NHS
Bedfordshire

Veterans

Health Needs Assessment

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1. Executive Summary

1.1 Introduction

A Health Needs Assessment (HNA) is a systematic method of identifying the unmet health needs of a specific population. The focus in this report is on veterans in Bedfordshire.

In recent years there has been a greater focus on the health care available for veterans, as acknowledged by the Department of Health Gateway Reference 9222, issued in 2007, which increased their entitlement for priority treatment. This guidance was subsequently supplemented by a series of Department of Health documents, including the 2010/11 Operating Framework, which further identified the need to address veterans' poor health experiences.

The term *veteran* refers to anyone who has experienced military service, or who is ex-military personnel. For example, the Ministry of Defence definition of a veteran is:

> "anyone who has served in HM Armed Forces at any time, irrespective of length of service… including National Servicemen and Reservists."

Although this is probably the narrowest definition, it still covers a very large and diverse range of the population. Using the most inclusive definitions as a guide, in 2006 it was estimated there were in the region of 5 million veterans in the UK, plus approximately 7 million family dependents. Each year a further 20,000 personnel leave the UK armed forces.

Because they are largely hidden in the general population, information about how veterans' health needs differ from those of the population generally is patchy, even at a national level. Regional or local data on veterans is even less available. But there is some evidence that veterans report poorer health, when compared with the general population. The health needs of all veterans are not the same; potentially they are as simple or complex as any other individual.

Because of the size of historical conflicts and increased mobilisation of armed forces to meet these needs, most veterans are elderly people who have the same health care need as other elderly people. But it is important to acknowledge the younger veteran population which has differing, specific and significant health needs.

1.2 Conclusions and Key Findings

The accepted wide definition of *veterans* means that the health experiences of this population, both nationally and locally, vary greatly. Levels of awareness relating to who veterans are, their needs and the barriers that they face accessing services, differ significantly, not least amongst health professionals.

Being in the armed forces is an overwhelmingly positive influence for the majority of service personnel, giving them the skills and experiences to live a positive and flourishing life beyond their time serving in the military.

Most veterans are over 65, and have similar health needs and experiences to the rest of the elderly population, such as mobility, independent living and social isolation, with the same implications on resources for both Health and Adult Social Care.

Outside of this group a significant minority of non-elderly veterans, probably numbering several thousands, experience a range of largely mental health problems related to their service in the military, which can have a number of serious consequences for their health outcomes and those of their families. Research suggests that the most common disorders among recent veterans are depression, anxiety disorders, Post Traumatic Stress Disorder (PTSD) and substance - particularly alcohol - misuse. The available evidence often suggests co-morbidity.

Exposure to combat, serious injury and the associated trauma has increased with ongoing and prolonged recent engagement in combat operations by British regular, reserve and territorial forces, and show no immediate sign of reducing. Given the expected delays in veterans experiencing and presenting symptoms of mental health problems, the implications for future health needs of veterans should not be underestimated, particularly where there is a quick return to civilian life from combat.

Accessing effective and appropriate services can be a major issue for those who are in the greatest need of them. Identifying these veterans and providing appropriate treatment should be the priorities for action. These and other issues for veterans nationwide seem to be mirrored in Bedfordshire, with no distinct differences identified.

Despite some significant limitations with data, the evidence collected during this HNA does not suggest that there are major implications for the commissioning of new services. Priorities for action should focus on the key themes indicated here, focusing on improving pathways and access to a range of services for veterans.

However, there is strong national evidence that mental health services are, and will continue to be, the greatest specific health need for veterans. This was consistent with findings indicating the need for more effective and accessible mental health services locally.

It should be noted that several of these recommendations are inter-dependent and implementation of one will support the achievement of others.

1.3 Key Recommendations

1. Mental Health

Address the priority mental health and related issues of non-elderly or recent veterans through:

- ensuring sufficient capacity in evidence-based interventions commissioned for a range of disorders, including alcohol and drug misuse, which:
    - are effectively linked up with mental health services;
    - are aware of the needs of veterans and can refer to a suitable MH service,

    - do not simply refer back to GPs as a default action. (N.B. Anecdotal evidence from this HNA reported veterans feeling they had been stuck in a referral loop between agencies without effective intervention).
    - can be accessed in a timely way – reduce waiting times for initial appointments, which currently can be up to 6 weeks.

- recognition by all those referring veterans with a mental health problem that generic counselling is not effective for PTSD, but that there are effective alternative interventions.

- identification and targeting, by providers, of veterans at greatest risk of mental health problems and suicide, i.e. young male veterans with short service, territorials and reservists, through effective collection and monitoring of patient information.

- Improvement of mental health promotion and awareness through:
    - provision of peer advocacy and support for veterans at risk or who need help for mental health problems so that looking for help with mental health is not seen as a sign of weakness.
    - involving veterans in the design, delivery and evaluation of these services.

    It would also be cost effective to offer support and training to veterans groups, developing them so that they can be commissioned to provide effective evidence-based interventions, such as the *Rewind Technique (see Appendix 2).* Currently this intervention is not widely available to veterans, and where it is available from private providers can have significant costs.

    However, it is important to ensure that any veterans undertaking the training and practice of this technique are deemed suitable to be involved in its delivery, i.e. that they are not themselves suffering from or vulnerable to mental health problems.

2. Inter Agency Working

A number of agencies exist to support veterans and it appears that they have little awareness of any duplication, or practical knowledge where agencies can support each other.

As a statutory partner with responsibilities for the healthcare of veterans, NHS Bedfordshire should:

- Lead the development of the recently established *Bedfordshire Military Veterans Multi Agency Forum* as a vehicle to:
    - Provide a partnership approach to addressing the wider health needs of Bedfordshire veterans, through;
        - sharing information, knowledge and experience of veterans issues
        - preventing duplication and sharing resources
        - prioritising and taking action for change through focused projects
        - monitoring the extent and impact of developments across the partnership

- Ensure the experiences and needs of veterans are explicitly acknowledged by existing strategic policy and implementation groups across Bedford Borough and Central Bedfordshire that have a role in supporting vulnerable populations, for example in relation to:
    - Housing
    - Physical disabilities
    - Mental health

3. Training and Information for Professionals

Because of their military service, the healthcare needs of veterans can be different from those of other patients in a number of ways. Acknowledgement of this fact is a crucial first step in providing effective healthcare for veterans.

It is crucial to increase awareness about, and knowledge of, this population, facilitating the provision of more focused and effective services.

- NHS Bedfordshire should offer information and training for Primary Care practitioners, including GPs, and other relevant social care professionals, who may come into regular contact with veterans to ensure that professionals:
    - Have greater awareness of the specific health needs of veterans and the implications of being a veteran, on their health experiences;
    - Better understand the culture of armed forces, the pressures veterans face and the risks of developing MH problems
    - Are able to identify the vulnerabilities and needs of non-regular and reservist veterans;
    - Are able to identify and acknowledge the barriers that veterans have in accessing services;
    - Implement effective solutions to overcome the barriers that ex-military personnel face in accessing services, and;
    - Provide effective referral, informing secondary care, so that veterans receive their entitlement to priority treatment for any injuries or illness attributable to their time serving in the Armed Forces:

N.B. It may be necessary to develop local information and training.

Consideration should be given to:

- the delivery of training by peer professionals to increase credibility and encourage good practice,
- involvement of veterans in development and delivery of training where appropriate.

4. Information/Data Collection

One obvious gap acknowledged repeatedly was the lack of knowledge/evidence base due to the difficulty in identifying and quantifying veterans in Bedfordshire. This could be addressed in the first instance by:

- Ensuring that Primary Care effectively use available systems to record veteran status, at appropriate points in patient pathways, for example, with new patients.

The DH suggests that veteran status is recorded in their medical record using the Read code 'History Relating to Military Service': Xa8Da.

- Ensuring that other services commissioned by NHS Bedfordshire, effectively record and submit information on veteran status of service users, improving evidence to influence effectiveness and priority of clinical care for veterans, for example:
    - Community drug and alcohol services
    - Mental health services
    - Healthcare at HMP Bedford

- Encouraging and supporting other partners, in both the statutory and voluntary sectors, to record veteran status, to inform service delivery and improved outcomes for veterans, for example.
    - Homelessness services, shelters, hostels etc.

In recognition of veterans' disproportionately high rate of criminalisation, the range of stakeholders involved in the criminal justice system should:

- Use opportunities presented during veterans' contact with the criminal justice system to identify specific causes for veterans' poor health experiences, build up a clearer, more quantified picture of need, so that issues can tackled as a matter of priority. Specifically to answer:
    - How many veterans are in the local criminal justice system?
    - How many veterans come into contact with the criminal justice system as a result of mental health problems related to time in the military?
    - How can support be made more effective for veterans within the criminal justice system?

NB NHS Bedfordshire could lead the process, through improved awareness and identification of key intervention points.

5. Information and Support for Veterans

Veterans reported a lack of knowledge about where to access information and support, in relation to a number of key health, social care and welfare needs. In partnership with other key organisations, NHS Bedfordshire should support:

- the provision of a range of key, basic information to be made available more systematically through veterans' agencies, acknowledging that they are usually the initial point of call for veterans seeking help, so that they are able to more effectively signpost and refer to appropriate service providers. With this in mind consideration should be given to:
    - The development of a directory of services, for use by veterans' agencies, containing basic welfare information and contacts, including for issues such as housing and benefits.
    - The use of a single/central point of contact for information, both for health and wider information needs of veterans, for example publicise/increase the use of an existing telephone helpline number.

One existing example of a veterans' 'one stop shop' for a range of services is *Veterans First Point (V1P*) in Lothian – see www.veteransfirstpoint.org.uk – part of the *Community Veterans' Mental Health Pilot Programme*.

- The evaluation of this service, as part of the *CVMH Pilot Programme*, should inform good practice, when available.

Provisions should also include:

- effective and accessible advocacy services for veterans and the families of veterans, building on what is currently offered by 3rd sector organisations.

- veterans' peer support services, to acknowledge the need for veterans to share military experiences and have empathetic social support opportunities.

N.B. Effectively meeting the welfare needs of veterans is very important in the prevention and management of mental health problems, so ensuring effective systems and pathways to support veterans' welfare needs should be a priority.

6. Adult Social Care

Several agencies reported barriers for elderly veterans accessing Adult Social Care. Reducing these barriers could be achieved by a designated focus on these issues, *for example*:

- creation of a sub group of the *Bedfordshire Military Veterans Multi Agency Forum* to establish and maintain clear communication and referral systems between voluntary veterans' agencies, e.g. the Royal British Legion, and Adult Social Care, to facilitate better sharing of information and identification of priorities for elderly veterans, including managing the expectations of all stakeholders.

- consideration to having a named contact/contacts with a responsibility for veterans in Adult Social Care, with clear targets and time limits for taking action when referrals are made by veterans' organisations.

2 Introduction

2.1 Health Needs Assessment: Aims, Objectives & Methodology

A Health Needs Assessment (HNA) is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities (Health Development Agency, 2005).

The aims of this HNA are to identify the health needs of veterans in Bedfordshire and recommend priorities for action.

The objectives of this HNA are

- To describe the veteran population in Bedfordshire;
- To assess the health and health needs of veterans in the community in Bedfordshire;
- To describe the healthcare services available to veterans in Bedfordshire and how they interact with services on leaving military service;
- To make recommendations, linked to evidence and existing good practice, for health service commissioning by NHS Bedfordshire and other agencies to meet the health needs of the veteran population in Bedfordshire.

A wide range of methods were used in this HNA.

A review of the relevant literature, national and local initiatives and government publications was conducted to acquire epidemiological data, where available, and identify issues, strategies and solutions.

Limited available quantitative evidence was assimilated from local service records and through extrapolation from national data and research.

As directed by good practice, it was important to access local sources for empirical and experiential evidence.

The author presented and facilitated at a local mapping event, organised by Commissioning at NHS Bedfordshire, and was invited to sit on the local Military Veterans Health and Wellbeing Forum, a Multi Agency Meeting for stakeholders with an interest in the health and wellbeing of veterans in Bedfordshire. These opportunities provided both insight and access to key stakeholders.

Qualitative evidence was obtained through semi-structured interviews with key representatives from the armed services, local statutory agencies and third sector organisations.

A range of quantitative and qualitative data, relating to both knowledge and experiences of veterans was gained through short self-completion questionnaires with Bedfordshire veterans and other stakeholders, including primary care professionals.

Finally, more detailed views and experiences of a sample of veterans were elicited through focus groups, with ex-military personnel in the community, from differing contexts, age groups and experiences. These were made possible by local Braveheart Programme and Royal British Legion representatives and provided further in-depth qualitative information.

It is important to note that the findings of this health needs assessment represent the views of a sample of stakeholders from across Bedfordshire. There is no claim that these are representative of all service users or providers, but they provide some insight into identifying and understanding the complex issues which merit initial action in addressing the health needs of veterans in Bedfordshire.

2.2 What is a Veteran?

The use of the simple term *veteran* has proved to be contentious and confusing, and its use could mask the complexity of needs faced by this population. There is a range of very similar, wide, but generally accepted, definitions of what is meant by the term *veteran*. The main differences between definitions are the time served in the forces. Two of those basic definitions are as follows:

> "anyone who has served for at least one day in HM Armed Forces, Regular or Reserve, as well as Merchant Navy seafarers and fishermen who have served in a vessel which was operated to facilitate military operations by HM Armed Forces."
>
> (*For those who served: Meeting the Healthcare Needs of Veterans in England NHS*/Royal British legion)

> "anyone who has served in HM Armed Forces at any time, irrespective of length of service… including National Servicemen and Reservists."
>
> (*www.mod.uk*)

A further Royal British Legion definition is a little more detailed, but basically covers the same population:

> Anyone who has previously served in any of the following ways is a veteran, eligible for welfare assistance from The Royal British Legion: the UK Armed Forces, both Regular Forces (including National Service or the Home Guard), or Reserve/Auxiliary Forces; the Mercantile Marines in hostile waters; the Allied Civil Police Forces; full-time, in uniform for a Voluntary Aid Society in direct support of the Armed Forces; or as a British subject serving under British command in the forces of an allied nation.
>
> (Royal British Legion, 2006)

It should be noted that, throughout the process of compiling this HNA, numerous stakeholders, including veterans themselves in the focus group and elsewhere, expressed dissatisfaction with the term *veteran.* One suggested that it was

“misleading”, another that it could be “confusing” and another that it was “meaningless.” A repeated concern was that it could be mistaken to mean anyone who was older or experienced in any field.

There were several alternatives offered, such as “military veterans”, “forces veterans”, “ex-military personnel”, “ex-servicemen” or “ex-forces personnel”. However, for consistency, the term veteran will be used through this report.

2.3 Recent Veterans

The range of veterans, and consequently the range of their needs, is complex. To illustrate this, during this HNA, stakeholders identified that there are, broadly speaking, three different categories of personnel that cover those personnel who could currently be leaving regular service. They would have different levels of experience and needs in making the transition to civilian life, but would all be similarly classed as veterans:

1. The first group tend to be younger veterans who are less likely to have done active service and have not served enough time in the forces to be fully institutionalised. They are more likely to have left the forces through dissatisfaction or medical reasons. They tend to still have relationships with parents or other family and be young enough to go back to live with them, giving them close support to improve the transition back to civilian life. As noted later in this report, those veterans at the greatest risk of suicide - males, ex-Army, with a short length of service (Kapur et al) - seem to fit into this category.

2. The second group are those who are likely to have done active service – possibly even a couple of tours. Subsequently, they tend to have experienced combat pressures and similar trauma and ‘want out’, without any long term planning for return to civilian life. They could be single or married and are likely to experience a more difficult transition back in to civilian life having been institutionalised for a longer period than the first group. A sub-section of this group is the increasing number of service personnel who are being medically discharged, often with serious physical injury as a result of active service, who face added complexities coping with a civilian life. This group are less likely than the previous one to have the option of existing close family support on leaving the forces.

3. The third group are older, and after perhaps 20 or more years service experience, maybe including active service, will leave the forces as natural career progression. They will have made gradual plans, over a period of time, to leave the forces and ease the transition to civilian life. Despite this planning they may still have difficulty adapting to their new life because of their ‘institutionalisation’ and the lack of structure outside of the forces. They too may have deep-rooted psychological issues and are at risk of losing the social support of colleagues which they relied on whilst serving in the forces.

A further specifically identified category is that which is made up of non-regular service personnel who have never been or are less likely to be fully institutionalised, such as Territorial or Reservist volunteers. Those with the greatest health needs have been mobilised to serve in conflicts or combat zones, and may have experienced combat pressures and similar trauma, which can lead to mental health issues on returning to civilian life. Some of these will have previously been in the regular forces.

The potential for those currently leaving the forces, after having served in a combat zone, to have been exposed to one or more traumatic events, and for them to have suffered mental or physical ill-effects as a result of their service, is significant. Between the 7th October 2001 and 31st August 2010, in Operations in Iraq and Afghanistan alone, there were 511 recorded fatalities of UK military and civilian personnel (for example, volunteers acting in direct support of the military). Added to these deaths there were 665 "very seriously" or "seriously", "injured or wounded". The total extent of incidents and physical injuries to personnel is further indicated by the total of 7,851 field hospital admissions during this period.[1]

2.4 Policy Context

Recognising that they have specific needs as a defined vulnerable group, veterans have increasingly become a focus for the local health and social care commissioning organisations, with successive recent governments giving direction that veterans get the best quality of service and care.

The 2008 Command Paper, *The Nation's Commitment, (*MoD, 2008*)* highlighted a need to better support veterans across all sections of government.

The 2008/9 Operating Framework contained a section entitled "Commissioning services for military personnel and veterans", which said charged PCTs to:

1. …take account of the particular difficulties that face serving personnel arising from frequent moves;
2. Provide an effective transition of care from Defence medical Services to the NHS, and;
3. Provide culturally sensitive mental health services.

As part of the local prioritisation process in the *Revision to the Operating Framework for the NHS in England 2010/11,* the document strongly suggested that there should be emphasis on;

> "ensuring that military veterans receive appropriate treatment. Here, ensuring a smooth transition for injured personnel into NHS care is important as well as providing priority treatment for conditions relating to their service."

[1] Operation Telic and Operation Herrick casualty and fatality tables, MoD

New Horizons – a shared vision for mental health, the Government's mental health strategy, December 2009, specifically called for "Improved care for… groups such as… veterans."

2.5 Veterans as a "Priority Group"

Service in the Armed Forces is rightly considered to be different from most other occupations. Apart from the obvious uncertainties and risks, the very act of "signing-up" means that service personnel voluntarily relinquish some of their own civil liberties and signifies acceptance that they will put themselves in danger on a routine basis to safeguard others.

As an illustration, occupational attributable mortality - the risk of death whilst at work - for the Army is approximately 1 in 1000 per year. This is 150 times greater than for the general working population. Risk of serious injury - for example loss of limbs, eyes or other body parts - is similarly greater.

The government's *Military Covenant*, a duty of care to its armed forces, promises to help and support members and ex-members of the Forces when they need it most.

The general principle calls for 'no disadvantage' to veterans and their families due to their military service, compared with society generally.

Consistent with this principle, whilst undertaking this HNA, including in the focus group, veterans themselves said that they did not want to receive preferential health care over others, simply because they were veterans. However, they were clear that there should be more and better help with any problems related to having served in the forces, whether that be consequential physical or mental health problems, having barriers accessing services or making the successful transition to civilian life.

3 The Veteran Population

3.1 The National Veteran Population

Using the various definitions stated previously as a guide, it has been estimated that, out of a UK population of 61.5 million, there are approximately 4.8 million veterans[2]. Of these, roughly 85% are male and 15% female. Added to these are somewhere near 7 million family dependents.

The number of veterans in the population is supplemented annually by the 20,000 or so personnel who leave the forces each year. This turnover represents approximately 10% of the total of current armed forces.

Veterans have a substantially older age profile than the general UK population. The average age of a veteran is 63 years, compared with 47 years as the average age for the general adult population. Nationally, over 60% of veterans are aged over 65,

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[2] A 2006 estimate, from the *Royal British Legion*

a much larger percentage than the proportion of the general population in that age range. This is accounted for by the mobilisation for World War 2 and the subsequent ‘National Service Generation.’ National Service officially ended 31 December 1960, and anyone who had been mobilized under this 1945 Act would, at the point of writing, be at least 67 years of age.

Although there are no officially published statistics to verify it, the overall number of veterans is almost certainly falling, year on year. Using available recent national mortality and population data[3], and making a number of extrapolations, it is probable that the number of current veterans is approximately 350,000 lower than the 2006 figures, shown below, largely due to the naturally higher death rate within the predominant older age group.

Age of Veterans	% of Veteran Population	Approximate No. of Veterans
Under 25 years	1.3	62,000
25 – 44 years	14.0	672,000
45- 65 years	24.3	1,167,000
Over 65 years	60.4	2,899,000
Total	**100.0**	**4,800,000**

Table 1: Estimated 2006 Age Profile of UK veterans (*Royal British Legion 2006*[ii])

Nationally, only 0.6% of veterans are from non-white ethnic minorities, whereas the 2001 Census said that 7.9% of the general UK population comes from these groups, and that latter figure will almost certainly have increased since then. Again, this is largely age-related, with the older population groups having lower proportions from non-white backgrounds, but despite active recruitment from non-white populations, ethnic minorities are still under-represented in the forces, at 6.6%, as at 1 October 2009 (MoD, 2009). There is no evidence of ethnicity amongst veterans in Bedfordshire.

3.2 The Local Veteran Population

Although there are some records held by a number of agencies on veterans with who they have contact, these are unsystematic and provide a very incomplete picture of veterans in Bedfordshire.

Without significantly more complete data being available it is impossible to be definitive about the number of veterans in Bedfordshire. A best estimate for the local Bedfordshire veteran population, extrapolating from the 2006 UK level data, and based on the county population of approximately 413,000[4], would be somewhere in the region of 32,000, as consistent with the above definitions. Anecdotal evidence from local sources, including both local veterans and support organisations, suggests that this figure is not unrealistic. However, none of the sources could offer reliable data to either support or contest the figure.

Age of Veterans	Number

[3] Source ONS
[4] Population Estimates and Forecasts 2008, Bedfordshire County Council; www.blisonline.info

Under 25 years	416
25 – 44 years	4,480
45- 65 years	7,776
Over 65 years	19,328
Total	**32,000**

Table 2: Estimation of the Number of Bedfordshire Veterans, by age [5]

Of the 1500 or so local Royal British Legion contacts over the last year, they estimate 400 were from Bedfordshire. Over the past 5 years the local Royal British Legion have interacted with approximately 1500 members of the veterans' community from across Bedfordshire[6]

Despite some differences in the recoded age ranges, the Royal British Legion's above-quoted data on local applicants seem to be reasonably consistent with national veterans' picture, although there were slightly more veterans under 50 years old in the figures than would be expected:

Age of Veterans	%
Under 31 years	6.2
31 – 50 years	20.0
51- 65 years	15.0
Over 65 years	58.8
Total	**100.0**

Table 3: Proportion of Local Royal British Legion Applicants by age

One suggestion offered for the slightly higher proportion of under 50 year old veterans in this contacts list was a that they were perceived to have more issues and are more likely to feel that they are entitled to, and can ask for, help.

Making the assumption that the pattern of those leaving the armed forces each year was even across the country and proportionate to the size of the local population, it would mean that there would be somewhere around 135 new veterans in Bedfordshire each year. Again, this estimate could not be verified, but local stakeholders suggested that there may be fewer than 135 new veterans in Bedfordshire annually because of the absence of large forces bases in the county, and the consequential lack of established ex-forces communities.

Army records, including data relating to those leaving service, are kept centrally in at the Army Personnel Centre in Glasgow. Although this information might enable further identification of the Bedfordshire veterans' population, after initial enquiries, as part of the stakeholder interviews, accessing it from that source appeared not to be possible within timescales for completion of this HNA.

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[5] Extrapolated from national data in table 1.

[6] This is an estimate taken from a total of 4150 recorded applicants from Beds, Herts, Cambs and Hunts RBL.

The only military establishments in Bedfordshire are the Defence Intelligence and Security Centre (DISC) at Chicksands and RAF Henlow, which includes the HQ for the RAF Police.

Although no army regiments are actually based in Bedfordshire, the 2nd Battalion of the Royal Anglians does actively recruit from the county.

3.3 Transition from Military to Civilian Services

One source reported that almost 75% of personnel found leaving the services as easy as, or easier than, expected. Counter intuitively, it appears that those who had served a shorter time found the transition hardest, although those with long service do routinely plan their exit from the military. There are a small minority who experience significant difficulties, such as homelessness (National Audit Office) – see 4.7.2.

> *"Being in the forces … gave me a structure and a sense of family that I'd never had."*
>
> Anonymous Veteran – 20 years service, including The Falklands Conflict

On leaving the forces it is not uncommon for veterans to miss the structure, support and friendship that being in the forces can provide. Several primary sources claimed that this 'institutionalisation' - reliance on both formal and informal military structures and systems – could be a major barrier in the transition to civilian life.

Standard resettlement resources, distributed through the forces – largely standard magazines and leaflets - routinely include contact information for higher and further education, other learning institutions, local councils, information on advice and finance, but rarely health services. Unsurprisingly there is an emphasis on career and personal development.

Each forces leaver should receive a discharge pack, containing information on pension and other entitlements, for example the Joint Services Housing Scheme. Local army welfare officers told this study that they give their service leavers details about services, including those delivered by voluntary agencies, which are available in the community to support veterans.

The NHS is responsible for the health care of service personnel on leaving the Armed Forces, provided the individual is entitled to residency in the UK. At this point it is the responsibility of the individual to register with a GP. Stakeholders suggested that this requires a cultural shift on behalf of veterans, both because whilst in the forces medical provision is accessed routinely, and because serving members of the armed forces are not permitted to be registered with a civilian GP.

If leaving the forces on medical grounds, specific injuries are noted and individuals will have a plan for rehabilitation. The MoD normally liaises with the local PCT and providers if there are significant ongoing health needs, for example in the case of amputees.

For those with a medical discharge on mental health grounds, a military social worker works with veterans for up to 12 months to help them access the right NHS services.

Service leavers are not specifically provided with health information if they are leaving the forces through their own choice, and they do not have any existing health issues. However, they should be given a summary record of their military health history on discharge, which should be retained to inform their treatment on registering with a GP. This summary will also contain details about how their new GP can obtain their medical records.

GPs do not call for a veteran's medical records routinely. These records are 'held' centrally by the military, until they are requested by civilian primary care health services.

4 Veterans' Health Experience

4.1 Differing Health Needs

Veterans are a very diverse group and their health needs are not the same or similar. Most veterans are elderly people – the latest official estimate stated that 60.4% were over 65 years of age - who have the same health care need as other elderly people. But it is important to acknowledge the wide age range of the group too, and that many of the younger or more recently-served veteran population have specific and differing health needs.

In terms of health experience, younger (non-elderly) veterans, or those that have served in more recent years, can be basically categorised in 2 ways:

1. *Those discharged with significant health problems (*both as a direct result of their service and not so*)*
2. *Those discharged with no identified significant health problems*

Because they are largely hidden in the general population, specific and practical information about how veterans' health experiences and health needs differ from those of the general population is patchy, even at a national level. There is no single, comprehensive, reliable or regularly updated source for this data.

Nationally, there is some evidence that veterans report poorer health, when compared with the general population, (Royal British Legion, 2006).

Other research, including some of the qualitative questionnaire survey findings from this study, shows that for most members of the armed forces, service is a positive experience, allowing them to access increased opportunities and enjoy a more favourable life trajectory. The vast majority of personnel are fully fit or have minor ailments only on or immediately after discharge. For those who leave the forces without a medical discharge, most make the transition to civilian life without difficulty and are able to access mainstream health services, including help from Primary Care, if they need to, like most other members of the civilian population.

4.2 Wider Health Needs

Consistent with the diversity and the age profile of the veteran population are their wider health needs.

As an indication of those wider needs, the local Royal British Legion usually provides financial help or advice for veterans. Their records indicate that the issues with which they financially assisted veterans, in the 5 year period August 2005 – August 2010, fell into 34 different categories, with the top 10 as follows:

Category	No. of Payments
Maintenance Grants	256
Electric Powered Vehicles	182
Other (19 categories)	158
White Household Goods	124
Priority Debt	120
Brown Household Goods	113
Riser/Recliner & Electric Chairs and Beds	81
Repairs and Maintenance to Property	76
Food and Household Essentials	63
Housing (Deposit Charge)	24
Total	***1197***

Table 4: Top 10 Categories of Financial Assistance Provided by Local Royal British Legion 2005-10

Wider needs are often linked to age and the length of time since military service ceased. The above list probably reflects the predominance of elderly in the general veteran population and in those seen by the RBL.

The 2 biggest wider health-related needs of those veterans who have recently left the forces were identified by stakeholders as being housing and employment.

Furthermore, evidence from interviews for this HNA revealed that local workers with several veterans' agencies have perceptions, shaped by their experience, that veterans needing support with fundamental issues, like housing and benefits, often have little knowledge about their entitlements. This can be compounded by the fact that they do not know who to contact for help and advice or "not knowing what's out there."

4.3 Existing Evidence on Veterans' Health Experiences – Specific Conditions

There have been a number of specific research studies on the health of veterans, but these have largely been focused on single issues which were a legacy of service. These studies have included:

- The Anthrax Voluntary Immunisation Programme (VIP);
- Veterans involved in the UK Atmospheric Nuclear Testing Programme;
- The Porton Down Volunteers and subsequent complaints of ill health;
- The Effects of Depleted Uranium Munitions, and;
- Gulf Veterans' Illnesses (including *Gulf War Syndrome*).

These have affected relatively few, but not an insignificant number, of veterans. For example, there are about 2,500 surviving veterans who were exposed to nuclear weapons testing in the South Pacific in the 1950s and 1960s.

Other than these specific studies, there is very little available detailed research and related data on the general health experience of current veterans. The Royal British Legion did undertake some research, published in 2006 and referred to in part later in this HNA, largely based on responses/findings from the 2003 General Household Survey.

4.4 NHS Guidance for Treatment of Veterans

DH Guidance covers priority treatment for war pensioners and veterans. It has been long-standing practice - i.e. since the early 1950s - that the NHS should give priority to war pensioners, both as out-patients and in-patients, for examination or treatment which relates to the condition or conditions for which they receive a pension or received a gratuity. The exceptions are where there is another emergency case or another case demands clinical priority.

From 1 January 2008 this Guidance was extended so that, "*all veterans should receive priority access to NHS secondary care for any conditions which are likely to be related to their service, subject to the clinical needs of all patients.*[7]"
.
It is possible that even after these recent changes, enabling wider participation in priority treatment for veterans, not many who experience service-related conditions will come forward to receive it, for a number of reasons. But the DH is hopeful that it will benefit a significant, if small, number of veterans whose conditions, largely mental health, become problems after discharge and do not currently qualify to receive a war pension.

There have been a number of questions raised about the effectiveness of this veterans' treatment scheme. One of these centres on concerns about whether the correct data is collected and available to measure success. A further matter for debate has been whether insisting collection of data on veterans being given priority treatment would be a significant additional administrative burden on the resources of service providers.

4.5 Conditions Related to Military Service

A significant number of veterans do have identified and acknowledged service-related health conditions. There are about 170,000 veterans who receive war pensions, or another form of compensation, as a result of a service-related condition, and who therefore have previously already had eligibility for priority treatment under the NHS for their service-related condition.

[7] DH, Gateway reference number: 9222

Extrapolating from this national figure, there should be approximately 1100 of these in Bedfordshire.

Other veterans will have received a lump sum gratuity rather than a pension because the degree of disablement caused by service is relatively minor. But they too are eligible for NHS priority treatment for service-related conditions, as are veterans who have an "assessed degree of disablement" caused by military service but to whom no award is paid.

Claims may be made for a war pension at any time after service termination (DH, *Access to Heath Services for Military Veterans*, December 2007).

In recent years there has been greater recognition that there are physical and psychological health consequences of military service other than obvious war injuries, which very often do not manifest themselves until long after discharge.

The National Gulf Veterans Families Association cites significant differences in recent conflicts as responsible for some of these health consequences, often with deeply psychological as well as physical implications:

- fighting conditions - Often facing 'hidden' enemies using covert tactics, such as improvised explosive devices, rather than 'standing to fight';
- modern munitions - Using and facing new and modern technologies, such as depleted uranium rounds;
- vaccinations - Like those given to troops during the Gulf conflicts;
- post combat care;
- extreme heat;
- limited supplies;
- limited or inadequate equipment – Leading to associated feelings of being left exposed or under-equipped for the job, and;
- live media coverage – Not only are there significant stresses associated with such close and 'real time' reporting, but such coverage also helps shape the sometimes-negative public perceptions of serving forces personnel, which they then experience on return from active service.

4.6 Self-reported Health

The limited available research[8] shows that veterans report poorer health than the general population: 25% say they have not been in good health over the last 12 months, compared with 14% of adults in the general population.

Number of Veterans with a Long Term Condition	Age Range in Years
380,000	16-44
1,010,000	45-64
1,440,000	65-74
1,590,000	75 or over

Table 5: Number of Veteran Community with Long Term Conditions, by Age (RBL, 2006[i])

[8] The most quoted source *Royal British Legion 2006*[i]

The prevalence of self-reported poor health among older people is broadly similar in veterans as in the elderly population in general. In contrast, younger veterans (aged 25-64) are significantly more likely to report poor health than their peers in the general population.

Long-term illness or disability is the most prevalent problem within the veteran community[9], affecting half of adults. The scale of need increases with age:

Condition	Age 16-44	Age 45-64	Age 65-74	Age 75+
Musculo-skeletal	*higher*	similar	*lower*	*lower*
Cardio-vascular	similar	*higher*	*lower*	similar
Respiratory	similar	*higher*	*lower*	similar
Mental health	*higher*	similar	similar	similar

Table 6: Prevalence of Veterans' Conditions, Relative to the General Population of Equivalent Age (RBL, 2006[i])

The prevalence of various long-term health conditions also increases with age, with the exception being long-term mental health problems, which are most prevalent among 16-44 year olds. This is consistent with the greater perceived mental health need in the younger veteran age groups.

More than half (52%) of veterans have a long-term illness, disability or infirmity, which is higher than in the general adult population (35%).

In both the general population and amongst veterans, in the UK, the prevalence of any long-term health problems or disabilities increases with age, and so the poorer health of veterans as a whole is at least partly explained by the fact that they are more elderly.

Therefore, it is important to consider the health of different age cohorts within the veteran population, relative to their peers nationally. This reveals that veterans under 65 years old are in poorer health than the UK general population; whereas veterans over retirement age are generally in better or equivalent health than their peers nationally.

In the UK, the prevalence of depression is higher among younger adults than among older people; this also appears to be true for veterans where, according to the RBL research, depression affects:

- 16% of 16-44 year olds
- 9% of 45-64 year olds
- 8% of over 65s.

The prevalence of depression amongst older veterans (8%) is at the lower end of the normal range of 8% to 14% found for older people in other research studies. Among

[9] The term *veteran community* is used in relation to this study to describe both veterans and their adult dependants, aged 16 and over, estimated as being 8.5 million people.

over 65s, in both veterans and nationally, various risk factors are associated with depression: gender[10], ill health, pain or disability, loneliness and bereavement.

In the general population below retirement age, self-reported common mental health problems peak at age 45-49 years for men and age 50-54 years for women. Veterans mental health problems seem to peak among younger adults: age 25-44 for men, and age 35-44 for women.

Women are generally more at risk of mental health problems than men, whereas with veterans both men and women have similar prevalence of mental health problems.

In both veterans and the general population mental health problems are associated with:

- ill health
- disability
- unemployment
- economic inactivity
- debt
- relationship breakdown.

4.7 Social Exclusion and Poor Health Experience

As a section of the population, the available evidence suggests that veterans are vulnerable to poor health experiences and social exclusion, and there are significant correlations between homelessness, unemployment, alcohol issues, mental health problems and prison.

4.7.1 Prison

The number of veterans amongst the national prison population is uncertain, although it certainly appears to be disproportionate with the rest of the population by age group. The National Association of Probation Officers estimated the number of veterans in UK prisons at around 8,500. This represents over 10% of prisoners.

A 2007 study by the organisation *Veterans in Prison* found 108 from a sample of 1191 UK prisoner to be ex Army, Royal Navy or RAF, at a rate of 9.1% (NAPO).

In a 2009 study, IAPT reported that around 6% of the prison population were thought to be veterans (IAPT).

An official Government study undertaken by survey of all prisoners in prisons in England and Wales, in November 2009, indicated that the truer figure was much lower, at 2.7% (revised to 3.5% in September 2010). This was achieved by matching a database of all 81,000 remand and sentenced prisoners aged 18 and over from the Ministry of Justice against a database of Service leavers (Regulars only) from the MoD (DASA, 2010).

[10] Women are more likely than men to suffer from depression.

Data on the number of veterans currently in HMP Bedford was not available when the HNA for that establishment was undertaken in January 2010, but a recommendation was made as part of that work advising that veteran status be routinely recorded, both in order to document the size of the issue locally as well as to inform any necessary and relevant health interventions.

One significant barrier to the collection of veteran status in prison was highlighted in the focus group. It was felt that even if there is a suitable data collection system, prisoners may not declare their veteran status, due to their pride and not wanting to "bring shame on their regiment" having ended up in prison. A suggested solution would be to have an effective incentive for them to register as a veteran, which could be in the form of enhanced in-reach support provided by external agencies, such as the RBL.

At the time of writing, the Howard League is undertaking an inquiry to investigate how so many veterans find their way into not only prison, but also the criminal justice system in the UK. This work will also investigate whether specialist veterans' courts, as operational in the United States, could be an effective intervention.

4.7.2 Homelessness

Veterans also appear to be over-represented in the national homeless population. There were an estimated 1,100 homeless veterans in London on any one night, mainly hostel residents but also including some rough sleepers (Centre for Housing Policy, University of York). Others estimate suggests that, in some areas, over 10% of homeless are veterans (Glasgow Homelessness Partnership) and (Sir Oswald Stoll Foundation[11]).

A significant result of homelessness, as with social exclusion generally, can be that veterans do not register with a GP and therefore have poorer access to primary health care, subsequent secondary care services, and ultimately they experience poorer health outcomes.

Rough Sleeper counts in Bedfordshire do not yet identify veteran status, although anecdotal evidence from local practitioners collected for this HNA suggests that veterans are not uncommon in the homeless and hostel populations.

4.7.3 Alcohol

Several of the stakeholders interviewed during this HNA acknowledged that, in their experience, they found that both current and ex-forces personnel are likely use alcohol as a mechanism for socialising and/or coping with personal problems. Within the services there is often a culture of high alcohol consumption. A number of sources indicate that mis-use of alcohol is an issue for both current forces members and veterans, with one stating that 18% of serving and former servicemen abuse alcohol (King's Centre for Military Health Research). Alcohol mis-use is strongly linked with domestic violence and other violent crimes (Cabinet Office, 2003) and can result in further social exclusion for veterans and their families, including prison and homelessness. It is not possible to identify the scale of alcohol problems experienced by local veterans. After an initial enquiry, the National Treatment

[11] http://news.bbc.co.uk/1/hi/uk/6934300.stm

Agency (NTA) confirmed that it does not collect data on veteran status in its routine monitoring of service use and doesn't have any indication of prevalence of veterans experiencing alcohol issues in Bedfordshire.

4.8 Mental Health

In May 2010, the Coalition Government acknowledged that action needed to be taken when it promised to "…rebuild the Military Covenant by… providing extra support for veterans' mental health ." (H.M Government, 2010).

Despite some indications that certain age groups have differing experiences, the prevalence of mental health problems in serving personnel and veterans generally appears to be similar to that of the general population (DH, 2009).

The number of military personnel who are officially discharged because of a mental health condition is very low. In the period 2001 and 2007 the annual number varied between 155 to 215. This means that only around 0.1% of regular service personnel discharged annually were done so for mental health reasons. Of this low percentage, only 20-25 individuals were annually diagnosed with Post-Traumatic Stress Disorder (PTSD).

It is worth noting that, during this HNA, several stakeholders identified that they felt there is a strong disincentive for serving military personnel to present with any mental health symptoms. They explained that a consequence of doing so could be discharge from the services, and that this could at least partly explain these low numbers.

But, in 2009 Combat Stress, the veterans' mental health charity, received 1257 new referrals. This was an increase of over 60% since 2005 (Murrison, 2010).

Typical New Referral

- **Average age 44 year old (youngest aged 19 oldest 93)**
- **Ex Army**
- **Childhood trauma, neglect, poor care giving**
- **Multiple traumatic exposure. Service in many war theatres (N.Ireland commonest)**
- **Family Ultimatum –usually second marriage**
- **History of multiple house moves, employers, long spells of unemployment or homelessness**
- **Many children mostly not in touch**
- **History of domestic violence**
- **Significant physical illness**
- **Classically diagnosed with PTSD, Depression; Alcohol misuse**
- **No prior intervention**
- **NHS has not helped (for a variety of reasons, see page 29)**

Table 8: The profile of a typical 2009 referral to Combat Stress (Busuttil, 2010)

Highly debilitating service-related mental health conditions such as PTSD, and more commonly depression and anxiety disorders, can lead to problems in relationships and at work, and there are links to behaviour change, most notably, anger and substance misuse, particularly alcohol. Those with these PTSD report being constantly anxious, being unable to relax, vividly re-experiencing a traumatic event and avoiding anything that might trigger distressing memories or feelings. Problems can remain masked for a number of years, and veterans and their families may be struggling to deal with matters at home.

The most common mental disorders in the UK military are alcohol abuse (18%) and neurotic disorders (13.5%). The prevalence of PTSD symptoms remains low in the UK military, but it appears that reservists are at greater risk of psychiatric injury than regular personnel (Iversen et al).

Other sources also state that it appears that territorial or reserves forces are at the greatest risk of suffering from mental health problems. One study suggested that 26% of reservists who served in Iraq were likely to have a mental health disorder, compared to only 16% of reserve forces personnel who were not deployed in Iraq. (Hotopf et al).

Veterans with mental health problems have an even higher risk of social exclusion after leaving the Forces and therefore these individuals represent a very vulnerable group of veterans.

> *Most [veterans] do not develop mental health problems as a result of serving [but] the minority who do, fare badly.*
>
> King's College London, 2003.

Psychological, social, cognitive and medical reactions following exposure to traumatic events, like combat, are complex.

After any traumatic event it is normal to experience anxiety or nightmares, and these usually go away within a few weeks. However, some individuals experience lasting psychological problems, resulting in depression and anxiety.

As a simplistic indicator of the potential scale of current and future mental health problems for non-elderly veterans, it is estimated that about 40% of those currently leaving the forces each year have served in recent operations (Morrison, 2010).

Some veterans believe that their symptoms are part of being in the armed forces and experiencing combat (Combat Stress). While some symptoms, such as nightmares, are normal in the weeks following a traumatic event, symptoms that last for longer can indicate a problem.

Veterans can suffer from co-morbidity of mental health conditions, and these problems are often complicated by other issues, such as relationship and home-life difficulties.

But mental health problems are not an inevitable outcome of either time served in the military generally, or specifically combat or operational deployment - sometimes called active service.

Individuals may enter the military with mental health problems or a susceptibility to suffer from mental health problems, if it's undiagnosed, not on their medical records and they choose not to disclose it. If they do disclose any mental health history prior to 'signing-up' they will almost certainly be deemed as unsuitable and be prevented from joining the military.

4.8.1 Suicide Amongst Veterans

One statistic reveals that, in the three decades since the Falklands conflict, more veterans from that theatre have died through having taken their own lives than were actually killed as a direct result of the fighting (South Atlantic Medal Association).

More rigorous recent research has highlighted that, during the period 1996 to 2005, those at the greatest risk of suicide were men aged 24 and under, who served in the Army for four years or less, were of low rank and were unmarried. This was most likely to occur in the first two years after discharge. However, contact with NHS mental health services after discharge was lowest among the age groups at the greatest risk of suicide (Kapur et al).

The reasons behind this population's vulnerability to suicide are not clear, but factors will almost certainly include one or more of the following, as identified by Kapur:

- finding the transition back to civilian life more difficult than others
- being adversely affected by service-related experiences
- having a pre-service vulnerability which has not been addressed.

Contrary to previous perceptions, the overall suicide risk appears no greater for veterans than for civilians when all age groups were considered, from 16 to 49 years. In the Kapur study male veterans aged 30-49 years appeared to have a lower rate of suicide than the general population.

These figures have prompted further questions about whether there is sufficient and/or accessible support for vulnerable veterans on leaving the forces and there have been calls from veterans' welfare groups, prompted by the research, for better awareness and assessment of the needs of young veterans by health professionals.

Following review of the Bedfordshire data since 2007, there was no indication of any veteran suicides, although it is not possible to be definitive about the actual number, because veteran status would not automatically be recorded in this documentation.

However, in the course of writing this HNA, stakeholders provided reliable anecdotal evidence of attempted suicide by that population group in that same period.

On further investigation, this anecdotal evidence suggested that these attempts were at least partly triggered by barriers that meant the individuals did not, or could not, access the mental health services that they felt they needed, with the urgency they needed them.

The National Suicide Prevention Strategy is due to be refreshed in the near future and should include a review of the needs of veterans.

5 Health Care and Services

5.1 Barriers to Accessing Services

It can take a number of years for a veteran to seek help after leaving the services and/or becoming unwell, for a number of reasons, including the associated stigma, particularly around mental health problems, or because they believe that nothing can be done.

It is not untypical, especially for men - who at over 85% make up the overwhelmingly large majority of the veteran population - to take a significant amount of time to seek help for health problems. This delay can often be further exacerbated when related to mental health problems. One suggestion is that the average time between becoming unwell and seeking help for problems with mental health is around 10 years (Palmer, MAP).

> *The mental resilience instilled by military training has one unwelcome by-product: a reluctance to seek help when times are tough.*
>
> CommunityCare.co.uk

Social exclusion can mean that some veterans do not register with GPs and therefore have poorer access to primary health care. If veterans are able to access primary care, and then be referred to other services, it can be true that these services are not geared to meet the needs of veterans. For example, service providers often:

- do not identify veterans – maybe due to time constraints, lack of awareness about the needs of veterans, not being required to record or collect data relating to veterans;
- lack knowledge and understanding of veterans and the Armed Forces;
- are not aware that veterans may have specific needs because of past military cultures;
- may lack confidence in working with veterans, or perceive them to have special needs which they can't meet, and;
- may be fearful that veterans can be violent. (IAPT, 2009)

When veterans present to primary care, with general problems like sleeping difficulties or relationships problems, it is important that primary health care professionals are able to identify veteran status, in order that they are able to better identify/understand causes and determine effective treatment.

> *Veterans wanted to be treated alongside their peers and by organisations that understand service related psychological injury.*
>
> Wing Commander David Hill, CE, Combat Stress

The *Improving Access to Psychological Therapies* (IAPT) report (Veterans' Positive Practice Guide, March 2009) acknowledges that it's important for veterans to be able to access services, particularly mental healthcare, through whichever route they feel most comfortable. The services that many are routinely in contact with, and with which they feel most comfortable are often a services charity. These include the large national organisations, such as The Royal British Legion, Soldiers, Sailors, Airmen and Families Association (SSAFA) or Combat Stress as well as smaller or more localised ones.

Fundamentally, the treatment of mental illnesses, including alcohol and other substance mis-use is the same for both veterans and non-veterans.

However, existing mental health services often have a number of barriers preventing access by veterans. Often, veterans' beliefs and behaviours may prevent access or worsen health experience, such as:

- believing that mental health problems are shameful and so deliberately hiding symptoms from health professionals;
- believing that NHS professionals will not understand them/their service history;
- believing that the effort, stigma and shame will outweigh the benefits of asking for and receiving help;
- self-medicating with alcohol in order to mask their moods or problems, and stop them being detected;
- believing that psychological therapies are not effective for veterans
- being dis-enchanted by previous exposure to mental health services in the military or NHS, as well as;
- having difficulty accessing general health services in the first place - especially for those who are socially excluded (IAPT, 2009)

There is conflicting evidence as to whether these existing mental health services are appropriate or effective.

A report on the problems veterans can face accessing mental health services has been produced as part of the IAPT programme. These problems include:

- not having contact with local services, and;
- feeling that GPs won't understand them.

> *"I went to see a counsellor. She was a nice enough… but as soon as I went into detail [about an incident in Iraq] it was obvious that she wasn't on my level… I don't think she'd heard anything like that before."*
>
> Anonymous Veteran - 2nd Gulf War

The actual or expected waiting time for veterans to access services, specifically mental health services, was raised as a serious concern by veterans, voluntary agency staff and health professionals, during this HNA.

5.2 Existing Support and Treatment

Within the Armed Forces, mental health care for serving personnel is provided by primary care professionals, community mental health departments and specially commissioned inpatient services. In addition, interventions aimed at prevention have been introduced (DH, 2009).

After a combat tour, serving military personnel should go through "decompression", a process which aims to act as support for any immediate trauma or psychological effects of that active service. This is delivered in a dedicated facility, with a community mental health nurse on hand to provide psycho-educational briefing and deal with any immediate issues. This is followed by leave, and on return further stress management is available if necessary.

There is also increasing use of Trauma Risk Management (TRiM), an evidence-based model of peer-group mentoring and support for use after traumatic events, particularly in military operations. It is delivered by non-medical staff, who are trained in the early identification of those who may have been affected by traumatic events.

Other positive aspects of TRiM are that it can reduce the stigma of mental health problems and raise awareness of the importance good mental health for active service personnel.

But, as previously mentioned, there still appear to be disincentives for serving forces personnel to admit to suffering or presenting with mental health problems.

On leaving the forces, veterans should be allocated general support from a welfare officer in the area to where they are moving. Stakeholders reported that one coping mechanism is for veterans to deliberately seek to move to an area where they know there will be an ex-army community, which can be used as a means of support. Others decide to make a clean break from the forces altogether and so do not have the same opportunity to use ex-army peer networks to act as their social support.

There are a range of specific treatments in civilian life to help people cope with the psychological consequences of exposure to traumatic events, including trauma-focused cognitive behavioural therapy.

The IAPT report, referred to previously, recommends that local NHS health services liaise with veterans' organisations so that care can be specially tailored for veterans' needs.

5.2.1 Local NHS Services

Primary Mental Health Care in Bedfordshire includes IAPT services, which offer Cognitive Behaviour Therapy (CBT), the intervention that NICE (The National Institute for Health and Clinical Excellence) guidance recommends for PTSD. Veterans with a range of mental health problems including depression and anxiety can self-refer to IAPT, or be referred through a GP or other health professional.

Consistent with much health service monitoring, the local IAPT service is not currently required to specifically record or report the veteran status of patients, so it is not possible to ascertain the level of service use by veterans.

Referral to General Practice Counselling is another Primary Mental Health Care option available for veterans, and could be very appropriate if they have depression or life/relationship issues. However, general counselling is not an effective intervention for PTSD.

Secondary Care, from the Community Mental Health Team, or acute care is locally provided by South Essex Partnership University NHS Foundation Trust (SEPT).

NHS Bedfordshire has one alcohol providers, Alcohol Services in The Community (ASC) which offers services through The James Kingham Project (JKP). Individuals can self-refer or be referred through any health professional or service to either of these.

JKP provide open access, information and support for individuals who are experiencing issues around alcohol use. In addition to this JKP offer structured alcohol interventions to reduce alcohol related harm and associated personal and social issues.

Healthlink - provided by SEPT - is a specialist dual diagnosis service in Bedford which offers advice, support and information on drug and alcohol-related problems. The service is aimed at those with mental health problems and an alcohol or drug issue who are in need of a higher degree of support.

Healthlink do currently undertake a clinic at JKP and there is a close working relationship between the organisations.

Detoxification and pharmacological therapies takes place through Healthlink and referral back to JKP for ongoing support is encouraged following engagement with Healthlink.

There can be confusion about the remits of these agencies and to which one patients should be referred. This can add to existing delays in accessing services, some of which already experience long waiting times of up to 6 weeks before initial appointments, and sometimes 2-3 weeks between subsequent visits. One stakeholder suggested that if GPs know about these delays they can be less likely to refer to these services.

CAN are another local agency, who are available to help people with alcohol problems, but only if they have other drug problems too.

The evidence from this Health Needs Assessment indicates that there are a number of effective services available to meet the needs of veterans in Bedfordshire. Ensuring that those services are accessible in a timescale that enables them to effectively meet the needs of veterans, and that there is equitable access to those services by veterans who need them, are priorities.

5.2.2 National Specialist Services

5.2.2.1 Medical Assessment Programme (MAP)

The Medical Assessment Programme (MAP) based at Guy's and St Thomas' in London is available for anyone who has served since 1982, including in the Falklands, and has a mental health problem that they think is related to service.

Veterans can be referred by a GP or can contact the MAP directly, and anyone caring for a veteran can also contact the MAP if they have concerns about the mental health of someone in their care.

MAP provides diagnosis and a treatment plan, and communicates these to the medical and mental health team involved in the veteran's care.

5.2.2.2 Reserves' Mental Health Programme

When reserve forces are demobilised, their medical care becomes the responsibility of their local NHS. In November 2006, the MoD and NHS launched a new initiative called the Reserves' Mental Health Programme (RMHP). It is open to anyone who meets these criteria:

- has seen active service as a volunteer or reservist since January 1 2003,
- is now demobilised, and
- has mental health problems that might be linked to service on operations.

Between November 2006 and May 2009, the RMHP was contacted by around 300 qualifying individuals. Most of them received the help they needed simply by contacting the professional team members, but 92 individuals attended to be assessed. Of these:

- 70% were diagnosed as having a combat-related mental health problem,
- 25% were assessed as not having a mental health disorder, and
- 5% were assessed as having a problem not related to their deployment.

Reservists who are eligible and who would like an assessment can ask their GP for a referral. This is the preferred method of contact, as it ensures consistency between GP and RMHP assessors, and that both are aware of all the factors affecting the individual's health.

Referrals from civilian psychiatric services (such as Combat Stress) are also accepted but the patient's GP will be informed. Individuals can contact the assessment centre directly, but Defence Medical Services (DMS) staff will liaise with the individual's GP before offering a mental health assessment at the Reserves Training and Mobilisation Centre in Chilwell, Nottinghamshire.

If an individual is diagnosed with a combat-related mental health condition, outpatient treatment is offered at one of the MoD's 15 military Departments of Community Mental Health (DCMH). If acute care is needed, the DMS will help provide access to NHS inpatient treatment.

5.2.2.3 Veterans Mental Health Pilot Projects

The Community Veterans Mental Health Pilot Project was an initiative designed to prove a model of community-based mental health recommended by the Health and

Social Care Advisory Service (an independent expert charity) and advised by a panel of appropriate experts. It recognised that, in some areas of the country, the NHS can no longer easily access the expertise in military mental health required to meet the needs of some mentally ill veterans. It addresses this by establishing on a regional basis networks of expertise in military mental health to provide specialist assessment and treatment in a culturally sensitive setting.

Since 2007, six pilot projects were set up in Stafford, Camden and Islington, St Austell, Cardiff, Newcastle & Bishop Auckland and Edinburgh to give NHS staff the appropriate understanding and support to help veterans. The aim is to provide veterans with a service that tries to understand what they need and provides a link between the NHS and the military so that they'll feel more comfortable coming forward. Veterans could self-refer directly or be referred by a GP or veterans' organisation.

The MoD, Department of Health, Combat Stress and clinicians worked together to design these pilot projects. Each pilot area has a Community Veterans Mental Health Therapist who offers understanding of the issues, including combat, which might affect ex-services personnel. They also build links with local veterans' organisations to try to identify people who aren't getting the care they need.

Staff might provide treatment or arrange for referrals, such as to community mental health services, social services or for specialist assessment and treatment elsewhere.

Because the pilots started at different times, the evaluation report is not due to be published until early 2011.

The DH's mental health strategy, *New Horizons*, which called for "Improved care for specific groups such as… veterans" said the pilots would inform wider roll-out of community mental health services for military veterans.

> *Early evidence showed that veterans will see and engage with therapists who have no military background, provided the therapist shows interest, honesty and understanding, and acknowledges that there will be issues they don't understand.*
>
> Preliminary findings, Community Veterans Mental Health Pilot Project

5.3 The Potential Scope of Future Mental Health Need

Several participants, in more than one of the phases of stakeholder involvement, expressed concern about the potential scale of future need, particularly in relation to mental health problems faced by ex-military personnel.

The main stated due cause was the increased number of not only regular, but also territorial forces that have been and are currently engaged in combat operations, and the associated exposure to combat-related trauma.

The effects being experienced by those returning quickly to civilian life from combat, coupled with the expected delays, in veterans experiencing and presenting symptoms of these mental health problems, were described by those who have seen and experienced the phenomenon as a potential ‘time bomb.’

Stakeholders pointed to the changes in recruitment and training of military personnel over the last few decades. Further anecdotal evidence suggested that this process is more rigorous and effective in “weeding out” those who do not have the appropriate aptitude, particularly for those in roles who are more likely to see combat. This may further explain a delay experiencing and presenting health problems amongst a ‘hardened’ core of veterans.

6 Summary of Local Stakeholder Views

The qualitative findings from the range of sources have been used to support the findings throughout this HNA, but separate concise summaries of local stakeholder views are provided below.

6.1 Local Stakeholders

A Mapping Event for local stakeholders was held at The Rufus Centre, Flitwick, on 14 June 2010 and attended by 28 representatives from a range of local statutory and voluntary agencies, including forces welfare organisations, and veterans.

The focus of discussion largely related to the needs of recent veterans and processes/outcomes for them and those who will leave the armed forces in the near future.

The group agreed that it is a very significant change to move from the discipline and routine of life in the forces to a largely unstructured civilian one.

A summary of common themes identified by each of the groups was as follows:
- Improved data collection
- Support for transition from MoD to civilian life
- Awareness raising in relation to the needs of veterans
- A service directory required for signposting
- Training for professionals

Other thoughts were grouped into the following, often linked, categories:

a). Information about local veterans:
- Need to better identify veterans in locality
- Assessment to include question of identification - evidence for commissioners to base actions on, regional/national strategy, critical mass, learning from areas such as Colchester with high concentration of veterans
- Need to collect same data

b). Specific veterans' issues

- Difficult to generalise veterans' experiences/needs, e.g. identified different pressures that come with normal or dishonourable discharge.

c). Improved processes

- Routine transfer of medical notes - NHS code for GPs to identify veterans should be available and used
- Treat the move from service life into 'civvy' street as a 'transition process'
- Have clearer expectations and protocols about medical handovers

d). Improved resources and services

- Need for advocacy for veterans
- Directory of Services
- Information for families
  - tie information given into Poppy Day
  - need to have joined up information
- Mental health and physical health are related, need access to physical activity
- Help and support with information about:
  - home, job, social life
- Preparation pack should be available – 'what civilian life is like'
  - support available
  - could be on a DVD
- Central directory, physical directory left in pubs or other meeting places
- National helpline
- Publicity - Post Office leaflets, local focal point, GPs, educational events
- training for family members, parents, children and other relatives to identify signs if someone is having flashback, they may not talk about it openly because of macho culture.
- Provide all Service leavers with an effective mental health education programme at the point of resettlement, so those at high risk know where to go for help.

e). Co-ordination of support for veterans

- Services are fragmented, BL and SAFFA have important lead role to play
- Combat stress, there is the 'Warrior' programme but other elements such as primary mental health care or assertive outreach are not always joined up
- Co-operation amongst teams
- Tap into public goodwill which seems to have grown in recent years and continues to do.

f). Better strategic planning

- Establish a longer term vision – the number of veterans needing support is likely to be bigger issue in future

A summary of priorities listed were:

1. Awareness raising
   - including veterans' own awareness of the support they may benefit from and where to get it.
2. Information directory
   - for signposting
   - with information for veterans
3. Training for professionals, GPs and family services.

4. Appreciation that ‘dormant’ health needs may only become apparent many years after leaving service
5. Formation of a cross-sector veterans' forum to drive change and progress in Bedfordshire.

6.2 Primary Care Practitioners

A brief questionnaire (see Appendix 2) was distributed to Primary Care professionals in Bedford for self-completion. A very encouraging 15 responses were received by email and in hard copy form, from a range of practitioners; 3 General Practitioners, 10 Practice Nurses, 1 Nurse Specialist and 1 Health Care Assistant. Whilst this sample should not be regarded as representative enough to provide definitive findings, it does begin to indicate some consistent themes amongst the respondents.

A summary of the findings are as follows:

a) *A veteran’s military service is unlikely to be routinely identified and recorded in primary care*

b) *Awareness of the need for recording veteran status appears to be low.*

Of the 15 respondents only 3 said that they identify or acknowledge whether new patients are ex-military personnel. One of these seemed to indicate that the information was more likely to be volunteered, rather than prompted. One mentioned a “Sign requesting [the] information.” Another specified that the information was collected as “Free text at New Patient Check.”

One of the respondents who did not routinely make note of ex-military service by patients stated that they “…would only note if was an issue raised specifically by patient at registration, or was something of significance in past medical history that made it relevant.”

There were 6 respondents who identified the lack of a specific “READ Code” as the reason for not asking or recording information on veteran status.

Other notable responses related to recording veteran status included:

“…it has not been an issue to record this data.”

“Not sure where it’s recorded.”

“Not asked, not disclosed.”

“Was unaware of the need to [record the information on veteran status].”

“Never identified as a need unless sustained health issue related.”

One further response, from a GP, was “Never thought about it – don’t ask occupation”.

c) *Awareness of the specific health needs of veterans and the implications of being a veteran on health experiences/outcomes is mixed.*

9 of the practitioners said that they had experienced, or had knowledge about, specific health needs of ex-military personnel.

Responses from 7 questionnaires indicated experience/knowledge of veterans with mental health needs, including 3 which specifically mentioned Post Traumatic Stress Disorder. 3 respondents identified needs related to physical injury, as a result of service. A further 2 responses acknowledged needs in relation to social determinants of health, e.g. "housing, benefits" and "adjustment back into society."

These 3 final responses in this section, all from GPs, indicated a lack of distinction between veterans and non-veterans:

"They [the health needs of veterans] are as complex as any other potential individual – [it is] important to consider the individual's needs."

"… [I am concerned about veterans' health being] politicised with us being asked to provide enhanced care that wasn't based on any meaningful evidence…"

"I am interested in ALL my patients past history… [and]…not sure that the 'ex military' prompt makes me or should make me do anything unique to that group."

d) *Awareness of barriers for ex-military personnel accessing health services appears low.*

Only 4 respondents, when specifically asked, identified barriers for veterans in accessing health services.

Those responses were:
"[there is a] …lack of awareness re. military fast tracking"

"[There is] …very limited support for PTSD and reluctance on the patients' part to discuss/engage."

"[Veterans are]… not aware what services are available to them in general practice. [There may be] …concerns that any mental health issues may be revealed to [the] military"

"[Veterans have a] …Reluctance to attend unless with a specific physical need, i.e. keen not to waste time, resources."

As well as 8 blank responses to the question about barriers for veterans, 3 specific responses were:

"A question for them….."
"No idea"
"Not aware of any"

e) *Some suggestions to improve access to services appear relatively simple to implement*

5 responses identified the need for training and information for primary care practitioners relating to veterans' health experiences and the services that are available for veterans to be signposted or referred to. 2 respondents suggested the addition of specific codes to record veteran status.

One of these suggested a further question be added to "new patient health checks."

One respondent felt that access could be improved through encouragement of "routine screening, e.g. alcohol screening, cvd screening, and access to other options, i.e. smoking cessation, IAPT, exercise referral."

A final suggestion - which implied knowledge of a patient's veteran status - suggested better advice "[for] ex military patients when they join the practice, of the services and confidentiality."

6.3 Veterans

6.3.1 Self Completion Questionnaire

A self-completion questionnaire (see Appendix 3) was designed to identify the basic health experiences and issues faced by a sample of veterans in Bedfordshire.

A total of 60 questionnaires were distributed at a veterans' informal social event in Leighton Buzzard and also through the local Bedfordshire, Cambridgeshire, Hertfordshire and Huntingdonshire Royal British Legion. Subsequently 16 completed questionnaires were received. The responses from each of the individual questions have been summarised, and where possible, themes or trends identified.

The small sample size meant that more complex statistical analysis of the response data was not feasible. Efforts were made to ensure wider representation, but findings from this survey should be regarded as indicative only, due to the nature and size of the sample. Due to rounding, totals may not add up to exactly 100%.

6.3.1.1 Summary of Findings

All 16 respondents were Bedfordshire residents. 14 (87.5%) were male, 2 (12.5%) female. The ages of the respondents were quite evenly spread across 3 older groups, as indicated in Table 9, although there were no respondents under 25 years of age.

However, the proportion of veterans in each age group from this small survey was not too dissimilar from the estimated national picture, including the older age group being the largest.

Age Group	Number (%) of Veterans
Under 25 years	- (-)
25-40 years	4 (25.00)
41-60 years	6 (37.50)
Over 60 years	6 (37.50)
Total	**16**

Table 9: Age of Respondents, Bedfordshire Veterans' Self Completion Questionnaire

Length of service varied dramatically, with the shortest service being only 5 days, and the longest 45 years. Average (mean) length of service was 12 years, 2 months. 11 (68.75%) respondents indicated that they had served in a combat theatre.

2 (12.50%) were or had been reservists. Both had served in a combat theatre.

Only 2 respondents (12. 50%) stated that they had received a war pension or similar payment.

Respondents reported their current health as indicated in the table below:

Current Health Status	Number (%) of Veterans
very good	7 (43.75)
good	6 (37.50)
poor	3 (18.75)
very poor	- (-)
Total	**16**

Table 10: Current Health Status of Respondents, Bedfordshire Veterans' Self Completion Questionnaire

This local picture of veterans' current health status appears to be more positive than the self-reported health experiences of veterans that have been indicated in the available national research.

Of the "*poor*" responses, 1 related to a diagnosis of PTSD (service related) and 2 referred to musculo-skeletal or joint problems. One of these was also said to be related to military service.

Half of the respondents (8 or 50.00%) said that their health was "*worse*" than when they left the services, with 4 of these explicit that this was age-related. Given the ages of the respondents, this is not surprising.

8 (50.00%) respondents identified other health issues which had "*affected you and your family*" since leaving the forces. 6 of these were physical, whilst 2 referred to relationship issues, specifically "violent outbursts", "arguments", "short temper/no patience". Both of these latter 2 respondents indicated that these issues "*related to your time in the armed forces*"

Only 1 respondent indicated any barriers to “*being healthy or having a healthy lifestyle since leaving the forces.*” These were all mental health issues, i.e. “mood swings”, “lack of self confidence” and “lack of pride”.

Responses in the grid below indicated that accessing health services generally was rated as “*easy*”.

2 of the respondents, who did not indicate how easy they found accessing services, did make general negative comments about waiting times for appointments.

The one respondent who indicated that accessing health services generally was “*quite hard*” was a military reservist, who had found it hard accessing both MoD and ‘civilian’ services related to mental health needs.

The respondent who answered “*very hard*” did not give any further detail.

Generally how veterans found accessing health services, since leaving the services	Number (%) of Veterans
very easy	4 (25.00)
easy	7 (43.75)
quite hard	1 (6.25)
very hard	1 (6.25)
not indicated	3 (18.75)
Total	**16**

Table 11: Ease of Accessing Services, Bedfordshire Veterans’ Self Completion Questionnaire

None of the respondents indicated that they had been “*unable to access a health service that you needed.*”

Only 1 of the respondents had “*ever used a health service that has not met your needs.*” This was explained as simply “Dental”.

Further to this, 3 respondents offered suggestions as to how services could have “…*been improved to meet your needs*”. These were:

> “Instead of waiting 6 months maybe I could have seen someone earlier.”;
> “Councelling (sic) for the transition from being alert 24/7 to nothingness. I no longer felt important in what I was doing”, and;
> “Greater knowledge of military within the NHS”

This latter comment was directly related to a noted perception from one of the earlier questions, that the “NHS has a lack of understanding of military trauma.”

3 (18.75%) out of the 16 indicated that they had ever used a health service that had been “*particularly effective.*” These comments were:

> “The NHS is excellent and the only fault I have is that there is always a long wait to get treatment”;
> “Local Doctor surgery/Health centre for general health problems”, and;
> “NHS Health Link for alcoholism.”

One of the other respondents said, "…all [health services] have been adequate.

Only 4 (25.00%) of the respondents indicated that they had heard about NHS priority treatment for veterans. One who appeared not to be aware of it did make the comment,"…our service personnel should have absolute priority and should be treated as special needs."

One of the respondents stated that he felt that sometimes veterans find it difficult to prove that the conditions that they have are related to their service. To compound this, veterans often face barriers to do with negative attitudes towards them, including from service providers. These specifically included the view that veterans do not deserve preferential or priority treatment because they had made the conscious decision to join the military, almost as if subsequent negative health experiences were an accepted consequence of service.

But the attitudes and expectations of the veterans themselves were also acknowledged as being a potential barrier to making the transition into civilian life. One respondent said that, after returning from serving in the 2nd Gulf War "…I thought the world owed me a favour."

A related comment made by another respondent indicated that he felt the transition to civilian life after leaving the forces "was the main issue", and that any barriers or problems were most easily overcome by "being able to find someone who you feel can empathise with the military perspective", although this was not always possible to do.

One final general comment acknowledged that the respondent had received unhelpful health advice from his GP, such as "move to a warm climate", "give up [your] job" and "move house."

6.3.1.2 Comment

This was a small sample, and there was some sampling bias, given that all respondents were in contact with one or both of the local veterans' organisations involved. Because of these factors, it is not be possible to make any definitive conclusions relating to the veteran population in Bedfordshire. However, the spread of ages, lengths of service, differing roles, involvement of men and women roughly proportionate with the national veteran population and the inclusion of several reservist veterans does ensure some representativeness and start to give some interesting insights into local veterans' experiences and provides further first hand evidence of their health needs.

6.3.2 Focus Group

The focus group took place at the Merton Centre in September 2010. It was approximately 90 minutes in duration, based on a schedule with 6 distinct sections, each one with a number of prompt questions, as below. The group was a small one, consisting of 3 male veterans from Bedfordshire; one was aged '41 - 60' and 2 were in the 'over 60' age group. They represented both ex-regulars and reservists, coming from the army and navy.

Prior to the questioning, the participants were given some background information, including the aims of the HNA as context. Some direct quotes are provided for further illustration. The participants were asked to look wider beyond their personal experiences when answering the questions.

6.3.2.1 Summary of Findings

1. How helpful is this definition (of 'veterans')?
Prompt: Participants given the widely-accepted definition of veterans.
Consensus was that the definition is not helpful in identifying veterans. One participant said that it was "confusing." Another said that it could refer to "anyone who is over 65."

A suggestion for a more appropriate term was "ex-service veteran."

2. What does the veteran population in Bedfordshire look like?
Prompt: Participants given extrapolation from national data.
The group were not sure about the size and nature of the Bedfordshire veteran population, although one suggested that the data probably was "not far off." Another said that he had "no idea."

Views indicated frustrations about the lack of available data to help identify the veteran population and also the recording of veteran status.

However having an opportunity for veterans to register that status is not necessarily an adequate solution. Attitudes of the veterans may prevent them from volunteering information unless they see a positive consequence resulting from them doing so.

3. What are the health experiences of Bedfordshire veterans?
Prompt: How are military personnel prepared for a living healthy life when they leave the forces
Consensus was that veterans are not well prepared for a healthy life after the forces; one participant said that there was "not much help." Experiences indicated that veterans were "Bottom of the housing list" partly because on leaving the services you are viewed as "having made yourself unemployed."

In terms of physical health "you are kept fit" and "looked after when in [the forces], but if medically fit for discharge you're just waved goodbye to."

There was some discussion that medical tests on leaving the forces were basic and not rigorous; one participant reported that "My ears were still ringing from the flight when I had my hearing test."

A suggested solution was that veterans should have tests at ongoing periods after discharge.

Prompt: How does this differ for TA when they have finished a tour?
The group thought that TA has the same fitness tests after they have finished a tour, and if connected to a regiment they will report to the regimental medical facilities. They may be gaps, in care though, as TA have the option of using their own civilian GP, with a result that neither are accessed.

Prompt: What health issues do veterans have when leaving the services?
There were perceptions that registering with a GP, after leaving the forces, could be inconsistent across the veteran population, with some veterans "Not too sure how to find a doctor, unless you're married and your wife is registered."

Even when a veteran is registered with a GP the group felt that it was crucial that the GP record veteran status to inform any diagnosis and treatment; "Doctors need to know that you are a veteran" because "military personnel have different needs and experiences."

2 of the respondents mentioned mental health issues or "dark clouds". These were made worse without the support systems that might be there whilst still in the forces; "In civvy street you haven't got your mates to talk to."

Prompt: What are the biggest issues?
Mentioned first were those who are coming back from Afghanistan with "obvious physical injuries".

The group also thought Post Traumatic Stress Disorder to be significant, "both in the immediate and long term."

The lack of regimentation and organisation was thought to be an issue for some veterans, no longer "being told what to do, when to do it" and losing the social support, having "lost their mates." Some veterans miss the excitement.

Prompt: What are the causes of these biggest issues?
The group recognised the diversity of the veteran population and subsequent needs, as well as causes of issues for veterans, particularly related to mental health; "We are all different people and we all handle situations differently." They talked about some people "being asked to live in stressful situations…and not being equipped to cope with it."

They strongly felt that traumatic situations affect people differently. They [traumatic experiences] "don't leave you" but whilst "others deal with it, some can't."

4. What are the health needs of Bedfordshire veterans?
Prompt: What prevents veterans being healthy after military service?
- *Lifestyle and behaviour*
- *Information and advice*
- *Specific health conditions*
- *Using services*

The first and main issue identified was alcohol. This was perceived to be a major factor in the services, where personnel "learn to drink enough to cope" but don't drink to excess as they have organisational controls – i.e. having to be disciplined and fit to serve. However, the group identified that on leaving the forces these same controls are not there, leading to greater risk of mis-using alcohol.

Participants felt that services personnel involvement in other drugs use and trafficking, leading to an increase in criminalisation, may be a consequence of service in Afghanistan. Alcohol also increases potential for criminal behaviour and interaction with the criminal justice system.

The barriers which prevent service use include not being told about services when in the forces and also on discharge. The view that veterans do not get the information they need to be healthy was held by all the participants.

When specifically asked what the typical relationship between a veteran and health professional would be like, the view was that veterans would “respect health service personnel” and that this was a legacy of time in the forces, where medical staff were well regarded, not least because they are generally at least mid-ranking officers.

In terms of wider health determinants, the group felt that “Lots [of veterans] do not have fundamental needs met – housing, employment…”

Prompt: What services are effective?
No specific services were identified as effective.

Prompt: What are the barriers that prevent services from meeting the needs of Bedfordshire veterans?
The group felt that veterans themselves have a large degree of responsibility for their health outcomes. For example, one member said that there was “…no differentiation between civilian and a veteran alcoholics.”

The veterans’ attitudes were identified as barriers to using services. Military personnel were said to develop negative associations with being ill and “don’t like going sick.” The group said that being in the forces teaches individuals to be independent and, where possible, to “sort things out for themselves”, being “self supporting whilst part of a team.” “If servicemen go crying to the GPs they are sissies” and being ill can be seen as letting your team down. It was regarded as “a servicemen’s mentality.”

The group said that it is crucial to get the communication between services and veterans right. When it comes to discussing potentially sensitive or difficult issues, they said that veterans “find it easier to speak to military or ex-military” personnel. Using the right language and pitching services correctly was thought to be very important so that they are seen as appropriate and accessible for veterans.

Another identified barrier was not knowing which services are available to meet a wider range health, social care and welfare needs, or where to go for help or advice.

Prompt: What are the biggest barriers?
The largest barrier identified by the group was the mentality of veterans themselves. This included being conditioned whilst serving in the forces to “do things on their own.” Also when no longer in the military veterans do not have the support from peers to act on things when they need to; “They don’t have their mates around to help them through it or talk them into [taking appropriate action].”

The other significant barrier identified was the time-delay in service-related symptoms occurring, not only with relation to mental health problems, but also physical wear and tear injuries which may be related back to time served in the military. The group perceived that it was often difficult to prove the causes of mental and physical injuries to health care professionals, who would not always make or confirm the links with military service.

5. What are the solutions for addressing veterans health needs?
Prompt: What would make the most difference?
Solutions suggested were:

- Take on ex-military staff that veterans may find easier to talk to;
- Develop social networks for peer support;
- Use existing services and organisations to publicise services;
- Work closely with the MoD to improve information and transition on discharge;
- Ensure that GPs know whether their patients are ex-service – have one simple question for patients.

6. What do you know about NHS priority treatment for Veterans?
The group did not think that veterans should be allowed to "queue-jump" for services over non-veterans, but that "if you pick up an injury on service your country should look after you for the rest of your life."

7. Any other comments?
None.

6.3.2.2 Comment

This was a small focus group, but it did provide opportunity to both confirm issues that had been previously identified and to add further detail from a local veteran perspective.

7 Conclusion

The term 'veteran' is used to define a large section of the population, covering a considerable spectrum of ages and with greatly varying health needs and experiences, and this presents difficulties when trying to identify and prioritise actions for improvement.

The aims and objectives of the HNA have largely been fulfilled but the difficulty in developing these is the recurring lack of any systematic or reliable data relating to the local veteran population. National data can be inconsistent and even contradictory, which limits the effectiveness of extrapolation.

Almost exclusively, national research focuses on those recent veterans, with the main focus being on their mental health experiences.

The needs of older veterans are significant but because they are largely consistent with those of the rest of the elderly population should be addressed in that context.

8 Recommendations

The following recommendations are based on the national and local evidence collected, which is expressed within this report. Whilst this HNA was intended to provide evidence for health commissioners, there are also implications for a number of other stakeholders.

The improvements recommended are, in many cases, fundamentally connected. To be most effective they should not be viewed or implemented in isolation. For example, some specific actions in relation to awareness of veterans' experiences will influence data capture and the collection of evidence, which in turn will underpin and facilitate more effective practice further down the line. This interdependence makes it more difficult to prioritise or sequentially implement or the recommendations.

8.1 Key Recommendations

1. Mental Health

Address the priority mental health and related issues of non-elderly or recent veterans through:

- ensuring sufficient capacity in evidence-based interventions commissioned for a range of disorders, including alcohol and drug misuse, which:
    - are effectively linked up with mental health services;
    - are aware of the needs of veterans and can refer to a suitable MH service,
    - do not simply refer back to GPs as a default action. (N.B. Anecdotal evidence from this HNA reported veterans feeling they had been stuck in a referral loop between agencies without effective intervention).
    - can be accessed in a timely way – reduce waiting times for initial appointments, which currently can be up to 6 weeks.

- recognition by all those referring veterans with a mental health problem that generic counselling is not effective for PTSD, but that there are effective alternative interventions.

- identification and targeting, by providers, of veterans at greatest risk of mental health problems and suicide, i.e. young male veterans with short service, territorials and reservists, through effective collection and monitoring of patient information.

- Improvement of mental health promotion and awareness through:
    - provision of peer advocacy and support for veterans at risk or who need help for mental health problems so that looking for help with mental health is not seen as a sign of weakness.
    - involving veterans in the design, delivery and evaluation of these services.

    It would also be cost effective to offer support and training to veterans groups, developing them so that they can be commissioned to provide effective evidence-based interventions, such as the *Rewind Technique*

(see Appendix 2). Currently this intervention is not widely available to veterans, and where it is available from private providers can have significant costs.

However, it is important to ensure that any veterans undertaking the training and practice of this technique are deemed suitable to be involved in its delivery, i.e. that they are not themselves suffering from or vulnerable to mental health problems.

2. Inter Agency Working
A number of agencies exist to support veterans and it appears that they have little awareness of any duplication, or practical knowledge where agencies can support each other.
As a statutory partner with responsibilities for the healthcare of veterans, NHS Bedfordshire should:

- Lead the development of the recently established *Bedfordshire Military Veterans Multi Agency Forum* as a vehicle to:
    - Provide a partnership approach to addressing the wider health needs of Bedfordshire veterans, through;
        - sharing information, knowledge and experience of veterans issues
        - preventing duplication and sharing resources
        - prioritising and taking action for change through focused projects
        - monitoring the extent and impact of developments across the partnership

- Ensure the experiences and needs of veterans are explicitly acknowledged by existing strategic policy and implementation groups across Bedford Borough and Central Bedfordshire that have a role in supporting vulnerable populations, for example in relation to:
    - Housing
    - Physical disabilities
    - Mental health

3. Training and Information for Professionals
Because of their military service, the healthcare needs of veterans can be different from those of other patients in a number of ways. Acknowledgement of this fact is a crucial first step in providing effective healthcare for veterans.

It is crucial to increase awareness about, and knowledge of, this population, facilitating the provision of more focused and effective services.

- NHS Bedfordshire should offer information and training for Primary Care practitioners, including GPs, and other relevant social care professionals, who may come into regular contact with veterans to ensure that professionals:
    - Have greater awareness of the specific health needs of veterans and the implications of being a veteran, on their health experiences;
    - Better understand the culture of armed forces, the pressures veterans face and the risks of developing MH problems
    - Are able to identify the vulnerabilities and needs of non-regular and reservist veterans;

- Are able to identify and acknowledge the barriers that veterans have in accessing services;
- Implement effective solutions to overcome the barriers that ex-military personnel face in accessing services, and;
- Provide effective referral, informing secondary care, so that veterans receive their entitlement to priority treatment for any injuries or illness attributable to their time serving in the Armed Forces:

N.B. It may be necessary to develop local information and training.

Consideration should be given to:

- the delivery of training by peer professionals to increase credibility and encourage good practice,
- involvement of veterans in development and delivery of training where appropriate.

4. Information/Data Collection

One obvious gap acknowledged repeatedly was the lack of knowledge/evidence base due to the difficulty in identifying and quantifying veterans in Bedfordshire. This could be addressed in the first instance by:

- Ensuring that Primary Care effectively use available systems to record veteran status, at appropriate points in patient pathways, for example, with new patients.

The DH suggests that veteran status is recorded in their medical record using the Read code 'History Relating to Military Service': Xa8Da.

- Ensuring that other services commissioned by NHS Bedfordshire, effectively record and submit information on veteran status of service users, improving evidence to influence effectiveness and priority of clinical care for veterans, for example:
  - Community drug and alcohol services
  - Mental health services
  - Healthcare at HMP Bedford

- Encouraging and supporting other partners, in both the statutory and voluntary sectors, to record veteran status, to inform service delivery and improved outcomes for veterans, for example.
  - Homelessness services, shelters, hostels etc.

In recognition of veterans' disproportionately high rate of criminalisation, the range of stakeholders involved in the criminal justice system should:

- Use opportunities presented during veterans' contact with the criminal justice system to identify specific causes for veterans' poor health experiences, build up a clearer, more quantified picture of need, so that issues can tackled as a matter of priority. Specifically to answer:
  - How many veterans are in the local criminal justice system?
  - How many veterans come into contact with the criminal justice system as a result of mental health problems related to time in the military?

- How can support be made more effective for veterans within the criminal justice system?

NB NHS Bedfordshire could lead the process, through improved awareness and identification of key intervention points.

5. Information and Support for Veterans

Veterans reported a lack of knowledge about where to access information and support, in relation to a number of key health, social care and welfare needs. In partnership with other key organisations, NHS Bedfordshire should support:

- the provision of a range of key, basic information to be made available more systematically through veterans' agencies, acknowledging that they are usually the initial point of call for veterans seeking help, so that they are able to more effectively signpost and refer to appropriate service providers. With this in mind consideration should be given to:
    - The development of a directory of services, for use by veterans' agencies, containing basic welfare information and contacts, including for issues such as housing and benefits.
    - The use of a single/central point of contact for information, both for health and wider information needs of veterans, for example publicise/increase the use of an existing telephone helpline number.

One existing example of a veterans' 'one stop shop' for a range of services is *Veterans First Point (V1P*) in Lothian – see www.veteransfirstpoint.org.uk – part of the *Community Veterans' Mental Health Pilot Programme*.

- The evaluation of this service, as part of the *CVMH Pilot Programme*, should inform good practice, when available.

Provisions should also include:

- effective and accessible advocacy services for veterans and the families of veterans, building on what is currently offered by 3rd sector organisations.

- veterans' peer support services, to acknowledge the need for veterans to share military experiences and have empathetic social support opportunities.

N.B. Effectively meeting the welfare needs of veterans is very important in the prevention and management of mental health problems, so ensuring effective systems and pathways to support veterans' welfare needs should be a priority.

6. Adult Social Care

Several agencies reported barriers for elderly veterans accessing Adult Social Care. Reducing these barriers could be achieved by a designated focus on these issues, *for example*:

- creation of a sub group of the *Bedfordshire Military Veterans Multi Agency Forum* to establish and maintain clear communication and referral systems between voluntary veterans' agencies, e.g. the Royal British Legion, and Adult Social Care, to facilitate better sharing of information and identification of priorities for elderly veterans, including managing the expectations of all stakeholders.

- consideration to having a named contact/contacts with a responsibility for veterans in Adult Social Care, with clear targets and time limits for taking action when referrals are made by veterans' organisations.

8.2 Further Recommendations

1. Wider Mental Health

Mental health has nationally been identified as the biggest single issue for recent or non-elderly veterans. NHS Bedfordshire should ensure that:

- all services available to address veterans' mental health problems are based on existing specific evidence and good practice

- veterans are referred to services which meet their specific needs (i.e. shaped by their ex-military experiences) and which are evaluated by veterans

- good practice, as identified through *Community Veterans Mental Health Pilot Project,* is implemented, when information becomes available.

- mental health promotion and awareness is improved through:
    - Making effective links with local military establishments in order to offer support for mental health information and promotion, with the aims to:
        - reduce stigma of mental health in local armed forces.
        - improve the ability of the military to spot signs of mental health problems, not only for peers in the forces, but also for those who have command of or are responsible for a number of personnel.

2. Medical Information

Very often it appears that there is the need to improve the sharing of patient information between the military and the NHS.
Where necessary this can be achieved through the improved transfer of military medical records to the NHS for personnel leaving the Armed Forces. NHS Bedfordshire should:

- encourage GPs to request transfer of medical records from military when registering someone of veteran status, if records not already available, to ensure greater awareness of patient context and health needs.

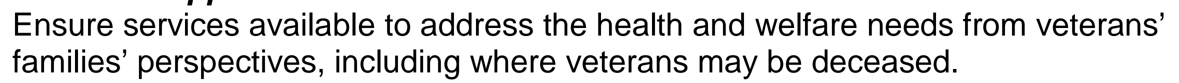
3. Military Discharge

The transition to civilian life for military personnel can be difficult. In order to improve this process:

- Develop links between military/forces establishments, statutory and voluntary services in Bedfordshire to identify information needs and enable the provision of effective and appropriate health, welfare and social care information for services leavers.
    - MoD to tailor help for veterans in the transition to civilian life on discharge, in relation to current and future need, rather than to reflect time served.
    - MoD to improve in-service transitional arrangements, especially housing and mental health support

4. Wider Support

Ensure services available to address the health and welfare needs from veterans' families' perspectives, including where veterans may be deceased.



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10 Appendices

Appendix 1 - Veterans' Organisations

A number of national and regional veterans' organisations exist as part of the Third, or Voluntary Sector, with both general and specific focuses, including some health and social care aspects.

The following brief information is largely taken from the organisations' own publicity materials.

1. Royal British Legion

The Royal British Legion safeguards the welfare, interests and memory of those who are serving or who have served in the Armed Forces. They are one off the UK's largest membership organisations and recognised as custodians of Remembrance.

They help serving and ex-Service personnel and their families. Not just those who fought in the two World Wars, but also those involved in the many conflicts since 1945 and those still fighting today.

They provide welfare services, campaign on a range of issues affecting Service people, are custodians of Remembrance, raise funds through the annual Poppy Appeal and are a membership organisation.

2. Veterans Welfare Service

The Veterans Welfare Service (VWS) focuses upon providing support that will enable the transition from Service to Civilian life, assist bereaved families or respond to key lift events that present welfare needs.

It achieves this by adopting a single central coordinating role that facilitates access to all appropriate services.

The VWS provides a caseworker approach that offers professional help and guidance through either telephone contact or a dedicated visiting service, Under Veterans UK the VWS works in collaborative partnerships with the tri-Services, ex-Service charities, statutory and non-statutory bodies, local community service providers and War Pensions Committees to deliver a quality welfare service that promotes independence, maintains dignity and provides continuous support through life.

3. Combat Stress

Combat Stress specialises in the care of British Veterans who have been profoundly traumatised during their Service career or who have conditions such as Post Traumatic Stress Disorder (PTSD), depression and anxiety disorders.

Combat Stress provides

- Dedicated, short-stay clinical treatment
- Community outreach

Last year alone, they received 1,257 new referrals – bringing the number veterans in their caseload to approximately 4,300, from every campaign that British Forces have been involved in since the Second World War.

Since 2005 the number of ex-Service men and women seeking our help has risen by 72%. The current caseload already includes 102 Veterans who have served in Afghanistan and 400 who served in Iraq.

4. Soldiers, Sailors, Airmen and Families Association (SSAFA)
Help and support for veterans and their families. Annually they provide services to more than 50,000 people.

They cover a very broad spectrum of issues to bring solutions to anybody whose life has been touched by time in the Armed Forces, including the provision of

- Health and Social services
- A confidential support line
- Holidays for children with additional needs.

5. Braveheart Programme
The Braveheart Programme is a grass roots charity, established for veterans, by veterans, with "a core belief that the men and women from our Armed Forces deserve to be helped when they leave the Services, to which so many have devoted and, in some cases given, their lives."

Braveheart's core aim is "to focus on mental health research through a programme that commissions detailed and, in some cases, ground-breaking studies into the effects of war trauma in order to better inform the outcomes for and treatment of veterans."

6. Veterans:UK/The Service Personnel & Veterans Agency (SPVA)
SPVA provides a range of diverse pay, pension and support services to both Military Personnel and the Veterans Community.

7. Gulf Veterans Association
Provides information for veterans and families of veterans that served during the Gulf Wars in 1991 and 2003.

8. National Gulf Veterans Families Association
Focuses on addressing the health or social problems, through support, information, advocacy and counselling, of service personnel who were deployed in both the Gulf Conflicts and Afghanistan.

Appendix 2 - Information -The Rewind Technique

The **Rewind Technique** (also known as the Fast Phobia Cure or Visual-Kinaesthetic Dissociation technique) is a startlingly effective method for treating post-traumatic stress disorder (PTSD), panic attacks and phobias.

It is known as the Rewind Technique due to the use of the sufferer's imagination to 'experience' rewinding occurrences of the incident(s) in their mind's eye. One of the great benefits of the technique is that the practitioner does not need to know any detail about the incidents, greatly relieving the discomfort often involved in the re-telling

It is thought that the process works as the traumatic memory is 're-processed' by the higher cortex, enabling the emergency pattern to be released by the amydala and the memory to be 're-classified' as non-threatening. Thus, the pattern-match that was causing the anxiety and panic no longer occurs.

The Rewind Technique was originally created by the originators of NLP (Neuro-Linguistic Programming) who called it the Visual-Kinaesthetic Dissociation Technique (V/K Dissociation) or the easier-to-remember 'Fast Phobia Cure'. It was refined into the Rewind Technique by Joseph Griffin and Ivan Tyrrell of the Human Givens Institute.

The vast majority of sufferers experience a significant (over 70%) reduction in their symptoms following one session lasting around one and a half hours. The process itself is comfortable, and does not involve 're-living' of unpleasant events.

For further information got to:

http://www.rewindtechnique.com/

Appendix 3 – Questionnaire for Primary Care Practitioners

Brief Questionnaire - Health Needs of Ex-Military Personnel

Please complete the brief questionnaire as fully as possible. All responses will be kept anonymous.

Please state your position/role: ……………………………………………………………………………..

1. Do you, as a health professional, identify or acknowledge whether new patients are ex-military personnel?

(Please tick) Yes ☐ No ☐

If "Yes" how?

………

If "No" why not?

………

2. In your experience, what are the *specific* health needs of ex-military personnel?

………..

………..

………..

………..

3. What barriers prevent ex-military personnel accessing health services they need?

………..

………..

………..

………..

4. How can those barriers be overcome?

………..

………..

………..

…………

Thank you! ……………………………………………………………………………………..

No.

Official use only

Appendix 4 – Self-completion Questionnaire for Veterans

***Veterans'* Health Needs Assessment Questionnaire – NHS Bedfordshire**

Any information you give will remain confidential. Any views will not be attributed to you personally.

Please tick ☑ the appropriate boxes and complete the other sections as fully as possible:

1. About you…

Are you? **Male☐ Female☐** (tick) How old are you? **Under 25☐ 25- 40☐ 41-60☐ Over 60☐** (tick)

County of Residence: ………………………………… Which of the forces were you in?. …………………………

Approximate dates of service: ……………………………….. What was your role?…………………………………..

Were you in a combat theatre? Yes☐ No☐ (tick) If "Yes" where? ………………………. ……………….

What was the reason you left the forces? ……………………………………………………………………...

Do you receive, or have you at any time received any of the following: **a)** a war pension, or **b)** any payment due to any injuries suffered whilst in the forces? Yes☐ No☐ (tick)

2. Your Health…

How would you rate your current health?

very good ☐ good ☐ poor☐ very poor☐ (tick)

If "poor" or "very poor" please explain: ……………………………………………………………………..

How would you say your health is now, compared with when you left the services?

better☐ the same☐ worse☐ (tick)

If "worse" please explain: …………………………………………………………………………………….

……

What health issues have you had since leaving the forces (if not stated above)?

……

……

How have your health issues affected you and your family?...

……

……

Are any of these issues related to your time in the armed forces? Yes☐ No☐ (tick)

If "Yes" please explain: ………………………………………………………………………………………

……

……

What else has stopped you from being healthy or having a healthy lifestyle since leaving the forces?

……

Please Turn Over…

3. Health Services…

Generally, how easy have you found it to access health services, since leaving the forces?

very easy☐ easy☐ quite hard☐ very hard☐ (tick)

If "quite hard" or "very hard" please explain. How could it have been made easier?

………

………

………

………

Since leaving the forces, have you ever been unable to access a health service that you needed?

Yes☐ No☐ (tick) If "Yes" please explain:

………

………

………

………

………

Since leaving the forces have you ever used a health service that has not met your needs?

Yes☐ No☐ (tick) If "Yes" please explain:

………

………

………

………

………

How could the service(s) have been improved to meet your needs ?

………

………

………

………

Since leaving the forces have you ever used a health service that was particularly effective?

Yes☐ No☐ (tick) If "Yes" please explain:

………

………

………

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………

Have you heard about NHS priority treatment for Veterans? Yes☐ No☐ (tick)

4. Any other comments…

Please use this space to add any other comments or information about your health experiences that you think might be helpful for the Bedfordshire Veterans' Health Needs Assessment.

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If you would like to take part in a small, 90 minute focus group looking at these issues in more detail, please complete the following section (the group will take place before 31 August 2010).

Name: …………………………………………………… **Daytime** contact number: ……………………..

Or **frequently used** email address: ……………………………………………………………………

Can you travel across Bedfordshire? Yes☐ No☐ (tick) (we will pay out of pocket expenses)

When would you usually be available? (tick)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Daytime	☐	☐	☐	☐	☐	☐	☐
Evening	☐	☐	☐	☐	☐	☐	☐

Thank you for your time.

Your input is very valuable.