy of the report detailing the size of the sample and how that sample was identified, the key findings reported in *Poppyscotland* report entitled "*Meeting the Need*" were as follows.
 - Thirty five per cent of Veterans experienced some form of difficulty although most of those interviewed (94%) reported being "happy or satisfied with their life in general", and reported being "happy or satisfied with their life". Older respondents however were less happy or satisfied than the younger respondents.
 - Those who experienced most difficulty were 75 years of age and above (45%).
 - In terms of the most common areas of difficulties reported, these were related to the following issues.
 - Mobility (15%) – these were linked to age with 24% of those who reported difficulties with mobility being aged 75 years and above.
 - Financial (12%) – these were encountered by both the younger and older participants.
 - Self care/ wellbeing (9%) – these were mainly reported by the older respondents.
 - Less common were the difficulties arising from dysfunctional relationships (6%), employment (6%) and housing (5%).
 - Sixteen per cent of respondents had experienced two or more difficulties identified.
 - Although the overall level of awareness of the main ex-Service organisations in Scotland was high, of those respondents who were aware of the existence of these organisations, 60% had not made contact and 80% had not received support from them. Reasons for not making contact was due to the view that they either had no need

to do so (70%) or had not experienced any problems (21%).

- Based on the outcome of the review of current support provision and the research undertaken by George Street Research, a gap analysis was undertaken to compare the current provision of support with that of the expectations of Veterans. One of the key areas identified was the absence of a specialist service that could deliver a single point for providing advice to the Veterans' community in Scotland. To this end, *Poppyscotland* proposed the establishment of a:
 - regional high profile one-stop advice centres where Veterans could receive advice and support that would encompass the full range of their specific needs;
 - national helpline;
 - website outlining the provision of support available to Veterans, and
 - portfolio of co-ordinated promotional material for wide distribution to raise awareness of the support available to Veterans and to other service providers (in both the voluntary and public sector). In addition, it was felt that this would also provide the opportunity to raise general awareness of the public in order to benefit future fund raising.
- *Poppyscotland's* Board of Directors agreed that *Poppyscotland* should proceed with establishing a pilot one-stop advice centre in Glasgow delivered by means of a designated telephone advice helpline with "active referral"¹⁶² to the local Citizens Advice Bureaux (CABx) or to telephone advice centres via Citizens Advice Direct (CAD). A Service Level Agreement between *Poppyscotland* and Glasgow Citizens Advice Bureau Consortium provided the operational guidelines for an "accelerated"¹⁶³ pilot service, which was launched in August 2007 and comprised a consortium of eight CABx¹⁶⁴.

¹⁶² The term "active referral" pertains to one where the referring agency initiates contact with the recipient agency about the client rather than simply advising the client to contact another agency, but does not contact the second agency on behalf of the client (i.e., "passive referral").

¹⁶³ Clients were "fast-tracked" through the system to receive appointments in the CAB or at home within one week.

¹⁶⁴ The eight participating CABs were: Bridgeton; Drumchapel; CAD; Central; Easterhouse; Maryhill; Parkhead, and Pollock.

5.3.2 Treatment Effectiveness and Client Satisfaction Evaluation

Hart & Lyons (2007)

- On the basis of recommendations made by the HACAS Review (2005) and by the Defence Committee Review (2006), *Combat Stress* commissioned a research study specifically designed to show evidence of treatment outcome in respect of those clients referred to one of their three treatment centres. In May 2007, Hart and Lyons produced the report of that study, the objectives of which were to examine the:
 - effectiveness of the residential treatment provided by *Combat Stress* in respect of contributing to the management of chronic combat-related mental health disorders, and
 - client satisfaction with treatment provision.
- Based on a convenience sampling design, potential participants were identified using the *Combat Stress* database, which was established in 2004 and constituted predominantly male Army Veterans between the ages of 40 and 50 years. The sample comprised 57 Veterans admitted to one of the three *Combat Stress* treatment centres ("Treatment Group") and 47 Veterans who were recommended for a first admission ("Control Group") resulting in a response rate of 53% and 48% respectively. Due to financial and temporal constraints, these two groups were not however matched for demographic variables although it was "...expected that both groups would reflect the demographic profile of the existing database" (p.17). Table 13 also shows the composition of the two groups was not markedly dissimilar. Furthermore, the two groups were not matched in respect of clinical presentations in view of their heterogenous nature comprising a variety of physiological and psychiatric diagnoses. On average the Treatment Group had had four previous admissions to the treatment centre whereas those in the Control Group had only received one visit from a RWO.
- To accommodate the diversity of clinical presentations of those *Combat Stress* clients who receive treatment, the General Health Questionnaire-28 item version (GHQ-28)¹⁶⁵ was used as a self-report measure of general psychopathology to assess

¹⁶⁵ Comprising four subscales to assess somatic symptoms, anxiety and insomnia, social dysfunction and severe depression, the GHQ-28 is a well-established self-report measure of general psychopathology with good psychometric properties for use with non psychiatric samples.

treatment outcome. A Client Satisfaction Survey was specifically designed to assess the extent to which the needs of clients were being met by the *Combat Stress* treatment centre. Having been piloted on 60 clients across all three treatment centres, the final version comprised a number of statements with Likert scale responses of 1-5 to measure the extent of agreement for each. Assessments were conducted at four weeks prior to admission of the Treatment Group (baseline), on discharge (midpoint), and at four weeks post-discharge (follow-up).

- A between-group comparison of the GHQ-28 scores at these three assessment points using non-parametric statistical methods (given the skewed distribution of the data for both groups) revealed that there was:
 - no significant difference between the two groups at baseline;
 - a significant improvement in GHQ-28 scores for the Treatment Group at discharge, and
 - no significant difference between the two groups at four weeks follow-up.

This finding highlights the fact that a major challenge of any therapeutic regimen is the durability of positive changes, which is a perennial problem for civilian clinical samples as well. Relapse can be too often the norm. There is a need, therefore, to find ways to sustain any initial positive treatment effects, and this would include identifying factors which either compromise or facilitate the durability of such effects.

Table 13. Profile of *Combat Stress* Sample

Characteristics	<i>Treatment</i> (n=57) %	<i>Control</i> (n=47) %
Gender:		
▪ Male	100	94
▪ Female		6
<i>Service:</i>		
▪ Army	75	77
▪ Air Force	9	4
▪ Marines	5	6
▪ Merchant Navy	3	4
▪ Navy	9	9
<i>Source of referral:</i>		
▪ GVMAP	4	-
▪ NHS	16	17
▪ Other	4	-
▪ Relative/other client	5	23

▪ Self	48	34
▪ Service charity/ welfare organisation	23	26
Mean age:	50 years	46 years

- A high level of client satisfaction was reported across all three *Combat Stress* treatment centres in respect of the:
 - preparation for admission by the Regional Welfare Officer
 - admission process
 - practical care and therapeutic aspects of their admission
 - treatment centre staff
 - recreational activities offered during the residential stay
 - discharge procedure
 - aftercare provision

- The lowest satisfaction scores were reported in respect of symptom improvement; a finding which was attributed to:
 - how the questions were framed (i.e., participants were asked to consider changes in their symptoms rather than how effective they perceived their admission to have been in terms of symptom improvement), and
 - an incongruity between client expectations of complete symptom resolution versus the clinical reality that substantial improvements in chronic conditions is unlikely to occur over a two-week admission period.

- Whilst this study had a number of methodological limitations (as declared by the researchers), it represented a significant step forward for *Combat Stress* with regards to:
 - obtaining empirical evidence to demonstrate treatment outcome;
 - implementing a number of operational changes across the three treatment centres (e.g., standardisation of procedures, introduction of new practices, and the development of appropriate operational guidelines);
 - on-going progress towards a treatment-focused model, and
 - enhancing opportunities for future research.

- For the purpose of future research, *Combat Stress* has made a concerted effort to improve the quality of the clinical data captured as part of its routine clinical audits (information about which is provided by Fletcher [2007] and Busuttill [2008]). This includes the pilot of a new assessment procedure for first time admissions within two of the *Combat Stress* treatment centres;

an endeavour that derived from the recommendations made by the HACAS Report (August 2005) and the subsequent Whole Person Plan (October 2006). In particular, this enhanced clinical database has the potential to benefit research on younger Veterans given reports of a substantial increase in referrals due to Op TELIC and Op HERRICK.

Atkinson (2009)

- In 2007, Gardening Leave was established as a horticultural therapy pilot project and hosted by *Combat Stress* at Hollybush House¹⁶⁶. It was designed as an adjunct to the standard therapies provided by *Combat Stress* in order to enhance the therapeutic experience of ex-Service personnel suffering from PTSD and other combat-related mental health problems. Residents of Hollybush House and non-residents (i.e., those within commutable distance) were able to attend Gardening Leave for either a whole or half day subject to their other therapeutic commitments and in accordance with their treatment plans.
- The principal aim of this pilot study was to evaluate the impact of Gardening Leave from the dual perspective of both service users and clinical staff and to ascertain why and in what ways. By means of a qualitative approach, a total of 44 face-to-face interviews were conducted with ex-Service personnel over a six month period from August 2008 to February 2009. The number of clinical staff interviewed is not evident from the report and no profile is provided for either group of participants.
- The report presents a brief summary of the preliminary findings which suggested that positive therapeutic benefits were derived by those who participated in Gardening Leave (particularly those with PTSD) for a variety of factors including: flexibility of and choice in participation; secure environment; ease of access; working outdoors; having a structure to the day, and sharing an exclusive experience with others who were suffering from the same illness. The positive benefits cited include: having a sense of purpose; regaining confidence; engaging in physical activity; developing transferable skills, and feeling understood. However, claims that "*Gardening Leave is having positive therapeutic benefits....helping individuals to cope better...*" would need to be substantiated by a more rigorous evaluative method and design than is evident from the report.

5.3.3 Service Provision Evaluation

¹⁶⁶ The Scottish treatment centre based in Ayrshire.

Bonnar Associates (2012)

- Funded by *Poppyscotland*, the evaluation of the Veterans' advice service pilot was commissioned Glasgow CABx and undertaken by an independent research consultancy (Bonnar Associates). The first part of the evaluation was a baseline assessment conducted during June 2007 by CAD and six of the consortium members to identify the number of Veterans who were already seeking advice from the CABx service by asking every client to reply to the following three questions.
 - (i) *"Have you ever served in the British Armed Forces?"*
 - (ii) *"Has your partner ever served in the British Armed Forces?"*
 - (iii) *"Has a member of your immediate family ever served in the British Armed Forces?"*¹⁶⁷

- The baseline evaluation revealed that a very small proportion of clients who had contacted the CABx service during the June 2007 were Veterans. Of the 2,542 calls received by CAD, 18 (0.7%) were from Veterans, 16 (0.6%) were from partners of Veterans, and 123 (4.8%) were calls from close relatives.

- An active publicity campaign prior to and post-launch of the service resulted in 151 clients accessing the service over the 12 month evaluation period from August 2007 to July 2008. An analysis of the profile of these clients showed that the majority were:
 - Veterans (71%) of whom 84 % were from the Army;
 - from Glasgow (95%) (The majority (78%) of those with Glasgow postcodes resided within areas identified as the top 15% most deprived areas of Glasgow.);
 - living in rented accommodation (Local Authority [21%]; RSL [29%]; private [6%]);
 - single adults (58%);
 - retired (70%), and
 - physically disabled or had experienced either a chronic illness or mental health issues (66%) (Of the 122 for whom details were available, five had a disability related to their Service.)

- Based on data obtained from 58 clients, 93% had an income of less than £15,000 and 38% reported an income of less than £6,000. Most client needs were for advice on financial matters relating to benefits (29%) and consumer debt (25%). CABx

¹⁶⁷ Following the baseline study and prior to commencing the pilot, this question was changed to: *"Are you a dependant of anyone who has ever served in the British Armed Forces?"*

service advisers were instrumental in assisting 37 clients with negotiating in excess of £550,000 worth of debt (i.e., £14,944 per client in debt which was more than of the average of £14,065 for the preceding year for all Glasgow CABx clients). In estimating the Client Financial Gains (CFG) using what data were available at the end of the pilot, the average of £898 for the Veteran pilot clients was considerably higher than the average of £336 for all Glasgow CABx clients in the previous year. In this regard, the Veteran pilot service was deemed to be “very successful”.

- In terms of service provision, 151 clients made a total of 455 contacts with the CABx service; 17 home visits were undertaken, and 1,024 separate issues were dealt with. A total of 14 clients were referred to SSAFA Forces Help and two were referred to Poppyscotland for the purpose of obtaining financial assistance. The total cost of providing the Glasgow pilot was calculated as £100,611 for the 112 closed cases (i.e., £898 per client). With regards to service uptake, however, the numbers of Veterans accessing the service remained lower than anticipated (although there was no detriment in terms of value for money with respect to reduced bureau participation since payment was based on uptake).

- The research consultants rightly highlight the fact that the interpretation of the findings is confounded by a number of factors which derive in part from amendments to the wording of the third question from “Veterans’ immediate family” to “Veterans’ dependents”. As such the validity of making direct comparisons between the baseline evaluation and the pilot evaluation was compromised because the eligibility criteria were not the same for both. Moreover, the lack of information for some aspects limited the extent to which it was valid to draw conclusions about the representativeness of the sample. No analysis was undertaken to establish to what extent the Veteran clients differed in respect of their needs to those of the civilian clients who contacted the CABx services during the pilot period. It is also not clear as to what was the proportion of the Veteran clients relative to the civilian users. However, in recognition that its purpose was to pilot a service to inform potential options, the outcome of the Glasgow CABx pilot has highlighted some important challenges facing the delivery of such a service on a national basis. These include the:
 - justification for providing a dedicated service for Veterans which is not embedded within a mainstream service given the relatively small number of Veteran client users;
 - potential ambivalence of other ex-Service organisations which may result in an unwillingness to co-operate;

- importance of increasing awareness of a service by means of an active publicity campaign whilst taking into consideration the cost implications of mass marketing;
- need to obtain high quality data to facilitate the analysis and ensure robust evidence;
- consideration of how best to measure the effectiveness of a service bearing in mind the resource implications associated with obtaining hard evidence (e.g., by means of Social Return on Investment), and
- need to ensure full co-operation from all agencies involved in providing the service.

5.3.4 Homelessness

Johnsen et al (2008)

- Commissioned by The Ex-Services Action Group (ESAG) on homelessness¹⁶⁸, an independent study was conducted by the Centre for Housing Policy (CHP) at the University of York. Its two main objectives were to assess the:
 - scale and nature of ex-Service homelessness in London, and
 - impact of homelessness projects¹⁶⁹ instigated by ESAG in an endeavour to reduce ex-Service homelessness in London.
- In fulfilment of these objectives, the data were obtained by means of:
 - *a review of existing studies* – to establish the context and identify gaps in the literature.
 - *interviews* – to obtain the views of:
 - 26 managers and front-line staff in ex-Service and specific and “mainstream” services who had experienced working with homeless ex-Service personnel, and
 - 3 representatives from central Government departments and national homelessness bodies.
 - *qualitative interviews* – to obtain:
 - an in-depth understanding of the experiences of 59 ex-Service personnel (32 of whom were homeless at the time of interview and 26 who had recently experienced homeless prior to being rehoused), and
 - a longitudinal perspective by following up the 32 currently homeless cohort over a one year period to

¹⁶⁸ ESAG was established in London in 1997 as a result of concerns about the welfare of homeless ex-Service personnel and the scale of ex-Service homelessness in London.

¹⁶⁹ ESAG has either developed or supported a number of homelessness initiatives including the Ex-Service Resettlement Project, Home Base, The Sir Oswald Stoll Foundation, SSAFA Forces Help Homeless Division, Project Compass and Veterans Aid.

evaluate the support of service use and experience pertaining thereto.

- The key findings to derive from the London-based study were as follows.
 - An estimated 6% of London's current non-statutory ("single") homeless population had served in the UK Armed Forces. In comparison with figures reported in the mid 1990s, this represented a substantial decrease of approximately 25%.
 - Whilst this decrease would suggest that the current service network has resulted in positive outcomes, the estimated figures of 1,100 single homeless ex-Service and 2,500 ex-Service personnel in statutorily homeless families would suggest that homelessness among this population should remain a cause for concern.
 - In comparison with the socio-demographic profile of the wider non-statutory homeless population, homeless ex-Service personnel were predominantly male from a white ethnic background and of an older age. In terms of other characteristics and experiences, however, there were more similarities than differences between the wider non-statutory homeless population and homeless ex-Service personnel. It would therefore appear to be the extent of the problems experienced which is the main differentiating factor. However, in comparing the findings from Dandeker *et al* (2005) with that of Johnsen *et al* (2008) there is a lack of consensus about the key differences between homeless civilians and homeless ex-Service personnel.
 - In the CHP study, only a small minority reported vulnerabilities and support needs that were unique to those who have served in the military. Thus, despite the myth fuelled by the media, few were found to have combat-related PTSD although some of the interviewees attributed their mental health problems to Service-related experiences mainly relating to active Service.
 - The majority attributed their mental health problems to either trauma encountered pre-Service (particularly in childhood) and/ or post-Service such as bereavement.
 - On the basis of the qualitative findings derived from the CHP study, Johnsen *et al* (2008) identified four main "life history trajectories", which they regarded as being "broadly indicative" of the pathways into homelessness experienced by ex-Service personnel. These four pathways have been graphically portrayed in *Figure 1*. Both of the groups who encountered post-adjustment problems reported having had a successful military career

in the UK Armed Forces; a finding that tallies with that of Dandeker *et al* (2005).

Pre-Service vulnerabilities In-Service difficulties Post-adjustment problems

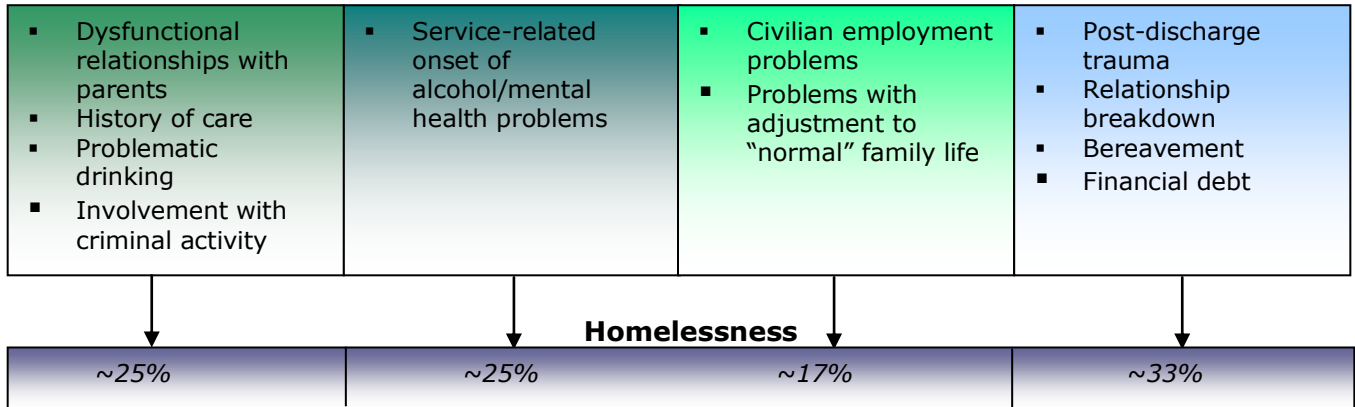


Figure 1: Life History Trajectories of Interviewees

- Although a number of the catalysing factors for homelessness encountered by the ex-Service personnel who participated in the CHP study were not found to be dissimilar to those reported by other homeless populations, the findings did suggest that a combination of military-related factors make ex-Service personnel more likely to experience sustained or repeat episodes of homelessness. These factors have been identified as follows.
 - The rigours of military life equipped ex-Service personnel with coping mechanisms to combat the hardships of homelessness.
 - The military characteristics of pride and stoicism elevate the perceived sense of "shame" about being homeless resulted in a reluctance to seek or accept help.

- Despite the recent expansion of priority need categories in homelessness legislation (as summarised in *Section 3*), in the main ex-Service personnel were not accepted as statutorily homeless by Local Authorities. As is the case with other non-statutory homeless men, they were invariably regarded as "low priority" in social housing allocations.

- Seven key recommendations emerged from this study, six of which pertained to identifying ways to enhance the provision of services as a means of preventing homelessness among ex-Service personnel. These were:
 - identifying ways to break down the "shame" barrier;
 - raising awareness of available services;
 - streamlining service access;
 - increasing the availability of settled accommodation;

- formalising tenancy sustainment services (particularly in respect of those re-housed into independent social housing), and
 - combating social isolation (a measure which could help those with substance misuse problems).
- From a research perspective, Johnsen *et al* (2008) endorsed the need for more commissioned research targeted at homelessness among ex-Service personnel elsewhere in the UK to identify the: (i) extent of the problem, and (ii) adequacy of service provision. They also emphasised the need to ensure that any subsequent action undertaken to address identified gaps in service provision should be preceded by engagement with all the agencies involved to justify the: (i) development of services dedicated specifically for ex-Service personnel, and/ or (ii) expansion of existing mainstream provision.

5.3.5 Employment

Harley et al (2009)

- In June 2008, *Poppyscotland* commissioned *Blake Stevenson* (in association with ESOTEC) to undertake a research study into the employment needs of disabled and vulnerable Veterans in Scotland. The purpose of the survey of Veterans in Scotland was to: (i) obtain their views on and experiences of barriers that ex-Service personnel may encounter when attempting to access employment, and (ii) identify how best these barriers may be overcome. The mechanism for distribution of approximately 900 paper copies of the questionnaire was by means of 12 organisations. In addition, electronic access to the survey was available through the unofficial army, navy, and airforces websites and the websites for *Poppyscotland* and *Veterans Scotland*. An advertisement was also placed in the *Royal British Legion Scotland* newsletter. The limitation of using such an approach as a sampling frame to obtain a representative sample is that it is not possible to gauge the total size of the target population. By the same token, although 389 completed surveys were received (of which 207 were Scottish Veterans), it is also not possible to establish what proportion that figure represents as evidenced by the fact that no response rate was reported. Moreover, as this questionnaire was made available on the worldwide web, there is no guarantee that all those who responded were genuine Veterans. However, the inclusion of six focus groups comprising Veterans (although it is not specified how many there were) would enable a validity check in order to ascertain to some extent whether or not that which was reported

in the surveys differed considerably in terms of the issues identified.

- Notwithstanding these methodological limitations, the survey findings highlights some of the key issues affecting Veterans in Scotland with regards to access to employment and the labour market barriers that mitigate the potential for securing civilian employment. Key findings were as follows.
 - Of the 383 individuals who completed the Veteran Survey, 207 (54%) lived in Scotland, with the majority residing in the City of Edinburgh (15.5%). Fife (9.7%), West Lothian (6.8%), Perth & Kinross (6.3%) and Glasgow City (6.3%) were the other areas which had the highest number of respondents across the 32 areas identified.
 - In terms of the whole sample, the majority (75%) had served in the British Army and 30% had served an average of more than 20 years. Only 4% had served for less than three years. Whilst in Service 41% had sustained an injury or illness that subsequently restricted their job opportunities.
 - Over half the sample had left the UK Armed Forces more than 10 years previously. Of the majority (70%) who were employed at the time of completing the survey, 90% worked fulltime and were in a permanent job (93%). On leaving the Service, it took less than 3 months for 58% to find a job. However, a range of problems were experienced by a number since leaving the Service which respondents perceived as making it more difficult to find or keep a job, as shown in *Table 14*.

Table 14. Issues Affecting Employment

Type of Problem	Percentage of respondents who experienced a problem(s)	Took one year or longer to find a job	Suffered an injury or illness
	%	%	%
Family or relationship problems	42	50	63
Lack of relevant training or skills	40	48	58
Financial problems	40	62	65
Social isolation	35	55	60
Mental health difficulties	34	53	58
Problems with anger management	34	52	54
Problems with drug or alcohol misuse	21	25	38
Homelessness	14	25	27
A criminal record	11	18	19

- The report also provides a comprehensive overview of the policy context for improving access to employment for ex-Service personnel and a thorough evaluation of the current status of service provision to ascertain the extent to which the employment needs of disabled and vulnerable Veterans are being met in Scotland.
- Of particular value given the purpose of our scoping review, was the finding that there is a paucity of comprehensive data available to enable the accurate identification of unemployment levels and “economic inactivity” amongst Veterans in Scotland (as well as in the UK).

- In accordance with previous studies, the findings reported by Hurley and colleagues showed that the majority of Veterans made a successful transition from military to civilian life in terms of securing employment. However, for those individuals adversely affected by different types of problems, gaining and sustaining employment in “civvy” street presented a major challenge.
- The outcome of the review of current service provision confirmed that Scotland has a host of employment services available to Service leavers and Veterans including the CTP resettlement packages (described in *Section 3*). However, a number of gaps were identified particularly in terms of meeting the needs of disabled and vulnerable Veterans.

5.3.6 Criminal Justice System

NAPO (2008, 2009)

- In 2008, NAPO published a briefing which included findings from a survey conducted by Veterans in Prison on 10 UK prisons. Based on self report data, the figures were extrapolated to estimate that 9.1% of the UK prison population had served in the military; a figure that equated to 8,500 individuals.
- In 2009, NAPO undertook a further survey of probationer staff. By means of the same extrapolation techniques, it was reported that the Probation Service in England and Wales was responsible for the supervision of an estimated 12,000 Veterans who were either on community sentences or parole (i.e., 6% of all those under supervision).
- The estimates from both surveys, however, need to be interpreted with caution on the grounds that they were based on small samples, failed to confirm Veteran status, and did not account for geographical variations.

5.4 ACADEMIC-BASED RESEARCH REPORTED IN THE PEER REVIEW LITERATURE

5.4.1 Methods and Caveats

- In view of time and budgetary constraints, it was not possible to conduct a systematic literature review. The main purpose of the search strategy therefore was to identify key papers and systematic reviews informed by themes identified during the course of the six week consultation process.

- To source this literature involved accessing the peer-review medical and social science literature electronic databases principally using *PubMed*, *Medline*, *Psychlit*, and *EMBASE*.
- Although the main focus of the search was on the UK literature published predominantly over the past decade, key references were also sought from the Australian, Canadian, American and European literature.
- In accordance with the holistic approach described in *Section 1*, the themes incorporated within this search cover a broad spectrum.

5.4.2 Pre-Service Factors

5.4.2.1 Childhood adversity

- Early studies (e.g., Engel *et al*, 1993) suggested that a history of childhood adversity may increase the risk of developing combat-related PTSD. Bremner *et al* (1993) found that Vietnam Veterans with combat-related PTSD reported higher rates of childhood physical abuse than Veterans without PTSD (26% versus 7% respectively) after controlling for the extent of combat exposure.
- Within a military context, Iversen *et al* (2007) sought to investigate the association between childhood adversity (based on self-reported childhood vulnerability) and subsequent health outcomes (including general psychopathology, alcohol misuse and previous self harm). The sample derived from the first phase of the KCMHR cohort study and comprised Service personnel who were in service at the time of the Iraq war in March 2003. The analysis was restricted to males only because of the relatively small number of women in the military and, therefore, in the sample as a whole. In addition, Reserve personnel were excluded from the analysis due to the KCMHR evidence of an interactive effect between their unique military status and operational deployment (Hotopf *et al*, 2006; Browne *et al*, 2007). Of particular note was the evidence that a higher number of vulnerability factors reported in childhood (i.e., "pre-enlistment vulnerability") were positively associated with individuals who were single, of lower rank, with lower educational status, and serving in the Army, and a range of adverse health outcomes. The two key pathological predictors were factors relating to "family relationships" and "externalising behaviours" thereby reflecting the home environment and behavioural disturbance respectively (Iversen *et al*, 2007). However, the extent to which the prevalence of these factors as predictors of pathology in a

military population compares to that of a similar age-matched general population cannot be addressed by this study. To do so requires the linking of the KCMHR cohort with a concurrent general population cohort that has been assessed on comparative vulnerability and health outcomes.

- The association between childhood adversity and PTSD reported in the Iversen *et al* (2007, 2008) studies however does concur with the findings of the robust meta-analyses undertaken by Brewin *et al* (2000) and Ozer *et al* (2003). Similar findings have also been reported in the US military population (e.g., Cabrera *et al*, 2007). Various explanations for this association have been proffered including genetic (e.g., Koenen *et al*, 2003) and psychosocial (e.g., Koenen *et al*, 2007) factors. King *et al* (2006) suggested that childhood adversity may increase the likelihood of individuals developing PTSD by means of a “double hit”. In other words, they are not only predisposed to getting PTSD following exposure to a traumatic event but they are also more likely to encounter trauma in a combat-related situation. However, findings of a study conducted by Stein *et al* (2005), which explored the effects of childhood, lifetime trauma, combat exposure and coping on PTSD symptoms among a sample of Gulf War Veterans, found that for individuals with a low combat exposure, more severe childhood trauma was related to greater PTSD severity. Conversely, a greater severity of childhood trauma was associated with lower PTSD severity in individuals with high combat exposure. The authors suggested that individuals who experience early childhood adversity may develop coping skills that help them deal with subsequent traumatic experiences such as combat.
- Owens *et al* (2009) investigated the effects of combat exposure, childhood trauma and depression on the severity of PTSD in 299 male Veterans from the Korean War, World War II, Vietnam, and the first Gulf War who were screened on admission to a PTSD unit. Results of a multiple regression analysis showed that combat exposure and depression were significant predictors of PTSD severity. The relationship of early childhood adversity and PTSD severity however was found to be more complex, but supported the earlier findings of Stein *et al* (2005). The extent to which these findings would generalise to women and to non treatment-seeking populations has yet to be established.
- Whilst the relationship between PTSD and other factors are complex and interactive, the evidence from the meta-analyses undertaken by Brewin *et al*, (2000) and Ozer *et al* (2003) suggests however that pre-trauma factors have a weaker

association with PTSD than do peri-traumatic or post-traumatic factors. Post-traumatic factors are the most potent of all three categories. This has important implications (principally because we do most about what happens after a trauma).

5.4.2.2 Socio-economic adversity

- In civilian studies following traumatic experiences, socioeconomically disadvantaged populations have been found to be at greater risk for psychiatric and somatic disorders (Neeleman *et al*, 2001). Those in the lowest social and economic strata have two to three times the risk of psychiatric disorders, in particular with regards to depression and anxiety disorders. Similar relationships are apparent in military populations. Low income and lack of education are associated with chronic stress-related disorders (e.g., anxiety disorders, major depression, and substance- use disorders). In some studies, low military rank was also associated with a greater risk of a stress-related disorder (e.g., Fiedler *et al*, 2006); a finding which may in part reflect the fact that higher ranking Service personnel are not engaged directly in combat. Ikin *et al* (2004) however found that, although Australian Gulf War deployed Veterans were at higher risk for developing any anxiety disorder post-combat than were non deployed Veterans, the risk did not vary significantly by rank, whether officer or enlisted.

5.4.2.3 Psychiatric history

- Black *et al* (2004) in a study of Gulf War Veterans found that the greatest risk of developing an anxiety disorder post-combat was the presence of a pre-existing anxiety disorder (of any type) and a pre-existing depressive disorder. A previous history of any psychiatric disorder increased the overall risk of developing an anxiety disorder post-combat was increased by a factor of four.
- A study by Ikin *et al* (2004) found that similar percentages of Australian Gulf War deployed Veterans (31%) and a comparison group of non-deployed (Era) Veterans (34%) reported having had a psychiatric disorder prior to deployment, the most frequent disorders of which were substance use and anxiety.
- Prior to their deployment in Iraq in 2003, Hoge *et al* (2004) screened 2,530 US Infantry soldiers for mental health disorders. A total of 14.3% of the sample reported having suffered from a moderate or severe mental health problem before deployment. In terms of specific problems, these were: depression (5.3%); anxiety (6.4%); alcohol misuse (17.3%), and PTSD (5.0 %).

- These findings highlight that a substantial proportion of military personnel may be deployed on operations at increased risk of a mental health disorder on the basis of their psychiatric history alone. However, the extent to which these figures would be sustained across all three Services is questionable.

5.4.2.4 Personality

- Studies of Vietnam and Gulf War Veterans suggest that particular personality or psychological characteristics can affect an individual's response to deployment-related stress. For example hardiness has been found to be protective against the adverse effects of combat stress and stressful life events as well as being a significant predictor of health outcomes (Bartone, 1999). Dolan & Adler (2006) surveyed US Army soldiers pre- and post- a six month peacekeeping mission in Kosovo. "Military hardiness" (i.e., the degree to which individuals felt committed to and had a sense of control over their work experiences) was found to be correlated with psychological but not physical health during and after deployment. Among those soldiers who experienced high levels of deployment stressors, those with greater levels of hardiness suffered less from depression post-deployment.

5.4.2.5 Coping style

- In addition to positive coping style (e.g., Wolfe *et al*, 1993), a perception that some benefit derives from military experience is associated with a reduced potential for adverse health effects after combat exposure. Findings reported by Jennings *et al* (2006) on Veterans in the "Normative Aging Study" (mean age of 74 years) who had a favourable appraisal of their combat experience, perceived benefits of military experience, and had positive coping strategies, suggested that these may mitigate against long term adverse health consequences.

5.4.3 In-Service Factors

5.4.3.1 Changing nature of combat

- There is no single "experience" of war (Wessely, 2005). Combat zones vary, as do weaponry, strategies and tactics, and the motives for the aggressive encounter. These and related factors need to be identified and considered to advance knowledge and understanding of the differences and similarities of reactions displayed by combat troops (Alexander & Klein, 2009). Almost every military era generates some technological innovation which

transforms the conduct and effectiveness of combatants. Contemporary weapons, however, are not only more devastating in their destructive power but they are much more mobile and flexible in their use. Another important issue is that modern warfare has moved from "linear"¹⁷⁰ to "swirling"¹⁷¹ tactics (Gabriel, 1987, p.19).

- In this new combative environment troops may find themselves deep in the heart of enemy territory and isolated from their main supporting force. Strike aircraft (fixed wing and helicopters) through their weaponry, speed and mobility have re-designated what are the "safe" rear zones. Modern communications and optical technology have ensured that military combat can now be engaged 24 hours a day; in poor weather and night conditions, and in the most inhospitable terrains. As a consequence, there is little respite for combat troops, particularly from anticipatory anxiety. The range and accuracy of contemporary weapons have transformed the "killing zone". In World War I this was measured somewhere between five and 10 miles; now, it has to be measured in hundreds of miles. A number of these technological and related changes in combat present themselves most recently in the theatres of Iraq and Afghanistan.
- Furthermore, with advances in body armour and battlefield medicine, catastrophic combat injuries that would not have been survived in previous conflict can be effectively treated, as evidenced by the outcome of the recent Healthcare Commission Review of the Defence Medical Services (2008) and the National Audit Office (NAO) report on treating injury and illness arising on military operations (NAO, 2010). Moreover, both of these reviews confirm that there has been a steady increase in Service-related illness and injury rates. For example, the NAO found that, in comparison with the data for 2001 (when rates of the level of injury and illness sustained on Operation HERRICK were at zero), in 2009 a total of 131 Service personnel had suffered serious injuries on deployment. As the figures for Operation HERRICK have increased over time, the figures pertaining to Operation TELIC have gradually decreased from the highest rate of 46 in 2003 to the lowest rate of 1 in 2009. Both sets of figures however are likely to be an underestimate given that the data for 2009 based on recorded medical attendances on military operations were only available up to 31 October 2009. Relative to the

¹⁷⁰ Linear tactics were represented by clearly defined front and rear lines, with serried ranks of advancing and (less serried) ranks of the retreating forces.

¹⁷¹ "Swirling" tactics refer to a very different combat environment, one characterised by fluidity, changing boundaries, greater personal vulnerability (particularly for the infantry) and more insecurity, particularly with regard to the risk of "friendly fire" or "blue on blue" tragedies.

number of serious injuries sustained on Operation HERRICK and Operation TELIC, a considerably higher rate was reported for the total level of minor injury and illness. In 2009, the combined rate for both operations suggested that the health of 31,687 Service personnel had been compromised to some extent, although this was less than that reported in 2007 ($n=38,419$) and 2008 ($n=47,035$).

- As has been the case with the increase in the level of serious physical injury, the numbers of Service personnel with mental health conditions have also increased since 2006 from 45 to 380 in 2009 for those deployed on Operation HERRICK. However, although the 2009 level ($n=199$) is higher than that of the 2006 level ($n=74$), there has been a decrease when compared with the previous two years of 2007 and 2008 ($n=298$ and $n=239$ respectively).
- Women's roles in the contemporary conflicts of Iraq and Afghanistan have expanded well beyond their roles in previous conflicts, both in terms of the number of women involved and the nature of their involvement. In 2010, the total percentage of women in the UK Armed Forces was 9.1% ($N=17,900$). Whilst it remains the case that female military personnel are excluded from any specialisation where "...*the primary duty is to close with or kill the enemy*", this does not protect a number of them from exposure to combat situations given a war with no front line, in which they serve in a variety of support positions that involve leaving military bases with a substantial risk of coming under direct fire (Hoge *et al*, 2007).
- Analysis of data from a random sample of UK Armed Forces deployed to Iraq revealed that 16% of women had come under small arms fire, 40% had come under mortar/artillery fire, and 37% had witnessed serious injury to personnel (Rona *et al*, 2007). However, the extent to which robust conclusions can be drawn regarding the differential effects of combat exposure on male and female military personnel is severely restricted. Previous research on the effects of combat exposure on mental health has either focussed exclusively men or the sample has contained only a small subset of women as confirmed by a recent review conducted by Street *et al* (2009) on stressors faced by female service personnel deployed to Iraq and Afghanistan. The authors concluded that additional research is required on gender differences in combat exposure and its impact on mental health post-deployment. Such research should include the additive effects of other trauma-related experiences on combat exposure (e.g., sexual assault) and other interpersonal stressors (e.g., lack

of perceived support from comrades) as well as the role of pre-military and post-military interpersonal trauma. In terms of differential effects of training and military service on physical health, analysis of medical discharge data by Geary *et al* (2002) support previous reports that female personnel in the UK Armed Forces are significantly more likely than their male counterparts to be medically discharged from the UK Armed Forces due to physical injuries and musculoskeletal problems.

5.4.3.2 Changing nature of operational deployment

- The high operational tempo of Iraq and Afghanistan has led to a significant acceleration in typical deployment rotations. The length of deployment, once relatively predictable, has now become uncertain in the face of frequent deployment extensions, as well as the heightened likelihood of multiple deployments in a relatively short period of time. This change in the nature of operational deployment has raised concerns about the possible adverse effects on the mental health of military personnel. To address these concerns, Fear *et al* (2010) investigated the psychological impact of deployment to Iraq and Afghanistan of UK Armed Forces personnel from 2003 to 2009, the effect of multiple deployments, and time since return from deployment. A total of 9,990 participants from three randomly selected samples completed the study questionnaire, of whom 83% were Regulars and the remainder were Reservists. The number of deployments was not found to be significantly associated with any of the three outcomes under study (i.e., probable PTSD, common mental disorders, and alcohol misuse). Furthermore, the overall prevalence of mental disorders had not significantly changed between 2003 and 2009. A modest effect of deployment to Iraq and Afghanistan was observed for Regulars in respect of increased alcohol consumption. In addition, those Regulars who were deployed in combat roles also reported a small increase in probable PTSD with time since return from deployment. Despite variation in the intensity of combat over different deployment periods in both Iraq and Afghanistan (and consequently the number of casualties sustained), no fluctuations in the reporting of probable PTSD was observed. However, the injurious effect of more recent deployment in Afghanistan has yet to be evaluated thereby highlighting the importance of continued surveillance and monitoring of mental health outcomes for deployed UK military personnel. This is particularly the case for deployed reservists who, despite various endeavours to improve their mental health pre- and post-deployment, continue to report an increase in PTSD.

- Few studies, however, have evaluated the effects of a “mismatch” between actual and expected duration of deployment on mental health and well-being. However, a recent systematic review of nine studies found that a deployment period of more than six months coupled with an increased likelihood of having these periods unexpectedly extended, can adversely affect the health and well-being of both deployed personnel and their families (Buckman *et al*, 2010). The adverse effect of long deployments, however, is not just about the risks associated with being in theatre but also the stressors associated with concern for family members and difficulties in maintaining family relationships. Being separated from family was perceived by UK military personnel as one of the least rewarding aspects of deployment in Iraq (Sundin *et al*, 2010).
- Evidence of higher levels of psychological difficulties in combat and, most strikingly, on demobilisation has been found among UK reservists who have served in Iraq (Browne *et al*, 2007). Compared with Regular service personnel, reservists reported more problems at home during deployment, more negative homecoming experiences and poorer marital satisfaction. Of note is that adjustment for military factors accounted for the excess of all adverse health outcomes except for PTSD. The PTSD health effect only disappeared when adjustment was made for problems at home. One explanation for the increase in adverse health outcomes is that, for reservists at least, adverse domestic experiences may be exacerbating and prolonging PTSD symptoms (Browne *et al*, 2007).
- The effect of parental deployment on families and children is of increasing concern as tours lengthen and multiple deployments to combat zones increase. More than a million children and families have experienced the stress of deployment of a family member to either Iraq and/ or Afghanistan (McFarlane, 2009). The effect of combat-related parental separation on family stress requires an understanding of the unique culture of military life and military families. Although many occupations may require extended periods of parental separation, the risk of parental injury or death intensify the stress experienced by military family members, which is often exacerbated by unsuitable media coverage (Pinder *et al*, 2009).
- In addition, it is important to recognise that deployment comprises a number of different phases (known as the “*cycle of deployment*”) as shown in *Table 15*, each of which is characterised by a different time frame and specific emotional

challenges including the need for emotional detachment, changes in family roles and routines, emotional destabilization and reintegration of the returning parent (Lincoln *et al*, 2008).

- Reviews of the impact of military deployment on children and family adjustment have predominantly been addressed from a descriptive and clinical perspective. In developing the emergent themes from these reviews, McFarlane (2009) has identified a number of limitations in the current literature including the fact that the research to date has been US-based and has focussed predominantly on traditional two-parent families where the male parent is deployed. Research that takes into consideration military personnel with different family configurations (e.g., dual-deployed parents and single parents) and from other countries is urgently required. Moreover, an increase in the deployment of Reservists in the UK Armed Forces and concerns about poorer health outcomes following deployment highlights the need for a greater understanding of the impact of the additional challenges facing families of Reservists compared to the family members of Regular personnel.

Table 15. "Cycle of Deployment"

Phases	Time
▪ Pre-deployment (notification to departure)	Varies from several weeks to over a year
▪ Deployment (departure to return)	1 st month
▪ Sustainment	2-8 months
▪ Re-deployment	last month
▪ Post-deployment	3-6 months

Source: Pincus *et al* (2005)

5.4.3.3 Social support

- Most studies about social support focus on homecoming support, whether given by family, friends, or the community. Few studies have investigated social support during the period of deployment to a war zone. One notable exception was an early study conducted by Stretch (1985) of Vietnam-theatre and Vietnam-era Veterans. Social support pre- and post-deployment was found to be a key factor in the development of PTSD symptoms with social support accounting for 12% of the explained variance. The lack of

studies of the role of social support during deployment is an important gap to be addressed given that military personnel report "being away from the family" as a leading deployment stressor (Rona *et al*, 2007). It is difficult however to determine whether low social support leads to mental health sequelae or whether psychiatric problems reduce social support, or whether the relationship is indirect with other variables, such as the association of personality with both social support and other psychopathology.

5.4.3.4 Unit cohesion

- The role of unit cohesion has attracted increasing attention in studies of mental health outcomes in military personnel. A positive association between unit cohesion and performance have been reported by several studies and meta-analyses along with support for a relationship between enhanced wellbeing and readiness with higher levels of unit cohesion. The identification of risk factors for PTSD among UK Armed Forces personnel suggested that unit cohesion may also protect against the development of PTSD and combat stress reactions (Iversen *et al*, 2008). Of concern, however, is that excessive alcohol use is also associated with moderate to high levels of comradeship on operational deployment (Browne *et al*, 2008).
- A more recent study conducted by Sundin *et al* (2010) found that the level of unit cohesion did not explain differences found in mental health outcomes and occupational risk among three groups of military personnel (commando, airborne and other army infantry). Although the Royal Marine Commandos and the paratroopers were more likely to report multiple physical symptoms or fatigue compared with other army infantry, the Royal Marine Commandos had significantly lower levels of general mental health problems and lower scores on the Post-traumatic Checklist compared with the other army infantry. As this effect was found to be independent of combat exposure and socio-demographic differences and not due to the theatre of deployment, the researchers proffered differences in level of preparedness as one possible explanation. The high level of preparedness in the Royal Marine Commandos and paratroopers may protect against the adverse impact of combat-related experiences in theatre. However, because the study was limited by data collected as part of UK military cohort study of personnel serving at the time of the 2003 Iraq war, it was not possible to evaluate differences in selection and training among the three groups. Interpretation of the findings is also limited by the cross-sectional nature of the study.

5.4.3.5 Mortality

Suicide-related mortality

- Macfarlane *et al* (2000) published a post-war mortality study of all 53,462 UK Gulf War Veterans who served in the Gulf at sometime between September 1990 and June 1991. Comparisons were made with an equal number of Veterans who were serving in the UK Armed Forces on 1 January 1991 but who were not deployed to the Gulf. Selection was random but stratified to match the Gulf cohort on age (within a five year span), gender, service, fitness for active service, and rank. Data from the NHS Central Register (Office for National Statistics; ONS) provided information on the date and cause of death recorded on the death certificate or the Defence Analytical Services Agency. For each cause of death a mortality rate was calculated based on the number of deaths and the person-years risk to compare the mortality ratio (MRR) with 95% confidence intervals (CI) between Gulf War Veterans and non-Gulf War Veterans. As was the case with US Gulf War Veterans, mortality from external causes was higher in the UK Gulf War Veteran cohort while mortality from disease-related causes was lower. The higher mortality rate due to external causes was predominantly due to a higher number of road traffic incidents, air/space incidents, deaths associated with submersion, suffocation or foreign bodies. No excess of deaths in the Gulf War Veterans cohort were recorded either as suicide or injury from unknown cause.
- Significant controversy exists as to whether serving personnel are at increased risk for suicide and suicidal behaviors compared with civilians in the general population. Thoresen *et al* (2003) investigated the suicide mortality in Norwegian former peacekeepers who had been deployed at some time between 1978 and 1995. General population data were used for comparison. Standardized Mortality Ratios (SMRs) were calculated for different suicide methods and certain peacekeeping-related variables. Marital status was available for each year and controlled for by using separate suicide rates for unmarried, married and divorced. A moderately, but significantly, increased risk for suicide was found among the former peacekeepers. After adjusting for marital status, that risk was reduced to insignificance. There was however a significant increase in suicide by means of firearms and carbon monoxide poisoning. The increased risk of suicide in former peacekeepers was related to the peacekeepers' lower marriage rate compared to the general population. This finding may indicate that the influence of certain vulnerability factors prior to being deployed

resulting in a reduced ability to enter into and remain in stable marital relationship. However, it cannot be excluded that stress reactions following peacekeeping may have contributed to possible strains on interpersonal relationships thereby highlighting the need for psychosocial support for ex-Service personnel and their families.

- Belik *et al* (2010) suggest that the differences reported in suicide rates in soldiers and their comparability to civilian population rates vary according to the subpopulation being investigated. These authors claim that most studies suggesting higher suicide rates in military personnel compared with the general population are often conducted in Veteran populations (e.g., Kaplan *et al*, 2007). In contrast, the majority of studies suggesting lower suicide rates are those conducted in active duty forces including Fear *et al* (2009a) who identified 694 suicide and open verdict deaths among male Regular UK Armed Forces personnel between 1984 and 2007. In comparison with the UK general population, this equated to statistically fewer suicides across all three of the Services. Moreover for each age group (with the exception of Army males under 20 years of age), the number of suicides in each Service was lower than the number expected based on UK general population rates. In respect of those younger male Army Service Personnel, there were 1.5 times more deaths by suicide than anticipated.
- Within the US Army, however, suicide is also the second most common cause of death, with rates varying between 9 and 15 deaths by suicide per 100,000 people (Ritchie *et al*, 2003). Whilst these figures are similar to death by suicide rates in the US civilian population, the military suicide rate during times of peace has generally been reported as being lower than the civilian rate (Kang & Bullman, 2008). Furthermore, previous studies suggest that military service may be a risk factor for suicidal behavior (Kaplan *et al*, 2007), and that the most common type of traumatic death suffered during armed forces training was suicide (Scoville *et al*, 2004). More recently, the rate of suicide among US military personnel and Veterans appears to be rising (Kang & Bullman, 2008). Since the start of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom(OIF), the suicide rate for US military personnel who have seen combat has increased to at least that of the general population (Kang & Bullman, 2008); an increase which suggests that exposure to combat may be an important factor that may cause or at least contribute to subsequent death by suicide (Selby *et al*, 2010). By the same token, military service appears to have some qualities that lower suicide risk in times of peace, with deaths by suicide during basic

- training being as low as five deaths for every 100,000 military recruits (Scoville *et al*, 2004).
- The complexity of the relationship between military service and suicidal behaviour has triggered an increasing interest in identifying risk factors of suicidal ideation in military personnel in order to identify more effective ways treat those who are affected. Thoresen *et al* (2008) investigated the association between war zone stress exposure during international military operations and later suicidal ideation. A follow-up study of 1172 Norwegian male peacekeepers was conducted seven years, on average, after redeployment. Of a subsample of individuals who were prematurely repatriated 17% reported suicidal ideation compared with an overall 6% of Veterans. After controlling for socio-demographic factors, repatriation status, negative life events, social support, alcohol consumption, and marital and occupational status, suicidal ideation remained significantly associated with the level of exposure to Service-related stress and was mediated by a combination of post-traumatic stress symptoms and general mental health problems.
 - More recently, Belik *et al* (2010) sought to determine whether the prevalence and correlates of past-year suicidal ideation and suicide attempts differ in Canadian soldiers when compared with Canadian civilians. The data derived from the Canadian Community Health Survey Cycle 1.2-Canadian Forces Supplement in conjunction with the 2001–2002 Canadian Community Health Survey Cycle 1.2. Logistic regression interaction models were used to explore differences between correlates of suicidal ideation and suicide attempts comparing Canadian military personnel with civilians in the general population. Although no significant difference was found between these two samples in terms of the prevalence of past-year suicidal ideation, the prevalence of past-year suicide attempts was significantly lower in the Canadian forces sample compared with the civilian population; a finding which is consistent with other studies that have shown that Service personnel are at lower risk of completed suicide than the general population (e.g., Fear *et al*, 2007). Key correlates of suicidal ideation and suicide attempts that differentially affected Canadian Forces personnel when compared with Canadian civilians included gender and marital status. Women in the Canadian Forces had a higher likelihood of suicide attempts than did women in the civilian population, which may suggest that military women experience a more negative impact of combat exposure compared with men (Tolin & Foa, 2006). Moreover, the prevalence of sexual trauma during deployment (including sexual assault, rape, and sexual harassment) has been reported as being higher among female military personnel than their male

counterparts (Street *et al*, 2007), which may exacerbate the negative mental health consequences of combat exposure (Smith *et al*, 2008).

- Contrary to earlier studies (e.g., Fear *et al*, 2007), no significant differences were found between members of the Canadian Forces and the civilian population with regards to the association between age and suicidal behavior. There were however higher rates of suicidal ideation and suicide attempts among individuals in the younger age groups in both populations. Canadian Forces personnel with depression were found to be more likely to attempt suicide than depressed individuals in the civilian population. Alcohol dependence and high levels of alcohol use among Canadian forces members were less likely to be associated with suicidal ideation than was alcohol misuse in the civilian population. Overall, these findings support the hypothesis that lower suicide rates among military personnel may be a result of the “healthy soldier effect”. At the point of enlistment, Service personnel are generally physically and mentally healthier than the general civilian population, due to the selection procedures for military service combined with requirements to maintain that standard of well-being (McLaughlin *et al*, 2008).

Injury-related mortality

- Whilst the focus of many studies of post-conflict mortality has varied and their findings are commonly equivocal, one relatively consistent finding pertains injury-related mortality. Knapik *et al* (2009) undertook a systematic literature review of post-deployment injury-related mortality among military personnel deployed to conflict zones. A total of 20 studies were eligible for inclusion, and all involved Veterans serving during either Vietnam or the Persian Gulf War. Meta-analysis was conducted to compare injury-related mortality of military Veterans who had served in these conflict zones with that of contemporary Veterans who had not. Key findings to emerge from that analysis was that in the deployed Veterans:
 - injury-related mortality was elevated for Veterans serving in Vietnam during 9 to 18 years of follow-up;
 - a substantial excess of mortality was associated with road traffic incidents;
 - excess mortality decreased over time.

It was hypothesised that the excess mortality in Veterans deployed to conflict zones was due to a number of factors including PTSD, coping behaviours (e.g., misuse of substances), ill defined symptoms and diseases, risk taking behaviours, and a

lower level of survivability due to the nature of injuries sustained in conflict zones.

5.4.4 Physical Health

5.4.4.1 Cancer

- There has been concern about a possible link between service in the Gulf and an increased risk of cancer, particularly among those who are exposed to depleted uranium, oil well fire smoke and other petrochemical products. McCauley *et al* (2002) investigated rates of cancer in US Gulf War Veterans residing in five US states in 1999. This investigation formed part of a larger study to evaluate neurologic and neurophysiologic signs and symptoms in 653 Veterans who may have been exposed to chemical-warfare agents due to the destruction of munitions at Khamisiyah, Iraq. The control group comprised 516 non-deployed Veterans who served in the military at the time, but who were not deployed to Southwest Asia. The frequency of cancer was 1.2% for the Khamisiyah deployed Veterans and 0.6% for non-deployed Veterans. The study is limited however by the: (i) small sample size, (ii) few reports of cancer, and (iii) incomplete verification of the diagnosis with medical records and examination.
- McFarlane *et al* (2003) assessed all first diagnoses of malignant cancer in a cohort of UK Armed Forces military personnel. The deployed group consisted of all 51,721 military personnel who were deployed to the Persian Gulf during September 1990 to June 1991. The comparison group was made up of 50,755 randomly selected members of the UK Armed Forces who were in service on 1 January 1991 but who did not serve in the Persian Gulf (the Era cohort). The sample was stratified to match for age, sex, service branch, rank, and level of fitness for active service. Follow-up was from 1 April 1991 until diagnosis of cancer, emigration, death or July 21 2002, whichever was the earlier. Cancers were identified by means of the NHS Central Register. During follow-up, 270 incident cases of cancer were identified among the Gulf War Veterans and 269 cases among the non-deployed group. No evidence was found to support an association of Gulf War service with site-specific cancers. Moreover, a review of mortality studies of Australia, US and UK Veterans however has found no significant increase in the risk of death from cancer (Gray & Kang, 2006).
- *Testicular cancer*: Some evidence of an association of testicular cancer with Gulf War deployment was found in a pilot cancer-registry-based study. Levine *et al* (2005) matched a stratified

sample of 621,902 Gulf War deployed active-duty, Reserve, and National Guard Veterans and 746,248 non-deployed Veterans with the central cancer registries of New Jersey and the District of Columbia. From 1991 to 1999, a total of 17 deployed and 11 non-deployed Veterans were identified with testicular cancer, the greatest proportions of which in the deployed men aged 25 to 34 years and in non-deployed men aged 30 to 39 years.

- *Skin cancer*: The risk of skin cancer in Australian Gulf War Veterans was investigated by Kelsall *et al*, (2004). The entire Australian cohort of 1,871 Veterans who were deployed to South East Asia was compared with a sample of non-deployed Veterans matched for service type, sex and age. Participants completed a self-report questionnaire about medical conditions that had been diagnosed or treated by a medical doctor and about when those conditions had been diagnosed. A comprehensive health assessment was also conducted by a specially trained health professional who was blind to the deployment status of the participants. No increase in the prevalence of probable or possible skin cancers diagnosed after 1991 was found in the Australian Gulf War Veterans when compared with their non-deployed counterparts.
- *PTSD and cancer*: Few studies have assessed cancer in Vietnam War and Gulf War Veterans who have been diagnosed with PTSD. Boscarino (2005) examined the excess post-service mortality from cancer in Vietnam Veterans who were known to be alive in 1983 and who completed a telephone interview at that time on PTSD symptoms and health status. The telephone interview was administered to 7,294 Vietnam-theatre Veterans and 7,364 Vietnam-era Veterans. A total of 377 Veterans were diagnosed with lifetime PTSD according to the Diagnostic Interview Schedule Version III (DIS-III). Boscarino found an increase in the risk of death from cancer in Vietnam-theatre Veterans with PTSD.

5.4.4.2 Diabetes

- Eisen *et al* (2005) conducted a cross-sectional prevalence study that investigated diabetes among US Gulf War Veterans. In 2001, 1,061 Gulf War deployed Veterans and 1,128 non-deployed Veterans underwent physical examinations at 16 VA medical centres. As part of the "*National Health Survey of Gulf War Era Veterans and Their Families*", the study participants were randomly selected from among the 11,441 deployed and the 9,476 non-deployed Veterans who had participated in the 1995 phase of the study by completing a postal self-report questionnaire or telephone administered questionnaire about

their health. Diabetes mellitus was found in 4.2% of the deployed and 3.5% of the non-deployed Veterans, but this difference was not a statistically significant one.

5.4.4.3 Thyroid disease

- In the Eisen *et al* (2005) study, thyroid function was also assessed in the Gulf War deployed and non-deployed Veterans. Of the deployed Gulf War Veterans, 1.6% had hypothyroidism compared with 1.2% of the non-deployed Veterans. No significant increase in the risk of hypothyroidism was found in deployed Gulf War Veterans.

5.4.4.4 PTSD and endocrine diseases

- Schnurr *et al* (2000) found no significant association between combat-related PTSD and physician-diagnosed medical conditions in 605 combat Veterans of World War II and the Korean War. Only six were found to be positive for PTSD (as measured by the Mississippi Scale for Combat-Related PTSD). Endocrine disease was evident in 93 (15%) of the Veterans on medical examination.
- Spiro *et al* (2006) assessed the prevalence of PTSD, depression, and several medical conditions in a sample of 2,425 male ambulatory-care patients at a VA medical facility as part of the Veterans Health Study. The screening criteria for PTSD were met by 20.2% of patients. When compared with those who did not meet the criteria for PTSD or depression, no significant increase in the risk of Type 2 diabetes or thyroid disease was found.

5.4.4.5 Obesity

- Exposure to stressors may affect eating behaviour and theoretically predispose to obesity or eating problems. Jacobsen *et al* (2009) analysed longitudinal data from the Millennium Cohort Study on participants who completed baseline (2001–2003) and follow-up (2004–2006) questionnaires (n=48,378) to investigate new-onset disordered eating and weight changes in a large military cohort. Multivariable logistic regression was used to compare these outcomes among those who: (i) deployed and reported combat exposures, (ii) deployed but did not report combat exposures, and (iii) did not deploy to Iraq and Afghanistan. After adjustment for baseline demographics, military, and behavioural characteristics, no significant association was found between deployment and new-onset disordered eating in women or men. A subgroup comparison

analysis of deployers revealed however that deployed women reporting combat exposures were 1.8 times more likely to report new-onset disordered eating and 2.4 times more likely to lose 10% or more of their body weight compared with women who deployed but who did not report combat exposures. Although no significant overall association was found between deployment and disordered eating and weight changes, the evidence from this analysis suggests that deployed women reporting combat exposures represent a subgroup at higher risk for developing eating problems and weight loss.

5.4.4.6 Arthritis

- Dominick *et al* (2006) undertook a study to compare the prevalence of arthritis symptoms between: (i) Veterans of the US Armed Forces and non-Veterans, and (ii) Veterans who were users of the US Department of Veterans Affairs (VA) healthcare and Veterans who were nonusers. Participants comprised 123,395 respondents from 36 States in the US who completed the 2000 Behavioral Risk Factor Surveillance System arthritis module. The data analysis was based on self-reports of doctor-diagnosed arthritis, chronic joint symptoms, and activity limitation according to Veteran status. The relationships of demographic characteristics to arthritis were also compared according to Veteran status. Compared with non-Veterans, US Veterans were more likely to report doctor-diagnosed arthritis and VA healthcare users were more likely to report doctor-diagnosed arthritis than Veteran nonusers. Among respondents with arthritis, Veterans were more likely to report chronic joint symptoms and activity limitation than non-Veterans, and VA healthcare users were more likely to report chronic symptoms and activity limitation than Veteran nonusers. Demographic predictors of arthritis diagnosed by a doctor were similar among the three groups. The authors conclude that their findings highlight a need for the increasing prevention of orthopedic injuries in the military (e.g., by means of self management interventions) as a potential way of reducing the risk of arthritis in military personnel.

5.4.4.7 Reproductive health

- *Birth defects*: Araneta *et al* (2003) conducted a study investigating birth defects in the offspring of Gulf War Veterans by examining hospital records of births in 1989 to 1993 to military personnel in the USA. These records were subsequently linked to data from State and county birth-defects surveillance programmes to identify infants born to military personnel who served in the Gulf War. During this time period, a total of 11,961

infants were born to those Veterans who served in the Gulf War (including 450 female Veterans) compared with 33,052 infants born to Gulf War era Veterans (including 3,966 females). In infants conceived before and during the Gulf War, there was no significant difference in birth defects between these two groups of Veterans. In infants conceived after the war, the rate of hypospadias was significantly higher in infants born to Gulf War male Veterans than to era male Veterans as was the prevalence of aortic valve stenosis. However, Ryan *et al* (2004) have suggested that there may be a significant limitation to the interpretation of these findings by virtue of the fact that comparisons were made for 26 birth-defect categories without correction for multiple comparisons. Consequently, there is the possibility that the statistical significance of the observations observed is due to chance.

- *Infertility*: Maconochie *et al* (2004) examined infertility based on self report from UK Gulf War Veterans in respect of inability to achieve conception (Type I infertility) and to achieve a live birth (Type II infertility). Male Gulf War Veterans reported significantly higher levels of infertility compared with non-deployed Veterans. Among those males not reporting infertility, time to conception was shorter among non deployed fathers than among Gulf War fathers. Limitations of this study include low response rates which may have increased the possibility of response and recall bias. Kelsall *et al* (2007) provided self-report data on the fertility of male Australian Veterans of the Gulf War. Compared with non-deployed Veterans the deployed Veterans reported more fertility difficulties after the war although they were more successful at subsequently fathering children. Both groups reported similar rates of pregnancies and live births.
- *Sexual dysfunction*: Ishoy *et al* (2001) conducted a clinical examination of 661 Danish peacekeepers who served in the Gulf in 1990 to 1997 and 215 Danish military personnel who were not deployed to the Gulf. By means of a health interview (which included questions about sexual health), participants were asked whether they had experienced any sexual problems (decreased libido or nonorganic erectile dysfunction) that they attributed to service in the Gulf. Self-reported sexual problems were higher among Gulf War Veterans than among controls. A clinical evaluation for serum concentrations of reproductive hormones found no significant differences between the deployed and non-deployed Veterans. Deployed Veterans however were more likely to report sexual problems if they had seen people killed or wounded, witnessed a friend or colleague being threatened or shot, or been personally threatened than if they had not

experienced these traumatic events. Compared with Veterans without sexual dysfunction, deployed Veterans with sexual dysfunction also reported more perceived psychological stress during deployment. Simmons *et al* (2004) used a postal questionnaire survey to collect self-report data on sexual dysfunction in UK Gulf War Veterans. Of the 42,818 male Veterans who responded, 24,379 had been deployed and 18,439 had not. Sexual dysfunction was reported by 0.8% and 0.2.% of the deployed and non-deployed Veterans respectively.

- *PTSD and reproductive effects:* Cosgrove *et al* (2002) examined the association between PTSD and sexual dysfunction in 44 US combat Veterans who were undergoing treatment for PTSD at a VA clinic and 46 age-matched combat Veterans without PTSD. Eighty five per cent of Veterans with PTSD had erectile dysfunction compared with 22% of Veterans without PTSD. Severity of PTSD was associated with severity of erectile dysfunction. However, more than half the PTSD Veterans were using psychotropic medications compared with only 17% of non-PTSD Veterans.
- A review of the literature on the reproductive health of Gulf War Veterans has highlighted the extent to which all of the studies comprising that review had methodological limitations (Doyle *et al*, 2006). To this end, the interpretation of findings from these studies is problematic. Overall, however, the authors concluded the following.
 - For male Veterans of the first Gulf War there was no evidence of an adverse effect of service on the risk of birth defects or stillbirth in infants conceived post-deployment.
 - There was some evidence of a small increase of risk for miscarriage and infertility associated with military service.
 - In respect of female Veterans, no robust conclusions could be reached due to insufficient data.
 - Future investigations of Veterans' reproductive health require prospective surveillance post-deployment.

5.4.4.8 Chronic Fatigue Syndrome (CFS)

- Unexplained chronic fatigue, experienced by both military and civilian populations, has been the subject of much debate by clinicians and researchers alike, but its aetiology and course remain unclear. Moreover, information on the incidence and prevalence of CFS is contradictory. In the UK, prevalence estimates vary by a factor of eight by virtue of natural variation between populations and artefactual variations (e.g., due to differences in research methods and case definitions and/ or to

selection bias). Much of the epidemiological research has used complex clinical research definitions, which are designed primarily to enable identification of homogeneous groups of individuals for participation in clinical trials. Such studies generally have exclusion criteria of varying stringency, and, consequently, tend to underestimate the public-health burden of the disease when used in epidemiological research. Most epidemiological studies have been on a small scale, giving inconclusive results with wide confidence intervals. In some cases, inferences about population proportions have been made on the basis of studies that themselves lack a population base.

- Many Veterans returning from the Gulf War and other wars have reported experiencing chronic fatigue (McCauley *et al*, 2002). Eisen *et al* (2005) conducted a cross-sectional prevalence study in 2001 of 12 health measures in 1,061 Gulf War deployed and 1,128 non deployed Veterans. As part of the “*National Health Survey of Gulf War Era Veterans and Their Families*”, all participants had completed a postal or telephone administered questionnaire about their health in 1995 phase of that survey. CFS was diagnosed by clinical examination on the basis of the International Chronic Fatigue Syndrome Study Group case definition (Fakuda *et al*, 1994) by VA clinicians who were blind to the deployment status of participants. Veterans with psychiatric disorders were excluded from participation. However, given the evidence to suggest that depression underlies CFS, by excluding depressed individuals the prevalence of CFS is likely to be substantially reduced. Of those who self-reported symptoms of CFS, only 3 of the 38 deployed Veterans and only 2 of the 8 non-deployed Veterans met the diagnostic criteria respectively. On this basis, the authors concluded that self-reports of CFS in both groups were unreliable. Clinically diagnosed CFS was more prevalent in deployed Veterans (1.6%) than non-deployed Veterans (0.1%) although the absolute difference was very small. The strengths of this particular study are its large sample size, stratified sampling method, analysis of participation bias, comprehensive examination, and use of computer-based algorithms by researchers who were blind to deployment status. Its main limitation is the relatively low response rate of 53% of the eligible deployed Veterans and 39 % of the eligible non-deployed Veterans.
- Several CFS focused studies have been undertaken on UK military personnel. For example, Reid *et al* (2001) found that the prevalence of CFS was not statistically different between UK military personnel deployed to the Gulf War and non-deployed troops (2.1 % versus 1.8%), but both groups had a greater

prevalence of CFS than did the group deployed to Bosnia (0.7%). This finding concurs with the study conducted by Unwin *et al* (1999). A more recent study by Ismail *et al* (2008) using baseline data from the original KCMHR cohort examined the prevalence of CFS and related disorders in UK Veterans of the 1990-1991 Gulf War. The 111 Gulf War Veterans who reported physical disability at baseline were compared with 133 non-Gulf War Veterans who reported similar levels of physical disability. In order to exclude any medical conditions which might explain that physical disability, screening was undertaken, and standardised criteria for CFS, chronic fatigue and fibromyalgia were employed. No significant differences were found between the two groups in terms of clinical markers of medically unexplained conditions. Physically disabled Gulf Veterans however were more likely to be overweight, screen positive for hypertension, and have elevated levels of c-glutamyl transferase. In terms of CFS, compared with the physically disabled non-Gulf Veterans, physically disabled Gulf Veterans were more likely to fulfil the criteria for CFS. On the basis of these findings, Fear *et al* (2009b) suggest that symptoms of CFS in Gulf War Veterans represent a substantial part of the symptomatic distress reported.

5.4.5 Mental Health

5.4.5.1 Post-Traumatic Stress Disorder (PTSD)

- There have been numerous epidemiological studies of the operational health consequences of deployment on military populations exposed to different conflicts and wars. The majority of these studies have focused on providing estimates of the prevalence of PTSD. In World War I most enemies suffered similar levels of psychiatric casualties. By 1917 about 20% (representing 40,000 troops) of the total number of war pensioners from the British Forces were suffering from psychiatric disability (O'Brien, 1998, p.9). Despite their extensive pre-deployment selection scheme, in the Second World War, admissions to the US military hospitals for psychiatric reasons were twice those of the First World War (Gabriel, 1987, p.117). The Korean War (a largely neglected one by researchers) generated, according to Ikin *et al* (2007), high levels of psychopathology, evident even 50 years after the conflict. The most extensive survey of post-traumatic psychopathology among Vietnam Vets was the National Vietnam Readjustment Study conducted by Kulka *et al* (1990). It reported PTSD prevalence of 15.2% and 8.5% of male and female troops respectively. (Although post Vietnam figures have been challenged by Frueh *et*

al [2005] on the basis of the veracity of the reports of personal combat exposure.)

- Contemporary conflicts tend to yield lower figures. For example, Kang *et al* (2003) found that 12.1% of deployed Gulf War Veterans and 4.3% of non-deployed Veterans met the screening criteria for current PTSD using the PTSD Checklist. The risk of PTSD increased with the severity of stress experienced ranging from 3.3% in activated but non-deployed Reserve personnel ("minimal stress") to 22.6% in Gulf War deployed Veterans who had worn chemical protective gear, heard chemical alarms, been involved in active combat duty, and witnessed death ("maximal stress").
- A systematic review of Veterans of the Persian Gulf War of 1991 compared the prevalence of psychiatric disorders in Gulf War Veterans with a group of Service personnel not deployed to the Gulf War (Stimpson *et al*, 2003). All were cross-sectional studies, and the samples comprised military personnel from the UK Armed Forces, the Canadian forces, the US forces, and the Danish military. A total of 20 primary studies were eligible for inclusion in that review, and nine were subject to a meta-analysis for dichotomous outcomes for PTSD. Although the heterogeneity among studies was substantial, all reported an increased prevalence in PTSD for Gulf War Veterans when compared with non-deployed Veterans. However, the majority of studies relied on self-report symptoms to assess the prevalence of PTSD, and the earlier studies were less robust in terms of their methods with less representative samples, lower response rates and smaller sample sizes.
- The risk of USA combat troops deployed to Afghanistan developing PTSD three to four months post-deployment was found to be 6.2% for Army troops returning from Afghanistan and 12.9% for Army troops and 12.2% for Marines returning from Iraq (Hoge *et al*, 2007). The risk of developing PTSD pre-deployment was 5% (Hoge *et al*, 2004). A year after their return from Iraq, 16.6% of the US Army combat troops fulfilled the screening criteria for PTSD (Hoge *et al*, 2007). Engelhard *et al* (2007) reported rates varying from 4% - 21% among Dutch troops returning from Iraq. These figures contrast with findings from studies of UK Veterans of the Iraq War where no significant differences were observed in rates of PTSD between those who deployed to Iraq and those who did not (Hotopf *et al*, 2006), although a slightly increased rate of PTSD was observed for Reservists and those involved in combat. In general, rates of PTSD have been found to be significantly lower among UK

Veterans than US Veterans as evidenced by a review of the literature undertaken by Sundin *et al* (2010) and the findings of a recent study by Fear *et al*, 2010, which reported a prevalence rate of 4% of PTSD compared with 19.7% for common mental disorders and 13% for alcohol misuse.

- Recent studies of returning Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Veterans have raised a number of concerns about the long-term mental health consequences of combat exposure (e.g., Seal *et al*, 2007). Longitudinal evaluations of the persistence of symptoms however are lacking with a few notable exceptions. In a 10 year follow-up to study, Toomey *et al* (2007) found that 6.2% of US Gulf War deployed Veterans and 1.1% of non-deployed Veterans met a diagnosis for war-related PTSD. Kang *et al* (2009) analysed data from the 1995 *National Health Survey of Gulf War Era Veterans and their Families*; a retrospective cohort study in which the health indicators of a population-based sample of 15,000 troops deployed to the Persian Gulf were compared with those who were not deployed (Kang *et al*, 2000). The health indicators included chronic medical conditions, PTSD, unexplained multi-symptom illness (MSI), CFS, functional status, and health care utilisation. Symptoms of PTSD were measured by means of the PTSD Checklist (PCL); a self-report measure for assessing PTSD symptom severity and for estimating PTSD caseness when the administration of a structured clinical interview is not possible. Fourteen years after deployment, 1991 US Gulf War Veterans continued to report a higher prevalence of a variety of adverse health outcomes (including PTSD) when compared with the Gulf War Era Veterans. This would suggest that combat-related disorders increase the risk of developing chronic health problems.
- In response to health concerns of military members about deployment and other Service-related exposures, the US Department of Defence (DoD) initiated the largest prospective study ever undertaken in the US military. The Millennium Cohort used a phased enrolment strategy with a view to obtaining the participation of in excess of 100,000 US Service and ex-Service members who will continue to be followed up until the year 2022. Participants will be linked to DoD and VA databases with assessments conducted every three years to obtain objective and self-reported data on exposures and health outcomes (Ryan *et al*, 2007). The sample was provided by the Defense Manpower Data Center (DMDC) representing approximately 11.3% of the 2.2 million US military personnel (both males and females) who were in service as of 1 October 2000 including those from the Army, Navy, Coast Guard, Air Force, and Marine Corps. Individuals

deployed to Southwest Asia, Bosnia and Kosovo during the 1998-2000 time period, US Reserve and National Guard members, and female service members were oversampled to generate sufficient power for statistical inferences over the study period. Enrolment commenced in July 2001 and ended in June 2003 resulting in 77,047 consenting participants (i.e., 35% of the eligible contacted target population). Smith *et al* (2008) sought to evaluate the new onset and persistence of self reported PTSD symptoms in this large population based military cohort by comparing baseline data with follow-up health outcomes data collected between June 2004 and February 2006 on 50,184 participants. At the time of follow-up in excess of 40% of the cohort were deployed between the start of enrollment in 2001 and completion of follow-up in 2006. Of those, 24% had been deployed for the first time in either Iraq or Afghanistan. Incidence rates of 10 to 13 cases of PTSD per 1000 person years were found in this cohort. New onset of self-reported PTSD symptoms or diagnosis were identified in 7.6-8.7% of those deployed individuals who reported exposure to combat compared with 1.4-2.1% of deployed individuals who did not report exposure to combat and 2.3-3% of non-deployers. No evidence was found for deployment affecting the persistence of symptoms in those with self-reported symptoms of PTSD. After adjustment for baseline characteristics, a three-fold increase in new onset of PTSD (according to both self-report and clinician-based diagnosis) was found among deployed military personnel who reported exposure to combat. Smith *et al* (2008) conclude that these findings emphasise: (i) the importance of PTSD in this population, and (ii) that deployment itself does not significantly affect the onset of PTSD post-deployment, rather it is the nature of the specific exposure to combat which is the main contributory factor.

5.4.5.2 Comorbidity

- Whilst PTSD commonly adopts centre stage, however, it is a condition that is neither the sole psychopathology to emerge post-trauma nor does it commonly occur in isolation from other comorbid conditions, most notably, anxiety, depression and substance abuse (Klein & Alexander, 2009). A European study conducted by Perkonigg *et al* (2000) reported that 87.5% of individuals diagnosed with PTSD also met diagnostic criteria for at least one other psychiatric disorder, and 77.5% had two or more additional diagnoses. Four hypotheses have been proposed to explain these high rates of comorbidity associated with PTSD. First, it has been hypothesized that pre-existing disorders constitute a vulnerability to PTSD. Second, other disorders are subsequent complications of PTSD. Third, the disorders co-occur because of shared risk factors. Fourth, considering that none of

the psychopathology evident in PTSD is unique to the disorder, it has been suggested that PTSD does not exist as a distinct entity and is merely an atypical presentation of an anxiety or affective disorder “...*pathoplastically modified by culture, context and traumatic events*” (Deahl, 2003).

- Iversen *et al* (2009b) sought to evaluate the prevalence of and risk factors associated with common mental disorders and PTSD symptoms in a sample of participants which derived from the existing KCMHR cohort during the main fighting period of the Iraq war and subsequent deployments. Using a standard two phase survey technique stratified by deployment status and engagement type (i.e. Regular or Reserve), a structured telephone interview was administered along with standardised measures of health and PTSD. Comparisons of the prevalence of depression, PTSD symptoms and suicidal ideation in Regular and Reserve personnel of the UK Armed Forces were made with their US counterparts. No significant difference was found between the Regular US and UK military personnel who experienced combat in Iraq. Contrary to previous studies this included the absence of substantial differences in the prevalence of PTSD symptoms. In terms of the UK Service personnel, the most common mental disorders were alcohol abuse (18%) and neurotic disorders (13.5%). Few (4.8%) reported symptoms of PTSD. However as is the case with previous studies, those most at risk of psychiatric injury were the Reserve UK Armed Forces personnel, which extended beyond those who served in the initial fighting period of the Iraq war. This finding endorses the value of ongoing commitments to ensuring enhanced care provision to Reservists.

5.4.5.3 PTSD and physical injury

- Over the past 20 years there has been a particular interest in the interplay between physical and psychological injuries (i.e., to the psychological consequences of physical injury caused by a traumatic event) among survivors of a variety of traumatic events including road traffic incidents, terrorism, criminal assault, and burn injuries (O'Donnell *et al*, 2003).
- While a few studies have shown that risk for PTSD is associated with severity of injury, other studies have failed to replicate these results in civilian populations. The survivors of injuries in contemporary conflicts however face significant psychological and physical challenges, lengthy rehabilitation and readjustment to family, work, and social activities. Multiple amputations pose a significant challenge for survivors and their families. Traumatic brain injuries (TBI) and tympanic membrane injuries are on the

increase due to insurgents using improvised explosive devices (IED). Hotopf *et al* (2006) estimated a 4% incidence of PTSD among UK troops returning from Iraq; Hoge *et al* (2004) however described a higher figure of just under 13% for returning troops, and Engelhard *et al* (2007) reported rates varying from 4% to 21% among Dutch troops returning from Iraq. Higher rates of PTSD were associated with higher levels of direct combat exposure and minor wounds or injury, and rates of PTSD among soldiers returning from war increased over time post-deployment as the majority of soldiers with PTSD or depression at seven months had not met the criteria for either condition one month following injury. These findings highlight the clinical challenges of providing early psychiatric care for combat exposed personnel.

- In one of the few studies which have attempted to identify predictors of PTSD following combat-related injury, Koren *et al* (2005) directly compared in a matched case-control design, injured and non injured Israeli soldiers who experienced the same combat events to estimate the unique contribution of physical injury over and above that of the trauma itself to the subsequent development of PTSD. Consistent with the outcome of some earlier studies (e.g., Kulka *et al*, 1990; Michaels *et al*, 1999), their findings unequivocally indicated that bodily injury is a risk factor – rather than a protective one – for PTSD. Approximately 15 months post-injury, 16.7% of injured soldiers had PTSD compared to 2.5% of non injured soldiers with similar combat experiences. Moreover, the data also suggested that the odds of developing PTSD following traumatic injury are approximately eight times higher than those following injury-free trauma. Interpretation of the validity of these figures requires careful analysis of such factors as the intensity of combat; whether the data were from Reservists or full time troops; whether the data derived from self-report or from structured clinical interviews; whether the psychopathology was genuinely combat-related, and how long after deployment were the surveys conducted. Moreover, objective measures of physical injury are often not related to PTSD outcome. This is a very important finding because it highlights the significance of the patient's subjective appraisals in the development of posttraumatic psychological problems (Malt & Olafsen, 1992; Schynder *et al*, 2001) High quality surgical and nursing care may also provide opportunities for talking through and facilitating adjustment to trauma.

5.4.5.4 Alcohol misuse

- Historically, the soldier has always been a “chemical warrior” (Alexander & Klein, 2008). Alcohol has played a significant role in

the military due to the following four inter-related, and possibly inseparable, influences.

- A substance-abusing personal history (especially among Scots recruits).
 - The (genuinely) protective factor of psychoactive substances against the emotionally deleterious effects of combat (pain, fear and hyperarousal).
 - The ameliorative (if only temporary) effects of psychoactive substances against intrusive memories, insomnia, hyperarousal, and low mood/ high anxiety.
 - The socially cohesive effect of “drinking buddies”.
- Although some earlier research was conducted on alcohol use within the UK Armed Forces (e.g., Micklewright, 1993), many of these studies have been limited by adequate comparison groups and by the inability to control for baseline factors that might influence the association between combat, mental health outcomes, and alcohol misuse.
 - In 2007, Fear *et al* reported on a cross-sectional study undertaken to examine: (i) patterns of drinking in the UK Armed Forces, (ii) the extent to which those patterns of drinking varied by gender and other demographic variables, and (iii) differences in drinking patterns when compared with the general population of Great Britain. Based on the random representative sample of the 8686 Regular UK Armed Forces (7937 men and 749 women) who were in service in March 2003. As part of a self-report questionnaire, the assessment of alcohol use was based on the WHO AUDIT (Alcohol Use Disorders Identification Test, Saunders *et al*, 1993)¹⁷². Key findings which derived from that study showed that the level of “hazardous”¹⁷³ drinking in Service men (67%) and Service women (49%) was higher than for the 38% of men and 16% of women in the general population. This also applied to all ages for both men and women in the UK Armed Forces. For Service personnel, binge drinking was associated with being:
 - younger;
 - single;
 - in the Naval service or the Army;
 - deployed to Iraq;
 - childless;
 - a smoker;
 - deployed in a combat-related role, and

¹⁷² AUDIT is widely used measure comprising 10 items to assess alcohol consumption, alcohol dependence, and the consequences of alcohol abuse in the previous 12 months.

¹⁷³ “Hazardous” drinking was defined by an AUDIT score of 8 or more (Fear *et al*, 2007)

- the offspring of a parent with a substance use problem (drink or drugs).
- A subsequent paper by Browne *et al* (2007) reported on statistically significant associations between alcohol use and deployment to OpTELIC using a random representative sample of 3,578 Regular male UK Armed Forces personnel. The rationale for this evaluation derived from the finding by Fear *et al* (2007), which showed that there was a statistical difference (albeit small) in the patterns of drinking by deployment status. On this basis, Browne *et al* (2007) sought to undertake a more detailed analysis that focused on the association between “heavy” drinking¹⁷⁴ and specific deployment-related factors (including in-theatre related experiences, perception of comradeship and leadership and problems encountered at home during and deployment on OpTELIC). Furthermore, it was the first study in the UK to examine the association between comradeship and alcohol use. Heavy drinking was found to be more prevalent in Service personnel who had: (i) been deployed with their parent unit; (ii) experienced medium to high unit comradeship; encountered poor unit leadership, and (iii) suffered problems at home during and post-deployment. However, because the number of women identified as heavy drinkers was relatively small ($n=64$) in the Fear *et al* (2007) study, the analyses undertaken by Browne *et al* (2007) focussed on males only. In line with the findings reported by Fear *et al* (2007) however heavy drinking was associated with all of the same demographic variables. Although previous USA evidence suggested a significant relationship between exposure to combat and the use of alcohol (Prigerson *et al*, 2002), this was not evident in the Browne *et al* (2007) study. However, the findings from a previous KCMHR study did report that the risk of alcohol misuse increased with the time spent on deployments (Rona *et al*, 2007).
 - More recently, examination of consequences of deployment to Iraq and Afghanistan by the third largest epidemiological study of UK Armed Forces personnel showed that the effect of deployment on alcohol misuse continues to be most problematic for those in combat roles. Furthermore, despite adjusting for differences in the higher predominance of young males in the military, the levels of misuse were found to be substantially higher level than those reported in the general population (Fear *et al*, 2010). The extent to which the recent introduction of new alcohol policies by the UK Armed Forces in each of the three services will be effective in addressing this ongoing concern has yet to be

¹⁷⁴ An AUDIT score of 16 or more is defined as a “high level of alcohol problems” (Browne *et al*, 2007).

established. However, despite attitudinal differences between the UK Armed Forces and the US military towards alcohol use, studies of the US military report similar problems in respect of the effects of deployment and related experiences on alcohol misuse (e.g., Wilk *et al*, 2010).

- A limitation of a cross-sectional design research design however is that it not possible to determine the causality of association (Silman & Macfarlane, 2004). Thus, interpretation can be problematic as acknowledged by Browne *et al* (2007) because the use of alcohol was only assessed at one time point (i.e., after deployment). For this reason, for example, the 18.5% who were classified as “heavy drinkers” would have been classified as such prior to deployment. Evidence from the US Millenium Cohort Study¹⁷⁵ however found that Reserve and National Guard personnel and younger service members who deploy with reported combat exposures are at an increased risk of new-onset heavy weekly drinking and alcohol problems (Jacobsen *et al*, 2008).
- In terms of those who leave Service post-deployment, Browne *et al* (2007) highlight the need for further longitudinal data to determine whether the deployment issues they identified have any longer term implications for alcohol consumption of Veterans of the UK Armed Forces. Furthermore, it is imperative to establish the extent to which predictors of excessive drinking in the Veteran population differ from those in the general population in order to inform service provision and the development of appropriate interventions.

5.4.5.5 “Ripple Effect”

- The concept of the “ripple effect” was originally developed to emphasise the fact that traumatic events can have a radiating effect on others, especially the families of the primary victims. Military personnel returning from Iraq and Afghanistan face psychological challenges that can exert profound effects on families and couples (Erbes *et al*, 2008). Feelings of detachment, or estrangement from others, restricted affect, irritability, and outbursts of anger, may adversely affect the interpersonal relationships of service members with their spouse/ partners. In dealing with such problems, family members may experience a burden of care and may themselves develop psychological

¹⁷⁵ The Millenium Cohort Study was launched in 2001 with the principal goal of enabling a prospective evaluation of the long-term health of military service members and the potential influence of deployment and other military exposures on health (Ryan *et al*, 2007)

symptoms. Thus, the impact of a traumatic event is not limited to traumatized persons but can also impact on their spouse/ partner of family member; a concept which has been referred to as the “ripple effect” of trauma (Klein & Alexander, 2005) or secondary traumatisation (Figley, 1998).

- There is some evidence to suggest that combat or other military-related traumatic experiences may be particularly detrimental to marriage. Cook and colleagues (2004) reported that 31% of World War II prisoners of war with PTSD reported marital distress compared with 11% of those without PTSD. A major limitation of this research however is the undue emphasis placed on the diagnosis of PTSD to the exclusion of identifying problems associated with other post-traumatic psychopathology such as substance abuse, depression, relationship conflict, and occupational dysfunction that are more common and potentially more troublesome to Service members and their families (Batten & Pollack, 2008).
- In a subsequent investigation of reasons for the excess of ill health in Reservists, Browne *et al* (2007) included problems at home (readjustment or relationship difficulties) and marital satisfaction. Following deployment, Reservists reported experiencing significantly more major problems and readjustment difficulties than Regulars. Because couple and family relationships may serve as either a vital support or challenging obstacle to recovery from combat-related pathology, including physical injury, research is required to identify factors associated with adjustment and recovery.
- Collins & Kennedy (2008) further extend this particular approach to the case of Service members experiencing multiple and severe injuries requiring treatment in the polytrauma system of care due to the substantial burden which may be placed on family members in fulfilling an unexpected caretaking role. There is a need therefore to adopt a dual focus on the individual needs of the Service member in his or her rehabilitation and on the support and functioning of the caregiving spouse/ partner (Sammons & Batten, 2008). It represents a highly topical issue as it concerns an “invisible healthcare system” which constitutes the core long-term care in the community. Despite increasing recognition by policy makers of the need to consider such effects (e.g., National Service Framework for Mental Health [Department of Health 1999]), relatively few studies have systematically pursued a focus on this important aspect of trauma care, and none has specifically examined this issue with regards to combat-

injured personnel despite the likelihood that the welfare of partners or immediate family members will impact on the rehabilitation and adjustment of the injured.

- Death of partners in military combat may pose a particular challenge to their families given the possibility of missing bodies and “ambiguous loss”¹⁷⁶ (Alexander & Klein, 2012). For the military, “Missing in Action” is not an uncommon outcome. Modern weaponry is so powerful that bodies can be completely atomised: there is nothing to be retrieved. Indeed, it is for this reason that most countries set up a tomb to “The Unknown Warrior” to at least partially provide some closure for families and colleagues.
- Parkes (1985) identified the lack of a body as a poor prognostic indicator for the bereaved. Without a body, denial and wishful thinking may unhelpfully persist. Alexander (1993) noted that, after the Piper Alpha oil platform disaster, some families (who had no bodies returned) lived with the vain hope that their loved ones had been picked up by some foreign sea vessel and would soon be returned to them. The availability of a body provides the bereaved with an opportunity to say “goodbye”, “I am sorry”, and “I love you” etc. Relatedly, the physical reality of a body helps to release emotions which otherwise can be “frozen”. Also, a body, or even a body part, allows families and colleagues to initiate mourning rituals and practices which, as has been argued above, further facilitate grieving and mourning.
- Whether bereaved relatives should be encouraged to view the body after a traumatic death remains a topic for debate. Findings from a UK qualitative study (Chapple & Ziebland, 2010) based on an analysis of 80 narrative interviews undertaken with respondents of different social economic backgrounds, ethnic groups, and types of traumatic death (including suicide) found that, although decisions about viewing the body varied, there was no regret voiced by those who took the decision to view the body of the deceased. On this basis, the authors concluded that, even after a traumatic death, relatives should have the opportunity to view the body and be given time to decide whether to view the body or not.

5.4.6 Transition-Related Factors

- Each year in the UK, approximately 25,000 men and women leave the Armed Forces (Fletcher, 2007) and return to civilian life

¹⁷⁶ Boss (2002) introduced the useful concept of “ambiguous loss”, reflecting the fact that a body, or even a body part, can facilitate grieving.

for a variety of reasons and in a variety of different circumstances (Iversen *et al*, 2005a). Although the current average length of military service is about four and a half years there are some Service personnel who leave the Service early having failed to pass their basic training or due to discharge for administrative or medical reasons.

- Those leaving the Services within four years have been identified as being particularly vulnerable, particularly with regards to developing mental health problems (Iversen *et al*, 2005b).
- The recent resurgence of interest in what happens to those Service personnel who leave the UK Armed Forces has been greatly fuelled by the media. Coverage however has typically focused on the minority who fare badly and subsequently experience social exclusion on leaving the UK Armed Forces. What little empirical evidence exists suggest that the majority fare well. For example, analysis of the longitudinal outcomes for a cohort of service leavers from a large randomly selected military cohort showed that 87.5% of those who left the UK Armed Forces were in full-time employment (Iversen *et al*, 2005a). Moreover, the chances of employment were increased as a result of the “medal effect” of the tour of duty such that those who returned in good health from the 1991 Gulf War had a greater chance of being employed than those who had not been deployed (Iversen & Greenberg, 2009a). However, the findings also showed that a substantial minority of ex-Service personnel are at risk of social exclusion on leaving service due to mental health problems and chronic ill health.
- More recently, a unique study conducted by van Staden *et al* (2007) identified factors associated with poor outcomes for 74 military personnel leaving the UK Armed Forces prematurely. Being disadvantaged was associated with: (i) experiencing pre-discharge mental health problems, (ii) receiving an administrative discharge, and (iii) serving a short sentence in Colchester Military Corrective Training Centre prior to discharge. These young men reported difficulties in accessing available resettlement services due to: (i) an absence of knowledge about the availability of services, (ii) a negative perception regarding the helpfulness of services, and (iii) previous bad experiences with other services. Most of the small minority who sought help for their mental health problems preferred to use informal networks of support (e.g., family and friends). At six months post-discharge only one participant had sought help for his mental health problem.

5.4.7 Post-Service Outcomes

5.4.7.1 Veterans in prison

- As reported by a recent *Royal British Legion* literature review on UK Veterans and the criminal justice system (2011), few research studies have been conducted on Veterans in prisons in the UK, and there is considerable variation in the levels of incarceration reported. However, DASA in collaboration with the Ministry of Justice undertook a robust study, which sought to match the records held on a database of all prisoners in England and Wales with another database comprising the records of Regular UK Veterans in November 2009. This resulted in a total of 2,207 matches (i.e., 2.7% of the total prison population). However, because the records were incomplete prior to certain years for each of the tri-Services, the outcome of further analyses of the Veteran population in England and Wales was reported in 2010 with a revised estimated total number of 2,820 (i.e., 3.5% of the total prison population). The second DASA report also provided a unique profile of UK Veterans in prison, as follows.
 - Regular Veterans are 30% less likely to be in prison compared with non-Veterans.
 - Around 50% are aged between 18-44 years.
 - Only 1% are aged 75 years and above.
 - Only 1% held the rank of Officer.
 - The length of time between discharge from military service and the start of their custodial sentence ranged from 0-41 years with the majority (41%) beginning their current sentence within 10 years.
 - The most common offences were violence against a person and sexual offences (33% and 25% respectively). Drugs accounted for 11%.

A key finding was that, with the exception of sexual offences, the Regular Veteran population has a lower rate of offending than that of the general population in England and Wales.

- Fletcher (2007) reports that the majority of legal problems experienced by Veterans referred to *Combat Stress* treatment centres relate to excessive alcohol use and episodes of violent behaviour, which may be triggered by combat-related memories and is frequently an important underlying factor in relation to self-harm and attempted suicide. KCMHR are currently exploring the impact of deployment.
- Whilst there has been some research on suicide risk among Veterans in general (e.g., Kapur *et al*, 2009) and on suicide among inmates of prisons (e.g., Fazel *et al*, 2005) there remains

a paucity of research literature on suicide among incarcerated Veterans (Wortzel *et al*, 2009). Thus, the suicide rate and the extent of excess risk remain unknown. Hence, meaningful estimates are not available. However, striking similarities and overlapping characteristics link the data on Veteran suicide, inmate suicide, and incarcerated Veterans, suggesting that Veterans in prison faces a higher level of suicide risk beyond that conferred by either Veteran status or incarceration alone. To this end, there is a clear need for a better characterisation of the incarcerated Veteran population and the suicide rate of this group.

5.4.7.2 Self-harm

- The UK has one of the highest self-harm rates in Europe affecting approximately 400 per 100,000 people (Horrocks *et al*, 2002). To define self-harm, however, is problematic because it comprises different types of behaviour, occurs in different contexts and holds different motivations and meaning for the individual concerned (Royal College of Psychiatrists, 2010). According to the National Collaborating Centre for Mental Health Guidelines (2004), self-harm is defined as: "*Self-poisoning or self-injury, irrespective of the apparent purpose of the act*". The most widely used definition in Europe and elsewhere refer to self-harm as: "*Intentional acts of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent*" (Hawton *et al*, 2007).
- Evidence from general UK population studies suggests that the most common form of self-injury is cutting, which is more repetitive than other forms of self-harm and, contrary to popular belief, is not more prevalent in females (Lilley *et al*, 2008). Men tend to choose more violent (and thus more likely to be lethal) suicide methods such as hanging, asphyxiation and firearms. Women, on the other hand, are more likely to choose self-poisoning. Another difference is the evidence that men die from suicide more frequently than do women (Hawton, 2000). In recent years, compared with females the suicide rates for males have increased, particularly in the younger age group (Cantor, 2000); a pattern which is especially marked in the UK (Hawton, 1992). These gender differences not only apply to the risk of suicidal behaviour, but also to its nature, causes, prevention and treatment. Further epidemiological studies of this kind are required to enhance understanding of the social and economic associations with suicidal behaviour in each gender. In addition, there is a need to generate information that can guide clinical

practice and prevention strategies for preventing suicidal behaviours in both genders (Hawton, 2000).

- Few studies however have sought to undertake a systematic empirical evaluation of self-harm and suicide risk in the ex-Service population. Using qualitative research methods, Crawford *et al* (2009) sought to examine the context of suicidal behaviour among soldiers in the UK Armed Forces in order to identify preventative factors. In-depth interviews were conducted with 21 service providers to obtain data on: (i) factors predictive of suicidal behaviour among soldiers; (ii) methods used for deliberate self-harm; (iii) help-seeking behaviour before and after an episode of self-harm, and (iv) concomitant barriers to accessing support services. The data were subsequently cross-validated with interview data obtained from 10 Service personnel who had received treatment from staff at DCMHs following an episode of deliberate self-harm (DSH). A key issue to emerge from the findings of the Crawford *et al* (2009) qualitative study is the need to focus on efforts to reduce stigmatisation of mental illness within the military and specifically with regard to the role of the Commanding Officers. Crawford *et al* (2009) also suggested that more needs to be done with regards to raising awareness about existing sources of help and to reduce levels of alcohol misuse. In view of the evidence that prior self-harm behaviour elevates the risk of subsequent suicide by 100 times (Jenkins *et al*, 2002), the need for further research in this domain has been highlighted by Dandeker *et al* (2003). Such research should also include identifying the gender differences in DSH given the evidence which shows that women more often engage in DSH than do men (Hawton, 2000).
- Thoresen & Mehlum (2006) reported on the investigation of risk factors for suicide in Veterans of peacekeeping duties. A total of 43 suicides and 41 fatal accidents in Norwegian peacekeepers (1978 to 1995) were compared in a psychological autopsy study. Mental health problems were the most important risk factor for suicide. Both living alone and the break-up of a marital relationship contributed uniquely to suicide risk, even when controlling for mental health problems. No peacekeeping-related factor was associated with suicide. On the basis of these findings, the authors suggested that preventive measures should focus on firearms control, improved detection systems for mental health problems in the military, and peer support through Veterans' associations.
- Kapur *et al* (2009) conducted a unique retrospective cohort study of ex-Service personnel who had left the UK Armed Forces

between 1996 and 2005. By linking national databases¹⁷⁷ of Service leavers and suicide deaths¹⁷⁸, the Veteran cohort was compared with an age-matched general population in order to investigate the:

- rate of suicide in Veterans;
 - timing of suicide in respect of the time elapsed since discharge;
 - potential risk factors for death by suicide, and
 - rates of contact with mental health services prior to suicide (and to generate a profile of those who make contact with those services).
- Covering the whole of the UK and the three Services, Kapur *et al* (2009) obtained data on 233,803 Veterans who had left the UK Armed Forces between 1 April 1996 and 31 December 2005; a figure representing nearly all (>98%) of all those who had been discharged during that time period. The median age of the cohort was 25 years and the majority were male (90%) and had served in the Army (59%). Medical discharge was recorded as the reason for leaving for some 7% of those identified. In total 224 (0.095%) were found to have taken their lives after leaving service, the majority of whom did so by strangulation (44%). Few deaths (5%) involved the use of a firearm. In the main the methods of suicide did not differ significantly from those found in the general population. In interpreting this finding however it is important to bear in mind that one of the most commonly reported differences in male and female suicide behaviours is which method of suicide they select.
 - Although, the overall rate of suicide of Veterans reported by Kapur *et al* (2009) was not found to exceed that of the general population, the risk of suicide in the two youngest age groups (under 20 years and 20 to 24 years) was around two to three times greater than in those in the general population who fell within these two age groups. The risk of suicide in Veterans was found to be higher in males, those who had served in the Army, those with a shorter length of service, and those of lower rank. Risk of suicide was greatest in the first two years after leaving Service. Twenty one per cent of the 224 Veterans who had committed suicide had made contact with the mental health services in the year preceding the event, a figure which was slightly less than for those in the general population who had also

¹⁷⁷ A link was made between the DASA database comprising data held by the Manpower Branches of each of the three Services and the suicide databases held by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (April 1996-December 2005).

¹⁷⁸ These included deaths receiving either a suicide or undetermined verdict (Kapur *et al*, 2009)

approached the mental health services in the same time period. Kapur *et al* (2009) proposed that the higher rate of suicide found in younger individuals after leaving service could be due to:

- problems associated with the transition from military to civilian life,
 - exposure to adverse experiences whilst in-Service, or
 - pre-service vulnerability factors.
- Whilst it was not possible to ascertain which of the above was the most likely cause, the Kapur *et al* (2009) findings support evidence of:
 - the relationship between pre-service vulnerability and ill health (e.g., Iversen *et al*, 2007), and
 - difficulties in the accessibility or acceptability of NHS mental health services (e.g., Iversen *et al*, 2005b).

Another contributory factor which has not been investigated in the Veteran population is the increased vulnerability of those who have been released from prison.

- The retrospective evaluation of suicide however is inevitably restricted to those data that are available from routine records and other secondary databases. Thus, whilst such data can be used to quantify the strength of association between risk factors and suicide, they are limited in terms of permitting an understanding of the context in which suicidal behaviour occurs.
- Another key issue, which could not be addressed by Kapur *et al* (2009), relates to identifying the extent to which military service is a protective factor. Given that there is evidence that military service can have a positive effect on various outcomes including employment [e.g., Iversen *et al*, 2005b]), it may also be the case with regards to helping to prevent suicide. In considering the benefit of their findings in terms of the existing service provision for health and welfare support of Veterans in the UK, Kapur *et al* (2009) emphasise the importance of recognising that those individuals who are selected out of service during the preliminary stages of enlistment (from the initial pre-recruitment interview through to training) may be at increased risk of detrimental outcomes (which would also include suicide).
- The identification of a vulnerable group also highlights the need for targeted interventions with a view to saving lives. Sareen and Belik (2009) highlight one example of a programme that was specifically targeted at an at-risk military population, which was initiated by the US Air Force in 1996¹⁷⁹. The purpose of that programme was to: (i) educate military personnel about suicide

¹⁷⁹ (<http://afspp.afms.mil/>).

prevention strategies; (ii) help military personnel to manage their emotional reactions post-trauma; (iii) provide referral guidelines for Commanding Officers for mental health services. An evaluation of the programme based on data derived from a cohort study found that its implementation was associated with a 33% relative risk reduction in suicide (Knox *et al*, 2003).

- One of the more general public health strategies highlighted in a recent systematic review of suicide prevention programmes (Mann *et al*, 2005) includes the safe media reporting of suicides. This is particularly pertinent in the UK where there has been a plethora of dramatic media portrayals of suicide in soldiers and Veterans¹⁸⁰. Whether or not such sensationalised media coverage elevates the risk of copycat suicides is subject to debate (PloS Medicine Editors, 2009). However, for the reasons highlighted by Dandeker *et al* (2005), such press coverage has a potentially detrimental effect on the image of the UK Armed Forces and public support, which in turn may have recruitment implications. As highlighted by Alexander and Klein (2006), it is also important to bear in mind however that the media can potentially make a major contribution in terms of education, information, and destigmatisation. To our knowledge, however, this is an area that has not been subject to empirical investigation.

5.4.7.3 Barriers to mental healthcare

- There is an increasing acknowledgement of the need to address barriers to mental health care by the military given that untreated mental health problems have a substantial impact on both individual well-being and operational effectiveness of the fighting force (Hoge *et al*, 2002). Yet, despite efforts to enhance access to mental health services for both service and ex-service personnel research findings from both the US (e.g., Milliken *et al*, 2007) and the UK (e.g., Iversen *et al*, 2005b) indicate that the majority do not seek help from these services. A recent US review by Vogt (2011) highlights the extent to which research on barriers to mental health care for military health personnel and Veterans has burgeoned revealing a number of factors that substantially affect service use and health and well-being outcomes. In respect of the UK, Fletcher (2007) states that:

"Barriers to obtaining help include the stigma attached to mental health problems, military ethos, NHS mental health services that are configured to prioritise severe enduring

¹⁸⁰ For example, on the 25 July 2009 The Telegraph ran a story with the headline "Traumatised former soldier committed suicide after Afghan repatriation" (see: http://www.telegraph.co.uk/news/uknews/590217197/Traumatised_former_soldier_committed_suicide_after_Afghan_repatriation).

mental illness, and problems for Veterans in engaging with treatment services that have very little understanding of military culture or combat-related psychological trauma.”
p.92.

5.4.7.4 Lack of integration across services

- Hoge *et al* (2006) described a substantial degree of psychopathology among Veterans returning from Iraq and Afghanistan and the barrier to adequate care. Potential targets for intervention involve the multiple periods of transition faced by returning Veterans. As individuals move from one system of care to another, treatment lapses commonly occur, and critical information may be lost in transit. Integration across services and systems has been identified as crucial in ensuring an effective mental health system.

5.4.7.5 Durability of therapeutic gain

- A major challenge for any therapeutic regimen is to attain durability of positive changes. Outcome research conducted on Veterans referred to *Combat Stress* (Fletcher, 2007) showed that positive gains achieved through the efforts of *Combat Stress* to address the complex needs of Veterans with mental health problems were frequently short term for a variety of reasons including limited resources. Furthermore, 75% experience more than one diagnosis, which can make it difficult for GPs of psychiatric services to manage the typically severe and complex mental health problems presented by this potentially vulnerable population (Fletcher, 2007).

5.4.7.6 Stigma

- Evidence suggests that the stigma associated with mental health problems (and resulting discrimination) is as much a problem for Service and ex-Service personnel as those who experience such problems in general population (Fossey, 2010). Stigma has been variously described in the literature as a “*mark or sign of disgrace or discredit*” (Oxford English Dictionary) to “*an attribute that is deeply discrediting and that reduces the bearer from a whole and usual person to a tainted, discounted one*” (Goffman, 1963, p3). Mental health experts suggest that it refers to the “*negative effects of a label placed on any group including those who have been diagnosed as having mental health problems*” (Hayward & Bright, 1997).

- Iversen *et al* (2011) conducted a cross sectional study of 821 participants to compare barriers to care in: (i) Regulars, Reservists and Veterans (i.e. those who had left the UK Armed Forces) and (ii) those individuals diagnosed with and without a current mental health diagnosis. Drawing on the existing KCMHR military cohort, the sample was stratified by deployment history and Regular/ Reserve status. Stigma associated with a mental health problem presented as the most common barrier to care along with the practicalities of consulting (e.g. arranging an appointment and getting time off work for treatment). Even after leaving the Service, barriers to care persisted for ex-Service personnel particularly in terms of identifying where to obtain help and a fear that employers would not be sympathetic to their problems. Compared to those without a diagnosis of a mental disorder, those with a diagnosis were more likely to report barriers to care. These findings suggest that stigma and practical barriers to care persist and prevent Service and ex-Service personnel from getting help regardless of recent endeavours by the UK Armed Forces to remove the stigma associated with mental disorders in the military. On this basis, Iversen *et al* (2011) call for the prioritisation of further interventions to address this issue in order to facilitate help seeking in Service personnel for mental health problems. Such interventions include outreach and formal educational programmes to reduce the stigma of help seeking as well as ensuring that the chain of command actively encourage those at high risk (e.g., returning from operational duties) to seek help.

5.4.7.7 Help seeking

- Evidence suggests that there is a significant reluctance by Veterans to seek help on leaving the service (Iversen *et al*, 2005a). In addition, the decline in civilian-military understanding may have had an adverse impact on the way in which Veterans are capable of dealing with civilian agencies (Deahl *et al*, 2011).
- Iversen *et al* (2005a) conducted a study to establish the frequency and associations of common mental disorders and help-seeking behaviours in a representative sample of UK Veterans who were deemed to be at high risk of developing mental health problems. By means of a structured interview 43.8% of the sample was found to have one or more psychiatric diagnoses, the most common of which were depressive-spectrum disorders. In comparison, PTSD accounted for 16.3 % of the psychiatric diagnoses identified although the majority (75.5%) of these also had a comorbid diagnosis including probable alcohol dependence (34.7%). Only 3.3% of PTSD diagnoses were made

by primary care practitioners with the majority made by military psychiatrists (30%). Approximately a third of the sample declared by self report that they had suffered a mental problem whilst in Service, the predominant problems of which were depression (48.3%) and stress (37.9%). Those with a psychiatric diagnosis compared with those without were more likely to be of lower rank, single and served in the Army. Fifty per cent who had a psychiatric diagnosis had sought help with the majority consulting their medical officer (69.6%). "Embarrassment or stigma" accounted for the main reason why the other 50% had not sought help. On leaving Service, 58.4% with self reported mental health problems were currently seeking help in the main from their general practitioners (86.9%). Fear of stigma and embarrassment (20%) and the belief that they could self manage their problems (72%) were reported by non help seekers. The majority of help seekers received treatment (83%) mostly in the form of medication (70%). A fifth of the help seekers were in contact with a Service charity and only 4% were being treated with cognitive-behavioural therapy. Overall, the majority (95.9%) of participants were employed although, compared to those individuals without a current diagnosis, those with a current diagnosis had experienced longer periods of unemployment and had changed their jobs more frequently. There are three limitations of this study which need to be considered in determining the implications of these findings. First, the reliance on retrospective self report is subject to recall bias and potential inaccuracies. Second, as a random sample of vulnerable Veterans was not used there is the potential likelihood that individuals who were more at risk of social exclusion and mental health problems were missed due to lack of compliance and difficulties in tracing Veterans. Third, because the sample derives from a cohort of individuals who served in the UK Armed Forces in 1991, the findings may not generalise to earlier or later military cohorts.

- Iversen *et al* (2010) examined healthcare service use and receipt of treatment in a sample of participants drawn from the existing KCMHR cohort. Stratified by Reserve status and by participation in the main war-fighting period of the Iraq war, this cross-sectional study used a structured telephone-administered interview along with standardised diagnostic measures and a series of questions regarding the use of services and the receipt of treatment. Around a fifth of those with common mental disorders who were currently serving in the UK Armed Forces reported receiving any form of help from a healthcare professional. Most relied on non-medical sources of help such as military chaplains. Of those Regular personnel who had received professional help, primary care provided the most common

source of help (79%) and medication or counselling/ psychotherapy was the most common form of treatment. A minority received cognitive behavioural therapy. The low rates of help-seeking from medical sources and receipt of treatment are similar to those reported for US military personnel and the UK general population. These findings highlight further the need to understand barriers to care in light of the fact that a significant minority of Service personnel are at risk of "occupational psychiatric injury". Furthermore, of significance in meeting the mental health needs of ex-Service personnel is the evidence which suggests that the main reason why individuals do not access services is based on the belief that they do not need help at a much earlier point in the care pathway. This finding challenges the previously held assumption that the unmet burden of mental health problems in Service and ex-Service personnel is due to the unavailability of suitable services. Thus, further research and evaluation is required to develop interventions which would enable Service personnel to recognise common mental health problems that require professional treatment and to reduce the stigma associated with seeking help for such problems within the military.

- Jones *et al* (2011) conducted a follow-up study of Reservists who had accessed the RMHP during the initial three years of clinical activity (November 2006 to November 2009) to compare mental health outcomes in a treatment group with operationally attributable mental health problems versus a non-intervention group with non-operationally attributable problems. Self report measures of PTSD, common mental health disorders, alcohol use and occupational functioning were delivered either by telephone or post to a sample of 83 Reservists. The majority of these RMHP attendees were from the Army. In comparison with the Regular Army, the sample were older in age and included relatively more combat troops than the Army as a whole, and a higher number of Junior NCOs and Warrant Officers. Approximately half of the sample had completed a minimum of one tour of operational duty the majority of which was for 6 months duration (85%). For one third the last tour was completed in Afghanistan. The treatment group were more likely than the non treatment group to be cases at baseline on all the mental health outcome measures with the exception of PTSD. This difference however did not persist at follow-up. On completion of treatment the majority (76.5%) of the Mobilised Reserve Force personnel resumed full occupational fitness whereas 14.9% were medically discharged from the UK Armed Forces. The findings from this clinical evaluation counter concerns that the RMHP could be at risk of overload from personnel who seek help for non operationally-related mental

health problems. Despite the relatively small number of personnel who accessed the RMHP, the evidence suggests effective mental health and occupational outcomes on completion of treatment comprising short-term psychotherapy or medication. The findings from this study however need to be treated with caution in light of the incomplete dataset, low response rate and restriction of the measurement of clinical outcomes only of those who accessed the RMHP. Those Reserve personnel requiring further treatment were predominantly suffering from an adjustment disorder, probable PTSD or depressive disorder, which is not dissimilar to their Regular force counterparts (Gould *et al*, 2008). Given that the majority of personnel used self-referral rather than accessing the system via their general practitioner, the authors suggest that open access for Regular forces to speciality services may address the issue of stigma and barriers to care identified by other studies (e.g., Gould *et al*, 2010) as is the case with improving access to psychological therapies (Clark *et al*, 2009).

SECTION 6: Summary, Conclusions and Recommendations

6.1 PREFACE

The purpose of this section is to conclude by summarising the key evidence that emerged from the consultation process and the review of the eminence- and evidence-based literature and to consider the case for undertaking a methodologically robust needs-based assessment and population-based survey of Veterans and their families in Scotland. In so doing, the extent to which similar studies conducted elsewhere might offer a valid blueprint for such a study are explored and potential models of funding and delivery are recommended.

6.2 SUMMARY OF FINDINGS: CONSULTATION PROCESS

The following key issues and suggestions emerged from the interviews conducted with stakeholders and Veterans.

6.2.1 Pre-Service Factors

- Pre-enlistment vulnerabilities play a major factor in determining those who fare least well on leaving Service and who are at an increased risk of social exclusion.

6.2.2 Service-Related Factors

- Paradoxically, whilst military life offers a number of positive benefits in terms of providing structure, security, a sense of identity and an *esprit de corps*, these benefits may exact a penalty on demobilisation and the transition to civilian life including the risk of fostering a “dependency culture”.
- Those who enlist in the Army and of a lower rank experience the greatest problems in adjusting to civilian life.
- The prevailing culture/ethos of “machismo” and “toughness” does not readily accommodate the need to report mental health problems and seek help. It also was also suggested as being a major reason why the heavy use of alcohol is a common feature of military life.
- Stigma is a prevailing issue in relation to mental health problems and help seeking.

- Support for partners of Service personnel is lacking, particularly for Reservists.
- Significant advances in military prehospital care and trauma management have generated a new major challenge in terms of the long term physical and emotional adjustment for severely injured personnel.
- Efforts by the Services to facilitate the transition from military to civilian life are inadequate, particularly for those who are most vulnerable to transition difficulties such as Early Service Leavers and those discharged on medical grounds. The primary problem is not so much the volume of information provided but the manner in which it is presented and/ or reported.

6.2.3 Post-Service Factors

- Differences in need exist between older and younger Veterans.
- A number of barriers to provision of mental health care for Veterans exist including:
 - attitudes and behaviours of the individual (e.g., fear of stigma, denial, excessive alcohol use);
 - attitudes and behaviour of others (e.g., employers, healthcare professionals, GPs), and
 - delivery of mental health services for Veterans (e.g., lack of specialist trauma services, conflict of interest between voluntary and statutory agencies, lack of integration among agencies).
- For some, the transition from military to civilian life includes a number of social and environmental problems in terms of:
 - employment (e.g., lack of experience in applying for a job)
 - housing (e.g., lack of sympathy from LAs)
 - finance (e.g., inability to manage financial affairs)
 - support for partners (e.g., lack of recognition for supportive role to ex-Service partner)
 - personal (e.g., perceived loss of special and valued identity)
 - social exclusion (e.g., due to alcohol/alcohol misuse, unemployment, debt, homelessness, mental ill health)

6.3 SUMMARY OF FINDINGS: REVIEW OF EMINENCE- AND EVIDENCE-BASED LITERATURE

- Overall, the evidence suggests that military life is beneficial for the majority who serve and that their transition to civilian life is

successful. However, there is a significant minority who fare badly, particularly Early Service leavers (i.e., those who have completed less than four years of Service) and those who have served time at the MCTC prior to discharge. Both of these groups are more likely to have had a previous history of childhood anti-social behaviour than their Serving counterparts.

- Military personnel with mental health problems are more likely to leave Service early and have an increased risk of ongoing social exclusion and ongoing ill-health.
- Pre-enlistment factors known to affect the risk of adverse health and wellbeing outcomes include:
 - childhood traumatic experiences
 - socio-economic adversity
 - previous psychiatric history
 - personality
 - coping style
- Single males, of lower rank, with lower educational status and who have served in the Army are most at risk of pre-service vulnerability factors experienced in childhood. To what extent, however, this association would be significantly different from a similar age-matched group in the general population has yet to be established. Moreover, it is not known to what extent these findings would generalise to women.
- Recent KCMHR studies of Veterans report a prevalence rate of 4% for “probable” PTSD, 19.7% for symptoms of common mental health problems and 13% for alcohol misuse.
- Reports from the charitable sector suggest that presentation with combat-related mental health problems can be as long as 14 years post-discharge. There is however no evidence to suggest that ex-Service personnel are no more or less likely to seek help than people who have never served.
- Compared with their Regular counterparts, Reserve UK Armed Forces personnel (particularly medical Reservists) have an increased risk of experiencing mental health problems as a consequence of deployment to Iraq and Afghanistan. However, the evidence suggests that this finding is more likely due to family issues prior to deployment, support to families during deployment, and experiences of home coming than events in theatre.

- Relative to the general population, both Serving and ex-Service personnel report higher levels of alcohol consumption (but only in younger age groups). Alcohol misuse has also been identified as a problem affecting Service women.
- The overall rate of suicide is no greater among UK ex-Service personnel than in the general population. However, for men aged 24 years and less who have left the UK Armed Forces the risk of suicide is approximately two to three times higher than that of the same age group in both the general and serving populations.

6.4 RESEARCH RECOMMENDATIONS

- Underpinning an evidence-based approach to Veteran care requires the necessary epidemiological data and needs assessment to quantify the clinical and economic burden of ill-health and characterise the excess morbidity reported as well as to identify those factors which conduce to a positive transition from the UK Armed Forces to civilian life including resilience, recovery, and post-traumatic growth (Sundin *et al*, 2010). Whilst a considerable body of literature exists on the health and wellbeing outcomes in respect of serving military personnel, few studies have been specifically dedicated to those who have left the UK Armed Forces.
- Most of the literature relating to ex-Service personnel in this domain derives from the US. The extent to which the findings from such studies are generalisable to ex-Service personnel in the UK is limited by virtue of two key differences that exist between these two nations, *viz*, the Vietnam War experience and the subsequent establishment of the US Veterans Administration designed to provide bespoke medical and psychiatric treatment for US Veterans (Fear *et al*, 2009). Within the UK, most of the academic research of note has been conducted by the KCMHR and is predominantly based on their military cohort data. However, to inform service provision and the development of appropriate interventions it is imperative to establish the extent to which the Veteran population differ from those in the general population. Whilst there have been two studies in the UK that have adopted this approach, one in England (Woodhead *et al*, 2011a; 2011b), and one in Wales (<http://medicine.cf.ac.uk/primary-care-public-health/research/healthy-places/completed-projects/Veterans-needs-assessment/>),

comparisons between the two are limited due to variations in the design, sampling strategies, and method of diagnostic assessments used.

- There is a paucity of robust epidemiological data about the health and wellbeing, views, expectations, and needs of ex-Service personnel and their families in Scotland, and how these compare with the general population. The current evidence-base is therefore not sufficient to design specific health strategies or develop new services—within or outside the conventional health care system—particularly in order to reach non-treatment seeking ex-Service personnel who suffer from mental health problems and are at risk of the downward social spiral that can lead to breakdown in relationships, homelessness, debt, and encounters with the criminal justice system. A key related factor that requires further investigation is the role of alcohol with regards to increasing the risk of social exclusion.
- Historically the profile of the UK Armed Forces has not been representative of the general population. To deliver operational capability, the UK Armed Forces employ people who meet specific standards of health and fitness and certain nationality criteria. The ratio of men to women in the UK Armed Forces is substantially higher than would be the case in most other occupations; a circumstance which in part derives from the fact that the military are unique in having to conduct operations on behalf of the nation, which if necessary involves combat. Although the number of Service women has gradually increased in line with the implementation of equal opportunities policies by the MoD, there is a paucity of research about their specific health and wellbeing needs, particularly post-Service.
- Given the evidence that military service has a positive impact for the majority of UK Armed Forces personnel, it is important to study not just those who may be damaged by service but also those who gain by it. Thus, whilst a greater understanding of pre-enlistment vulnerability risk factors is required, it is also necessary to understand what factors facilitate and enable those with the same vulnerabilities to fare well by using appropriate comparison groups. Such an approach would enable the UK Armed Forces to identify what could be done to improve the life chances of young people with pre-enlistment vulnerabilities in preparation for leaving military service.
- Many regiments have historical regional areas of recruitment, which for traditional forces include areas of economic and social deprivation (Fossey, 2010). Although evidence suggests a link

between areas of high social deprivation and offending behaviour, it is not known for example whether recruitment into the UK Armed Forces from such areas has a positive or negative impact on the risk of subsequent offending and incarceration of those particular recruits on leaving military service and to what extent regional variation exists.

- Relatively little is known about the health and wellbeing outcomes in the longer term for ex-Service personnel due to the paucity of large prospective longitudinal studies. Well-designed cohort studies offer a number of advantages in respect of identifying the longer term implications of military service (Fear *et al*, 2009).
- Epidemiological data are lacking on specific groups who are at risk of health and wellbeing problems such as the wounded and disabled and those exposed to high intensity combat (Deahl *et al*, 2011). For example, in respect of the increasing numbers of injured combat troops returning from Iraq and Afghanistan with blast related polytrauma (Sayer *et al*, 2008) and associated traumatic brain injury [TBI] (French & Parkinson, 2008). Relatedly, there is a particular need to understand the longitudinal course of post-traumatic reactions and to assess the factors which may affect the reporting of symptoms at follow-up such as persisting physical problems, anticipation of returning home and starting work, concern over healthcare, and pending disability. Relatedly, whilst the acute clinical management of polytrauma has been well described, the post-acute clinical management of such cases in rehabilitation and primary care settings has not been adequately addressed in the literature. Very little is known about the impact of military and ex-Service life on partners and families. Research that takes into consideration military personnel with different family configurations (e.g., dual-deployed parents and single parents) is urgently required. In 2009, the ACTR was commissioned by the Headley Court Trust to undertake a 3-year longitudinal study to identify factors which conduce to and prevent rehabilitation and adjustment in military personnel and their partners following combat-related injury (Forbes *et al*, 2011a; 2011b). The Final Report for that study is due to be submitted to the Headley Court Trust in January 2013.
- An increase in the deployment of Reservists in the UK Armed Forces and concerns about their health outcomes following deployment highlights the need for a greater understanding of the impact of the additional challenges facing families of

Reservists compared to the family members of Regular personnel.

- To date there has been no health economic evaluation of the financial impact of providing health and welfare support services to ex-Service personnel. McCrone *et al* (2003) highlight this gap in the literature with specific reference to the health economic considerations relating to service interventions for ex-Service personnel who are diagnosed with PTSD.
- There remain gaps in the evidence with regards to determining the effectiveness of health and welfare interventions in relation to:
 - establishing whether recommended treatments are best delivered in specialist Veterans' mental health facilities or in the mainstream NHS (Fossey, 2010);
 - identifying factors that facilitate or inhibit help-seeking (e.g., due to a fear of stigmatisation) and to establish whether differences do indeed exist between ex-Service personnel and the general population;
 - identifying factors that facilitate resettlement, in particular for those who are at greatest risk of experiencing problems in making a transition from military to civilian life (e.g., Early Service Leavers);
 - promoting social inclusion (e.g., by enhancing employment opportunities, and reducing the number, experiences and outcomes of homeless ex-Service personnel), and
 - health economic considerations.

6.5 NEEDS-BASED ASSESSMENT AND POPULATION-BASED SURVEY OF VETERANS AND THEIR FAMILIES IN SCOTLAND

- The principal aim of this scoping review was to identify to what extent a population-based survey is required to inform the national commitment to meeting the health and wellbeing needs of ex-Service personnel and their families in Scotland. The outcome of this comprehensive review has confirmed that there is a paucity of robust epidemiological data about the health and wellbeing, views, expectations, and needs of ex-Service personnel and their families in Scotland, and how these compare with the general population. On this basis, there are sufficient grounds to warrant consideration of the case for undertaking a methodologically robust needs-based assessment and population-based survey of Veterans and their families in Scotland. The outcome of such an endeavour is that it would provide an important first step to informing the scale and nature

of health and welfare provision (Busuttill, 2010) and facilitating the development of a “flexible, needs-led, high quality standard of care” (Deahl *et al*, 2011).

- Such an approach is in accordance with the promotion of a well-being and recovery-based mental health community-based service model produced by the former Scottish Executive’s Mental Health Division (DfMH, 2006), which combines a population-based approach to social inclusion to prevent mental illness and inequalities in mental health and highlight the link between mental and physical health. The guidance in DfMH is based on evidence of what works in terms of achieving better outcomes for individuals through using appropriate services that meet their needs. It promotes a functional model of service design and requires local partners to ensure service effectiveness and achieve high standards in response to local needs.
- Presented below are the key issues that need to be considered in order to determine how best to undertake such a study, the approach for which has been informed by that of Anderson *et al* (2008b) in undertaking a Scoping Study to identify the need for a Scottish Longitudinal Study of Ageing.

6.5.1 Identification of an Appropriate Comparison Group

- Identification of an appropriate general population comparison group is potentially problematic due to the socio-demographic profile of the UK Armed Forces (Fear *et al*, 2009). One option would be to identify specific index and comparison groups against that could be meaningfully contrasted with other occupational groups to control for the “healthy worker” effect such as first responders (e.g., fire-fighters, police, and paramedics).

6.5.2 Data Protection and Ethical Issues

- The UK’s Data Protection Act (1998) has had a substantial impact on health-related research. At present the 1998 Act allows medical data to be used for any medical research purposes without the need for consent of individuals. Changes in the implementation of UK data protection law has placed major bureaucratic obstacles for epidemiologists to overcome in seeking to trace individuals who have not yet consented to participate in research (Iversen *et al*, 2006). Consequently most codes of ethical conduct recommend informed consent for any medical research whether it involves direct contact with

participants or access to their records. To obtain consent however incurs participation bias and inevitably reduces the response rate, in particular when using a sampling frame that prevents researchers immediate access to contact details to make a direct approach to potential participants. Those who are most likely to respond are those for whom the study has the greatest salience. Consequently the sample size is likely to become too small and lack sufficient statistical power to reach generalisable conclusions (Iversen *et al*, 2006).

- A pertinent illustration of the issues raised above is the outcome of a pilot conducted by Klein *et al* (2004) to test out the feasibility of conducting an epidemiological community-based clinical, psychological and economic survey of post-traumatic stress disorder and trauma-related psychopathology in Grampian. To maximise the efficiency of the pilot study in capturing variation by socio-economic status and area of residence (urban vs rural), a random sample of 500 adults (18 years and above) registered for primary care, and stratified according to census-based indicators of deprivation and degree of urbanisation of residence, were selected by means of the Community Health Index (CHI); a computerised database of all patients registered with general practitioners in Scotland. Five stages were required before it was possible to conduct the telephone screening interviews, as follows.
 - *Stage 1:* Prior to commencing with recruitment, full ethical approval was obtained from the Grampian Research Ethics Committee, and permission was obtained from the Director of Public Health for access to the CHI.
 - *Stage 2:* Randomisation and identification of potential participants was conducted by the Data Manager (Data Management Team, College for Life Sciences and Medicine, University of Aberdeen).
 - *Stage 3:* In accordance with ethical procedures governing the use of the CHI, a letter was sent under the aegis of the Director of Public Health to all the general practitioners, whose patients had been identified, to obtain approval for the inclusion of their patients in the study. A total of 27 (5.4%) patients were identified by this means as being ineligible to participate on clinical grounds. Thus reducing the number from 500 to 473.
 - *Stage 4:* As the research team were not permitted to know the identity of the 473 (94.6%) eligible individuals until consent to participate had been obtained, a letter was sent by the Director of Public Health inviting them to take part in the study and requesting them to complete a consent form

and a contact details form to be returned directly to the research team.

- *Stage 5*: Once permission was finally granted for the research team to contact the 473 individuals who had consented to participate, a response was received from 133 (28.1%), 29 of whom subsequently declined to participate. A total of 104 telephone screening interviews were completed.
- In an endeavour to promote health care research, the new General Medical Council (GMC) Guidelines on Confidentiality (September 2009) have indicated a more proportionate approach to using health care data (Fear *et al*, 2009).

6.5.3 Tracing Issues

- For reasons already described above, a high participation rate is recognised as a key priority for any research study. However, health-related research involving ex-Service personnel presents a considerable challenge in this regard since the group least likely to return questionnaires in the general population are typically young single males (Tolonon *et al*, 2006) who represent a significant proportion of this target population. The problem is further compounded by virtue of the fact that on leaving military service it becomes increasingly difficult to trace individuals (Hotopf & Wessely, 2005) as obtaining a valid address becomes increasingly difficult with the passage of time, in particular with regards to those service leavers who are peripatetic due to frequent changes in employment and accommodation. Evidence suggests that such factors are associated with mental health problems and increase the risk of social exclusion. Whilst tracing these individuals is notoriously difficult, a recent article by Fear *et al* (2010) provides a helpful account of the methods used by KCMHR when conducting a telephone survey to identify the prevalence of mental health, health service usage, and stigma within serving and ex-Service personnel. Methods to trace participants included the:
 - military database that contains last known address;
 - NHS address registry (but this is contingent on the individual being registered with a GP), and
 - next of kin contact details.All contact details were subsequently cross-referenced against the electoral roll to determine if resident at the specified address.
- Fear *et al* (2010) concluded that the use of “multiple simultaneous” tracing methods and tailoring the approach in

accordance with the target population helps to increase rapport with participants and encourage compliance.

- Efforts have been made to improve the recording of data relating to identifying those who have served in the UK Armed Forces. For example, as a result of communications between DASA and ONS, a question to this effect has been included in the 2011 Census.

6.5.4 Regional Variation

- Within Scotland there are distinct regional differences in terms of poor health, with different rates depending on deprivation, remoteness and the urban/rural setting. In addition, there are distinct regions that are typically associated with the military. This has implications in respect of the sampling strategy to ensure a nationally representative sample.

6.5.5 Sampling Frame

- The sampling frame operationally defines the target population from which the sample is drawn and to which the sample data will be generalized. most familiar type of probability sample is the *simple random sample*, for which all elements in the sampling frame have an equal chance of selection, and sampling is done in a single stage with each element selected independently (rather than, for example, in clusters).
- Somewhat more common than simple random samples are *systematic samples*, which are drawn by starting at a randomly selected element in the sampling frame and then taking every *n*th element (e.g., starting at a random location in a telephone book and then taking every 100th name).
- In yet another approach, *cluster sampling*, a researcher selects the sample in stages, first selecting groups of elements, or clusters (e.g., census tracts), and then selecting individual elements from each cluster (e.g., randomly or by systematic sampling).
- Three main sampling options have been identified as being available for a study of this type.
 - (i) Bolt on to an existing national survey.
 - (ii) Screen addresses to identify eligible households/ individuals.
 - (iii) Identify a sample from an individual-level sampling frame or database.

- The particular advantages and disadvantages of each of these three sampling options is summarised below.

(i) Bolt on to an existing national survey

- Based on the broad range of health and welfare outcomes identified in this scoping review, four Scottish national data sources were considered as potential sampling frames on the grounds that they have been designed and implemented exclusively in Scotland to address specific Scottish issues and contexts alongside the more general demographic information needed to cross classify them.
 - *Scottish Longitudinal Survey (SLS)*¹⁸¹ – The *SLS* is a large scale linkage study that links data from the Census with data provided by various administrative and statistical sources (including health records). The 1991 Census was used to identify approximately 274,000 *SLS* members and information from these individuals have been linked to other datasets including the 2001 Census, vital events and health information. It has been widely used to study health variations over time and has the benefits of low attrition (because the data collected are either required by law or as part of a standard administrative data) and high linkage with events.
 - *Scottish Health Survey (SHeS)*¹⁸² – The *SHeS* provides a detailed picture of the health of the Scottish population in private households and is designed to make a major contribution to the monitoring of health in Scotland. It is regarded as being essential for the Scottish Government's forward planning, for identifying gaps in health services provision and for identifying which groups are at particular risk of future ill-health. The specific aims of the *SHeS* are to:
 - estimate the prevalence of particular health conditions in Scotland;
 - estimate the prevalence of certain risk factors associated with these health conditions and to document the pattern of related health behaviours;
 - identify differences between regions and between subgroups of the population in the extent of their having these particular health conditions or risk factors, and to make comparisons with other national statistics for Scotland and England;
 - monitor trends in the population's health over time, and

¹⁸¹ <http://www.lscs.ac.uk/sls/>

¹⁸² <http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/scottish-health-survey>

- make a major contribution to monitoring progress towards health targets.

From 2012-2015 the survey has been designed to produce an achieved sample size of around 4,000 adults and 1,800 children per year.

- *Scottish Crime and Justice Survey (SCJS)*¹⁸³ - The *SCJS* is an annual social survey that involves interviewing a randomly selected adult in 12,000 households across Scotland identified by means of the Postal Address File. The principal aims of the *SCJS* are to:
 - generate reliable statistics on peoples experience of crime, including services provided to victims of crime;
 - evaluate the varying risk of crime for different groups of people in the population;
 - examine temporal trends in the level and nature of crime in Scotland;
 - obtain information about people's experiences of, and attitudes on a wide range of crime and justice-related matters;
 - provide an alternative and complementary measure of crime to the police recorded crime statistics, which provide statistics on crimes and offences recorded and cleared up by the eight Scottish police forces.

Findings from the *SCJS* are used by policy makers across the public sector in Scotland to help understand the nature of crime in Scotland, target resources and monitor the impact of initiatives to target crime.

- *Scottish Household Survey (SHS)*¹⁸⁴ - The *SHS* is designed to provide accurate, up-to-date information about the characteristics, attitudes and behaviour of Scottish households and individuals on a range of issues. It is a "continuous cross-sectional survey", each complete sample being covered in the course of two years to amount to 31,000 households. The sample is being drawn from the small user file of the Postcode Address File.
- Whilst there are a number of potential advantages to bolting on to an existing national survey (particularly in terms of reducing cost) discussion with those responsible for overseeing these national surveys confirmed for a variety of reasons it would not be a viable option.

¹⁸³ <http://www.scotland.gov.uk/Topics/Statistics/Browse/Crime-Justice/crime-and-justice-survey>

¹⁸⁴ <http://www.scotland.gov.uk/Topics/Statistics/16002>

- Although the *Adult Psychiatric Morbidity Survey (APMS)*¹⁸⁵, which is another nationally representative survey, was used to generate a community-based sample to compare the health of conscripted national service Veterans with population controls (Woodhead *et al*, 2010b), it would not be suitable for the proposed Scottish survey because:
 - it is based on a community-dwelling sample of adults (aged 16 years and above) in England only, and
 - the sample size would be insufficient to draw reliable conclusions about younger Veterans given the majority were aged over 65 years.

- Discussion also took place with Professor Simon Wessely (Director, KCMHR) and Dr Nicola Fear (Reader in Epidemiology, ACDMH) to explore the possibility of identifying a sample of ex-Service personnel from the KCMHR 2003 cohort in light of plans to re-contact 12,000 Service personnel of whom 4,000 had since left Service and 400 were identified as residing in Scotland. However, whilst this approach would potentially provide a representative sample of ex-Service personnel (given that it is based on a random selection), the question remains as to how best to identify a suitable comparison group that would be representative of the Scottish general population.

- An alternative approach was recently reported that used the KCMHR 2003 cohort to provide evidence to inform service provision for military ex-Service personnel residing in Wales (<http://medicine.cf.ac.uk/primary-care-public-health/research/healthy-places/completed-projects/Veterans-needs-assessment/>). It was funded by the Welsh Assembly Government (WAG) to develop a service specification for a Wales-wide service for Veterans and led by Professor Jonathan Bisson (Department of Psychological Medicine and Neurology, Cardiff University). The study was a cross-sectional survey to assess the needs of military Veterans in Wales and involved a telephone study of a sample recruited from the following three sources.
 - The KCMHR randomly selected cohort of all 261 Veterans who were living in Wales.
 - A random sample of 150 Veterans out of the total of 262 living in Wales and in contact with *Combat Stress*.
 - A random sample of 150 Veterans out of the total of 12,017 living in Wales who had made contact with the SPVA.

¹⁸⁵ <http://www.ic.nhs.uk/pubs/psychiatricmorbidity07>

(ii) Screen addresses to identify eligible households/individuals

- The main advantage of a new sample based on screening of households from the Postcode Address File is that it has no "inherited" response bias and it offers more flexibility with regards to geographic clustering as data collection is not tied to other surveys. Its main disadvantage is that it is typically considerably far more expensive to conduct and can be unpopular with interviewers, who prefer to spend their time interviewing rather than screening and, as such, adversely affect response rates.

(iii) Identify a sample from an individual-level sampling frame or database

- The ideal option would be to draw a fresh sample from an individual-level database containing former military service as an identifier variable. In Scotland, the National Health Service Central Register (NHSCR) offers potential opportunities as a sampling frame for this approach. It maintains records of all NHS patients and birth records of those not registered with a GP (unlike the Community Health Index which is a listing of everyone who has been or is registered with a Scottish General Practice) including more recently those who have joined the UK Armed Forces. As an electronic administrative database it enables the:
 - capturing of data on migration to identify exits and re-entry from one Health Board to another and from NHSScotland to retain contact with individuals who relocate within the UK by virtue of co-operation with NHS Information Centre (NHSIC) and Medical Research Information Service (MRIS), Southport;
 - flagging of the date of death of consenting participants (a key factor given the shifting demographic profile of an increasingly older population), and
 - availability of record linkage techniques to match self-report data with medical records held by the ISD National Health Service (NHS) Scotland and facilitate the economic analysis.
- Use of the NHSCR for a military study has been piloted in Scotland. In principle, the NHSCR would offer an ideal sample frame and would lend itself well to the data linkage aspects of the study. However, there would be potential problems about achieving a sufficiently large sample size for the same reasons described in 6.5.2 above with regards to the use of the

Community Health Index in the Grampian pilot (Klein *et al*, 2004). For this reason, the costs involved would be considerably more than those for the other two approaches identified above.

- A pertinent example of this type of approach is an epidemiological study of trauma, health and conflict conducted in Northern Ireland (Ferry *et al*, 2008). The rationale for the study was based on the fact that because Northern Ireland has experienced 30-40 years of civil conflict in its recent history (often termed the "Troubles") there was a need to identify the traumatic impact on health and trauma-related disorders. It comprised two parts. The first was based on the *Northern Ireland Study of Health and Stress* (NISHS), which represents one of the largest ever population based studies of mental health undertaken in Northern Ireland and is part of the World Mental Health (WMH) surveys conducted in over 28 countries worldwide under the aegis of the WHO. As is the case for all WMH surveys, the sampling frame is based on the generation of random numbers to select a multistage household probability sample using clusters in order to link in with Government figures and Census output areas. At the time of the study a total of 3,100 individuals had been interviewed face-to-face using the WMH-Composite Diagnostic Interview (WMH-CIDI; WHO, 1997); a comprehensive, fully structured interview designed for use by trained lay interviewers for the assessment of mental, behavioural, and substance use disorders according to the definitions and criteria of ICD-10 (WHO, 1992) and DSM-IV (APA, 1994). A number of screening questions are asked to determine the direction of the interview. To achieve that number of interviews required the identification of 6,000 in the sampling frame and cost in the region of £1 million, which was spent on postgraduate awards although the majority of costs were attributed to undertaking the interviews as the data collection for the NISHS was outsourced given that it required 40 trained interviews. The second part of the study used qualitative methods to find out more about the experiences of individuals who had been traumatised by their experience of civil conflict in Northern Ireland. Data was collected over a period of three to four years.
- An interview with Professor Brendan Bunting (Professor of Psychology, Psychology Research Institute) as the lead for the Northern Ireland study revealed that the key issues apart from the cost were as follows. First, although the age for eligibility to participate was 16 years and above, he recommended increasing it to 18 years and above. Second, because of legislation in Northern Ireland dating back to 1968 which required the passing

on of information regarding knowledge of any criminal act, this required the interviewer to state as part of the informed consent process that any such knowledge would have to be reported to the authorities. Third, there was a problem in terms of determining how best to deal with mental health problems identified as part of the assessment process. Two psychiatric social workers were subsequently employed on a standby list to deal with any participants in need of help. Fourth, each participant was paid £10 per interview. Fifth, in addition to providing a greater understanding of some of the experiences reported in the first part of the data collection, the qualitative interviews were also of benefit in terms of enhancing the face validity by providing a context and bringing to life the personal experiences of participants.

6.6 DESIGN AND FUNDING RECOMMENDATIONS

- The possible options for the design of a population based survey to inform policy development in meeting the health and wellbeing needs of ex-Service personnel and their families in Scotland need to take into consideration the following challenges.
 - Identification and tracking of Scottish Veterans and their families to permit a representative sampling frame and strategy.
 - Adequate sample size(s) to ensure sufficient power to detect statistically significant differences thereby maximising the generalisability of findings.
 - Recruitment and retention mechanisms to maximise compliance rates and minimise loss at follow-up thereby enhancing the representativeness of the sample(s).
 - Reliable and valid assessments.
 - Identification of index and comparison groups against which different sub-samples of the Veteran population (e.g., those who are at risk of social exclusion) could be meaningfully contrasted.
 - Data protection and ethical requirements (including identifying mechanisms to ensure the safety of research personnel involved in the recruitment and assessment of participants).
 - Costing requirements associated with possible approaches according to:
 - a realistic and feasible timeframe, and
 - a realistic estimation of the resources required (i.e., research personnel, travel, subsistence, equipment, consumables, consultancy, data entry and analysis).

- The design should be ambitious in terms of sample size to allow for detailed sub-group analysis and to take into account the potential effects of attrition due to the nature of the target population.
- Commitment should be sought for funding for at least 3 years but preferably longer to ensure that the long term value of the resource is fully realised.
- A mixed methods approach should be used to allow for the in-depth understanding of key issues (e.g., barriers to help seeking).
- The design must be founded on the rigorous application of population-based research methods to:
 - assess a broad range of health and wellbeing needs;
 - accurately identify those individuals who require health and social care services;
 - reliably evaluate the use and perceived effectiveness of health and social support and clinical care currently available, and
 - identify factors conducive to recovery, wellbeing, and psychosocial adjustment.
- Given the likely scale of a population based survey in Scotland and the range of interests it is likely to serve, a form of collaborative funding is recommended. One approach would be to seek matched funding from the Scottish Government for resources elsewhere. Other potential sources of funding include the Economic and Social Research Council (ESRC), the Chief Scientist Office (CSO), and the Wellcome Trust. This approach proved successful in a recently completed collaborative study involving the KCMHR, the ACTR and the National Centre for Social Research (NatCen), which was funded by the ESRC. The principal aim of the study was to investigate the attitudes and perceptions to the Iraq and Afghanistan missions amongst the British public using the 2011 *British Social Attitudes (BSA)*¹⁸⁶ survey as a platform for a module of 40 questions (Gribble *et al*, 2012). The concept for this study originally derived from one of the findings from this Scoping Review, *viz*, the potential for stigma experienced by ex-Service personnel to affect their ability to adjust successfully to civilian life in terms of employment, housing, and health care.

¹⁸⁶ The BSA sample is selected each year from the Post Office Address File (PAF), and comprises around 3,300 interviews with adults (aged 18 years and above) across Britain.

APPENDICES

APPENDIX A: Roles of Key Partners and Designated Responsibilities

PARTNERS

MoD

**Government
Departments &
Devolved
Administrations**

**Ex-Service
Organisations**

ROLES

**Former employer
of Veterans**

**Secretariat
support to the
Minister for
Veterans**

**Devise policies
and services that
affect Veterans**

**Co-operation
with devolved
administrations**

**Advocacy and
partnership**

**Campaigning to
represent the
concerns of
Veterans**

RESPONSIBILITIES

**Resettlement,
training and
advice**

**Pension and
compensation
advice**

**Provision of
healthcare and
social services**

**Identify wider
and specific
initiatives and
priorities**

**Formulate
appropriate
solutions**

**Identify work
required to
address Veterans'
needs**

**Provide additional
welfare support
and social
environment**

APPENDIX B: Outline of commitments pledged in the Command Paper 7424 "The Nation's Commitment: Cross Government Support to our Armed Forces, their Families and Veterans"

AREAS OF COMMITMENT

Compensation

- Armed Forces Compensation Scheme Review - the upfront lump sum payment for injury under the AFCD will be doubled for the most serious injuries, e.g., loss of limb. All recipients will receive an uplift of between 10 and 100% on upfront lump payments according to severity of injury.

Health

- Improve information held by Government about how Veterans' health needs differ from the population generally.
- Identify whether more needs to be done to assess the healthcare needs of Veterans.
- Raise awareness among healthcare professionals about the needs of Veterans to ensure that those needs are met.
- Establish pilot schemes to provide community mental health services for Veterans in six locations across the UK in acknowledgement that mental health services do not always fully address the needs of Veterans.
- Pilots concentrate on improving Veterans' access to mental health services.
- Community Mental Health Services will be provided across the UK based on lessons learned from pilots.
- Meeting the needs of Veterans will be an important element in the selection of the next round of psychological therapies sites in England for 2009/10.

Housing

- *Affordable homes:* The Key Worker status will be extended to enable service leavers to access the Key Worker Living scheme 12 months after discharge. Scottish Ministers have agreed to extend access to their affordable housing schemes to Service leavers 12 months after discharge.
- *Adapted social housing:* In view of the fact that seriously injured service personnel can face delays in obtaining suitable adapted housing where they are not given sufficient priority, seriously injured personnel in England and Wales should be given "additional preference" (i.e., high priority for social housing) and statutory guidance will be issued accordingly. Scottish Ministers will remind landlords of existing high

priority that seriously injured personnel in Scotland receive for adapted social housing.

- *Adaptable affordable homes:* Low cost initiative for First Time buyers in Scotland may also be eligible for a grant from the Local Authority to cover the cost of any necessary adaptations.
- *Disabled Facilities Grant Means Test:* AFCS and WPS payments for most seriously disabled will be disregarded in the means test for DFG in England and Wales. In Scotland this means test is being considered for discontinuation.
- *Homelessness:* The Department for Communities and Local Government (CLG) will contribute £400,000 to provide new supported housing for Service Leavers in England to enable them to make a successful transition to civilian life. Opportunities will be explored with Scottish Ministers and ex-Service charities on housing ventures to meet the accommodation needs of Veterans in Scotland.

Education and Skills

- *Education and training for Service leavers:* As those who join the Armed Forces often commit to this career path before they can take advantage of opportunities in further and higher education, all Service leavers with over 6 year's service will have the opportunity to achieve their first Level 3 qualification or progress to higher levels free from tuition fees. Scottish Ministers have agreed to put similar measures in place.

Transport

- *Concessionary bus travel:* By 1 April 2011, the statutory bus concession in England will be extended to include Service personnel and Veterans under the age of 60, who were seriously injured in service and who are resident in England. Scottish Ministers will consider by April 2009 how take forward this proposal as part of the three year review being conducted on the Scotland-wide Free Bus Scheme for Older and Disabled People.
- *Blue Badge Scheme:* In England and Scotland severely disabled Veterans will receive automatic entitlement to a Blue Badge without further assessment.

Support for Families

- *Inquests:* Explore with the British Legion and the War Widows Associations, how to make the inquest process as rapid and supportive to families as possible.
- *Support to bereaved families:* Review procedures to ensure that sufficient account is taken of the needs of the family.

Benefits

- *Seamless transfer onto benefits:* The DWP will use the Service medical board evidence for those claiming Incapacity Benefit/ Employment and Service Allowance.

Building Careers

- *Employment of Service leavers in the public sector:* Develop with public sector employers access routes tailored to meet the needs of Service leavers. Scottish Ministers have agreed that their Administrations will support this commitment.

Recommendations

- *Departmental co-operation:* between Government departments and Devolved Administrations should ensure that policy is not made nor enacted upon without taking into account its impact on the Service community.
- *Armed Forces Advocate:* Each Department of State will appoint a senior Director as an "Armed Forces Advocate" to identify and resolve policy or legislative issues that may affect this sector of the population. Advocates will meet regularly with the MoD.
- *Local co-operation:* The Department for Communities and Local Government (CLG) has issued new statutory guidance to local authorities in England (Creating Strong, Safe and Prosperous Communities) encouraging them to consult their local Armed Forces. This ensures that Service needs are considered as part of local authority planning.
- *Ensuring delivery:* Progress will be assured by regular external and cross-Government audit.
- *Keeping everybody informed:*
- The consultation exercise conducted to inform the preparation of this paper revealed that a number of Service personnel, their families and Veterans did not know or understand what was available to them or how to get access to it.
- It was also evident that some Government departments and agencies were not communicating with them or each other as well as they should.
- Issue widely easily-accessible advice on what the commitments in this cross-Government strategy will mean for them on the ground.
- Publicise organisations from which advice can be sought.
- Provide straight forward guidance on where individuals should turn to for assistance and how to complain when local agencies or Departments are not delivering on any of the commitments in the strategy.

APPENDIX C: Scottish Government Initiatives Associated with the Commitment to Meeting the Needs of Veterans and Forces' Communities in Scotland

HEALTHCARE

Measures already in place or in the Consultation Paper

- Extend the priority treatment scheme to all Veterans (including Reservists¹⁸⁷) as of 29 February 2008.
- Develop a pilot project to provide services for Veterans' with mental health problems in partnership with the MoD, NHS Lothian and Veterans' organisations (e.g., *Combat Stress*); the outcome of which was to be applied across all NHS Boards in Scotland.
- Improve access to dental services in Fife to accommodate demand at RAF Leuchars.
- Ensure injured Veterans have access to prosthetic limbs through NHSScotland equal to that provided by the Defence Medical Services.
- Ensure a continuity of care and treatment within the national waiting time targets to compensate for the adverse impact on treatment waiting times imposed by Service mobility.
- Permit the completion of IVF programme for women serving in the UK Armed Forces.

Measures to be implemented

- Support proposals to increase:
 - dental service provision in areas with increased Forces populations.
 - level of health service awareness of Forces and Veterans' needs.
- Increase the awareness of health needs.

¹⁸⁷ This goes beyond what the Priority Treatment scheme in England offered where Reservists were excluded from entitlement to priority treatment according to clinical need.

HOUSING

Measures already in place or in the Consultation Paper

- Seek guidance on the issue of preventing homelessness.
- Provide priority access to the Low-cost Initiative for First Time Buyers (LIFT) shared equity schemes to enable the purchase of property.
- Seek MoD agreement to providing Scottish Ministers, LAs and Registered Social Landlords (RSLs) priority in purchasing any surplus MoD land or properties in order to meet the high demand for housing in Scotland.
- Ensure accessibility to shared equity schemes for people with disabilities including injured Service personnel and Veterans.
- Facilitate priority need for accommodation to assist Service leavers at risk of homelessness under the Scottish homelessness legislation.
- Ensure a high priority in the allocation of adapted social housing for seriously injured ex-Service personnel.
- Implement changes to the method of assessing entitlement for grant adaptations in Scotland with a view to benefiting all disabled home owners seeking to adapt their homes.

Measures to be implemented

- Investigate the prevalence of Local Authorities (LAs) not accepting Certificates of Cessation for Service personnel giving up Services Accommodation.

LOCAL CO- OPERATION

Measures already in place or in the Consultation Paper

Measures to be implemented

- Establish contacts between MoD and childcare partnerships in LAs in areas with a high Forces' population to ensure that Service needs are taken into consideration in the childcare partnership review of supply and demand.
- Double the level of funding for the Scottish Veteran's Fund to approximately £250,000 over a three year period to support projects and initiatives undertaken by Veteran's organisations and charities.

EDUCATION

Measures already in place or in the Consultation Paper

Measures to be implemented

- Ensure a high level of schooling continuity for the children of Force's families.
- Identify issues of under-achievement, and implement measures subject to requirement.
 - Introduce measures to enable Service leavers resident in Scotland the opportunity to achieve their first SCQF level 6 qualification without having to pay tuition fees.
 - Extend fee arrangements for Service leavers with 6 year's service to ensure that they can study an HNC, HND, or full degree, without having to pay tuition fees.
 - Develop new opportunities for Service families to access Basic Skills training through the spare capacity of UK Armed Forces education facilities.

EMPLOYMENT AND EMPLOYABILITY

Measures already in place or in the Consultation Paper

Measures to be implemented

- Enhance the two-way flow between Service and civilian employment through development of the Defence Career Partnering project in partnership with stakeholders, employers and the MoD.
- Provide support for Scottish Government and NHSScotland staff members who are also members of the Volunteer Reserve Forces.
- Assist family members of Service personnel to transfer their public sector employment resulting from a Service move.
- Develop tailored access routes for Service leavers into employment in the public sector.
- Enhance the signposting of Service leavers with relevant skills to other public sector employers (e.g. LAs).

TRANSPORT

Measures already in place or in the Consultation Paper

Measures to be implemented

- Extend the provision of concessionary bus travel to injured Veterans as part of the review of the Scottish wide Free Bus Travel Scheme for Older and Disabled People.
- Extend the Blue Badge parking concession scheme to ensure that severely disabled Veterans receive automatic entitlement without being subjected to further assessment.

APPENDIX D: Summary of Progress Achieved Since the Implementation of the Scottish Government Commitment with Meeting the Needs of Veterans and Forces' Communities in Scotland since July 2008

HEALTHCARE	
Measures	Progress
<i>Dental provision</i>	<ul style="list-style-type: none"> ▪ Being met through measures being taken to improve dental access across Scotland
<i>Health service awareness</i>	<ul style="list-style-type: none"> ▪ Publication of educational literature: "<i>Have You Served Your Country? Taking Care of Veterans</i>" (A leaflet produced in collaboration with Veterans' associations in Scotland, NHS stakeholders and Citizens Advice Scotland was published in May 2008); "<i>Life Force</i>" (Guidance on how to provide support to Veterans with mental health problems published by the Scottish Association for Mental Health (SAMH) in May 2008 and subsequently distributed to GP Practices and Primary Care services.) ▪ Nomination of an individual within each NHS Board to monitor the treatment of Veterans. ▪ Exploration of eHealth options to improve healthcare (Includes the possible flagging of Veterans' health records and the potential for GP records to follow personnel on joining the Service with a return to the GP on discharge.)
<i>Priority treatment</i>	<ul style="list-style-type: none"> ▪ Priority access for all Veterans with Service-related conditions
<i>Mental health</i>	<ul style="list-style-type: none"> ▪ Pilot of the delivery of evidence-based mental health services to Veterans ("<i>Veterans First Point</i>" became operational in March 2009 in the form of a "one-stop shop" located in Edinburgh with total funding to 2011 provided by means of a partnership involving Scottish Government (£640,000), NHS Lothian (£220,000), and the MoD (£70,000). ▪ Extension and simplification of arrangements pertaining to the access of specialist mental health for Veterans resident in Scotland with services provided by Combat Stress (Hollybush House, Ayr) (Resources of £1.2 million have been made available per annum until 2011 through arrangements with NHS Ayrshire and Arran, the primary objective of which is to enhance the access for Veterans to specialist assessment, treatment, education, advice and welfare support irrespective of their war pension status.) ▪ Financial assistance of £560,000 provided from 2008 to 2011 to Combat Stress. (To support the delivery improved community outreach and welfare services across Scotland.)
<i>Prosthetic limb provision</i>	<ul style="list-style-type: none"> ▪ Roll out of a £300,000 prosthetic limb project across Scotland, which was originally initiated in NHS Lothian Rehabilitation Centre. (To ensure that Veterans who lose limbs whilst on active service receive a similar standard of "state of the art" prosthetics from NHSScotland to that provided by the MoD Defence Medical Services.
<i>NHS waiting list</i>	<ul style="list-style-type: none"> ▪ Circular issued to all NHS Boards in January 2009 to confirm that previous waiting time for Service personnel and their families who move within Scotland or across the UK should be taken into account in providing treatment.

HOUSING

Measures	Progress
<i>Preventing homelessness</i>	<ul style="list-style-type: none"> ▪ Advice issued to Local Authorities (LAs) in Scotland regarding the insistence of a possession order. (June 2009) ▪ Legislation on homelessness. (To be taken forward as part of the 2010 Housing Bill to ensure that employment and residence associated with the UK Armed Forces constitute a "local connection".)
<i>Affordable housing</i>	<ul style="list-style-type: none"> ▪ Priority access to shared equity schemes for all eligible Service personnel and Veterans who have left service within the previous 12 months.
<i>Surplus MoD property</i>	<ul style="list-style-type: none"> ▪ Circular issued to ensure that LAs work in co-operation with military establishments within their areas to locate suitable accommodation and to flag up availability within MoD vacant property (February 2009). ▪ Discussions with MoD regarding the circulation of information pertaining to surplus MoD land and property within Scotland prior to going on the open market.
<i>Adapted social housing</i>	<ul style="list-style-type: none"> ▪ Circular issued to remind all social landlords that seriously injured Service personnel have a high priority to adapted social housing (February 2009). ▪ Additional flexibility offered in respect of shared equity schemes managed by the "Registered Social Landlord" (either LAs or housing association) for seriously injured Veterans. (To ensure that the type of property meets individual requirements.) ▪ Consideration of the needs of Veterans and their families under the aegis of the Scottish Government's review of social housing allocations policy. (Guidance will be forthcoming in early 2010.)
<i>Disabled home owners</i>	<ul style="list-style-type: none"> ▪ Enforcement of regulations to abolish means testing for disabled home owners who require housing adaptations as of the 1 April 2009.

EDUCATION

Measures	Progress
<i>Children of Forces' families</i>	<ul style="list-style-type: none"> Provision of comprehensive information and support to Service families (including eligible MoD civilians) on education provision for their children in the UK and overseas. (Involves collaboration between the Scottish Government and the Children's Education Advisory Service.) Requirement by the LAs to meet the additional support needs of all children whose education they are responsible for providing. (Of particular relevance to the children of Service families are the provision of support in respect of "interrupted" learning as a result of Service mobility requirements and coping with bereavement.)
<i>Service leavers</i>	<ul style="list-style-type: none"> Confirmation that the majority of those who have left service and who are resident in Scotland will be entitled to existing fee waiver support under the MoD scheme. Confirmation that the majority of those who have left service and who are resident in Scotland are already eligible for free tuition under the provision made by the Scottish Government for standard student support.

TRANSPORT

Measures	Progress
<i>Extension of "Blue Badge" scheme</i>	<ul style="list-style-type: none"> Participation of Scottish Government officials in the current review to implement changes to the "Blue Badge" concessionary scheme, which is being led by the Department of Transport. Establishment of a Blue Badge Reform Working Group to consider reforms being implemented in England (and proposed in Wales) to ensure that subsequent changes made in Scotland will be comparable with the rest of the UK.
<i>Extension of "Concessionary Travel" scheme</i>	<ul style="list-style-type: none"> Commitment to extend eligibility criteria from 1 April 2011 to include HM Service Personnel and Veterans (below 60 years of age) who suffered serious Service-related injuries and who are resident in Scotland. (This represented one of nine recommendations that derived from the report of the review of the Scottish Wide Free Bus Travel Scheme for Older and Disabled People published in May 2009.)

EMPLOYMENT/ EMPLOYABILITY

Measures	Progress
<i>Flexible careers and Reservists</i>	<ul style="list-style-type: none">▪ Improved signposting in respect of the availability of public sector jobs.▪ Statement of Employer Support issued by SaBRE (Supporting Britain's Reservists and Employers) has been endorsed by the First Minister
<i>Supported employment</i>	<ul style="list-style-type: none">▪ Establishment of standards and outcomes as part of the Supported Employment Framework for those who encounter particular difficulty in gaining access to the labour market. (A package of support tailored to meet specific needs in this regard will be provided to facilitate employment prospects.)

WORKING TOGETHER

Measures	Progress
<i>Scottish Veterans Fund</i>	<ul style="list-style-type: none"> Allocation of funding under the aegis of the Scottish Veterans Fund (SVF) of £240,000 over three years until 2010-11. (Created by the Scottish Government and administered by Veterans Scotland, the SVF has already supported awards totalling £160,000 for the combined period of 2008-2009.)
<i>Armed Forces Advocate</i>	<ul style="list-style-type: none"> The Scottish Government appointed Dr Kevin Woods (DG Health and Chief Executive of NHS Scotland) as the Armed Forces Advocate (AFA). Establishment within the Scottish Government of an Armed Forces and Veterans' Issues team, the purpose of which is to: (i) provide support to the AFA, (ii) act as a "conduit" between policy areas and the MoD, and (iii) interact with relevant UK Departments regarding matters affecting the UK Armed Forces, their families and the Veterans' community.
<i>Veterans Programme Scottish Steering Group</i>	<ul style="list-style-type: none"> Meetings of the Veterans Programme Scottish Steering Group (VPSSG) seek to: (i) facilitate the exchange of information on Government-related initiatives, (ii) obtain the views of the Veterans' community in respect of these initiatives, and (iii) garner information about a variety of health and welfare issues concerning Veterans.
<i>Military and Civilian Health Partnership Awards</i>	<ul style="list-style-type: none"> Scotland hosted the Military and Civilian Health Partnership Awards 2009; a scheme that seeks to recognise and promote the successful partnership between the Defence Medical Services and civilian organisations involved in the provision of healthcare to the UK Armed Forces.
<i>Direct engagement with the UK Armed Forces</i>	<ul style="list-style-type: none"> Meeting of the Scottish Government with the heads of the tri-Services to address issues of concern to the UK Armed Forces community whose members are resident in Scotland, establish an effective means of working collaboratively to deliver the commitments made in July 2008. Visits to operational bases in Scotland have been undertaken by Scottish Ministers to consult directly with Service personnel about issues of concern and to establish how best to meet their needs accordingly.

APPENDIX E: Outline of the DMS Rehabilitation and Aftercare Chain

PRIMARY CARE

70 Primary Casualty Receiving Facilities (PCRFs)

REHABILITATION

15 Regional Rehabilitation Units (RRUs)

- Receives referrals from PCRFs
- Staffed by multidisciplinary teams
- Focuses on the assessment of musculo-skeletal injuries and sports medicine

REHABILITATION

Defence Medical Rehabilitation Centre (DMRC)

- Located in Headley Court (Surrey) since 2004 and governed by the Headley Court Trust
- Employs 220 staff (approximately half of whom are military)
- Comprises 156 patient beds (36 of which are ward-based)
- Deals predominantly with the rehabilitation of patients with complex problems
- Provides physiotherapy and rehabilitation for complex musculo-skeletal injuries and specialised neuro-rehabilitation for patients with brain injuries
- Houses the Complex Rehabilitation and Amputee Unit (CRAU) since 2006
- Manufactures prosthetics tailored to meet individual patient requirements
- Aims to return patients to functional independence and return to military duties (where possible)

Source: *Medical Care for the Armed Forces (7th Report of Session 2007-08)*
House of Commons Defence Committee 18th February 2008

APPENDIX F: Scoping Review Consultations

EX-SERVICE AGENCIES/ CHARITABLE SECTOR

Paul Hayllor	Project Co-ordinator, Veteran First Point
Paul Oliver	Manager, Bethany House
Alasdair Bennett	Manager, Bethany Christian Centre
Gavin Lawson	Lead Facilitator Passing the Baton, Bethany Christian Trust
Peter Poole	Director Welfare Services, Combat Stress
Commodore Toby Elliott OBE	CEO, <i>Combat Stress</i>
Gary Gray	Head of Charitable Services, PoppyScotland
Jim Panton	CEO, PoppyScotland
Mike Bray	Secretary, COBSEO

EMPLOYMENT AGENCIES

George Clark	Regular Forces Employment
Adrian Peters	Officers Association Scotland

ACADEMICS

Dr Sarah Johnsen	University of York – Homeless exService study in London
Professor Michael Barkham	NHS pilot evaluation, University of Sheffield
Dr Kim Dent-Brown	NHS pilot evaluation, University of Sheffield
Dr Jon Bisson	Reader, University of Cardiff
Professor Simon Wessely	Director, King’s Centre for Military Health Research
Professor Neil Greenberg	Academic Centre KCMHR
Dr Amy Iversen	Lecturer, KCMHR
Dr Nicola Fear	Reader in Epidemiology, KCMHR
Professor Amanda J Lee	Professor of Medical Statistics, Academic Centre for Primary Care, University of Aberdeen
Dr John Love	Senior Lecturer, Applied Social Studies, RGU
Stephanie Morrison	Lecturer, OT, RGU
Dr Colin Macduff	Reader, School of Nursing & Midwifery, RGU
Rob Mackay	Applied Social Studies, RGU
Dr Thilo Kroll	Alliance for Self Care, University of Dundee
Dr Dennis Petrie	Lecturer, School of Economics, University of Dundee
Professor Allan Findlay	Department of Geography, University of Dundee
Professor Paul Boyle	Scottish Longitudinal Study, Longitudinal Studies Centre, St Andrew’s University

Dr Claire Lightowler	The Scottish Centre for Crime and Justice Research, Stirling University
Professor Nick Buck	British Household Panel Survey – University of Essex
Dr Paul Lambert	Department of Applied Social Science, Scottish Social Survey Network, Stirling University
Professor Sandy Macfarlane	Director, University of Adelaide, Australia

MoD

Dr Anne Braidwood CBE	MoD
Lieutenant Lilly White	Surgeon General, MoD
Charlie Wilcox	
Dr Caroline Fox	

Scottish Government

Dr Denise Coia	Directorate of Health and Primary Care
Frank Dixon	Senior Statistician, General Registrars Office, Scotland

NHS

Dr Ken Lawton	GP
Dr Claire Kenwood	Consultant Psychiatrist, Department of Psychiatry, St John's Hospital, Livingston
Dr Rob Waller	Consultant Psychiatrist, Department of Psychiatry, St John's Hospital, Livingston
Duncan Tennant	Senior Specialist in Psychological Therapies, Department of Psychiatry, St John's Hospital, Livingston
Dr Claire Fyvie	Edinburgh Traumatic Stress Clinic, NHS Lothian
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