NHS
Sussex

Military Veterans Health Needs Assessment – Sussex 2012

This report is a summary of the health needs of military veterans resident in Sussex. It considers health needs relating to military service, and has been produced in response to increasing recognition nationally of the health needs of military veterans. The renewed Military Covenant includes specific commitments relating to health, in line with the principle that people should not be disadvantaged as a result of serving in Her Majesty's Armed Forces.

For the purposes of this needs assessment, a veteran is someone who has served in the Armed Forces for at least one day. This includes people who have served in Reserve / Auxiliary Forces.

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Military Veterans Health Needs Assessment – Sussex 2012

Summary and recommendations

Definition and numbers

- There is no single agreed definition of the term "military veteran" used by all organisations and services. For the purposes of this needs assessment, a veteran is someone who has served in the Armed Forces for at least one day. This includes people who have served in Reserve / Auxiliary Forces.
- There is limited recording of veteran status within services. To estimate the local veteran population *national* prevalence assumptions have been applied to local population figures. There are an estimated 130,000 military veterans in Sussex; 17,360 in Brighton and Hove, 46,555 in East Sussex and 66,405 in West Sussex.

Recommendation 1: Data collection

There is currently very limited information on the number of military veterans in Sussex, and their access to health services. For this reason it is difficult to establish whether their health needs are being met, and to plan services for this group. Improved data collection *within* health services to reflect whether individuals are veterans would go some way to addressing this. If military veterans disclose their status this should be recorded to allow clinicians to assess whether their condition is related to their service and to refer in line with the commitments made in the Armed Forces Covenant. *This issue is being considered nationally.*

(**Lead organisation/group**: Sussex Armed Forces Health Network)

Reservists

- The Royal British Legion (RBL) have estimated that reserve forces make up approximately 16% of the veteran population, however it should be noted that given the lack of "regular" military presence in Sussex it is likely that the proportion of reservists to regulars is higher locally.

Recommendation 2: Support for reservists

Employer policies relating to reservists should consider support for people who have left the service; notably for veterans who may have delayed reactions post-mobilisation. Public sector employers should show leadership and ensure they are exemplar reservist employers. Including this recommendation in the Community Covenant across Sussex would be a suggested way forward.

(**Lead organisation/group:** Local public sector organisations.

***Summary and recommendations continued*:**

Physical health

- Under the Military Covenant, veterans who have lost limbs due to military service are entitled to replacement prosthetics of at least an equivalent technological standard to the original limb provide by the MoD, where clinically necessary.
- The nature of recent conflicts and improvements in military medical care mean that personnel are surviving more severe and complex injuries than previously. Younger amputees from more recent conflicts tend to have more complex injuries and more have multiple amputations than ever before.
- Younger veterans are significantly more likely to report long term health problems than their peers in the general population.
- Alcohol misuse is more common among younger personnel, particularly those who have been to combat zones.
- Under the Military Covenant the Government has committed to ensure that veterans who have sustained serious genital injuries be guaranteed three cycles of IVF.

Recommendation 3: Physical health

i) Consider local prosthetic limb and rehabilitation services in light of the Murrison report recommendations.

Following the Murrison report on prosthetics services there are plans to develop a network of specialist prosthetics centres nationally. Until these centres are developed there will be a need to consider whether local prosthetics services can meet this need. It is likely that the number of veterans requiring this service in Sussex will be very small, but potentially very high cost. The Armed Forces Network should consider how this risk can be managed across Sussex whilst ensuring that the requirements set out in the Military Covenant are met.

ii) The Armed Forces Network should consider how to promote the health of younger veterans, reducing their alcohol consumption and ensuring that they are aware of their entitlements under the Military Covenant.

iii) CCGs should ensure that policies relating to IVF acknowledge the entitlement of veterans who have sustained genital injuries to receive three cycles of IVF.

(**Lead organisation/group:** Sussex Armed Forces Health Network)

Mental health

- The most common mental health conditions among veterans are depression and anxiety, as for the general population.
- Alcohol misuse is much more frequent among veterans than the general population, particularly those who have been to combat zones in Iraq or Afghanistan
- The risk of Post Traumatic Stress Disorder (PTSD) is low among veterans, but increased for specific groups including Reservists who have been to combat zones, and amputees.
- Young male veterans, particularly from lower ranks or who have left service early, are at increased risk of mental health problems and suicide.

Recommendation 4: Mental health

The implementation of the Murrison report on mental health services for veterans in Sussex should also be based on the findings of this needs assessment. In general the mental health needs of veterans are in line with the general population, but they do have specific needs such as alcohol misuse and PTSD, and any future commissioning plans for mental health should reflect these needs. The specific needs of Reservists should be addressed.

(**Lead organisation/group**: Sussex Armed Forces Health Network/Military Veterans Mental Health lead/Sussex CCGs)

Summary and recommendations continued

Veterans and prison

- There is conflicting evidence as to the likelihood of veterans being in prison compared to the non-veteran population.
- Specific vulnerabilities have been identified for veterans who have problems adjusting to civilian life.

Recommendation 5: Support for ex-service personnel in prison

(i) Better identification of veterans in the criminal justice system.

(ii) Extension of the Veterans in Custody scheme, Prison In reach delivered by a Veteran Liaison Officer linking the veteran to the charity best able to provide assistance on release

(iii) Consider using a similar approach to schemes that divert offenders away from custody and into treatment so that at the point of arrest, offending ex-servicemen can be signposted to assessment and support services

(**Lead organisation/group :** Sussex Armed Forces Health Network through liaison with National Offender Management Service in Sussex)

Wider Community Needs - Housing and adapted housing needs

- A number of disadvantages have been identified in relation to accessing housing support or adapted housing. In the past this has included proving a "local connection" in order to be accepted onto a local housing register, or receive homelessness relief, and establishing a credit history to access financial products including mortgages.

Recommendation 6: Department for Communities and Local Government (DCLG) guidance

Housing departments to confirm progress on incorporating DCLG guidance into allocation schemes and policies across Sussex.

(**Lead organisation/group:** Lead housing officers / LAs

Wider community needs – Risk of homelessness

The number of homeless veterans has declined markedly as resettlement support has improved. But specific groups, at greater risk of homelessness have been identified:-

- homeless veterans are far more likely to be from the Army, reflecting a greater intake from disadvantaged communities,
- young leavers who have served less than four years, and/or are compulsory leavers have been also identified at a greater risk

Recommendation 7: At risk leavers are identified with appropriate signposting in place to specialist support

(**Lead organisation/group:** Sussex Armed Forces Health Network Transition Sub-group)

Summary and recommendations continued

Recommendation 8: Confirmation that national guidance has been implemented

(i) Ensure that PCTs have made GP referrers and acute and mental health trust providers aware of veterans' entitlement to priority access to secondary care for any conditions that might be related to their service

(ii) Evidence that commissioned mental health services are culturally sensitive to the particular needs of veterans

(iii) Ensure that the requirements of the Ministry of Defence / NHS Transition Protocol have been implemented

(iv) Ensure that a minimum dataset transfers alongside patients when they move between providers during a treatment journey

(v) Ensure that housing allocation policies explicitly recognise service leavers and that "local connection" policies take account of time spent in service accommodation

(vi) Clarify the position on sign-up to the Community Covenant across Sussex

(**Lead organisation/group:** Sussex Armed Forces Health Network / NHS Sussex / PCTs /CCGs/Housing Departments)

1.0 Background and context

Key points

- A Command Paper was produced in 2008 to end any disadvantage faced by armed service personnel as a result of moving around the country and the world, and to provide better support and recognition for those wounded serving their country
- The Military Covenant has been renewed, with a particular focus on priority service-related NHS treatment for veterans, subject to clinical need
- Recommendations have been made to services for those with mental health needs and for amputees with prosthetic needs through Armed Forces Health Networks (of which there is a Sussex-wide group)
- Transition from the Defence Medical Service provider on discharge from service into NHS service providers needs to be improved

In December 2007, the Department of Health issued a letter to all Chief Executives which extended the guidance on priority treatment for war pensioners to veterans from January 2008. This means that all veterans are entitled to priority access to secondary care for any conditions which are considered likely to be related to their service, subject to the clinical needs of all patients. The letter requires Primary Care Trusts to ensure that GPs are aware of the guidance when making a referral for diagnosis or treatment, and that acute and mental health trusts are aware of the guidance when receiving such referrals.

1.1 The Nation's Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans (2008)

A cross-Government Command Paper, The Nation's Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans, was produced in 2008.[2] The Command paper recognises the demands and obligations placed on those serving in the Armed Forces, and the sacrifice they make. The Command Paper has two aims. First, to end any disadvantage that armed service imposes on people, families and veterans as a result of moving around the country or the world. Second, it describes how we can better support and recognise those who have been wounded in the service of their country.

The Command Paper summarises progress made in relation to Armed Forces healthcare provision in the last decade. This includes the world class Royal Centre for Defence Medicine, better survival rates resulting from improved field hospitals and rapid repatriation for critically injured patients, expansion of rehabilitation units and military mental health departments, extension of priority NHS treatment to all veterans for conditions related to service, and fast-track access to secondary care to enable quick return to the frontline.

[2] Ministry of Defence (2008) The Nation's Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans Cm 7424

New measures introduced as part of the Command Paper address several areas outside the scope of this needs assessment including housing, education and skills, transport, support for families, building careers and a commitment to uplift the lump sum payment and retain the Guaranteed Income Payment under the Armed Forces Compensation Scheme.

New measures specific to health include :-

- continue to invest in and expand in the military ward in Birmingham and the facilities at Headley Court
- match the standard of prosthetic limb provision to injured personnel by the Defence Medical Services on leaving Service when transferring to NHS prosthetic limb provision
- meet the needs of service personnel and their families in accessing NHS dentistry and ensure that IVF treatment is not disrupted by mobility
- retaining waiting list places and counting time already spent waiting if service personnel move between providers
- introducing six pilot schemes to improve access to community mental health services for veterans prior to national roll-out

The Command Paper specifically addresses the different health needs of veterans, recognising and defining veterans as a vulnerable group. It is acknowledged that the health needs of veterans should be assessed and awareness of the particular healthcare needs should be raised. It is also recognised that health professionals may need to be sensitive to the healthcare needs of veterans which are likely to be different from the rest of the population. It is this aspect of the Command Paper that explicitly sets out the rationale for this Veterans Needs Assessment.

1.2 The Armed Forces Covenant (2011)

Since coming into power, following the recommendations of a taskforce, the Coalition Government has published a renewed Military Covenant,[3] with the intention that this be written into law. The four key principles of the Military Covenant for service people, their dependants and veterans are:

- no disadvantage
- ability to manage their lives as effortlessly as anyone else
- continuity of public services
- proper return for sacrifice

Regarding healthcare for veterans, the wording of the Military Covenant is:

“Veterans receive their healthcare from the NHS, and should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need. Those injured in Service, whether physically or mentally, should be cared for in a way which reflects the Nation’s moral obligation to them, whilst respecting the individual’s wishes. For those with concerns about their mental health, where symptoms

[3] Ministry of Defence (2011) The Armed Forces Covenant, MOD, 2011 http://www.mod.uk/NR/rdonlyres/4E9E2014-5CE6-43F2-AE28-6C5FA90B68F/0/Armed_Forces_Covenant.pdf

may not present for some time after leaving Service, they should be able to access services with health professionals who have an understanding of Armed Forces culture."

This work has culminated in a number of legislative initiatives to ensure that support for veterans remains a focus:

- Armed Forces Act 2011: Annual duty to report on progress against the Military Covenant to Parliament including Health.
- Health & Social Care Bill 2011:Includes duty of the NHS Commissioning Board to commission services on behalf of the Armed Forces (currently a PCT duty)
- NHS Mental Health Strategy 2011 Includes specific provision for veterans

1.3 Fighting Fit, a Mental Health Plan for Servicemen and Veterans (The Murrison Report) 2010

Fighting Fit[4] is part of the Coalition Government's commitment to renew and strengthen the Military Covenant, with a focus on the mental health needs of veterans. Dr Andrew Murrison, MP for South West Wiltshire, an ex-navy medical officer, was therefore asked by the government to undertake a review and make recommendations on healthcare for members of the service community. The principal recommendation in the subsequent reports 'Fighting Fit' and 'A Better Deal for Military Amputees' are now being rolled out by government. Fighting Fit acknowledges the possible stigma experienced by a population who take particular pride in being in peak condition mentally and physically and the need to bear this in mind when designing and delivering interventions.

There are thirteen action points, four of which are principal recommendations, within the Murrison Report :-

- incorporate a structured mental health systems enquiry into existing medical examinations performed whilst serving
- an uplift in the number of mental health professionals conducting veterans' outreach work from mental health trusts in partnership with a leading mental health charity
- a Veterans Information Service (VIS) to be available twelve months after a person leaves the Armed Forces
- trial of an online early intervention service for serving personnel and veterans

1.4 The Operating Framework for the NHS in England 2012/13

The 2008/9 NHS Operating Framework required PCTs to provide an effective transition of care from Defence Medical Services to the NHS and to ensure that commissioned mental health services are culturally sensitive to the particular needs of veterans. Subsequently, the revision to the Operating Framework for the NHS in England 2010/11,[5] identified the provision of appropriate treatment for veterans as one of two areas singled out as being given insufficient emphasis in Strategic Health Authoristy (SHA) plans. SHAs have been charged with ensuring continuity of this work during the NHS transition period

[4] Dr Andrew Murrison (2010) Fighting Fit, A mental health plan for servicemen and veterans
[5] Department of Health (2010) Revision to the Operating Framework for the NHS 2010/11 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_116860.pdf

The Operating Framework for the NHS in England 2012/13[6] states that SHAs should continue the work of their Armed Forces Network in delivering the principles of the Armed Forces Covenant for armed forces, veterans and their families until April 2013. The requirements are that the Ministry of Defence / NHS Transition Protocol should be implemented, meeting veteran's prosthetic needs and ensuring mental health services for veterans, and that NHS employers should be supportive towards volunteer reservists. Following April 2013, the new structures will take responsibility for addressing veterans' health needs.

1.5 Local policy context

In line with the latest NHS Operating Framework, 10 Regional Armed Forces Networks have been set up across the country covering each of the old SHA areas. The South East Coast Armed Forces Network was launched in February 2011, covering Kent, Surrey and Sussex, with the following aims:

1. To provide regional NHS leadership, advocacy and points of liaison for military health and veterans issues.
2. To work with regional military, social services and third sector organisations to ensure delivery of armed forces community programmes

An NHS Sussex Armed Forces Health Network has been established, with a remit to provide:

- A strategic networking and liaison group for NHS Sussex, to work with provider organisations to improve physical and mental health services for leaving service personnel and their families, families of serving military, reservists and veterans
- Strategic overview and assessment of Military Health work programmes within NHS Sussex to deliver the requirements within the annual NHS Operating Framework and Ministry of Defence (MOD) and NHS partnership agreement

The NHS Sussex Armed Forces Health Network has produced an action plan to address specific areas of work across Sussex:

- an implementation plan to deliver the MOD/NHS Transition Protocol including awareness raising particularly of mental health issues, primary and social care support;
- implementation of the Murrison Report by using Department of Health (DH) funding (£50,000)
- ensure equality of access for armed services personnel/veterans and their families
- communication and collaboration with relevant stakeholders through a communication strategy
- effective joint working with local authorities

[6] Department of Health (2011) The Operating Framework for the NHS in England 2012/13

1.6 Key issues relating to health services for the Armed Forces and Veterans

The NHS is responsible for Armed Forces dependents and veterans, and for the secondary care of Armed Forces personnel. The Defence Medical Services (DMS) are responsible for primary care for Armed Forces personnel.

It is estimated that there are five million veterans in the UK, and that 60% are concentrated in 10 PCT areas, none of which are in Sussex.

Where there are Armed Forces based in an area, and within Sussex this is relevant to West Sussex predominantly, there are difficulties in accessing dentistry, immunisation and prevention services.

The key issues relevant to NHS service provision for veterans are:[7]

1. Effective transition from Defence Medical Services on leaving the Armed Forces
2. The need for culturally sensitive mental health services within mainstream mental health provision

Broadly, it is important to recognise veterans as a group at risk of experiencing health inequalities.

Recommended actions for health services are:

- Ensure that a minimum dataset transfers alongside patients when they move between providers during their treatment referral pathway
- Raise awareness of priority treatment provision for veterans
- Main issues for younger veterans are:

1. for people discharged with significant health problems – a small number of amputees will need their receiving NHS provider to maintain and replace MOD standard prostheses
2. for people discharged with no significant health problems – better use of the systems in place to ensure that GPs can access past records for newly registering ex-service personnel
3. to enable veterans to access mainstream mental health services for service-related mental health problems, even if these problems are developed a considerable period of time after discharge from service

[7] Department of Health (2008) Health Services for the Armed Forces, their families and veterans – Guidance for SHAs Gateway reference : 10070

2. Military Veterans – Demographic profile

Key points

- Veterans are defined in this needs assessment as anyone who has served in the Armed Forces for at least one day
- The Regular military presence in Sussex is at Thorney Island in West Sussex
- Nationally it is estimated that 16% of veterans are from reserve or auxiliary services, this is likely to be higher in Sussex.
- Identifying the number of military veterans, either at a national or local level, is difficult because there is no single database, and previous service history is rarely included in national surveys.
- Nationally there are an estimated 4 – 5 million military veterans in the UK, approximately 8% of the adult population.
- Applying *national* assumptions to local population figures, there are an estimated 130,000 military veterans in Sussex; 17,360 in Brighton and Hove, 46,555 in East Sussex and 66,405 in West Sussex.
- At present the profile is dominated by veterans who served in World War II or were subject to compulsory National Service, as time passes this will change, the overall number of veterans will decline and the average age of veterans will fall.
- In 2010/11 approximately 270 people left the Forces with a Sussex home address.
- The vast majority of veterans are men – estimated at 87%.

2.1 Definition

Who is a veteran?

For the purposes of this needs assessment, a veteran is someone who has served in the Armed Forces for at least one day.

This includes people who have served in Reserve / Auxiliary Forces.

There is no single agreed definition used by all organisations and services.

The Ministry of Defence (MOD) defines a veteran “as anyone who has served in HM Armed Forces at any time, irrespective of length of service (including National Servicemen and Reservists)”.

The Royal British Legion (RBL) has a detailed definition:

"*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)

Using the MOD definition as the basis for this needs assessment, it is clear that the term veteran covers a diverse range of people with different experiences and needs. There will be older veterans who served in World War II, some veterans who have not been engaged in combat, many will have only served as part of National Service, and there will be younger veterans and those who served in the Reserve Forces.

This needs assessment identifies needs which are likely to be related to the act of serving; and uses the basic premise that serving in the Forces should not act to disadvantage an individual.

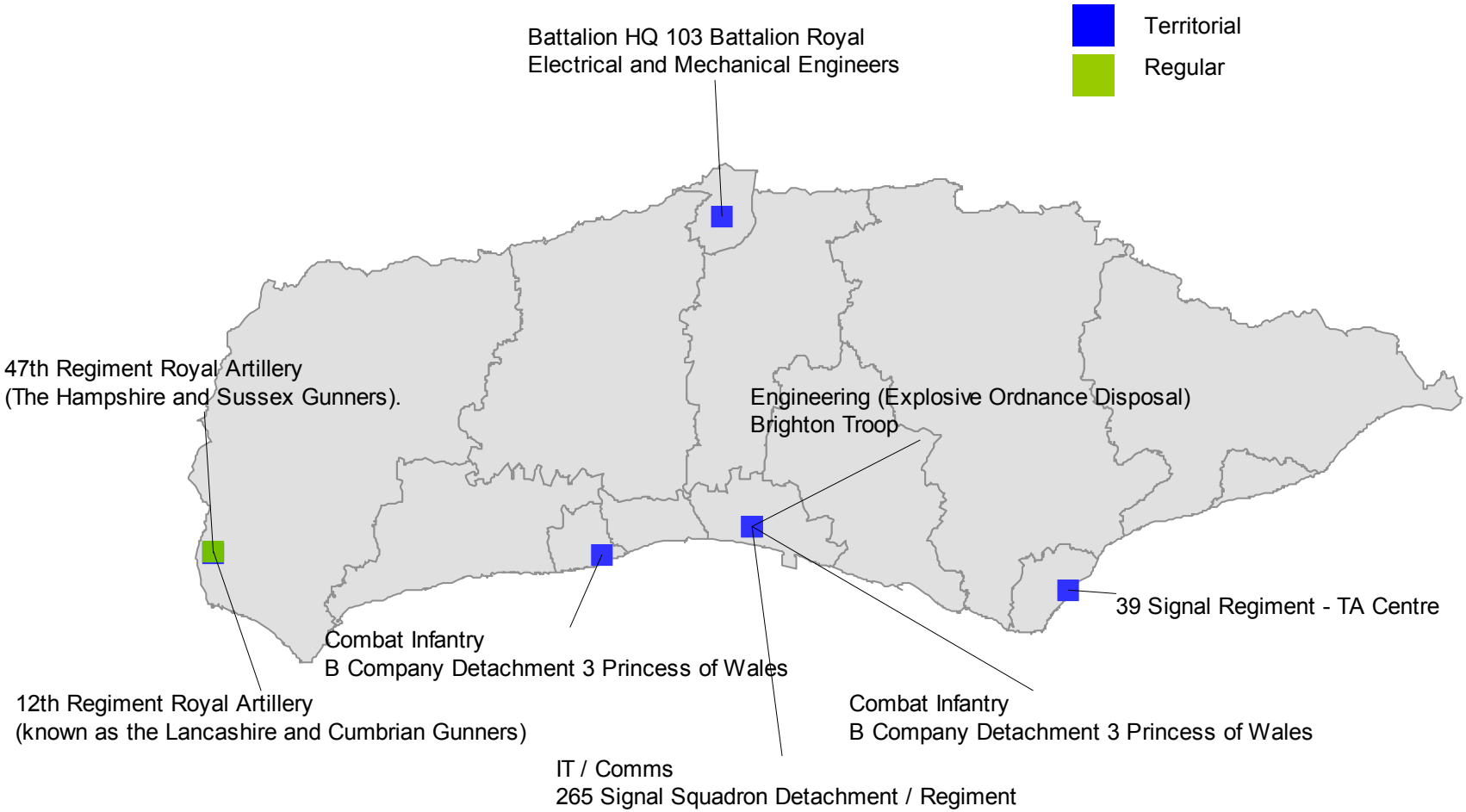
This report considers the needs of veterans themselves and not the wider needs of families or dependents.

Figure 1 MILITARY PRESENCE IN SUSSEX

REGULAR FORCES

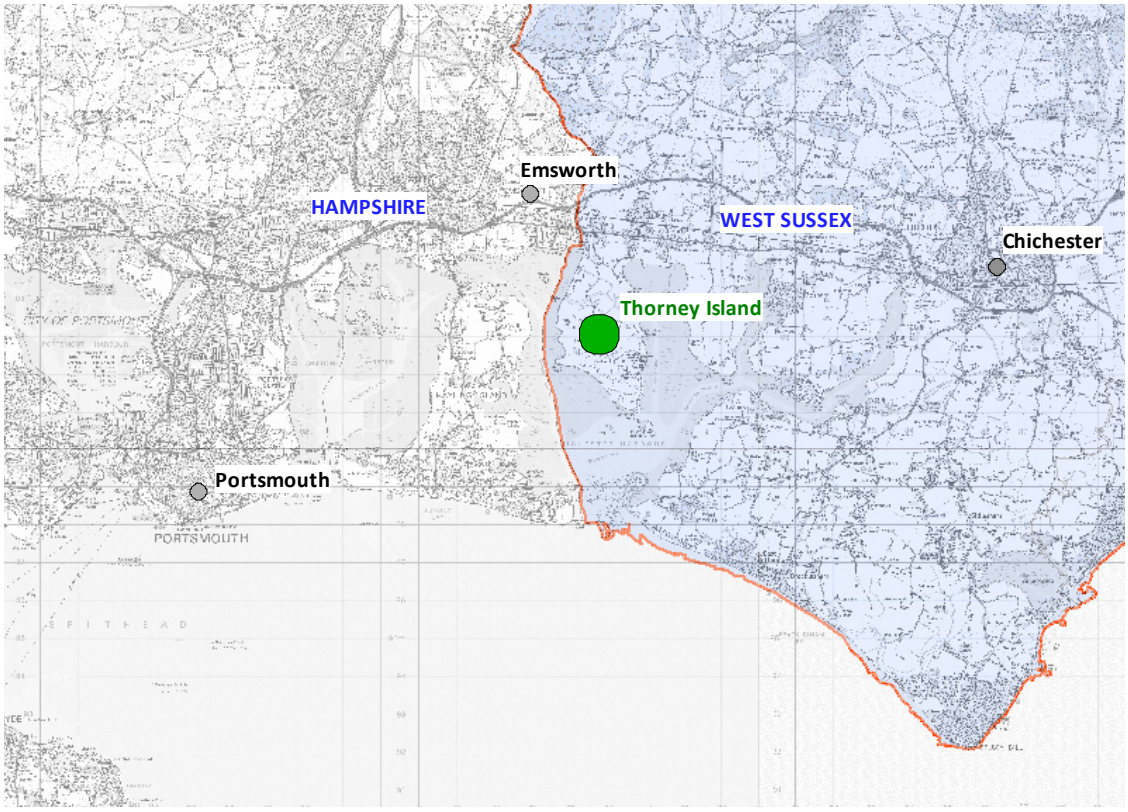
The Baker Barracks at Thorney Island is based in West Sussex on the border with Hampshire; approximately 250 families are quartered at Thorney.

- **12th Regiment Royal Artillery** – (known as the Lancashire and Cumbrian Gunners).The regiment relocated to Thorney Island from Germany in 2008.
- **47th Regiment Royal Artillery** – (The Hampshire and Sussex Gunners).



It should be noted that the Baker Barracks on Thorney Island is based within the county of West Sussex, and not, as frequently cited, Hampshire, although clearly given the location many services will be Hampshire based.

Figure 2 : Location of Baker Barracks, Thorney Island, West Sussex



2.2 Estimating the number of Military Veterans

There is no single data source for estimating the number of military veterans. Although the decennial census does include a question on *current* occupation, which includes a category for people serving in the Armed Forces, there is no question on *previous* service history. Two specific surveys have included a service history question, and these have been widely used to provide national prevalence estimates:

(i) In 2005 the Royal British Legion (RBL)[8] analysed data from a household survey of over 6,000 people across the UK. This survey included the question:-

" Are you currently serving, or have you ever served in the UK regular or reserve Armed Forces, including National Service of Home Guard".

Of the 6,218 people surveyed, 689 responded "yes" to the question.

RBL extrapolated the findings of this survey to provide an estimate of 4.8 million veterans in the UK, with approximately 3.9 million in England.

This equates to approximately 8% of the UK population aged 16 years or over.

(ii) In 2009 the Office for National Statistics (ONS) published an analysis of data[9] collected for the 2007 Adult Psychiatric Morbidity Survey, with the purpose of estimating the veteran population. This analysis also provided data by age and sex.

This report estimated that, in 2007, there were 3.8 million (95% confidence interval: 3.0–4.9 million) veterans living in residential households in England.

This equates to 9.1% of the 16+ years population (CI: 7.2–11.9%)

2.3 Estimating the number of Reservists

Definition

Regular reserves are former members of the UK regular forces who retain a liability for service

Volunteer Reserves and Auxiliary Forces are civilian volunteers who undertake to give a certain amount of their time to train in support of the Regular Forces.

- The Territorial Army (TA)
- Royal Naval Reserve (RNR)
- Royal Marines Reserve (RMR)
- Royal Air Force Volunteer Reserve (RAFVR)

Some Volunteer Reservists undertake (paid) Full-Time Reserve Service.

[8] The Royal British Legion *Profile of the Ex-Service Community in the UK* November 2005 (Revised copy)
[9] Woodhead, C. et al. *An estimate of the veteran population in England: based on data from the 2007 Adult Psychiatric Morbidity Survey*. Office for National Statistics 2009.

Due to data quality concerns the Ministry of Defence (MOD) has not published overall detailed figures for the total number of *regular* reserves for the years 2006 onwards. Using information released by the Defence Analytical Services and Advice (DASA), in 2005 there were 191,530 regular reserves in the UK.[10]

In relation to volunteer reserves, in April 2011 there were 35,320 people in the volunteer reserves forces in the UK.

RBL have estimated that reserve forces make up approximately 16%[11] of the veteran population, however it should be noted that given the lack of "regular" military presence in Sussex it is likely that the proportion of reservists to regulars is higher locally.

2.4 Gender of Veterans

Of people currently serving in the Armed Forces in the UK, 9.6% (17,850) are women.[12]

In relation to veterans it is estimated[13] that 87% of veterans are men, 13% women; the proportion of women is higher than serving personnel, as the current veteran population reflects the World War II conscription of single women in their 20s during 1941-1945.

2.5 Black and Ethnic Minorities

There is no specific data relating to the ethnic background of veterans; RBL estimate, at a national level, 99% of veterans are white, and less than 1% are from non-white minority ethnic groups. In relation to serving personnel 2.4% of officers and 7.6% of other ranks are from Black and Minority Ethnic groups.[14]

2.6 Veteran numbers in vulnerable groups

It should be noted that the RBL reports and analysis excluded veterans living in communal establishments, including nursing and residential care, prisons, hospitals or people living in temporary accommodation or homeless veterans. Separate research is available which estimate the number of veterans in these vulnerable groups. Specific issues relating to these groups are discussed in Section 4.

2.7 Wider Ex-Service "Community"

Clearly some of the needs of military veterans will impact on their spouses, carers and family. RBL defines the wider ex-service community as being military veterans and their dependents, with dependents being divided into dependent children (under 16 years) and dependent adults (current and ex partners / spouses, widows / widowers and dependent children up to the age of 18). The reason for defining these groups is that many will also be eligible for support from veteran organisations, although their specific needs are not separately identified in this report.

Approximately 10.2 million people are estimated to be in the wider ex-service community in the UK.[15]

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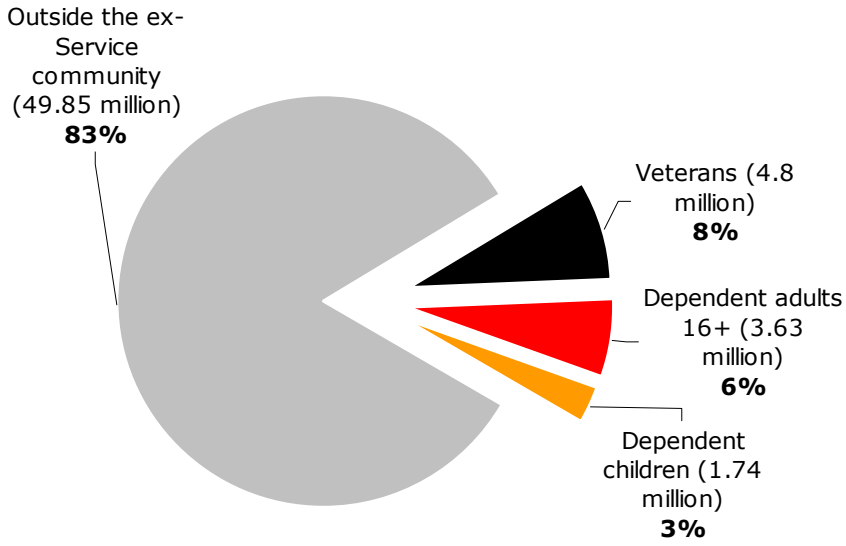
[10] Ministry of Defence *United Kingdom Defence Statistics 2011* September 2011 (Table 2.15)
[11] The Royal British Legion *Profile of the Ex-Service Community in the UK* November 2005 (Revised copy)
[12] Ministry of Defence United Kingdom *Defence Statistics 2011* September (Table 2.8)
[13] The Royal British Legion *Profile of the Ex-Service Community in the UK* November 2005 (Revised copy)
[14] Ministry of Defence United Kingdom *Defence Statistics 2011* September (Table 2.10)
[15] Royal British Legion *Profile and Needs of the Ex-Service Community 2005-2020* Sept 2006

Figure 3 Wider UK Ex-Service Community *(Serving, Ex and Families / Dependents)*



2.8 Change in veteran community – numbers and characteristics

The size of the veteran population is a function of deaths in the existing veteran population and the numbers of people leaving the Forces.

The numbers of people in the Armed Forces has changed over time and reflects the UK involvement in conflicts and policies, such as National Service. The effects of World War II and National Service still dominate the characteristics of today's veteran population, in two key ways:

- *The age profile* – reflecting services in the 1940s and National Service to 1960, the veteran population is older than the general population – with an estimated average age of 63.[16]

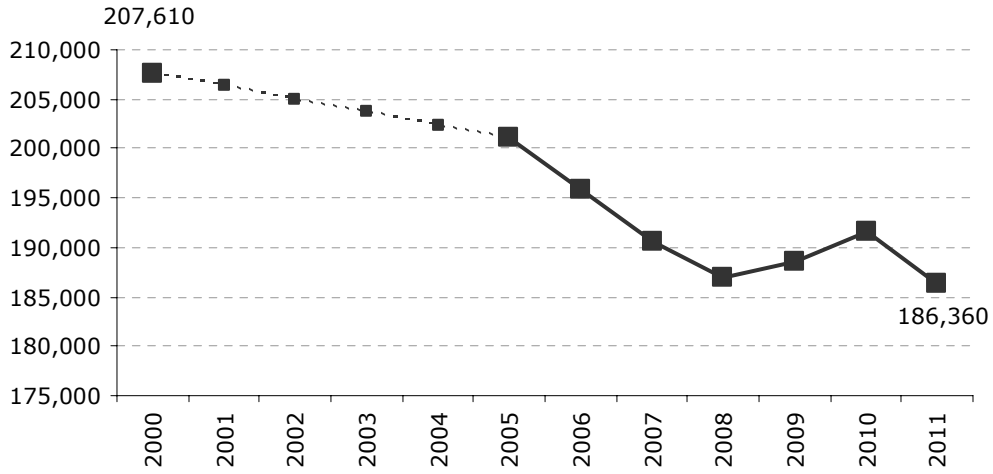
- *Socio-economic and geographic distribution* - For WWII and National Service people were drawn from a wide socio-economic and geographic base, with the result that the veteran population can be assumed to broadly reflect the wider population. Following the end of National Service (December 1960) this was no longer the case, and there may be greater variation in the geographic distribution of younger veterans and their socio-economic backgrounds.

As the effect of WWII and National Service fade, the nature of the veteran population will alter and although there is currently poor data to identify veterans, information is collected on existing service personnel, recruits and people leaving the service.

In 2011 there were approximately 186,400 regular service personnel in the UK; this is a decrease of over 21,000 over the last ten years.

[16] Gaskarth G, *Honouring The Armed Service Community* LGIU / Royal British Legion 2011

Figure 4 UK Regular Service Personnel – Total Numbers 2000 to 2011

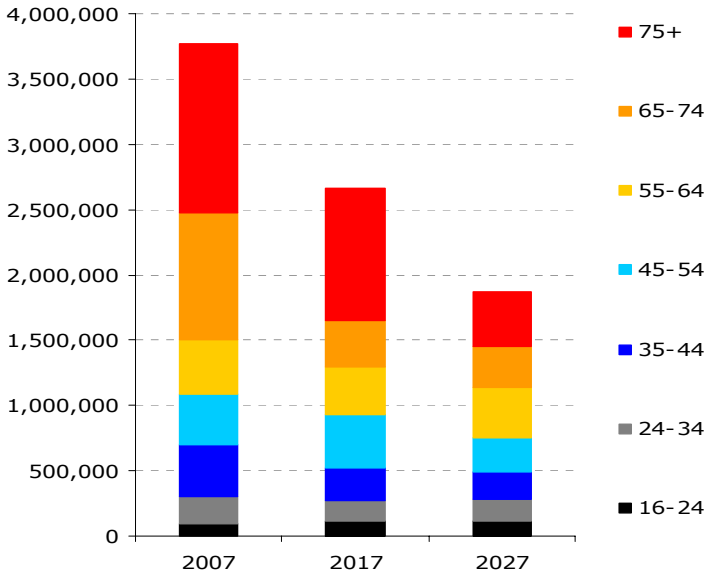


Source : UK Defence Statistics 2011 (DASA)[17]

11,300 people joined the services in the 2011 calendar year, and 19,200 people left, in the UK overall.

In the medium term, the profile of veterans will change. There will be many more very elderly (85+) veterans, people who served in WWII and National Service, an increase in the proportion of younger veterans and a large reduction of veterans aged 65-74 years.

Figure 5 Projected change in numbers and age profile of veteran population of England 2007 - 2027[18]



This graph shows that the overall number of veterans is projected to fall considerably over the next 20 years but that this decline is largely attributed to the fall in the number of older veterans. The age profile of the veteran population will shift with a younger average age.

Source: ONS

[17] Ministry of Defence *United Kingdom Defence Statistics 2011* September (Table 2.7)

[18] Woodhead, C. et al. *An estimate of the veteran population in England: based on data from the 2007 Adult Psychiatric Morbidity Survey*. Office for National Statistics 2009

2.9 Local estimates for Sussex

Note : In the absence of reliable national or local data, estimates have been calculated using prevalence assumptions from national research. These estimates have been calculated to provide a sense of scale but should be treated cautiously.

Using the assumptions of the RBL and ONS analysis, and applying the age specific prevalence assumptions to the same population cohort (2007 population), estimates have been calculated for local authority areas within Sussex.

Using these prevalence assumptions, there are an estimated 130,000 military veterans in Sussex, approximately 21,000 are estimated to be from Reserve Forces.

- 17,360 in Brighton and Hove,
- 46,555 in East Sussex
- 66,405 in West Sussex.

Of these veterans the vast majority are men (estimated at 87%) and 66% aged 65 years or over.

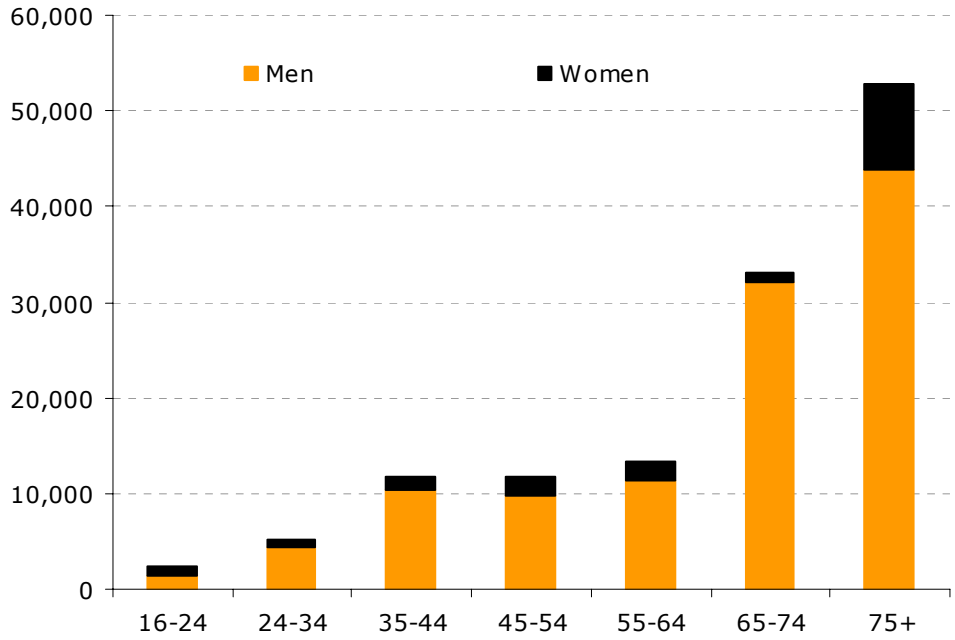
Table 1 Nationally extrapolated* estimates of military veterans in Sussex by age group
Estimates rounded to nearest 5 and based on 2007 Mid Year Estimates of Population

	16-24	24-34	35-44	45-54	55-64	65-74	75+	Total
Brighton and Hove	**575**	**1,260**	**2,265**	**1,710**	**1,610**	**3,840**	**6,090**	**17,360**
East Sussex total	**740**	**1,340**	**3,530**	**3,970**	**4,815**	**12,285**	**19,780**	**46,455**
Eastbourne	165	315	640	675	775	2,090	3,930	8,595
Hastings	150	280	640	690	755	1,650	2,385	6,550
Lewes	140	240	665	760	915	2,330	3,775	8,815
Rother	115	175	555	655	920	2,625	4,360	9,395
Wealden	175	330	1,025	1,195	1,450	3,595	5,325	13,100
West Sussex total	**1,165**	**2,555**	**5,875**	**6,100**	**6,890**	**16,905**	**26,920**	**66,405**
Adur	90	185	435	450	550	1,360	2,195	5,275
Arun	215	420	1,015	1,055	1,415	4,035	6,505	14,655
Chichester	160	305	720	855	1,050	2,865	4,280	10,230
Crawley	185	485	855	795	685	1,455	2,700	7,165
Horsham	175	385	1,015	1,110	1,180	2,620	3,695	10,185
Mid Sussex	180	400	1,025	1,080	1,180	2,525	3,640	10,035
Worthing	150	370	795	740	815	1,995	3,785	8,650
Sussex	**2,480**	**5,155**	**11,670**	**11,780**	**13,315**	**33,030**	**52,790**	**130,220**

Source: Estimates extrapolated from Woodhead et al figures (ONS 2007)

Figure 6 Sussex wide estimates of Military Veterans by age group

Source: Estimates extrapolated from Woodhead et al figures (ONS 2007) applied to 2007 population



2.10 Future number of Veterans in Sussex

Table 2 shows the projected change in veteran numbers in Sussex. These have been calculated applying assumptions to ONS projected population .

Table 2 Future Veteran Numbers in Sussex

	2007	2017	2027
Brighton and Hove	17,360	12,355	8,705
East Sussex	46,455	32,465	21,365
Eastbourne	8,595	6,045	3,910
Hastings	6,550	4,640	3,210
Lewes	8,815	6,165	4,045
Rother	9,395	6,480	4,130
Wealden	13,100	9,135	6,070
West Sussex	66,405	46,705	31,265
Adur	5,270	3,700	2,465
Arun	14,650	10,110	6,570
Chichester	10,235	7,080	4,680
Crawley	7,165	5,235	3,585
Horsham	10,180	7,195	4,950
Mid Sussex	10,035	7,100	4,900
Worthing	8,645	6,115	4,020
Sussex	132,227	93,542	63,362

Source: Estimates extrapolated from Woodhead et al figures (2007) applied to ONS 2010 based population projections

2.11 Discharge data – Financial year 2010/11 Sussex Local Authority Areas

In the financial year 2010/11, approximately 270 people left the armed forces and had a resettlement address in Sussex. This provides some estimate of an annual outflow of personnel into the Sussex area.

Table 3 Discharge numbers –Sussex resettlement address (2010/2011)

Local Authority Area	Number
Brighton and Hove	**43**
East Sussex Total	**77**
Eastbourne	18
Hastings	9
Lewes	17
Rother	10
Wealden	23
West Sussex Total	**152**
Adur	9
Arun	25
Chichester	53
Crawley	9
Horsham	21
Mid Sussex	27
Worthing	8
Sussex	**272**

Source: MOD Joint Personnel Administration system (1 April 2010 to 31 March 2011)

The MOD has provided this data with a number of caveats, stating that the figures provide an initial snapshot of transition locations but:

- Locations collated are the “Permanent Home Contact Addresses” from their personnel system; the address may have been provided at various times before departure and for some people the address may not be up to date.

- 25% of Service Leavers do not provide any contact address.

2.12 Armed Forces Pension Scheme – Disablement Pensions and Compensation data

The Armed Forces and Reserve Forces Compensation Scheme (AFCS) was established in April 2005 to pay compensation for injury, illness or death attributable to Service that occurred on or after that date. This scheme replaced similar provisions under the War Pensions Scheme (WPS) and elements of the Armed Forces Pensions Scheme.

The AFCS scheme provides a lump sum payment for injury and for the most serious injuries, an income stream is paid from the end of service to recognise loss of future earnings, this is known as the Guaranteed Income Payment (GIP). Under the AFCS, a claim can be made and awarded while still in Service.

It should be noted that while information is provided relating to people in receipt of AFCS / WPS at a local level, and so provides some local scale of veterans with *compensated* injuries, it should not be considered representative of the veteran community as a whole nor will it pick up *all* veterans with disabilities / injuries.

Snapshot data from March 31st 2011

- In Sussex 3,200 people were in receipt of a War Disablement Pension
- 65 people have been awarded compensation under the AFCS

Table 4 Numbers in Receipt of Compensation and Pension Payments

	Recipients of ongoing War Pensions under the War Pension Scheme (WPS)			All Armed Forces Compensation Scheme (AFCS)		
	All WPS	Disablement Pension	War Widow(er)s	All AFCS	In-Service	Post-Service
Brighton & Hove	**450**	**330**	**115**	**5**	**0**	**0**
East Sussex	**1550**	**1190**	**355**	**0**	**0**	**0**
-Eastbourne	325	250	70	0	0	0
-Hastings	195	150	45	0	0	0
-Lewes	280	215	65	0	0	0
-Rother	340	255	85	0	0	0
-Wealden	410	320	90	0	0	0
West Sussex	**2210**	**1680**	**525**	**60**	**30**	**30**
-Adur	190	140	55	0	0	0
-Arun	560	430	130	0	0	0
-Chichester	370	270	95	40	30	10
-Crawley	215	175	35	20	0	20
-Horsham	295	220	75	0	0	0
-Mid Sussex	290	225	65	0	0	0
-Worthing	290	220	70	0	0	0

2.13 Armed Forces Occupational Pension data

Detailed geographic data have been provided by the MOD relating to people in receipt of an occupational pension under the Armed Forces Pension Scheme. The value of this information is that broader estimates used in this report have simply applied national prevalence assumptions to local population figures, however the distribution of veterans is not likely to be uniform, there is evidence that many veterans settle close to their military base.

There are a number of different occupational pension schemes available to Armed Forces personnel. The data provided relate to Armed Forces Pension Scheme 1975 and Armed Forces Pensions Scheme 2005.

The people in receipt of pensions will be:

- 40 or above if they have completed their full 22 years service as a rank other than officer,
- or 37 and above if they have completed 16 years service as an officer
- if they have not completed this length of service they receive their pension from the age of 55.

A percentage of payments are paid to dependents, including war widows.

Again there are caveats with this data, the MOD have stated:

- Some pension recipient postcodes are unknown and the postcodes provided by the MOD are the latest available on the payment system.

- Clearly not all veterans are in receipt of a pension, nationally some 340,000 people receive a pension and this is estimated to represent 8% to 12% of the veteran population.

Table 5 People in receipt of an Armed Forces Pension ***(Source : MOD)***

Local Authority	Armed Forces Pension Scheme
Brighton and Hove	**580**
East Sussex	**2,535**
Eastbourne	505
Hastings	330
Lewes	440
Rother	505
Wealden	755
West Sussex	**4,895**
Adur	315
Arun	1,185
Chichester	1,375
Crawley	295
Horsham	705
Mid Sussex	495
Worthing	525
Sussex	**8,010**

This information indicates that Arun and notably Chichester may have far higher numbers of veterans than estimates based on extrapolating national assumptions; and Brighton and Hove may have far fewer military veterans.

3.0 Mental and physical health of military veterans

Key points

- There is some evidence to suggest that armed forces recruits, particularly those entering the Army, are drawn disproportionately from disadvantaged backgrounds and could be at risk of poorer health; but there are also health benefits from serving in the armed forces in a physically active occupation

- Compared to the general population, veterans may have a higher prevalence of musculoskeletal conditions, cardiovascular disease, respiratory problems, sight problems and a mental health problems

- Alcohol misuse is a problem in the Armed Forces, particularly amongst those who have been to combat zones such as Bosnia, Iraq and Afghanistan

- There are approximately 2,000 medical discharges in the United Kingdom each year with musculoskeletal conditions accounting for 60% of medical discharges

- Risk of injury or death varies depending on rank and location, and mortality rates in recent conflicts have at times been twice as high as in other times of major combat

- Over the last six years, since 2006, around 250 UK service personnel have had amputations, and amputees surviving recent conflicts increasingly have more complex injuries and multiple amputations

- Risks to mental health from serving in the armed forces include exposure to violent or traumatic experiences, instability in domestic life, difficulties making the transition from service to civilian life and the consequences of the excessive drinking culture

- Common mental disorders such as anxiety and depression are more prevalent than Post-traumatic Stress Disorder (PTSD) among veterans, and service in Iraq and Afghanistan is a risk factor for PTSD in reservists

- A Royal British Legion survey found that the prevalence of mental health disorders among younger veterans (aged 16-44 years) was three times that of the UK population of the same age

- Ex-service personnel may be at increased risk of self-harm and young male veterans, particularly those with shorter lengths of service, are at increased risk of suicide

- The Increasing Access to Psychological Therapies (IAPT) programme is particularly suitable for veterans

The health of military populations is comparatively good compared with the general population, due to a combination of factors including the physical fitness required to join the military, social support networks, and access to healthcare and employment.[19,20] While the Army does not collect data on the socioeconomic background of its recruits, it has been reported that recruitment occurs disproportionately from young people in economically disadvantaged communities and those with poor educational achievement.[21,22] Due to the lack of available data there is limited evidence available to support this suggestion. However one study found that British Army recruiters are more likely to visit schools in socio-economically disadvantaged communities than in wealthier areas, visiting 51% of schools in the most disadvantaged fifth, compared to 40% of those in the wealthiest fifth.[23]

Educational attainment among soldiers is below the national average; in 2008/09 only 9% of new soldier recruits with recorded grades for English GCSE had passed at Grade A*-C, compared with a national average of 61% (53% for boys and 69% for girls) in England in the same year.[24] A study of 500 Army recruits in the Cardiff area in 1999 found that the majority came from a deprived background, and over 60% had left school with no qualifications.[21] The British military has also been widely criticised for being one of the few countries which recruits from the age of 16 years.[25]

Some evidence on the socioeconomic status of veterans comes from the Royal British Legion survey of the welfare needs of the ex-Service community in 2006.[26] This was a large survey involving a representative sample of UK adults in private households, but did not include those living in institutions or the homeless, and therefore may have missed some of those with specific needs. The survey classified respondents into six social grades based on the job of the chief income earner in the household, with the lowest grade being E, and the highest grade A. The results showed that a quarter of the ex-Service community are in the lowest social grade (E), compared with 18% of the UK adult population. This is related to the older age profile of veterans because those dependent on the State pension fall into social grade E, however it is also true to a lesser extent for working age veterans. Compared with the general population, of those who are not retired, a greater proportion of

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[19] Pinder RJ, Iversen A, Kapur N, Wessely S, Fear NT. Self-harm and attempted suicide among UK Armed Forces personnel: Results of a cross-sectional survey. Int J Soc Psychiatry 0020764011408534.

[20] Smith TC, Zamorski M, Smith B, Riddle JR, Leardmann CA, Wells TS and the Millenium Cohort Study Team. The physical and mental health of a large military cohort: Baseline functional health status of the millennium cohort. BMC Public Health 2007;7:340.

[21] Ministry of Defence *MoD+. (2004). 'Analysis of socio-economic and educational background of non-officer recruits' *Memorandum to the House of Commons Defence Committee, 2004+, cited in House of Commons Defence Committee. (2005). *Duty of Care* (Third Report of Session 2004-05), Vol 2, Ev 255-257 http://www.publications.parliament.uk/pa/cm200405/cmselect/cmdfence/63/63we13.htm

[22] Gee D. Informed Choice? Armed Forces recruitment practice in the United Kingdom. 2007. http://www.essex.ac.uk/armedcon/story_id/000733.pdf

[23] Gee, D. and Goodman, A. (2010). Army recruiters visit London's poorest schools most often. Available at http://www.informedchoice.org.uk/armyvisitstoschools.pdf

[24] Department for Children, Schools and Families *DCSF+. (2008). 'Table 8: GCSE attempts and achievements in selected subjects of pupils at the end of Key Stage 4 in schools (percentages) Year: 2007-08', available at http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000815/SFR282008_Tables_Additional_Amended_121108.xls

[25] ForcesWatch. The recruitment of under 18s in to the UK Armed Forces. Briefing to the Joint Select Committee on Human Rights. Legislative Scrutiny: Armed Forces Bill 2011. http://www.parliament.uk/documents/joint-committees/human-rights/Briefing_from_Forces_Watch_age_of_recruitment.pdf

[26] Royal British Legion. 2006. Profile and Needs: Comparisons between the Ex-Service Community and the UK population. http://www.britishlegion.org.uk/media/33532/final%20comparisons%2001.06.pdf

the veteran community is in the lowest three social classes (C2 to E), and a smaller proportion are in the highest three (grade C1 and above). The study also found that the unemployment rate among veterans of working age is similar to that of the general population; however among those aged 18-49 years it was double the national average.

A recent study among 432 British military recruits found that there were significant variations in socioeconomic background and dental health of recruits to the three Services. Among Army recruits 63% were from the two most deprived quintiles of the Index of Multiple Deprivation compared to 43% of Royal Naval recruits and 37% of Royal Air Force recruits. Army recruits had significantly greater prevalence of dental decay, with a mean of 2.6 (2.1-3.1) decayed teeth compared to 1.9 (1.5-2.4, $p<0.01$) in Royal Navy recruits and 1.3 (1-1.5, $p <0.001$) in Royal Air Force recruits. This disparity in dental health was attributed to the variation in socioeconomic background.[27]

Economic disadvantage and low educational achievement are both independently associated with poor health and lower life expectancy.[28] This means that studying the effect of military service on health is complex, and it is difficult to ascertain whether ill health is related to military service or social circumstances. However it is clear that military veterans have particular healthcare needs which must be addressed.

3.1 Physical health needs

Military service is generally a physically active occupation and as such has health benefits. There is limited research on the lifestyle behaviour of military veterans and most research has focused on physical and mental health conditions associated with military service.

In general the health needs of older veterans are similar to the general population of the same age. A study comparing 484 National Service veterans to 301 non-veterans of similar age found that there were there were no significant differences in mental, behavioural or physical outcomes, except that veterans were less likely to have "any mental disorder" than non-veterans (age adjusted odds ratio (OR) = 0.56, 95% CI 0.31, 0.99). Longer serving veterans were older but were not different in terms of mental, behavioural or physical outcomes. The researchers concluded that community-dwelling National Service veterans are at no greater risk of current adverse mental, physical or behavioural health than population controls.[29]

However the Royal British Legion (RBL) survey found that the prevalence of self-reported long term illness or disability was much higher among veterans (52%) than the general population (35%), and 20% reported multiple conditions (Figure 7).[30] Among veterans and the general population, the prevalence of long term health problems increases with age,

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[27] Elmer TB. Langford J, McCormick R, Morris AJ. Is there a differential in the dental health of new recruits into the British Armed Forces? A pilot study. Br Dent J. 2011 Nov 11;211(9):E18. doi: 10.1038/sj.bdj.2011.937.

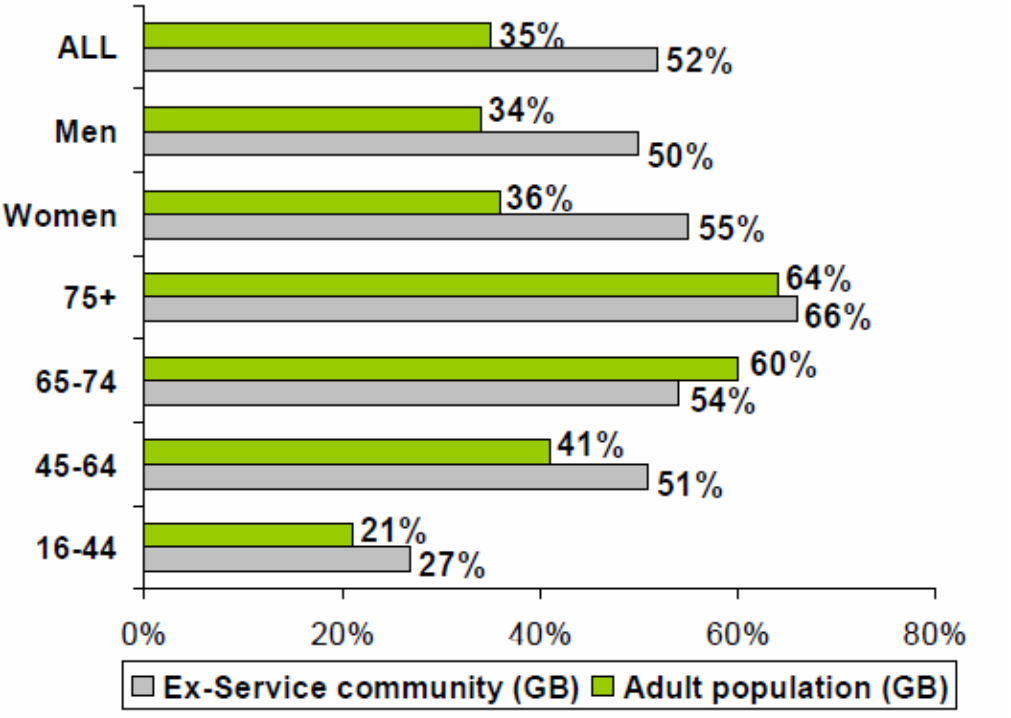
[28] The Marmot Review. Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010. The Marmot Review: London 2010. www.ucl.ac.uk/marmotreview

[29] Woodhead C, Rona RJ, Iversen AC, MacManus D, Hotopf M, Dean K, McManus S, Meltzer H, Brugha T, Jenkins R, Wessely S, Fear NT. Health of national service veterans: an analysis of a community-based sample using data from the 2007 Adult Psychiatric Morbidity Survey of England. Soc Psychiatry Psychiatr Epidemiol. 2011 Jul;46(7):559-66.

[30] Royal British Legion. Profile and Needs of the Ex-Service Community 2005-2020. Royal British Legion 2006. http://www.britishlegion.org.uk/media/33526/summary%20and%20cons.%20report.pdf

and therefore the older age profile of the veteran population may account for this to some extent, however the study also found that younger veterans (16-64 years) were significantly more likely to report long term health problems than their peers in the general population. This was not the case for older veterans: the prevalence of self reported long term health problems among veterans aged 65-74 years was slightly below that of the general population of the same age, while for over 75s it was slightly higher.

Figure 7 Long term illnesses, disabilities or infirmities, by age.
Ex-Service community and adult GB population, by age. Source: RBL 2006. Profile and Needs: Comparisons between the Ex-Service Community and the UK population. Figure 3.14.



Source: http://www.britishlegion.org.uk/media/33532/final%20comparisons%2001.06.pdf

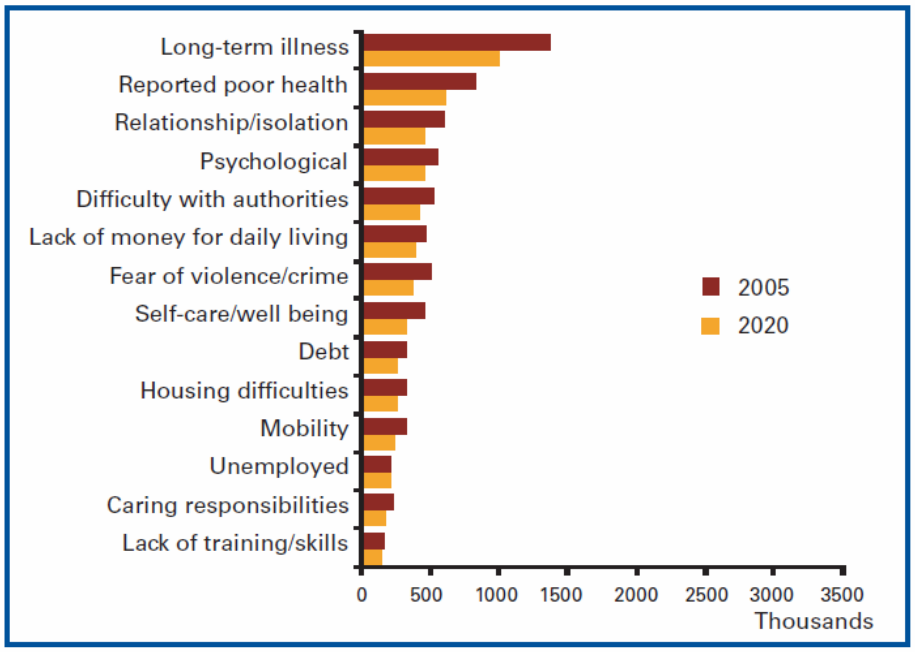
According to the RBL study, compared with those of equivalent age in the general population, veterans have a higher overall prevalence of:

- Musculoskeletal conditions (21% vs. 15%)
- Cardiovascular conditions (21% vs. 15%)
- Respiratory problems (8% vs. 6%)
- Mental health problems (4% vs. 3%)
- Sight problems (4% vs. 2%)
- Hearing problems (4% vs. 1%)

Future health needs

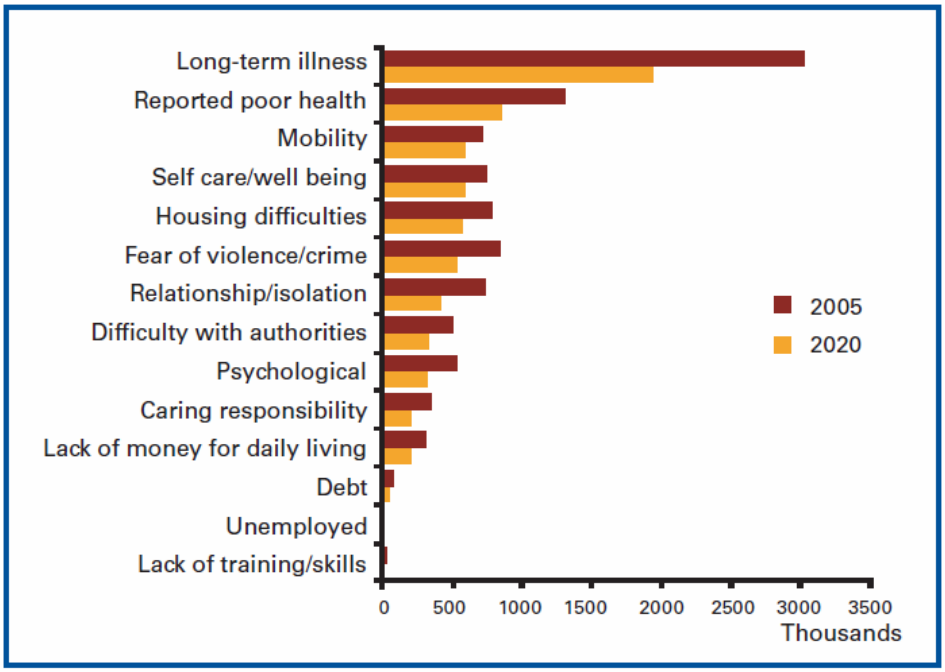
The RBL also projected the future needs of those surveyed, and found that for younger veterans long term illness or disability and mental health issues will remain the most prevalent health concerns in 2020 (Figure 8).

Figure 8 Forecast welfare needs of veterans aged 16-64 years, projected numbers, 2005-2020.



Source: RBL. Profile and Needs of the Ex-Service Community 2005-2020. Royal British Legion 2006. Figure 4.6 http://www.britishlegion.org.uk/media/33526/summary%20and%20cons.%20report.pdf

Figure 9 Forecast needs of those aged over 65, 2005-2020.



Source: RBL. Profile and Needs of the Ex-Service Community 2005-2020. Royal British Legion 2006. Figure 4.7.

As with the general population, the prevalence of long term health conditions increases with age among veterans. However, the overall number of veterans experiencing these health problems is projected to decline as the size of the veteran community declines over the next few years (Figure 9).

The RBL study also found that a large number of veterans are carers; 7% of participants had another adult in the household who was dependent on them for care because of a long term condition or old age, and it was estimated that over half a million veterans are carers. The survey also found that 55% had experienced personal or household difficulties in the past year. Among those below retirement age the greatest issues included financial difficulties, unemployment or lack of skill, depression and mobility, while for older veterans the greatest needs were house and garden maintenance, mobility and low income.

3.2 Substance and alcohol misuse

Alcohol consumption has historically been seen as an important part of military life; the naval 'rum ration' of 95.5% proof Jamaica rum was issued by the Royal Navy until 1970, and medical officers are still able to prescribe a routine ration of rum to personnel operating in an "arduous environment". Alcohol continues to be an important part of military culture and can be used as a bonding tool for people in stressful circumstances, particularly after having been to combat zones, or an intensive period of training.[31] Availability of alcohol is an important influence, and evidence shows that alcohol consumption is responsive to price.[32] Alcohol is often available relatively cheaply in military establishments, where it may be sold for limited profit or tax free on overseas postings. However there have been efforts in recent years to reduce the drinking culture in the military, such as by banning alcohol in certain settings and introducing a 'two-can rule' in others.[31]

Research shows that alcohol misuse is a problem in UK Armed Forces personnel and veterans, and is more frequent than among age and gender matched samples of the UK population.[33] The prevalence of alcohol misuse among regular personnel was higher in those who have been to combat zones in Iraq or Afghanistan compared to those who have not (16% vs. 11%).[34] A study investigating alcohol consumption among veterans of the Gulf and Bosnia conflicts found that heavy drinking (>30 units/week) was most common among younger personnel, particularly those who had served in Bosnia. Heavy drinking was also closely correlated with smoking, and slightly poorer subjective mental and physical health. However veterans were less likely to be heavy drinkers than those still serving.[35]

A survey of 1,382 UK Armed Forces personnel between 2004 and 2006 found that 42.5% drank regularly to a level classed as binge drinking. Alcohol consumption increased during the study period, and there was some evidence that certain experiences during combat,

[31] Fear N, Iversen A, Meltzer H, Workman L, Hull L, Greenberg N et al. Patterns of drinking in the UK Armed Forces. Addiction 2007;102:1749-1759.
[32] Room R, Babor T, Rehm J. Alcohol and public health. Lancet 2005;365:519-30.
[33] Greenberg N, Jones E, Jones N, Fear NT, Wessely S. The injured mind in the UK Armed Forces. Phil Trans R Soc B 2011;366:261-267.
[34] Fear NT, Jones M, Murphy D, Hull L, Iversen AC, Coker B et al. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. Lancet. 2010 May 22;375(9728):1783-97
[35] Iversen A, Waterdrinker A, Fear N, Greenberg N, Barker C, Hotopf M, Hull L, Wessely S. Factors associated with heavy alcohol consumption in the UK Armed Forces: Data from a health survey of Gulf, Bosnia, and Era veterans. Military Medicine. 2007 Sep;172(9):956-61.

such as fear of being killed and hostility from civilians, were associated with particular increases in alcohol consumption.[36]

A study in 2007 compared the alcohol consumption of 8,686 UK Armed Forces personnel who were in service in 2003, at the time of the Iraq war, and the general population. It found that across all age groups the prevalence of hazardous drinking (as assessed by the Alcohol Use Disorders Identification Test (AUDIT) and considered by the WHO to be harmful to health) was significantly higher among the military than the general population. Hazardous drinking was identified in 67% of men and 49% of women in the UK Armed Forces, compared to 38% of men and 16% of women in the general population. Risk factors for heavy drinking among military personnel included young age, being single and being a smoker. In men, heavy drinking was associated with being in the Naval Service or the Army, even after taking account of rank and educational attainment, possibly due to particular drinking subcultures or operational demands within the individual Services.[37]

3.3 Medical discharges

Around 18,000 UK Service people move back into civilian life every year, of whom around 2,000 (11%) leave the Services on medical grounds.[38] A medical discharge is the result of a medical board concluding that an individual's condition prevents their continued service in the Armed Forces. As such, medical discharge statistics are not a measure of morbidity in the Armed Forces but do provide an indication of the minimum burden of ill-health. The rate of medical discharges varies between the different Forces: during the reporting period 2006/07-2010/11 the crude rate of medical discharges was 7.1 per 1000 in the Navy; 7.9 per 1000 in the Army; and 4.4 per1000 in the RAF.

[36] Hooper R, Rona RJ, Jones M, Fear NT, Hull L, Wessely S. Cigarette and alcohol use in the UK Armed Forces, and their association with combat exposures: A prospective study. Addictive Behaviours 2008;33(8):1067-1071.
[37] Fear NT, Iversen A, Meltzer H, Workman L, Hull L, Greenberg N, et al. Patterns of drinking in the UK Armed Forces. Addiction 2007;102:1749-59.
[38] Meeting the healthcare needs of veterans. Royal College of General Practitioners. http://www.rcgp.org.uk/PDF/Veterans.pdf

Table 6 Most common causes of medical discharges for UK Service personnel, 2006/7 to 2010/11, by principal ICD10* cause code group.

Cause (ICD10 codes)		Regular Army	Naval Service	Regular RAF	Total
All coded discharges		4,223	1,331	871	6,425
Musculoskeletal disorders (M00-M99) and injuries (S00-T98)		2,603 (62%)	795 (60%)	447 (51%)	3,845 (60%)
Of which:	Knee injuries**	575 (14%)	225 (17%)	82 (9%)	882 (14%)
	Back pain (M549)	327 (8%)	115 (9%)	109 (13%)	551 (9%)
	Heat injury (T67)	10 (<1%)	-	-	10 (<1%)
	Cold injury (T68 & T69)	181 (4%)	13 (1%)	-	194 (3%)
Mental and behavioural disorders (F00-F48)		606 (14%)	172 (13%)	217 (25%)	995 (15%)
Of which:	Mood disorders (F30-F39)	175 (4%)	69 (5%)	95 (11%)	339 (5%)
	Depression (F32 & F33)	141 (3%)	61 (5%)	88 (10%)	290 (5%)
	Neurotic, stress related and somatoform disorders (F40-F48)	310 (7%)	79 (6%)	77 (9%)	466 (7%)
	Post-traumatic stress disorder (F431)	127 (3%)	29 (2%)	10 (1%)	166 (3%)
	Adjustment disorder (F432)	50 (1%)	21 (2%)	42 (5%)	113 (2%)
Nervous system disorders (G00-G99)		162 (4%)	71 (5%)	60 (7%)	293 (5%)
Eye and adnexa diseases (H00-H59)		47 (1%)	19 (1%)	10 (1%)	76 (1%)
Endocrine, nutritional and metabolic diseases (E00-E90)		28 (<1%)	32 (2%)	11 (1%)	71 (1%)
Of which:	Diabetes (E10-E14)	17 (<1%)	26 (2%)	9 (1%)	52 (1%)

Source: UK Defence Statistics 2011. http://www.dasa.mod.uk/modintranet/UKDS/UKDS2011/chapter3.php
*The International Classification of Diseases (ICD10) is a standard tool used to define and report diseases and is the global information standard for mortality and morbidity statistics.
http://www.who.int/classifications/icd/en/
**Includes ICD10 codes M17, M22, M23, M2406, M2416, M2436, M2446, M2536, M2566, M2586, M2596, M7046, M7126, M7636, M7656, M925, S83, S89.

Table 6 shows that musculoskeletal disorders and injuries accounted for 60% of medical discharges during this period, frequently due to knee injuries and back pain. Mental and behavioural disorders were also a frequent reason for discharge, accounting for 15%. There are significantly higher rates of medical discharges among females than males, among personnel in training, and among personnel in ranks other than Officer. Due to differences

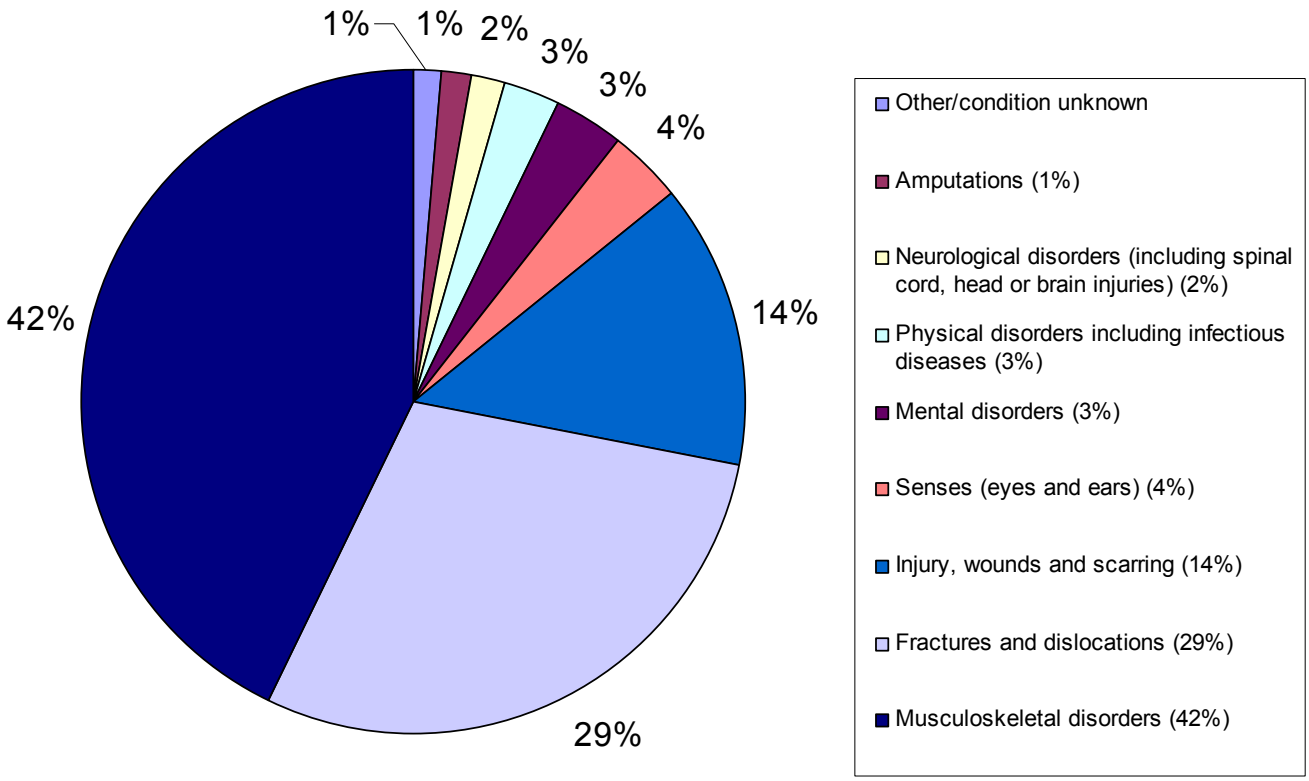
in the process of medical discharge between the three Services these rates are not comparable between services.[39]

3.4 Armed Forces Compensation Scheme/War Disablement Pensions

Statistics for War Disablement Pensions (WDP) and payments under the Armed Forces and Reserve Forces Compensation Scheme (AFCS) give an impression of the predominant long-term conditions resulting from injury during service. The AFCS replaced the WDP in 2005 to pay compensation for injury, illness or death attributable to service in the UK armed forces that occurred on or after the 6th April 2005. Depending on the severity of the condition individuals receive either a tariff based lump sum payment, or for the most serious injuries a Guaranteed Income Payment (GIP), a regular payment for life following termination of service to compensate for loss of earnings due to the condition. Some individuals receive both, and those with multiple injuries receive recognition for each injury.

The most recent data for the AFCS cover the six year period from 6th April 2005 to 31st March 2011, during which period there were 10,590 lump sum payments made and 1,185 recipients of GIPs. These data are only available at regional level – there are 85 GIP recipients in the South East region, of which 40 are veterans (the remainder being spouses or children), and 1,925 people who have received lump sums.

Figure 10 Lump sum payments 6th April 2005-31st March 2011, by injury category, UK



Source: DASA Armed Forces Compensation Scheme statistics.
http://data.gov.uk/dataset/armed_forces_compensation_scheme

[39] Defence Analytical Services and Advice. Medical Discharges in the UK Regular Armed Forces 2006/07-2010/11. 14th September 2011.
http://www.dasa.mod.uk/applications/newWeb/www/index.php?page=66&pubType=0

Figure 10 shows that physical conditions such as musculoskeletal disorders, fractures and dislocations, and injury, wounds and scarring are by far the most common service-related conditions resulting in compensation payments, accounting for 85% of payments.

3.5 Physical injury and mortality during service

While those serving in the military are generally fit and healthy, service in the Armed Forces is recognised as a physically dangerous occupation. Military Service personnel are at risk of sustaining injuries during training and whilst mobilised, particularly in war situations. Injury during training is common; a recent study of 600 British military recruits found that nearly 60% had experienced an injury during training, of which 83% were traumatic injuries, and 71% involved the lower body, particularly the back, knee and ankle. Younger recruits were at greatest risk of injury.[40] Non-mobilised reservists are now recognised as having the same status as serving personnel should they be injured on training operations.

The risk of injury or death varies greatly between the Forces, and by rank and location. Recent conflicts have been particularly severe. The Ministry of Defence defines 'major combat' as a mortality rate of six per 1000 personnel, however during periods of 2010 in Afghanistan the mortality rate was estimated at 13 per 1,000.

The risk of death (occupational attributable mortality) for the Army overall is approximately one in 1000 per year, which is about 150 times greater than for the general working population. Risk of serious injury (e.g. loss of limbs, eyes or other body parts) is substantially increased.[41] In 2010 the mortality rate in the Army was 1 per 1000 personnel. The mortality rate among the Armed Forces has fluctuated over the past decade, from a low of 0.7 per 1000 in 2001 to a high of 1.1 per 1000 in 2009. The mortality rate was highest in the Army, and lower in the Navy and the RAF (DASA 1st July 2011).

Overall in 2010 there was no statistically significant difference in the occurrence of deaths in the UK Armed Forces compared to the UK general population. However there were significant differences in mortality due to specific conditions; UK Armed Forces personnel were at 80% decreased risk of dying from a disease related condition than the UK general population in 2001, but they were at a 94% increased risk of dying due to external causes of injury and poisoning.[42]

[40] Wilkinson et al. Injuries and injury risk factors among British army infantry soldiers during pre-deployment training. Inj Prev 2011;17(6):381-7.
[41] Meeting the healthcare needs of veterans. A guide for General Practitioners. Royal College of General Practitioners, Royal British Legion, Combat Stress. January 2011. http://www.armedforceshealthpartnership.org.uk/media/31271/MeetingthehealthcareneedsofveteransGPsguide.pdf
[42] Defence and Analytical Services and Advice (DASA). Defence Analytical Services and Advice. Deaths in the UK regular Armed Forces 2010. National Statistics Statistical Notice. 1st July 2011. http://www.dasa.mod.uk/index.php?pub=MORTALITY

3.6 Amputations and prosthetics

Military service puts personnel at risk of traumatic injury during training and combat operations, which can result in traumatic amputation. Conflicts in Iraq and Afghanistan have led to a sharp increase in the number of personnel sustaining injuries resulting in amputation. The Defence Medical Services provides military amputees with prosthetic limbs of a standard to enable them to return to active duty, potentially on the frontline. The aim is to deliver optimal functional recovery regardless of the amputee's future role, in line with the "no disadvantage" principle of the Military Covenant.

On occasion prosthetics may require replacement or need to be refitted due to wear or discomfort. For serving personnel this is managed by the Defence Medical Services, mostly through the Defence Medical Rehabilitation Centre at Headley Court. Following discharge this becomes the responsibility of the NHS, via Disablement Services Centres (DSCs). Under the Military Covenant, veterans who have lost limbs due to their military service are entitled to replacement prosthetics of at least an equivalent technological standard to the original limb provided by the MoD, where clinically necessary.

This commitment has led to a number of concerns, in the context of increasing numbers of surviving amputees from conflicts in Iraq and Afghanistan, who would be leaving the Armed Forces in future years with high prosthetic expectations. Ethical concerns were raised regarding whether military amputees should be entitled to a higher standard of prosthetic than a civilian who has experienced traumatic limb loss. There was also uncertainty about whether the NHS was able to provide an equivalent level of care for military amputees as is available through the Defence Medical Rehabilitation Programme (DMRP) and its consultant based Complex Trauma Teams. For example, service personnel can expect to receive six to eight hours of physiotherapy per day for five days a week, however the NHS provides only 2 hours per week. In addition there are no nationally agreed guidelines for prosthetic prescription and rehabilitation, leading to regional variation in the standard of prosthetic provided. For these reasons the Government asked Dr Andrew Murrison to review the effectiveness of NHS prosthetics services for military amputees in 2011.[43] The report made the following recommendations, which were accepted by the Government:[44]

- there should be specialist commissioning of prosthetics and rehabilitation through five centres in England to cater for those veterans leaving the armed forces;
- veterans should be able to access mainstream NHS provision through a Disablement Services Centre (DSC) of their choice;
- the National Institute for Health and Clinical Excellence (NICE) should be tasked with the production of national guidelines for prosthetic prescription and rehabilitation for all amputees;
- there should be a programme of military/civilian exchange for healthcare professionals to grow the specialist prosthetic and rehabilitation network rapidly.

Quarterly statistics are released on the number of British injuries sustained in Afghanistan (Operation Herrick) and Iraq (Operation Telic), including the number of amputations. Among

[43] Murrison A. A better deal for military amputees. June 2011. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130827.pdf
[44] Department of Health 2011. Improved prosthetics services for military veterans. http://www.dh.gov.uk/health/2011/10/improved-prosthetics-services-for-military-veterans/

UK personnel, between 1st April 2006 and 31st March 2011 there were 246 partial or complete limb amputations among personnel serving in Afghanistan and at least 16 among those serving in Iraq (Table 7). Of the surviving UK Service personnel from Afghanistan or Iraq whose injuries included an amputation, partial or complete, for either upper or lower limbs, 22 have been medically discharged. Of these 22 personnel, 17 were discharged as a result of musculoskeletal disorders and injuries.[45]

Table 7 Amputations among UK service personnel in Afghanistan and Iraq, 01/04/2006-31/03/12.

Financial year	Partial or complete amputations		Of which are Significant Multiple Amputations*		Total Amputations
	Afghanistan	Iraq	Afghanistan	Iraq	
2006/07	9	10	<5	0	19
2007/08	17	6	<5	0	23
2008/09	28	<5	7	0	>28
2009/10	71	<5	32	0	>71
2010/11	75	<5	36	0	>75
2011/12	46	0	18	0	64
Total	246	>16	>93	0	>280

* Refers to partial or complete amputation of upper or lower limbs. These are included in the total amputations figures.
Source: DASA Quarterly Afghanistan and Iraq Amputation Statistics. www.dasa.mod.uk

The number of surviving amputees has increased in recent years, due in part to the increased use of Improvised Explosive Devices by the Taliban in Afghanistan, and the care provided by the Defence Medical Services.[46] A study of military combat amputees injured in Afghanistan and Iraq found that soldiers are surviving more severe and complex injuries than before, and after rehabilitation the majority are able to successfully return to work. Of the 52 amputees studied, eight had left the military due to medical discharge, while the remainder continued to serve.[47] This suggests that the number of prostheses required for medically discharged Iraq and Afghanistan veterans in the NHS is likely to be relatively small compared with the approximately 5,000 amputations carried out on civilians in the NHS each year. However loss of a limb is extremely distressing and people who have an amputation due to trauma have complex needs, including an increased risk of developing PTSD, which is of particular concern for military veterans.[48]

In addition amputees from more recent conflicts tend to have more complex injuries and more have multiple amputations than ever before. The ratio of limbs lost to military patients seen by the Defence Medical Rehabilitation Centre (DMRC) at Headley Court increased from 1.1 in 2006 to 1.5 in 2010. Younger amputee veterans often have complex injuries and co-morbidities and the Murrison report raised concerns that existing NHS centres would find it a challenge to meet these increasing requirements within their budgets.

[45] Quarterly Afghanistan and Iraq Amputation Statistics. 7 October 2001-31 December 2011. http://www.dasa.mod.uk
[46] Murrison A. A better deal for military amputees. June 2011. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130827.pdf
[47] Dharm-Datta S, Etherington J, Mistlin A, Rees J, Clasper J. The outcome of British combat amputees in relation to military service. Injury. 2011 Nov;42(11):1362-7. Epub 2011 Jul 14.
[48] NHS Choices. Amputation. http://www.nhs.uk/Conditions/Amputation/Pages/Introduction.aspx

The Murrison report estimated future demand for NHS prosthetics and rehabilitation services based on the 1,335 members of the British Limbless Ex-Servicemen's Association (BLESMA), believed to include the vast majority of veteran amputees in the UK. Many of these are older, single limb amputees whose needs are met by existing NHS provision. It was estimated that the 70% of amputees under the age of 70 years would require upgraded prosthetics in the coming years, equating to 278 individuals in the UK.

The Murrison report estimates the initial cost of prosthetics provided by the Defence Medical Rehabilitation Centre (Headley Court) at approximately £20,000 per patient, with an annual maintenance cost of £2,000, compared with £900 for NHS care. Following the report the Government is investing £15 million until 2015 to develop a small number of nationally commissioned specialist prosthetics and rehabilitation services across England. In response to concerns that these developments could create a two tier system, the Murrison report is clear that the civilian limbless population should not be disadvantaged by provision made for military veterans, and the intention is to extend these services to the rest of the population with a clinical need.[49]

3.7 Fertility treatment

Under the Armed Forces Covenant the Government has committed to ensure that veterans who have sustained serious genital injuries be guaranteed three cycles of IVF.[50] There is no data available on the prevalence of serious genital injuries among military veterans.

3.8 Mental health needs

Military service can affect the mental health of personnel, and there are often concerns that veterans may develop Post-traumatic Stress Disorder (PTSD) following distressing experiences during their service. Military personnel are drawn from the general population and as such will also experience mental health problems unrelated to their service; establishing whether mental health conditions are a consequence of military service is therefore difficult.

However it is clear that there are features of military life that pose a potential risk to the mental health of personnel. These may include:

- Violent or traumatic combat experiences
- Disruptions or instability in home life
- Making the transition from service to civilian life
- The consequences of the excessive drinking culture prevalent among service personnel.[51]

[49] Phillips C. Armed Forces and veterans health: innovation through coproduction 2011. http://www.armedforceshealthpartnership.org.uk/media/42580/01%20111124%20-RBL%20CS%20Conference%20Claire%20-%20v04.pdf

[50] Ministry of Defence. The Armed Forces Covenant: Today and Tomorrow. http://www.mod.uk/NR/rdonlyres/0117C914-174C-4DAE-B755-0A010F2427D5/0/Armed_Forces_Covenent_Today_and_Tomorrow.pdf

[51] Improving access to Psychological Therapies. Veterans Positive Practice Guide. http://iapt.nmhdu.org.uk/silo/files/veterans-positive-practice-guide.pdf

The most extensive study of the mental health of British current and ex-service personnel is the King's Military Cohort, a randomly selected cohort of serving personnel and veterans established by the King's Centre for Military Health Research (KCMHR). The cohort initially comprised more than 10,000 personnel serving at the time of the Iraq War, and was later expanded to include personnel who had served in Afghanistan.[52] It does not include veterans of previous conflicts, and so it cannot be assumed that the results of studies based on this cohort could be generalised to all military veterans. In addition the cohort has not been established long enough to study the very long term mental health of military veterans.

Nonetheless, the cohort provides a wealth of information about the mental health of this group of veterans. It is clear that many veterans of the Iraq and Afghanistan conflicts have experienced intense combat, and violent and traumatic situations. One study examined the number of times veterans had been exposed to specific traumatic situations to assess the impact on their mental health. This found that nearly half had seen personnel wounded and killed, and over 11% had experienced a landmine strike (Table 8).

Table 8: Experiences of personnel who have served in Iraq or Afghanistan[53]

Exposure	Proportion exposed
Seen personnel wounded and killed	Never: 53.4% Once: 15% 2-4 times: 19.8% ≥5 times: 11.9%
Come under mortar/artillery fire/rocket attack	Never: 22.4% Once: 6.8% 2-4 times: 15.9% ≥5 times: 54.9%
Experienced hostility from civilians	Never: 53.3% Once: 9.7% 2-4 times: 18.8% ≥5 times: 18.2%
Experienced a landmine strike	Never: 88.7% Once: 5.9% ≥2 times: 5.5%

Source: Fear et al. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. Lancet. 2010 May 22;375(9728):1783-97.

The charity Combat Stress provides psychological support to veterans experiencing mental health problems as a result of their service, predominantly PTSD. This includes a 24 hour helpline, 14 Community Outreach Teams and three short-stay treatment centres. They produced a profile of a 'typical' new referral to their service in 2010, based on the 1,303 cases referred between 1st April 2009 and 31st March 2010 (Figure 11).

[52] Pinder RJ, Greenberg N, Boyko EJ, Gacksetter GD, Hooper TI, Murphy D et al. Profile of two cohorts: UK and US prospective studies of military health. Int J Epidemiology 2011;1-11. doi:10.1093/ije/dyr096.
[53] Fear et al. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. Lancet. 2010 May 22;375(9728):1783-97.

Figure 11 Combat Stress 'typical' new referral, 2009/10.[54]

Typical new referral 2009

- Average age 44 year old (range 19 to 93 years)
- Ex-Army
- Childhood trauma, neglect, poor care giving
- Multiple traumatic exposures. Service in many war theatres (Northern 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)

The Royal British Legion survey found that the prevalence of mental health disorders among younger veterans (aged 16-44 years) was three times that of the UK population of the same age.[55]

It has also been reported that reservists who are sent to combat zones have worse mental health outcomes than regular armed forces personnel. One study found that reservists who served in the 2003 Iraq war were more than twice as likely as regular personnel to develop common mental health disorders.[56] In the KCMHR cohort, significant differences were found in the prevalence of certain conditions between those who have served in Iraq and Afghanistan and those who have not. Regulars who served in Iraq and Afghanistan were at 20% increased risk of alcohol misuse compared with those who did not, and reservists who served in Iraq and Afghanistan were nearly three times as likely to have probable PTSD (Table 9).

[54] Busuttil W. 2010. Management of Mental Health in Veterans: the role of the third sector charity, Combat Stress. http://www.rcpsych.ac.uk/pdf/6-Wbusuttil.pdf

[55] Royal British Legion. Profile and Needs of the Ex-Service Community 2005-2020. Royal British Legion 2006. http://www.britishlegion.org.uk/media/33526/summary%20and%20cons.%20report.pdf

[56] Hotopf M, Hull O, Fear NT, Browne T, Horn O et al. The health of UK military personnel who deployed to the 2003 Iraq war: a cohort study. Lancet 2006;367:1731-1741.

Table 9 Prevalence of mental health conditions and Iraq/Afghanistan combat status, Regulars and Reservists[57]

Condition	Regular personnel			Reservists		
	Combat zone	Not sent to combat zone	Adjusted OR (95% CI)	Combat zone	Not sent to combat zone	Adjusted OR (95% CI)
Common mental disorders	19.6%	19.9%	0.98 (0.84-1.14)	19.9%	18.1%	1.16 (0.85-1.59)
Probable PTSD	4.2%	4%	1.13 (0.82-1.54)	5%	1.8%	2.83 (1.23-6.51)
Alcohol misuse	15.7%	10.9%	1.22 (1.02-1.46)	9.5%	6.8%	1.38 (0.89-2.13)

Source: Fear et al. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. Lancet. 2010 May 22;375(9728):1783-97.

3.9 Post traumatic stress disorder (PTSD)

NICE guidance states that PTSD develops in up to 30% of people who have experienced a traumatic event. Onset is usually in the first month after the event, but may occur months or years later in a minority of patients (<15%). A substantial proportion recover without treatment in the following years, however at least a third remain symptomatic for three or more years and are at risk of secondary problems such as substance misuse. Women are more likely to develop PTSD following a traumatic event than men. Military personnel who have experienced traumatic injuries such as amputations are at increased risk of developing PTSD.[58] There is also some evidence that veterans may be more likely to develop delayed onset PTSD, which is likely to present within the first year after leaving military service.[59]

The NICE guidance for PTSD recognises the particular circumstances of military veterans and states "When experienced by ex-military personnel, PTSD is frequently co-morbid with other disorders, and there are often other important psychosocial issues that need to be addressed (including the impact of being discharged from the armed services and all that that entails). The adjustment from military to civilian life can be difficult; problematic social circumstances can occur and these may result in housing problems and financial hardship. These factors and the often prolonged and intense nature of traumatic exposure can result in a complex PTSD presentation that is potentially difficult to treat…..Primary and secondary care practitioners should be aware that ex-military personnel are at higher risk of having or developing PTSD (and other mental health problems) than most civilian populations and should consider assessing for this when they present with other problems."

It is often reported that PTSD is common among military personnel, however the KCMHR cohort study suggests that this is not the case. A study based on the original KCMHR

[57] Fear et al. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. Lancet. 2010 May 22;375(9728):1783-97.
[58] National Institute for Health and Clinical Excellence. Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care. 2005. http://www.nice.org.uk/CG26
[59] Improving access to Psychological Therapies. Veterans Positive Practice Guide. http://iapt.nmhdu.org.uk/silo/files/veterans-positive-practice-guide.pdf

cohort found that of those with a psychiatric diagnosis indicated at interview, the most common were classic psychiatric disorders such as depression and anxiety (53.4% and 18.2% of the cohort respectively) rather than specific service related problems. Those with PTSD were 30 times more likely to have a co-morbidity than those without, in particular alcohol dependence, which was reported in 34.7% of those with PTSD and 8.1% of those without. Of those with mental health problems only 58.4% were seeking help, for reasons including believing that they could deal with the problem themselves, and stigma and embarrassment. There was evidence of under diagnosis in this group, and only half of those found to have PTSD at interview had been diagnosed by a doctor. The authors commented that the most vulnerable people in the cohort were single, came from the lower ranks and were more likely to have served in the Army.[60]

A clinical interview based study of 821 participants in the original KCMHR study found that the most common mental health diagnoses were alcohol abuse (18%) and neurotic disorders (13.5%) including depression and anxiety. The prevalence of PTSD symptoms was relatively low at 4.8%. Reservists who went to Iraq and other areas were at increased risk of PTSD compared with those who did not.[61] One study based on 8,195 cohort members including those who had been to the Gulf (1990-91) and Bosnia (1992-97) found that in general those with symptomatic mental health problems during service remained symptomatic after leaving, whereas those who were well remained well in terms of mental health. The authors concluded that those with poor mental health were the most vulnerable to social exclusion or hardship such as unemployment.[62]

The original KCMHR cohort included personnel who had been involved in the early stages of Operation Telic in Iraq. The increased intensity of the later stages of this operation, and the conflict in Afghanistan, led to increasing numbers of physical casualties and fears that the personnel involved in these operations would experience much higher rates of mental ill health. However, further research extended the original KCMHR study and found that in general the overall mental health of participants remained good, and did not differ significantly from previous findings.[63] The prevalence of PTSD in the updated study remained relatively low (4%), while common mental disorders such as depression and anxiety remained the most frequently identified mental health condition (19.7%). The prevalence of alcohol abuse had declined but remained high at 13%. Service in Iraq or Afghanistan was significantly associated with alcohol misuse for regulars (odds ratio 1.22, 95% CI 1.02-1.46) and with probable PTSD for reservists (2.83, 1.23-6.51). PTSD was almost twice as prevalent among regular personnel in combat roles as those in support roles.[64]

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[60] Iversen A, Dyson C, Smith N, Greenberg N, Walwyn R, Unwin C et al. 'Goodbye and good luck': the mental health needs and treatment experiences of British ex-service personnel. Br J Psychiatry 2005;186:480-486.

[61] Iversen A, van Staden L, Hacker Hughes J, Browne T, Hull L, Hall J et al. The prevalence of common mental disorders and PTSD in the UK military: using data from a clinical interview-based study. BMC Psychiatry 2009;9(68). Doi:10.1186/1471-244X-9-68.

[62] Iversen A, Nikolaou V, Greenberg N, Unwin C, Hull L, Hotopf M et al. What happens to British veterans when they leave the armed forcer? European Journal of Public Health 2005;15(2):175-184.

[63] Greenberg N, Jones E, Jones N, Fear NT, Wessely S. The injured mind in the UK Armed Forces. Phil Trans R Soc B 2011;366:261-267.

[64] Fear NT, Jones M, Murphy D, Hull L, Iversen AC, Coker B et al. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. Lancet. 2010 May 22;375(9728):1783-97.

A recent review examined the impact of the conflicts in Iraq and Afghanistan on the health of UK Armed Forces personnel and concluded that as yet, service in Iraq or Afghanistan has not been associated with a general increase in mental health problems. However, although the rate of PTSD is low in the UK Armed Forces (1.6–6%), service in Iraq or Afghanistan is associated with an increased risk of PTSD for reserve personnel. In contrast to PTSD, the rate of alcohol misuse is high in the UK Armed Forces (between 16–20%), and has been associated with service in Iraq or Afghanistan for regular personnel. As the UK military engagement in Afghanistan continues and more personnel are involved, the demand for help from military health services, the NHS and the service charities is expected to increase.[65]

3.10 Self harm

Self harm in the military has been under-reported for many years, in part because it was deemed a disciplinary offence until relatively recently.[66] A survey of 821 current and ex-service personnel of the UK Armed Forces reported that the lifetime prevalence of intentional self-harm (self-harm or attempted suicide), among ex-Service personnel was more than double that of serving personnel (10.5% vs. 4.2%). This is also well above the estimates suggested by general population surveys, of between 4.4-5.6% for attempted suicide and 4.9% for self-harm.[67,68] The same survey found that intentional self-harm among serving and ex-Service personnel was strongly associated with PTSD, which was over eight times more common among those who had self harmed (Adjusted odds ratio 8.48, 95% CI 2.73-26.33). The increased risk of intentional self harm among ex-Service personnel may be due to social exclusion and loss of social networks developed during service, or reverse causality (i.e. self harm and mental distress may be a trigger for leaving service).

A study at a civilian hospital in Oxford compared the characteristics of armed forces personnel and matched civilian controls presenting with self-harm.[69] Armed forces personnel were less likely than civilians to have evidence of current or past psychiatric disorders or treatment or a prior history of self harm, and their suicidal intent was lower. The study found that although there were RAF and Army bases locally, the Army was overrepresented among those who self-harmed. The most common problems individual armed forces personnel reported were problems with a partner (62%) and employment problems (43.9%), mostly related to their job within the services being stressful, boring, repetitive or generally disliking the role and finding it difficult to progress. While little is known about self-harm in the military, it is estimated to be much more common among women than men and this study found that women were over-represented among those

[65] Sundin J, Forbes H, Fear NT, Dandeker C, Wessely S. The impact of the conflicts of Iraq and Afghanistan: A UK perspective. Int Rev Psychiatry 2011;23(2):153-159. doi:10.3109/09540261.2011.561303.
[66] Pinder RJ, Iversen A, Kapur N, Wessely S, Fear NT. Self-harm and attempted suicide among UK Armed Forces personnel: Results of a cross-sectional survey. Int J Soc Psychiatry 0020764011408534.
[67] Bebbington PE, Minot S, Cooper C, Dennis M, Meltzer H, Jenkins R, Brugha TS. Suicidal ideation, self-harm and attempted suicide: Results from the British Psychiatric Morbidity Survey 2000. European Psychiatry 2010;25:427-431.
[68] Nicholson S, Jenkins R, Meltzer H. Adult psychiatric morbidity in England, 2007. The Information Centre for Health and Social Care 2009. London, UK.
[69] Hawton K, Harriss L, Casey D, Simkin S, Harrison K, Bray I, Blatchley N. Self-harm in UK armed forces personnel: descriptive and case-control study of general hospital presentations. Br J Psych 2009;194:266-272.

who self harmed. A Royal Military Police report estimated the annual rate of self harm to be almost 2.5 times higher among women than men (265 per 100,000, 95% CI 232-304 vs. 114 per 100,000, 95% CI 108-121). Similarly the rate of self-harm in the Royal Navy has been estimated at 22 per 100,000 for males and 118 per 100,000 for females.[70]

A history of self-harm is strongly associated with subsequent suicide[71] and self-harm in serving personnel may be an indicator of future need for mental health support among veterans.

3.11 Suicide

Suicide among military personnel has attracted considerable media and public attention in recent years. However, the suicide rate among UK Armed Forces personnel has generally been lower than in people of similar age in the general populaton.[70] The overall incidence of suicide in the UK Armed Forces is lower than in the general population, with the exception of young Army males.[72]

Researching suicide among military veterans is more complex and evidence is limited. Of the 233,803 individuals who left the UK Armed Forces between 1996-2005, 224 are known to have died by suicide during this time. Researchers examined data for this group and found that the overall suicide rate was not greater among veterans than the general population during this time. However the risk of suicide in male veterans aged 24 years and under was approximately two to three times higher than for the same age groups in the general and serving population, but was lower among male veterans aged 30-49 years. Those at greatest risk of suicide were males, those who had served in the Army, and those with less than four years service. Veterans were also less likely to have had contact with mental health services in the 12 months before their death, particularly those in the youngest age groups, i.e. those at greatest risk of suicide. The authors' recommendations included encouraging appropriate help-seeking behaviour in those who have left the forces, and practical and psychological preparation for discharge from the military.[73] Ascertaining the reasons for the higher risk among young male veterans is complex, however the researchers concluded that this may reflect vulnerabilities dating from before joining the military. This is supported by the finding that those with the shortest length of service were at greatest risk of suicide after discharge.

3.12 Access to mental health services/interventions

Veterans with operational service since 1982 have access to a comprehensive assessment at the Medical Assessment Programme (MAP) based in London, for any mental health problem considered to be related to their service.

Support for current or former Reservists is available through the Reserves Mental Health Programme (RMHP). This is open to any current or former member of the UK Volunteer

[70] Hawton K, Harriss L, Casey D, Simkin S, Harrison K, Bray I et al. Self-harm in UK armed forces personnel: descriptive and case-control study of general hospital presentations. Br J Psychiatry 2009;194:277-272.
[71] Owens D, Horrocks J, House A. Fatal and non-fatal repetition of self-harm. Systematic review. Br J Psychiatry 2002;181:193-9.
[72] Kapur N, While D, Blatchley N, Bray I, Harrison K. Suicide after leaving the UK Armed Forces – a cohort study. PLoS Medicine 2009;6(3):e1000026. doi:10.1371/journal.pmed.1000026.
[73] Kapur N, While D, Blatchley N, Bray I, Harrison K. Suicide after leaving the UK Armed Forces – A cohort study. PLoS Medicine 2009;6(3):e10000026. doi:10.1371/journal.pmed.10000026.

and Regular Reserves who has been demobilised since 1 January 2003 following overseas operational service as a reservist, and who believes that the service in the combat zone may have adversely affected their mental health. Reservists must be referred by their GP or civilian psychiatric services. Mental health assessments are carried out at the Reserves Training and Mobilisation Centre in Chilwell, Nottinghamshire, and out-patient treatment is offered via one of the MOD's 15 Departments of Community Mental Health (DCMHs). If more acute cases present, the DMS will assist access to NHS in-patient treatment.[74]

The MOD is also piloting projects to identify vulnerable service leavers before they leave and to provide a 'light-touch' mentoring service for Early Service Leavers (those who leave within four years of enlistment) for six months to ease the individuals' transition from military life. Within the military there are strategies to support mental health, such as third location decompression (TLD), an approach which allows people to 'pause' in a third location between service and returning home. Trauma risk management (TRiM) is another technique using a peer-delivered psychological first aid process to support personnel to cope with potentially traumatic events.[75]

The main strategies used in the UK to date to prevent suicide among military veterans are practical and psychological preparation for discharge, and encouraging appropriate help seeking behaviour once individuals have left the Armed Forces.[76]

There are plans within the Armed Forces Covenant to allow Service personnel with mental health issues identified while serving to continue to access military mental health services for up to six months after discharge. Arrangements to ensure follow-on treatment is provided
were planned to be in place and operational by late Summer 2011.[77]

While most veterans are treated within NHS mental health services in the same way as the general population, the Improving Access to Psychological Services (IAPT) programme produced a report in 2009 describing some of the barriers which veterans face in accessing NHS psychological therapy services.[78] It notes that high levels of social exclusion prevent some veterans from registering with GPs, therefore limiting their access to healthcare.

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[74] http://www.nhs.uk/NHSEngland/Militaryhealthcare/Documents/rmhp.pdf
[75] Greenberg N, Jones E, Jones N, Fear NT, Wessely S. The injured mind in the UK Armed Forces. Phil Trans R Soc B 2011;366:261-267.
[76] Kapur N, While D, Blatchley N, Bray I, Harrison K. Suicide after leaving the UK Armed Forces – A cohort study. PLoS Medicine 2009;6(3):e10000026. doi:10.1371/journal.pmed.10000026.
[77] Ministry of Defence. The Armed Forces Covenant: Today and Tomorrow. http://www.mod.uk/NR/rdonlyres/0117C914-174C-4DAE-B755-0A010F2427D5/0/Armed_Forces_Covenent_Today_and_Tomorrow.pdf
[78] Improving Access to Psychological Therapies. Veterans Positive Practice Guide. http://iapt.nmhdu.org.uk/silo/files/veterans-positive-practice-guide.pdf

The programme recommends promoting self-referral and accepting referrals directly from ex-service charities into IAPT services. The report also identified barriers which may prevent veterans from receiving psychological therapies:[59]

Veterans' beliefs and behaviours may include:	**General Practitioners and other health professionals may:**
• believing that mental health problems are shameful and so deliberately hiding symptoms from health professionals; • believing that NHS professionals will not understand them or 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; • mistakenly believe that psychological therapies are not effective for Veterans • being disenchanted by previous exposure to mental health services in the military or NHS • having difficulty accessing general health services in the first place (especially relevant for veterans who are socially excluded).	• not understand that Veterans may have specific needs because of past military cultures • have time constraints in their surgeries that reduce the probability of them diagnosing veterans' mental health problems effectively • recognise symptoms of depression or anxiety disorders but fail to recognise that they can be treated with psychological therapies; • health professionals may mistakenly believe that psychological therapies are not effective for veterans; • believe that treating any physical health problems is a higher priority than treating mental health problems and consequently do not refer to psychological therapy services. **Specialist mental health services may:** • lack confidence in working with Veterans • be fearful that Veterans can be violent • have concerns about their ability or skills to build a therapeutic relationship with Veterans

There are a range of organisations which provide support to veterans in managing mental health conditions and accessing services including:

- The Service Personnel and Veterans Agency (SPVA)
- Combat Stress
- Royal British Legion
- Sailors Soldiers and Airmen and Families Association (SSAFA)
- Citizens Advice Bureau (CAB)
- Big White Wall: an online early intervention service for people experiencing psychological distress. It has been commissioned by NHS South East Coast to provide services to 1200 people across West Sussex, East Sussex, Brighton and Hove and Kent and Medway. http://www.bigwhitewall.com
- The MOD Medical Assessment Programme (MAP), which offers expert mental health assessments to any veteran with mental health problems who has served in operations since 1982.

4 Vulnerable groups

Key points

- Veterans who become homeless or involved with the criminal justice system are particularly vulnerable
- National estimates suggest around 3.5% of the prison population have a service background and this is felt to be an under-estimate of the true picture, partly because reservists are not included in the figure
- Applying the estimates to the prison population in Sussex would mean that there are approximately 50 male veterans in custody in Sussex at any one time
- Offending is almost exclusively confined to male veterans rather than female veterans
- Social isolation and exclusion, alcohol, and financial problems are drivers for offending in the veteran population, and the same drivers exist in the general prison population. Similarly, offending behaviour tends to be linked to socioeconomic disadvantage, which is in turn magnified by a combination of low educational attainment, family deprivation, drug and alcohol abuse, homelessness and poor health. These communities are those from which infantry recruits are often drawn.
- Estimates vary as to the proportion of rough sleeping homeless people who have a service background, with lower estimates at 6% and higher estimates at 25%, but a consistent finding is that Army leavers are disproportionately affected compared to the Navy or the Air Force

Veterans in vulnerable groups have specific needs, and there are estimates of the number of veterans in groups including living in communal establishments, in prisons, and the homeless;

- *Veterans living in communal establishments*

  The ONS report[79] provided a separate estimate for veterans living in communal establishments, in 2007 this was estimated to be 28,437 (95% CI: 23,200–35,439) (male veterans) and 4,761 (95% CI: 2,972–8,046) (female veterans).

- *Veterans in the prison population*

  There is conflicting information relating to military veterans in the criminal justice system and prison.

  - DASA analysis[80] estimated that 3.5% of the prison population were military veterans by examining details held on the prison data systems to Service leaver

[79] Woodhead, C. et al. *An estimate of the veteran population in England: based on data from the 2007 Adult Psychiatric Morbidity Survey.* Office for National Statistics 2009

records. Nationally this represented 2,820 out of 81,071 prisoners. Note – reservists were excluded from this analysis, only data on regular service personnel could be matched. It should be noted that the DASA report found that military veterans were less likely to be in prison that the non-veteran population.

- The Veterans In Prison Association (VIPA) project estimates that the true figure could be four times higher than this, with ex-servicemen reluctant to identify themselves due to feelings of embarrassment and not wanting to bring shame upon their regiment or squadron (see section 4.4 : Example of Good Practice). The Ministry of Justice and MoD study estimates that around 77% of ex-servicemen in prison served in the Army, 15% in the Navy and 8% in the RAF.

Table 10 shows the ratio of general population to veteran population: overall for men aged 18-54 the ratio was 1.43, meaning that the proportion of the general population in prison was found to be 43% greater than the proportion of veterans in prison. In relation to specific offences a higher proportion of veterans were in prison for sexual offences than the general population.

Table 10 Number in prison per 100,000 for veterans and for the general population in the UK, males aged 18-54 years (excludes ex-reservist forces)

	Number in Prison per 100,000 Population		Ratio of general population to veteran population		
	General Population	Veteran Population	Age Adjusted Ratio	95% LCL	95% UCL
Overall	496.3	298.4	1.43	1.37	1.49
Burglary	53.4	13.2	3.23	2.62	3.98
Fraud/Forgery	11.6	3.8	3.06	2.07	4.72
Theft/handling	19.9	7.2	2.33	1.75	3.11
Motoring	5.9	2.3	2.07	1.26	3.7
Drug offences	71.7	32.7	2.05	1.79	2.35
Robbery	62.2	23.8	1.79	1.53	2.1
Violence against the person	154.6	100.6	1.16	1.07	1.25
Sexual Offences	51.5	63.1	0.87	0.79	0.96

Source: DASA 2010

4.1 Estimates of the number of men in Sussex prisons with a service history

There are two prisons located in Sussex, HMP Ford in Arundel, West Sussex and HMP Lewes in East Sussex. The populations of these two prisons differ. HMP Ford is a Category D establishment with an emphasis on resettlement, converted to an open prison in 1960. The latest available figures on capacity report that there were 557 offenders as of 5 August 2008. The offenders in HMP Ford have less than two years left to serve and have generally been assessed as low risk, due to the nature of their offences and their low risk of

[80] Defence Analytical Services and Advice (DASA). *Estimating the proportion of prisoners in England and Wales who are ex-Armed Forces - further analysis.* September 2010

absconding. HMP Lewes is a Category B prison built in 1853, receiving remand and convicted male prisoners, mainly from East and West Sussex Courts. The latest available figures on capacity report that was capacity for 742 men in 2012. HMP Lewes has a population with needs associated with drug and alcohol use and anger management, and has a higher turnover due to prisoners being on remand and unconvicted.

Using the DASA analysis and applying to the prison population across Sussex, this would mean around 20 men in HMP Ford and around 25 men in HMP Lewes at any one time have a service history (although the DASA estimates do not include reservists so the true figure could be higher).

4.2 The Howard League for Penal Reform into former Armed Service Personnel in Prison[81]

The inquiry of the Howard League for Penal Reform into former Armed Service personnel in prison was launched on Armistice Day 2009 (published 2011), with the remit of better understanding the links between armed services and offending in order to reduce offending in ex-servicemen and to better meet the needs of offending ex-servicemen. The Howard League report that the issue of offending is confined to ex-servicemen almost exclusively, rather than ex-servicewomen.

Comparison between the general prison population and those with a service history indicate that ex-servicemen are older than the general prison population:-

- 51% of ex-servicemen in prison are over the age of 45 years
- 29% of ex-servicemen in prison are over the age of 55 years
- 9% of the general prison population are aged 50

Key findings from the Howard League Inquiry:-

- Making the transition to civilian life without the discipline and structure of relationships and the security of accommodation can be a challenge. Resettlement services are available, focussing on housing, education, employment and finances but often ex-servicemen neither recognise the need for help, nor feel able to ask for help.
- The proliferation of voluntary sector agencies and charities supporting ex-servicemen causes confusion for those seeking help
- It is estimated that there is a delay of around 10 years between leaving the Armed Forces and starting a custodial sentence, which accounts for the veteran prison population being older than the general prison population.
- Compared to the general prison population, the veteran prison population are more likely to be imprisoned for sexual offences.
- No evidence was found to support any hypotheses about links between PTSD and serving in Iraq or Afghanistan

[81] Howard League for Penal Reform *Report of the Inquiry into Former Armed Service Personnel in Prison* http://www.howardleague.org/fileadmin/howard_league/user/pdf/Veterans_inquiry/Military_inquiry_final_report.pdf (accessed 9 February 2012)

- Social isolation and exclusion, alcohol, and financial problems are drivers for offending in the veteran population, and the same drivers exist in the general prison population. Similarly, offending behaviour tends to be linked to socioeconomic disadvantage, which is in turn magnified by a combination of low educational attainment, family deprivation, drug and alcohol abuse, homelessness and poor health. These communities are those from which infantry recruits are often drawn.

The Howard League Report identifies three categories of overlapping vulnerabilities:

- those who had experienced traumatic and difficult lives during childhood or adolescence, and had witnessed or suffered extreme violence, some had been in local authority care and may have been involved in criminal activity and drug or alcohol use prior to joining the Forces
- those who experience difficulties, often related to mental health issues, whilst in military service and these problems may have lead to their discharge and continued to cause problems after discharge.
- those who experience post-Forces problems, often after having had successful careers in the Armed Forces, but who experience problems adjusting to civilian life

Needs assessment recommendations:-

- Better identification of veterans in the criminal justice system
- Extension of the Veterans in Custody scheme, Prison In reach delivered by a Veteran Liaison Officer linking the veteran to the charity best able to provide assistance on release
- Consider using a similar approach to schemes that divert offenders away from custody and into treatment so that at the point of arrest, offending ex-servicemen can be signposted to assessment and support services

4.3 Example of good practice

The Veterans in Prison Association (VIPA) was founded by two members of HM Prison Service. It is an independent organisation based at HMP Parkhurst, Isle of Wight, operated by staff in a voluntary capacity. The core aim of VIPA is to reduce re-offending and in turn the number of victims, by rehabilitating the veterans who are currently in the Criminal Justice System and to reconnect them with the positive aspects of their past while serving in the Forces (http://www.veteransinprison.org.uk/about.html).

4.4 Homeless Veterans

Evidence on the level of homelessness amongst the veteran community is patchy. RBL undertook a review of the evidence[82]:

- In relation to street homelessness, a number of surveys have been undertaken in London to establish the service history of people sleeping rough or staying in hostels. Surveys in the late 1990s found up to 25% of people sleeping rough had been in the armed forces at some time. Subsequent surveys have found the percentage to be approx 6% - 12%. Although a reduction, which may in part be to

[82] Royal British Legion *Literature review: UK veterans and homelessness* (accessed online February 14th 2011)

improved resettlement provision, this would still mean that military veterans are over represented in the homeless population.

- RBL found that limited research had taken place outside of London; a study in Scotland in 2006 found 12% of rough sleepers having a service history.

- In 2007, the National Audit Office (NAO) carried out a survey of service leavers across the country; 5% stated that they had been homeless at some point, although response to this survey was low and the NAO definition was less defined and included people temporarily staying with friends.[83] This was however similar to sample survey of Local Authorities in November 2002 of 1,500 single homeless people,[84] this found that 5% of these people had a service history; although the sample was only drawn from people in contact with agencies.

- Although quantifying the level of homelessness is problematic, some of the research findings on the characteristics of homeless veterans are more consistent. The various studies reviewed by RBL found that the majority of homeless veterans served in the Army, as opposed to the Navy or RAF, while this reflects the higher manpower of the Army it may also relate to the greater likelihood of the Army to recruit from more socially disadvantaged, generally more at risk of homelessness.

- In relation to the routes to being homeless the 2007 NAO report examined the pathway from leaving the services and homelessness. Three routes were outlined: social isolation; substance misuse problems; and institutionalisation. Broadly however the routes to homelessness for military veterans are much the same as the general population. For many veterans who had successfully left the service and resettled into civilian life homelessness came many years afterwards and as a result of family/relationship breakdown or a financial crisis.

[83] National Audit Office *Leaving the Services* 2007

[84] Dandeker C, Thomas S, Dolan M, Chapman F, Ross J, *Feasibility Study On The Extent, Causes, Impact And Costs Of Rough Sleeping And Homelessness Amongst Ex-Service Personnel In A Sample Of Local Authorities In England Final Report* King's Centre for Military Health Research / University of Manchester 2005

5.0 Housing and Social Care Needs

Key points

- Guidance has been issued to local authorities to ensure that ex-service personnel can establish a “local connection” to help in making applications for housing
- The most vulnerable service leavers, at greatest risk of homelessness, are those with shorter service histories
- The Disabled Facilities Grant is available to veterans, with specific funding set aside for the most severely disabled ex-service personnel and the Royal British Legion are both major funders of housing adaptations and provide advocacy for people applying for statutory funding
- Ex-service personnel face additional barriers to home ownership and now have priority for Government funded home ownership schemes
- A Welfare Pathway to improve the co-ordination of advice and access to education, housing and employment services and benefits is being piloted
- There are a number of voluntary sector services and online resources available to the ex-service community, including Soldiers, Sailors, Airmen and Families Association (SSAFA) and the Royal British Legion (RBL)
- Greater use of Armed Forces welfare benefits and compensation as evidence of disability should simplify the application for wider community benefits, including the Blue Badge scheme and concessionary travel.

In the past, serving personnel and military veterans have suffered a number of disadvantages in attaining support from local authorities or accessing mortgage finance. Considerable effort has been undertaken to address these disadvantages. Under the Housing Act 1996, those making a housing application are required to demonstrate that they have a “local connection”. A local connection is normally established by one of three ways:

- residence in the area for six out of the last 12 months or three out of the last five years
- immediate family members resident in the area for the last five years
- employment in the area – full or part time

Following the Housing and Regeneration Act 2008 amendments to the Housing Act 1996, time spent in military housing is now considered as a local connection and local authorities have been issued with guidance to help military veterans evidence a “local connection”. This central Government guidance should now be in place across Sussex. Although homelessness amongst veterans has decreased over the last 20 years, some service leavers are at greater risk than others and may need extra support and tracking.

Progress has been made across Sussex in relation to Supporting People, a government programme launched in 2003 to help vulnerable people in England live independently and keep their social housing tenancies. Supporting People is run by local government and provided by the voluntary sector. For example in East Sussex, the client record form used by Supporting People providers has been modified so that from April 2012, service users' armed forces background status is recorded. From 2012/13, this data will be analysed and presented in the annual report, to enable strategic planning in relation to the needs of veterans. Whilst the data will be self-reported, even within such limits it is worthwhile to collect the data from those presenting for housing-related support.

5.1 Housing and housing adaptation

Good quality housing and, where required, housing support is vital for longer term health and well being. The Armed Forces Covenant[85] set clear expectations in relation to housing, the overarching covenant guidance states:

"In addressing the accommodation requirements of Service personnel, the MOD seeks to promote choice, recognising the benefits of stability and home ownership amongst members of the Armed Forces where this is practicable and compatible with Service requirements, and also that their needs alter as they progress through Service and ultimately return to civilian life. Where Serving personnel are entitled to publicly-provided accommodation, it should be of good quality, affordable, and suitably located. They should have priority status in applying for Government-sponsored affordable housing schemes, and Service leavers should retain this status for a period after discharge. Personnel may have access to tailored Armed Forces housing schemes or financial arrangements, depending on their circumstances, to help them in purchasing their own property. Those injured in Service should also have preferential access to appropriate housing schemes, as well as assistance with necessary adaptations to private housing or Service accommodation whilst serving. Members of the Armed Forces Community should have the same access to social housing and other housing schemes as any other citizen, and not be disadvantaged in that respect by the requirement for mobility whilst in Service."

This statement references four key areas of housing need, issues that have been identified for military veterans and dependents; some, but not all, are adversely affected by military service:

(i) Provision of good quality of housing during service (including quality of homes on military bases) – note that this relates to serving personnel and their dependents and is out of scope for this report
(ii) Evidencing a local connection to an area – required to access social housing, and homelessness assistance
(iii) Accessing supported and adapted housing to meet health / social care need as a result of an injury sustained during military service
(iv) The low level of home ownership amongst the ex-service community

5.2 Establishing a local connection

[85] Ministry of Defence. *The Armed Forces Covenant* 2011

Local housing authorities require people who wish to be allocated available social housing or receive homelessness assistance to establish a local connection.

In the past the mobility of service personnel meant that proving a local connection was difficult. Prior to the 2008 Housing Act, authorities did not have to accept military personnel having a local connection where "residence in an area is not of a person's own *choice* if it is the consequence of serving in the Armed Forces."[86] This acted to discriminate against military veterans and their families. This exemption was removed in 2008[87] and specific reference was made in relation to current and previous Armed Forces personnel:

> "(a) applicants who are serving in the Armed Forces and who are either employed or resident in the district will be able to establish a local connection with the district
>
> (b) when considering applications from serving or former members of the Armed Forces, who are not currently employed or resident in the district, the local housing authority will need to consider whether they have a local connection through previous residence in the district as a result of a former posting in the area while serving in the Armed Forces."

The Localism Act 2011 has subsequently removed the requirement for local authorities to have to consider *all* housing applications, with greater local discretion on who is and who is not accepted for housing allocations.

In January 2012, the Department for Communities and Local Government (DCLG) issued a consultation document[88] on allocating social housing and this set out some additional options in relation to Armed Forces personnel:-

- That Armed Forces and former service personnel should not be disqualified on residency grounds and that five years, from the date of discharge, would be an appropriate time limit for that restriction.

- The local authorities must draft allocation schemes which take into account the needs of serving and ex-forces personnel, examples included as part of the consultation:

  " - Provide preference to people who have recently left or those close to leaving;
  - Using the power to determine priorities between applicants in the reasonable preference categories, so that applicants in housing need who have served in the armed forces are given greater priority for social housing over those who have not;
  - Setting aside a proportion of properties for former members of the armed forces under a local lettings policy;
  - Existing guidance that injured personnel should be given high priority may be extended to all ex-servicemen and women."

[86] Housing Act 1996 Section 199
[87] Housing Act 2008 Section 315
[88] Department for Communities and Local Government *Allocation of accommodation: guidance for local authorities in England Consultation Document* 2012

Clearly, pressures on social housing stock mean that all groups, including veterans, may have problems accessing this provision but, depending on local allocations schemes adopted, it is unlikely that veterans would be at a greater disadvantage in terms of access to social housing, and their service status may act to enhance their rights in this area.

For people leaving the service there is some specialist support available providing advice and also transition from service housing, including social housing provision. Specifically:-

- the Armed Forces Joint Service Housing Advice Office (JSHAO) provides advice on all housing options.

- The MOD Referral Scheme was established following the sale of some MOD housing to Housing Associations and for a period the MOD retained some nomination rights to those properties. Although nomination rights have ended, some places are still offered by associations. The scheme is open to people within six months of leaving the service. People don't require a "local connection" and the scheme is seen as a route into social housing for single leavers as well as families.

5.3 Homelessness assistance

The level of homelessness amongst veterans is believed to have declined over the last twenty to thirty years. In the main, this has been attributed to improved resettlement provision. However some veterans are known to be at a greater risk of becoming homeless:

- Of the services, homeless veterans are far more likely to be from the Army, reflecting a greater intake from disadvantaged communities
- Young leavers who have served less than four years, and/or are compulsory leavers have been also identified as being at a greater risk

The National Audit Office[89] made two recommendations in their 2007 report into resettlement provision for service leavers:-

> *"Recommendation 7:* The Department (*the MOD*) should further strengthen resettlement support for Early Service Leavers. In particular, it should:
>
> - monitor the resettlement outcomes of Early Service Leavers; and
> - ensure that all single Service Leavers are briefed on the additional support provided by SPACES and, where individuals consider their post-discharge plans are unsatisfactory, particularly where they put them at risk of homelessness or social exclusion, are offered referral to the organisation.
>
> *Recommendation 8:* The Department should identify which Service Leavers do not take up elements of resettlement support due to lack of awareness and take any necessary action to enhance the way it communicates the availability of such resettlement support."

SPACES (Single Persons Accommodation Centre for the Ex Services) are a nationwide specialist service to support single service leavers into good quality appropriate accommodation. Attention is focussed on the most vulnerable service leavers, as identified

[89] National Audit Office *Leaving the Services* (2007)

in the NAO report, leavers with shorter service history and supporting people irrespective of discharge reason.

5.4 Adapted housing to meet health / social care need

Disabled Facilities Grants (DFG) are available to people to help adapt their home to meet needs that have arisen from a change in health or a disability, for example to make a home wheelchair accessible, provide stair lifts, walk-in showers and so on. The grant is means tested, except where the grant is to meet the needs of a child under the age of 19. The maximum grant available is £30,000. Applications from ex-Service personnel and for people under the age of 20 are exempt from means-testing.

People can apply for a grant irrespective of whether they are home owners, private renters or in social housing and the grant is mandatory. Although the DFG framework and mandatory aspect of the grant applies across all tenures the main DFG budget cannot be used for funding adaptations to council homes, local authorities provide adaptations to their own housing stock through their Housing Revenue Account allowance

This Disabled Facilities Grant (DFG) is administered by the local housing authority, so in Sussex this is Brighton and Hove, as a unitary authority; the five district councils in East Sussex; and seven district councils in West Sussex.

Since 2008 central Government have set aside *specific* DFG funding to meet the needs of the most severely disabled ex-service personnel. In 2011/12, and again in the current financial year (2012/13), £1.5m was available for councils to bid for. Councils can claim back DFG costs for people who meet specific criteria. In 2010/11 Crawley was one of 16 councils across England to have been reimbursed under this scheme.

There are a several issues relating to DFGs, identified in a number of reports commissioned by DCLG[90]:

- the demand for DFGs is high and growing, irrespective of changes in allocation models, nationally the level of funding for DFGs is estimated to far lower (ten times lower) than would be required if all of those who are theoretically eligible under the current rules applied.
- existing allocations cannot anticipate localised demand for children with disabilities and ex-service personnel, these specific groups have been identified as representing low overall numbers but high costs.
- historically delays, often long delays, reported from referral to installation

In 2012 the Government stated[91] that the problems with DFG administration would be part of a wider review into social care and support. Outside of statutory provision, RBL are major funders of housing adaptations for veterans. In 2007 RBL spent £4m on adaptations,[92] almost three times the level of current DFG set aside funds for households not eligible for the statutory scheme. RBL also provide advocacy for people applying under for a DFG.

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[90] Departments of Health, Communities and Local Government and Education *Reviewing the Disabled Facilities Grant Programme* ODPM 2006

[91] House of Commons Library *Standard Note: SN/SP/3011 Disabled facilities grants (DFGs)* 2012

[92] Figure taken from the Royal British Legion – General Election Manifesto 2010

5.5 Low level of home ownership amongst the ex-service community

The ability to become an owner occupier has become increasing difficult for many people, including current and ex-service personnel. There is some evidence that the service community may face additional barriers to accessing financial and mortgage products given frequent overseas posting or living on bases which have non-standard postcodes which can affect credit scoring. This issue has been identified at national level and is being tackled through discussions with the financial sector and Royal Mail.

In relation to serving personnel, there are also discussions with mortgage providers on flexibility with mortgage terms to allow letting out of property during overseas postings without having to have “buy to let” mortgage terms.

In addition to improving access to financial products the Government has also given a commitment to prioritise members of the armed services for the FirstBuy scheme and to place “at the top of the priority list” for all other Government funded home ownership schemes.

It is intended that people will retain this priority level for 12 months after leaving the service and that in the event of death this priority can also be transferred to spouse or civil partner.

5.6 Social Care needs

Currently, eligibility for social care provision is assessed using the Fair Access to Care Services (FACS) framework. Assessment of need under this framework is broken down into four bands, Critical; Substantial; Moderate and Low.

East Sussex, Brighton and Hove and West Sussex, in line with the majority of English councils, have set their threshold of eligibility for adult social care at substantial and critical.

All people are assessed by the same criteria and there is no specific provision or reference made to military veterans in that framework.

5.7 Welfare pathways

In 2009, Kent County Council was chosen to pilot a new national initiative called the Welfare Pathway. The pathway aims to improve the co-ordination of advice and access to services for the Armed Forces community. This includes serving personnel and their families and veterans. Information is provided on a range of services, statutory and voluntary, generic and specialist services, ranging from education, employment, housing and benefits. The Pathway initiative is part of wider work to improve access to advice and services for the Armed Forces community, including a free phone national helpline, which acts to signpost callers to appropriate support.

Following the first phase of the pilot in Kent, additional pilots have been launched in Hampshire, North Yorkshire, Fife and Wigan. All these areas have strong military links and large numbers of serving personnel based in their authority. If the pilots are successful, further welfare pathways may be developed across the country.

5.8 Voluntary sector support

An existing service mapping exercise has been undertaken for the Surrey and Sussex area by Carolan Consultants in May 2011, this has been attached as Appendix 1.

Note this report wrongly states that there is no regular armed forces presence in Sussex. The Baker Barracks on Thorney Island is located within West Sussex.

The largest organisations supporting veterans are:

- **Soldiers, Sailors, Airmen and Families Association (SSAFA)**

SSAFA is a large organisation supporting serving personnel and veterans and families, both in the UK and overseas. They provide an extensive range of services including advice and information, providing accommodation for families to be close to a relative undergoing rehabilitation, supporting veterans and providing short breaks to children with disabilities.

- **Royal British Legion (RBL)**

The Royal British Legion (RBL) provides an wide range of support to veterans, and also supports serving personnel and dependents. RBL has an extensive network of offices and volunteers and also has a strong campaigning role promoting the welfare and rights of the ex-service community.

Online support portals for the service and veteran community

- **Veterans – UK**

This is described as a one-stop shop for veterans, bringing together support on issues such as service records, pensions and compensation, including access to the Service Personnel and Veterans Agency (SPVA).

5.9 Transport and mobility schemes

Recent changes to two key travel schemes with access administered by local authorities, have been introduced to ease the proof of eligibility to veterans already in receipt of Armed Forces Compensation or Disablement Pensions. These administration changes have acted to include Armed Forces benefits in the wider range of welfare benefits when considering eligibility. This should reduce the need for re-assessment / proof of entitlement.

- **(i) Changes to the Blue Badge Scheme**
  The Blue Badge Scheme enables drivers with severe disabilities or drivers of disabled passengers to park closer to where they want to go. Following a review of the scheme in 2011,[93] the scheme has undergone major changes in administration, in part to reduce abuse of the scheme. One of the main changes has been the wider use of Independent Mobility Assessments. Injured and wounded veterans have been exempted from these assessments and have continued automatic entitlement if they

[93] Department for Transport *The Blue Badge Scheme Local Authority Guidance (England)* 2011

are in receipt of specific Armed Forces Compensation / Disablement Pension payments.

- **(ii) Concessionary Bus Travel**
  The administration of concessionary bus travel schemes, providing free off-peak travel to older people and people with disabilities, has also been changed[94] to allow for automatic entitlement for veterans in receipt of specific compensations and disablement pensions.

[94] Department for Transport *Addendum to Guidance to Local Authorities on Assessing the Eligibility of Disabled People in England for Concessionary Bus Travel* 2011

6 The Community Covenant , Commemoration and Memorial

Key points

- Nationally, £30 million has been set aside to enable upper tier and unitary authorities to adopt a "Community Covenant" which aims to strengthen the relationship between civilian communities and the armed forces
- Maintenance of war memorials are often a key issue arising from consultation when veterans are asked about how they feel recognised and valued

The Community Covenant[95] scheme was launched by the Ministry of Defence in June 2011, intended to demonstrate mutual support between civilian communities and the armed forces, their families and veterans. Whilst this is not strictly within the scope of a health needs assessment there are links to the wider health and well-being agenda, promoting social cohesion and community engagement. The Community Covenant scheme aims to:

- to encourage local communities to support the Armed Forces Community in their areas, and vice versa;
- to promote understanding and awareness amongst the public of issues affecting the Armed Forces Community;
- to recognise and remember the sacrifices made by the Armed Forces Community; and
- to encourage activities which help to integrate the Armed Forces Community into local life.

There is £30m funding available nationally to support areas in adopting a Community Covenant. Across Sussex, the allocation is £50,000. Upper tier authorities in East and West Sussex and the unitary authority of Brighton & Hove have the lead responsibility for signing up to a Community Covenant and the Sussex Armed Forces Health Network is linked to each of these local authorities. The current status of the Community Covenant across Sussex requires clarification (May 2012).

The maintenance of war memorials, and ensuring that remembrance and commemoration is sustained nationally and locally, is raised by veterans themselves as an important issue.

In relation to war memorials, under the War Memorials (Local Authorities' Powers) Act 1923 (and its later amendments), local authorities have the power, though not a duty, to maintain, repair and protect war memorials. A detailed list of war memorials can be found on the National Inventory of War Memorials[96], a website supported by the Imperial War Museum. It is recognised that this will not include all memorials in the UK and people are encouraged to provide information to the inventory.
Guidance relating to the recording and maintenance of memorials is provided by the Department for Constitutional Affairs.[97]

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[95] Ministry of Defence *Community Covenant* 2011 http://www.mod.uk/NR/rdonlyres/4E9E2014-5CE6-43F2-AE28-B6C5FA90B68F/0/Armed_Forces_Covenant.pdf

[96] National Inventory of War Memorials http://www.ukniwm.org.uk/

[97] Department for Constitutional Affairs *War Memorials in England and Wales Guidance for Custodians* 2007

Appendix 1: Sussex Mapping Exercise: Improving Access to Psychological Therapy Services for Serving and Ex-Service Personnel and their families in Surrey and Sussex