Health needs assessment (HNA) of ex-Armed Forces personnel (‘Veterans’) in Halton

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FULL REPORT
FINAL: January 2014

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NHS Halton Clinical Commissioning Group (CCG)
Health needs assessment (HNA) of ex-Armed Forces personnel (‘Veterans’) in Halton

FULL REPORT - January 2014

Acknowledgements

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**APPENDICES**

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## Glossary of acronyms and abbreviations

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<th>Acronym</th>
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<td>AFCS</td>
<td>Armed Forces Compensation Scheme</td>
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<td>AFPS</td>
<td>Armed Forces Pension Scheme</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<tr>
<td>CJS</td>
<td>Criminal Justice System</td>
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<td>CPT</td>
<td>Cheshire Probation Trust</td>
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<td>DASA</td>
<td>Defence Analytical Services Agency</td>
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<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>FAMCASE</td>
<td>Families Continuous Attitude Survey</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HNA</td>
<td>Health Needs Assessment</td>
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<td>HWB</td>
<td>Health and Wellbeing Board</td>
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<td>JHWS</td>
<td>Joint Health &amp; Wellbeing Strategies</td>
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<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<tr>
<td>KCL</td>
<td>Kings College London</td>
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<td>KCMHR</td>
<td>Kings Centre for Mental Health Research</td>
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<td>MoD</td>
<td>Ministry of Defence</td>
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<tr>
<td>MV</td>
<td>Military Veteran</td>
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<tr>
<td>MV IAPT</td>
<td>Military Veterans Service Improving Access to Psychological Therapies</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<td>ONS</td>
<td>Office for National Statistics</td>
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<tr>
<td>PCT</td>
<td>Primary Care Trust (abolished March 2013)</td>
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<tr>
<td>PTSD</td>
<td>Post-traumatic Stress Disorder</td>
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<td>SPVA</td>
<td>Service Personnel and Veterans Agency</td>
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<tr>
<td>SSAFA</td>
<td>Sailors Soldiers and Airmen Families Association</td>
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<tr>
<td>VIS</td>
<td>Veterans Information Service</td>
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<td>WPS</td>
<td>War Pension Scheme</td>
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SUMMARY REPORT

CONTEXT & APPROACH

Background

A ‘rapid appraisal’ of ex-Armed Forces personnel (‘Veterans’1) health needs in Halton was commissioned in September 2013 by Halton Clinical Commissioning Group (CCG), to inform local commissioning intentions for 2014/15 and raise the profile of Veteran health needs locally.

A Veteran is “someone who has served in the Armed Forces for at least one day. There are around 4.5m Veterans in the UK2”. These men or women, who served as a ‘Regular’ or ‘Reserve’, can have quite different healthcare needs compared to the average citizen, due to their military service.

There has been a renewed interest in the duty of care the UK owes its Veterans, triggered partly by recent media coverage of conflicts in Iraq and Afghanistan. The local ‘Community Covenant’3 for Cheshire has shone a spotlight on local Veterans as a group who may have specific health needs. However there is very little local information relating to the health requirements of Veterans relevant to Halton service commissioning that is easily accessible.

In terms of policy drivers for change over the last five years, it is worth briefly highlighting two key documents. A cross-Government Command Paper4 was produced in 2008 that sought an end to 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. This led to the development of the 2011 Military Covenant5. Regarding healthcare for Veterans, the wording of the Military Covenant is clear: “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 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”.

The evidence-base on the health needs of Veterans in the UK has grown substantially in recent years. For example, Kings College London’s (KCL) specialist research centre, Kings Centre for Military Health Research (KCMHR), have published over 80 reports6 on military health (including Veteran health) since 2010. Mental health has been the focus for a considerable number of studies. In 2011, exploring the mental health needs of the Armed Forces deployed to Iraq and Afghanistan, the KCL study team found Veterans who did report mental health issues tended to be those who had not served for many years and often left early. Most recently, a report by pressure group Forces Watch titled ‘The Last Ambush? Aspects of mental health in the British armed forces’7 made national media headlines in October 2013 by asserting that the youngest and least educated of the Armed Forces are disproportionately vulnerable to post-traumatic

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1 The term ‘Veterans’ is used throughout this report for brevity, referring to ‘ex-Armed Forces personnel’ – whilst acknowledging that many ex-service personnel, especially younger people, do not associate themselves with the term Veteran.
2 Access here: http://www.nhs.uk/NHSEngland/Militaryhealthcare/Veteranshealthcare/Pages/Veterans.aspx
3 A voluntary statement of mutual support between a civilian community and its local Armed Forces Community, defined as Serving personnel, Veterans, and their families.
5 Access here: https://www.gov.uk/the-armed-forces-covenant
6 Access here: http://www.kcl.ac.uk/kcmhr/pubdb/
7 Access here: http://www.forceswatch.net/sites/default/files/The_Last_Ambush_web.pdf
stress disorder, with resistance to trauma increasing with age and level of education. Literature on the health needs of Veterans is summarised in the Full Report.

Most Veterans make the transition to civilian life without difficulty. When they leave service, the healthcare needs of Veterans are the responsibility of the NHS (and have been since 1948). For the great majority, this works well. However a significant minority struggle and have needs that differ from the general population, such as co-morbid or complicating conditions. Some may benefit from additional support to access services and make the transition as smooth as possible. Understanding the constituent parts of the Veteran community in Halton, defining their individual and specific needs, is critical for health and community service commissioners. For example, with further cuts in Ministry of Defence budgets likely as the austerity measures extend into 2018/19, and increasing reliance on a Reserve force that research suggests is more vulnerable to mental health problems, the potential rise in mental health needs among the future Veteran population is a distinct possibility in areas with large numbers of Reservists.

A myriad of support options for Veterans in Halton

Locally in Halton there are a myriad of third sector and not-for-profit support groups that have been established in the last few years, alongside more established national and regional ‘brands’ such as the Royal British Legion and Combat Stress, which deliver Veteran-specific care and support to the ‘Veteran community’. This has created a plethora of different approaches, interventions, philosophies and procedures – many of which impact on how a Veteran is able to seek advice and solutions to problems relating to health, wellbeing or wider determinants of health (such as poor housing). A diverse range of support options reflects the diverse range of people who are in the Veteran community (for example, needs vary according to age, gender, socio-economic classification, rank, combat history, etc) and can be seen as a positive feature – as long as the overarching service ‘offer’ in Halton is co-ordinated and clearly understood.

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Approach and report structure

A rapid appraisal approach was applied for this work, to deliver this health needs assessment (HNA) in the two month timescale. A participative, primarily qualitative method was adopted to yield an initial overview of this particular cohort and the specific health needs of Halton Veterans – focusing principally on perceptions of need and qualitative feedback. Key activities in this process were:

- Semi-structured interviews with staff, key stakeholders and personnel who work with Veterans across Halton.
- Recruitment of Veterans via a press release in the Halton media and local websites (including Halton Healthwatch\(^9\) and CCG web-pages\(^10\)), together with direct requests for service user ‘volunteers’ from support groups.
- One-to-one interviews with Veterans, to make comparison and triangulate the issues identified by other stakeholders and literature reviews.
- A secondary data collection exercise, requesting statistics from agencies relating to the population being studied.

Interviews with local service users (Veterans) and ‘strategic’ stakeholders were conducted, with perceptions of local health needs gathered from:

- **Ten strategic stakeholder interviews**, including representatives from local and regional support groups (including Runcorn Veterans Association, Sanctuary for Veterans, Halton Royal British Legion and Live At Ease), the 75 Engineer Regiment, the Council and a local general practitioner (GP).
- **Six interviews with Veterans** who are resident in Halton, including two ex-Reservists. Whilst all interviewees were male and white British, they were of a variety of ages and they served across many different decades of conflict – with service history ranging between three and 32 years. The two most elderly Veterans served in the 1950's/60's (interestingly, including one of less than 3000 surviving Veterans of nuclear tests conducted in the South Pacific), whilst the two youngest had experienced a period of intense combat in Iraq. All apart from one served in the Army (one was Navy).

Questions asked in interview covered the following themes:

- Local service provision relating to veterans health and any recent service changes.
- When/how/why veterans seek help.
- Use of health care and whether provision meets need.
- Quality of services.
- Health care prior to becoming a civilian and transition.
- Other health service improvement ideas.

Three reports have been produced:

- an eight side **Summary Report**, which provides context, an outline of the approach and spotlights the main recommendations that fall out from the findings of the study.
- a **Full Report**, split into three main chapters. Following on from the context and approach (Chapter 1), a literature review of health needs of Veterans is summarised (Chapter 2), prior to the presentation of local findings from the needs assessment and overview of service provision (Chapter 3).
- a supporting **Appendices**, that includes more detail on the stakeholders, outline interview results and the ‘proforma’ questionnaire templates / research resources used in the fieldwork.

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KEY FINDINGS & RECOMMENDATIONS

The remaining pages in this section of the report outline recommendations for action together with supporting narrative around key findings that have emerged from the Halton health needs assessment of Veterans conducted in Autumn 2013.

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<tr>
<th>Key Findings</th>
<th>Halton-specific Recommendations</th>
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<td><strong>H1. Defining the size of the local Veteran community</strong></td>
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<td>➢ There is a dearth of locally-relevant official statistics. In the absence of a single reliable dataset, the main source of regional and sub-regional estimates remains the 2007 estimates published in an NHS Wirral report in October 2011 (and refreshed in January 2014), that reveal:</td>
<td></td>
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<td>o around 200,000 Veterans are aged under 65 in the North West;</td>
<td><strong>H1.1 Scope and request external costs for robust estimates of local Veteran populations (and families) – if possible in consortia with other Cheshire/Merseyside areas.</strong></td>
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<td>o 3,406 Veterans are estimated to be aged under 65 in Halton (6,412 Veterans of all ages are Halton residents).</td>
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<td>➢ To fill the void, local support agencies and charities have generated their own estimates of Veterans (and the wider population that includes family members of Veterans, in some cases), by extrapolating or apportioning often dated statistics. The result is a confusing mass of unofficial estimates.</td>
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<td>➢ In tandem with putting pressure on the Defense Analytical Services Agency (DASA) to release local authority level statistics, commissioners should consider the merits of procuring a local population model, asking Experian and other similar consultancies to scope and cost for the provision of Veteran population estimates that use a robust methodology and can withstand external scrutiny. A Cheshire-wide approach might generate procurement cost savings, if County-wide demand exists for this type of population data.</td>
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<td><strong>H2. Service use and needs - recording of Veteran status on systems</strong></td>
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<td>➢ As mentioned previously, not being able to accurately gauge the scale of the population is one hindrance to any commissioning plans – another is the ability to track service use. Where systems are already in place to record Veteran status (for example, the efforts already put in to use ‘Read Codes’ in GP surgeries, and the recording of Veteran status by Cheshire Probation Trust (CPT) staff when dealing with offenders), a renewed impetus is needed to encourage recording, so as to:</td>
<td><strong>H2.1 Ensure that regular service-use monitoring statistics from partner agencies are fed back to commissioners – for example, statistics on the use of the GP Read Code “History Relating to Military Service: Xa8Da”</strong></td>
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<td>o Keep consistent record of the numbers, to inform future strategic and resource decisions.</td>
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<td>o To support the signposting of Veterans to the ex-service community agencies, charities and specific health referral options, like Military Veterans Service Improving Access to Psychological Therapies (MV IAPT).</td>
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<td>➢ Of course, an important consideration is how to make the recording process more effective and gain buy-in from those recording? Explaining why Veterans should be treated as a ‘special group’ is an important message to get right – with strategic stakeholder interviews revealing a general confusion and scepticism about this perceived preferential treatment.</td>
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- It should be noted that the use of recording systems, including Read Codes, is limited not only by awareness of the existence of the system and use by staff, but critically by the willingness of Veterans to identify themselves as such. When asked if they disclose their service history to GPs and other health professionals, several Veterans said they did not want to be seen as ‘jumping the queue’ or different.

- Registering leavers directly with primary care providers was suggested by a handful of strategic stakeholders. However, the Veteran interviewees revealed that GP registration didn’t appear a problem (albeit with the usual caveat that it was a very small group interviewed), so there is not enough evidence to warrant this as a recommendation.

### H2.2 Working with the Cheshire Community Covenant leads, support GPs in identifying Veterans (and their families), including delivery of awareness raising sessions at Protected Learning Times.

### H3. Community Covenant - further awareness-raising and promotion of the benefits locally

- Strategic stakeholders interviewed were aware of the local Community Covenant, but many were critical of how widely publicised the benefits were being broadcast across Halton, and most think more needs to be done. Veterans interviewed hadn’t heard of the Covenant or were aware of its implications.

- In particular, in 2014 the Covenant ‘message’ needs to be passed to Veterans in new and creative ways, to highlight the benefits of disclosure of their service history to agencies when health conditions may be related to their military service. Families have a critical role to play – wives and partners of Veterans were referred to in several interviews as being key success factors in linking health services to Veteran needs, overcoming a common reticence to seek attention. Marketing and communication messages have to be targeted at the families as well as Veterans.

- The Community Covenant has funds attached to it – in the form of the £30 million Community Covenant Grant scheme, which is assigned by a regional bid review team and allocates sums from £100 to £250,000. Local third sector and not-for-profit support groups, in particular, need further guidance on how to navigate the bidding process. It is recommended that the equivalent of an Invitation To Tender ‘Bidders Day’ is held, when successful and unsuccessful bidders could be asked to share their experiences, and practical advice distributed on how best to access funds.

### H4. Mental health

- Only a minority of Veterans experience mental health and social problems, yet these Veterans constitute an important minority. And there are particularly vulnerable groups. For example, a growing research base identifies young infantrymen as being particularly at risk to mental health problems. This may relate to both pre-service vulnerability as well as exposure to high levels of direct combat. In addition, the mental health effects of warfare can be delayed, sometimes for many years (for example, delayed-onset post-traumatic stress disorder PTSD), contributing to the higher prevalence figures for veterans returning to civilian life.

- Access to appropriate mental health services is important. Some Veterans interviewed were reluctant to talk about mental health issues and reticent to access care. Comparative research
suggests that this hesitancy appears more pronounced among those with a service background than the general public. Nationally, the Service Personnel and Veterans Agency (SPVA) as well as ex-service agencies and charities including Combat Stress, the Royal British Legion and the Sailors Soldiers and Airmen and Families Association (SSAFA), are trained to signpost to relevant health services. Local and regional agencies (like Sanctuary For Veterans, Runcorn Veterans Association and Live At Ease) also support Veterans in finding adequate care options, however each may have their own approach and philosophy – particularly towards mental health problems. The approach of smaller ex-service agencies is sometimes governed by their own members service experiences rather than specialist expertise or medical training.

- The present mix of support options available to local Veterans with mental health problems appears to meet a diverse range of needs, with the combination of clinical expertise via MV IAPT and more general ‘wrap-around’ support through Live At Ease being a popular and tested combination. Commissioners should ensure that post-2014 IAPT services, for example, are effective for veterans from a range of circumstances.

- Finally, the mental health of Reservists and early leavers, in particular, need to be explored more fully. Research suggests Reservists are particularly at risk of mental illness, as many return to normal life without the support structures in place at a base and without the peer support of others who have gone through the same experience. An interview with a Halton Veteran diagnosed with PTSD highlights the often unique pressures that Reservists are under – in this particular case, trauma experienced on a back-to-back tour of Iraq was exacerbated on return to the UK when difficulties accessing specialist support outside of the North West were pivotal in him ‘falling through the cracks’ in terms of the support offered by the Army. The ‘pathway’ via Live At Ease and referral to MV IAPT is an important support mechanism for him.

H4.1 Local commissioners should work closely with organisations such as MV IAPT to ensure that emerging needs of Halton Veterans are included in designing services in 2014/15, as localised evidence emerges in coming months.

H4.2 Further assessment of the specific needs of sub-groups of Veterans, including Reservists, is required in 2014.

H5. Veteran health and helpseeking behaviours – including alcohol misuse

- Health behaviours are often influenced by a Veterans experience in the Forces. For example, alcohol misuse was cited in interviews with the majority of Veterans as being a common way to relieve stress - a key ingredient for group bonding during social events, with binge drinking playing a part in many Veterans ‘decompression’ following a period of deployment. Add in the relative cheapness of alcohol when serving abroad, and alcohol misuse is an important element in Veteran health checks.

- Similarly, helpseeking behaviours can be linked back to how Veterans were accustomed to interact with health services when in the Armed Forces. Interviewees were asked when and why they would seek help, and the majority believed they were quite open when it came to talking about and seeking help for health concerns. However several remarked on being most comfortable when they were receiving medical attention from someone with an experience of the services or at the very least someone who “could speak their language”. Research suggests many Veterans prefer to see clinicians with an understanding of and sensitivity towards military life and culture.

H5.1 With the help of the local Veteran support groups, target an alcohol awareness campaign at Veterans, testing the effectiveness of the message with a range of age groups.

H5.2 Ensure training in veteran-sensitive practice is available to health professionals, to ensure practitioners in both Runcorn and Widnes have knowledge of working with Veterans and their needs.
H6. Veterans in the criminal justice system

- Referrals of Veterans from the three Cheshire custody suites via Live At Ease (and, in turn, onto local service charities and groups, or regional expertise such as MV IAPT) became fully active at the start of October 2013. At the time of writing 13 referrals of Halton residents who are ex-Armed Forces have been made since then, and two of those were interviewed for this project.

- The present mix of health ‘pathway’ options available to the local Veteran offender cohort appears to meet a diverse range of needs – i.e. specialist health referral pathways where needed (for example, clinical support via MV IAPT) together with more general ‘wrap-around’ options for the wider determinants of health (for example provided by agencies like Live At Ease).

H6.1 Whilst involving relatively small numbers, the innovative referral system from the custody suites (including Runcorn), initiated and maintained by Live At Ease, should be extended if possible into 2014, to ensure an early intervention stage is not lost for this cohort.

H7. Diversity – increase understanding to target commissioning effectively

- The make up of the Veteran community is complex and heterogeneous. Unfortunately the depth interviews in this study only provided insight into the needs of male, white British Veterans. This was not the outcome of any selection bias – most interviewees came forward after a press release. Future exercises need to include a more diverse range of interviewees – to reflect, for example, specific gender-related health issues.

- Segmenting the diverse Veteran community, to adequately target health promotion and interventions, is recommended. The term ‘Veteran’ relates to all ex-military servicemen and women, 60 per cent of whom are aged over 65 years old - largely explained by the high number conscripted during World War Two and National Service. Accounting for such a high proportion of that generation, elderly Veterans can hardly be described as having distinctive health needs. Future health needs assessments should focus on more recent veterans - the group with the most distinctive needs, and where interventions and alterations to services are most likely to have a beneficial impact on long-term health outcomes.

H7.1 Future needs assessments need to include a more diverse range of interviewees – to reflect, for example, gender issues.

H7.2 Future research should focus on more recent veterans - the group with the most distinctive needs, and where interventions are most likely to have a beneficial impact on long-term health outcomes.

H8. Clarifying the ‘support offer’ from support groups

- Locally, there are a myriad of third sector and not-for-profit support groups, theoretically accessible to all Halton Veterans seeking advice and ultimately solutions to problems relating to health, wellbeing or wider determinants of health (such as poor housing). However a clearer ‘offer’ from each is required to highlight specialisms and areas of strength, particularly relating to health issues, to aid more effective signposting / referral.

- Whether these community support structures can present a coordinated network of options to meet the health and wellbeing needs of Veterans is questionable – at present there is a rather disjointed system of support available, with duplication in places. Without effective signposting to expert advice and services, there is a danger that some support groups will try to extend beyond their expertise ‘comfort zone’. One interviewee, for example, alarmingly stated “if someone comes to me and says they have PTSD I just say ‘you’ve not got PTSD – don’t be daft’ and we move them onto other things”.

H8.1 If resource allows, map out the specialisms and areas of strength in the local Veteran support groups and networks, and broadcast the findings.
CHAPTER 1: CONTEXT AND APPROACH

1.1 Background

1.1.1 A ‘rapid appraisal’ of ex-Armed Forces personnel (‘Veterans’) health needs in Halton was commissioned in September 2013 by Halton Clinical Commissioning Group (CCG), to inform local commissioning intentions for 2014/15 and raise the profile of Veteran health needs locally.

1.1.2 A Veteran is “someone who has served in the Armed Forces for at least one day. There are around 4.5m Veterans in the UK”\(^{11}\). In addition to the estimated 4.5 million Veterans in the UK, there are an estimated 5.4 million adult spouses, partners, widowers and child dependants. Given the Office of National Statistics (ONS) population estimate for the UK stands at 63.7 million\(^{12}\), then this represents approximately one in six of the UK population who have close links to a Veteran or ‘Veteran community’.

1.1.3 In terms of recent policy and legislative context, a good starting point is the cross-Government Command Paper produced in 2008, that sought an end to any disadvantage faced by armed service personnel and to provide better support and recognition for those wounded serving their country. This led to the development of the 2011 Military Covenant and culminated in a number of legislative initiatives to ensure that support for Veterans remains a focus, including: ‘No health without mental health’\(^{13}\), the NHS Mental Health Strategy for England released in 2011, that includes specific provision for Veterans; the Armed Forces Act 2011\(^ {14}\), an Act to continue the Armed Forces Act 2006, which included an annual duty to report on progress against the Military Covenant to Parliament (including health issues); and the Health & Social Care Act 2012\(^ {15}\), that includes a duty on NHS England to commission prosthetic services for Veterans, whilst spelling out that CCGs will be responsible for commissioning health services for Veterans or reservists (when not mobilised).

1.1.4 A consistent message from these policy documents is that those members of the community who served as a ‘Regular’ or ‘Reserve’ can have quite different healthcare needs compared to the average citizen due to their military service. Locally the Community Covenant for Cheshire has shone a spotlight on local Veterans as a group who may have specific health needs. Health is one of the five ‘recurring themes’ that Covenant signatories have identified as being a priority element of a Veterans life that partnership working can have a significant and positive contribution upon. The health needs of Veterans is also entwined in other Covenant themes – for example, the link between mental health and homelessness is recognised as important; similarly “being in work is generally good for health and wellbeing, while being out of work can lead to poorer physical and mental health”.\(^ {16}\)

1.1.5 Whilst concerted efforts have been made at a national and local level to highlight potential differences in the healthcare needs of Veterans compared to

\(^{11}\) Access here: [http://www.nhs.uk/NHSEngland/Militaryhealthcare/Veteranshealthcare/Pages/Veterans.aspx](http://www.nhs.uk/NHSEngland/Militaryhealthcare/Veteranshealthcare/Pages/Veterans.aspx)


\(^{13}\) Access here: [https://www.gov.uk/government/publications/the-mental-health-strategy-for-england](https://www.gov.uk/government/publications/the-mental-health-strategy-for-england)


\(^{15}\) Access here: [http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted](http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted)

the general population, very little supporting local information exists relating to the health requirements of Veterans relevant to Halton service commissioning.

1.2. Overview of HNA process

1.2.1 Health needs assessment (HNA) is a systematic process which reviews the health issues affecting a population. “The process aims to improve health, and reduce health inequalities, by identifying local priorities for change and then planning the actions needed to make these changes happen”. There are a number of approaches to HNA. These can be applied singly or in combination to describe and explore health needs, their underlying causes and impacts. Where little routinely collected data is available, qualitative research methods can be employed to generate primary intelligence.

1.2.2 It was decided to adopt a rapid appraisal approach for delivery – a decision driven by a range of practical delivery factors, including the time constraints in delivering a HNA within two months and a lack of basic prevalence and epidemiological inputs available on health conditions affecting this population cohort. A participative method was adopted, focusing on perceptions of need.

1.2.3 In devising an approach to interviewing Veterans, this study targeted two main groups:

- Ex-‘Regulars’ – men and women who served as members of the Naval Service (Royal Navy and Royal Marines), Army or Royal Air Force.
- Ex-‘Reservists’ – men and women who had been Volunteer Reservists (who form the Royal Naval Reserve, Royal Marine Reserve, Territorial Army and the Royal Auxiliary Air Force) and Regular Reservists, (who comprise the Royal Fleet Reserve, Army Reserve and Royal Air Force Reserve).

1.2.4 The scope of the study did not allow for engagement with the wider Veteran community, that includes dependents (dependent spouses/partners, dependent divorced/separated spouses, dependent widow(er)s and dependent children) and other immediate family (which can where appropriate extend to parents, unmarried partners and other family members). Recommendations in this report include a call to expand the coverage of future research to take in the needs of the wider Veteran community in Halton.

1.3 Aim and objectives

1.3.1 Participants in the study were sent an introductory email in October 2013 outlining the purpose of the research, explaining that “NHS Halton CCG has commissioned the above to inform local commissioning intentions for 2014/15, and raise the profile of Veteran health needs locally, by formalising the description of their needs”.

1.3.2 Through meshing together existing evidence on Veteran health needs with findings from fieldwork, the study sought to:

- Summarise existing evidence on Veteran health needs;
- Integrate findings from fieldwork undertaken with Veterans and strategic stakeholders, to present an holistic overview of perceived need;
- Describe key characteristics of need for the Veteran population relevant to commissioning health services;
- Recommend actions for improvement.

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18 An approach outlined in more detail in this ‘toolkit’: [http://courses.essex.ac.uk/hc/hn915/Mid%20Hampshire%20PCT%20HNA%20Toolkit.pdf](http://courses.essex.ac.uk/hc/hn915/Mid%20Hampshire%20PCT%20HNA%20Toolkit.pdf)
1.4 Project steps

1.4.1 In terms of the process adopted, a straightforward four stage approach was used to bring together as much evidence and intelligence as possible in the timescale on the health needs of Veterans across the NHS Halton footprint.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Tasks include:</th>
</tr>
</thead>
</table>
| Stage One: **Mapping and scoping** | • Conducting literature reviews, summarising relevant findings from other HNAs, other local studies and policy documents;  
 • Assessment of available relevant data sources;  
 • Mapping of service provision / support groups;  
 • Preparation of fieldwork ‘proformas’ and interview resources |
| Stage Two: **Fieldwork – recruitment and consultation** | • Recruitment of Veterans via a press release in the local Halton media, together with direct requests for service user ‘volunteers’ from support groups.  
 • Acquiring intelligence from stakeholders (including Veterans themselves) to identify priority health issues, barriers to accessing services and barriers to delivering services. |
| Stage Three: **Analysis** | • Collation & analysis of available supporting data and statistics;  
 • Analysis of data obtained from stakeholders, linking findings from existing studies/HNAs to the primary evidence gathered. |
| Stage Four: **Report and Presentation** | • Drawing conclusions from data, summarising key findings and drafting recommendations;  
 • ‘Consultation Draft’ circulated December 2013 for comment, and final version by January 2014.  
 • Presentation to a strategic meeting in winter 2013. |

1.4.2 A purposive sample was selected and assessed following review with the client project lead at project inception. The two strands of fieldwork revolved around interviews with local service users (Veterans) and ‘strategic’ stakeholders, with perceptions of local health needs gathered from:

- **Ten strategic stakeholder interviews**, including representatives from local and regional support groups (including Runcorn Veterans Association, Sanctuary for Veterans, Halton Royal British Legion and Live At Ease), the 75 Engineer Regiment, the Council and a local general practitioner (GP).
- **Six interviews with Veterans** who are resident in Halton, including two ex-Reservists.

1.4.3 Questions asked in interview covered the following themes:

- Local service provision relating to veterans health and any recent service changes.
- When/how/why veterans seek help.
- Use of health care and whether provision meets need.
- Quality of services.
- Health care prior to becoming a civilian and transition.
- Other health service improvement ideas.

1.4.4 The Appendices provides a list of stakeholders targeted, anonymised Veteran interview responses, the proformas used in interviews, and other research resources to support consistent repetition of the study in years to come.
CHAPTER 2: OVERVIEW OF RESEARCH INTO VETERAN HEALTH

2.1.1 Entry into the Armed Forces requires individuals to demonstrate adequate physical and mental strength to meet the demands of the role. Once in the Forces, regular medicals and fitness tests ensure serving personnel keep in good health - however, on leaving, the health needs of individuals is not as closely monitored or widely known.

2.1.2 The evidence-base on the health needs of Veterans in the UK has grown substantially in recent years. For example, Kings College London's (KCL) specialist research centre, Kings Centre for Military Health Research (KCMHR), have published over 80 reports\(^{19}\) on military health (including Veteran health) since 2010. Mental health has been the focus for a considerable number of studies.

2.1.3 This section of the report outlines physical and mental health issues that have been identified in published research reports in the last five years since the cross-Government Command Paper was released.

Merseyside and Cheshire research

2.1.4 A recent HNA report covering the Cheshire and Merseyside\(^{20}\) ‘footprint’, published by the Liverpool Public Health Observatory in March 2013, begins to fill a major gap in the evidence-base relating to the needs of Veterans in the local sub-region, and provides valuable context for this study - outlining some of the health-related ‘pros and cons’ of service in the Forces, thus:

- “There are health benefits from serving in the armed Forces. Armed Forces personnel need to be physically fit and benefit from regular exercise and from regular medical checks. A high proportion of UK recruits come from more deprived backgrounds, and have limited education and work prospects, which makes comparisons with the population as a whole more difficult. However, Service in the armed Forces may therefore have a positive impact on the health of individuals who might otherwise have had a poorer diet, limited exercise, and been at risk of unemployment and criminality.

- However, Service in the military is a physically dangerous job – a study conducted by the Royal College of GPs found that the risk of death for those in the Army was 1 in 1000, for example, which is 150 times higher than for the population as a whole, although this rate is lower for those in the Navy and the RAF. Conflicts in Iraq and Afghanistan have also increased the risk of injury that results in amputation. In addition, there is some evidence, including a study by the RBL, that ex-Armed Forces personnel aged under 65 were more likely to report long term health problems than their peers in the general population”

2.1.5 Whilst providing a comprehensive overview of health issues at a sub-regional level, there is little locally-specific information or statistics for local commissioners to extract from this report relating to the needs of Halton Veterans - other than population data sourced from NHS Wirral reporting in 2011 that estimates the St Helens and Halton Veteran population aged under 65 (data referred to in section 3.1 of this report).

\(^{19}\) Access here: http://www.kcl.ac.uk/kcmhr/pubdb/

2.1.6 A summary of key facts from this report have been included in the 2013 Halton Joint Strategic Needs Assessment (JSNA) Summary Document\(^\text{21}\), replicated in the graphic that follows:

**Health needs assessment for ex-Armed Forces personnel (March 2013)**
- Estimated 42,659 ex-Service personnel in Merseyside, aged under 65.
- A high proportion of UK recruits come from more deprived areas.
- Service in the armed Forces may have a positive impact on the health of individuals who might otherwise have had a poorer diet, limited exercise, and been at risk of unemployment and criminality.
- However, a study conducted by the Royal College of GPs found that the risk of death for those in the Army was 1 in 1000, 150 times higher than for the population as a whole (rate is lower for those in the Navy and the RAF).
- Conflicts in Iraq and Afghanistan have increased the risk of injury that results in amputation.
- Some evidence that ex-Armed Forces personnel aged under 65 were more likely to report long term health problems than their peers in the general population.
- Some evidence that alcohol misuse is a problem.
- Stress and common mental health problems may also be a feature, although many personal do not ask for help.
- Younger members of the armed Forces returning from duty were more likely to commit violent offences than the rest of the population. 20% of males aged under 30 had been convicted with violence, compared with 6.7% of civilians.
- King’s College London has recently begun a large scale study, looking at the impact of military Service upon families.

*Graphic source note: Summary of University of Liverpool HNA findings for Cheshire and Merseyside, as summarised on p10 of 2013 JSNA Summary document.*

**National research findings**

2.1.7 Looking beyond the Cheshire/Merseyside sub-region, whilst many studies suggest that the overall health of the Veteran population is comparable to that of the general population, several pinpoint notable differences.

2.1.8 Mental health has been the focus for a considerable number of national and international studies. For example, a large percentage of the 80-plus reports released by KCL since 2010 delve into psychological and mental health issues. Findings from their 2011 study into personnel deployed to Iraq and Afghanistan reveal:
- Veterans who reported mental health issues tended to be those who had not served for many years and often left early.
- There were no major differences in the psychological health of armed forces personnel who have been deployed to Iraq and Afghanistan compared to those who haven’t.
- Most who had been deployed did not return with a mental health issue, but those who do tend to display symptoms of anxiety, depression or alcohol misuse.

2.1.9 A recent report by pressure group Forces Watch titled *‘The Last Ambush? Aspects of mental health in the British armed forces’*\(^\text{22}\) made national media headlines\(^\text{23}\) in October 2013 by asserting that the youngest and least educated
of the Armed Forces are disproportionately vulnerable to post-traumatic stress disorder (PTSD), with resistance to trauma increasing with age and level of education.

2.1.10 A common attitude of service personnel when it comes to health (and notably mental health) is the need to ‘soldier on’, and this reticence to access support can remain when back in civilian life. This often leads to individuals not asking for help until at crisis point, particularly for mental health issues – given the perceived stigma associated with admitting the need for help with these issues. The 2010 Report ‘Fighting Fit: a mental health plan for servicemen and veterans’\textsuperscript{24} (the ‘Murrison Report’) set out the Government’s commitment to the mental health of the Armed Forces and Veterans, leading to a commitment in the 2012 Mental Health Strategy to provide funding to ensure the best treatment possible is available for veterans.

2.1.11 In terms of physical health, when comparing the health of Veterans to the general population, research has found ex-Armed Forces personnel more likely to report a long-term illness, disability or long term condition than those who had not served. The main conditions reported by Veterans which were more prevalent than for the general population include musculoskeletal, cardiovascular, respiratory, sight and hearing problems.

2.1.12 A comprehensive literature review into mental health, psychological and social wellbeing, conducted as part of the independent evaluation\textsuperscript{25} of Military Veterans Service Improving Access to Psychological Therapies (MV IAPT), concludes that “the majority of veterans in the UK do not have any mental health problems. Of those who do, prevalence does not vary between veterans and civilians, where the most common symptoms are depression, anxiety, PTSD and substance misuse, including alcohol and drugs”. However perhaps most relevant to commissioners of services is the assertion that “although veterans do not seem to experience poorer psychological and social well-being than the civilian population, their needs are specific to their military experiences and appear to require tailored assistance from support services”.

2.1.13 The remainder of this report highlights thematic, localised findings from an assessment of the health needs of Halton Veterans – beginning with a fundamental problem faced by commissioners, namely gauging the size of the population and their service use.

\textsuperscript{24} Access here: https://www.gov.uk/government/publications/fighting-fit-a-mental-health-plan-for-servicemen-and-veterans--2
CHAPTER 3: THEMATIC HNA FINDINGS

3.1 Demography

Key findings:

1. There is a dearth of locally-relevant official statistics. In the absence of a single reliable dataset, the main source of regional and sub-regional estimates remains the 2007 estimates published in an NHS Wirral report in October 2011, that reveal that
   - around 200,000 Veterans are estimated to be aged under 65 in the North West.
   - 3,406 Veterans are estimated to be aged under 65 in Halton (6,412 Veterans of all ages are Halton residents).

2. To fill the void, local support agencies and charities have generated their own estimates of Veterans (and the wider population that includes family members of Veterans, in some cases), by extrapolating or apportioning often dated statistics. The result is a confusing mass of unofficial estimates.

3. In tandem with putting pressure on the Defense Analytical Services Agency (DASA) to release local authority level statistics, commissioners should consider the merits of procuring a local population model, asking Experian and other similar consultancies to scope and cost for the provision of Veteran population estimates that use a robust methodology and can withstand external scrutiny. A Cheshire-wide approach might generate procurement cost savings, if County-wide demand exists for this type of population data.

3.1.1 The Cheshire Community Covenant states that: “The public health agenda recognises the Armed Forces community as an important demographic to address in terms of health inequalities and specific health behaviours and needs that are related to Service. Health refers to both clinical and non-clinical elements.”

3.1.2 Sourcing local statistics for this ‘important demographic’ is fraught with difficulties however. A fundamental problem that hampers service commissioners across the UK is not being able to accurately estimate the size of their local Veteran population, which in turn undermines efforts to judge whether service provision is adequately meeting need. There is no single reliable data source, and estimates of the overall Veteran population therefore vary greatly.

Present estimates

3.1.3 The ONS estimate that approximately three to five million veterans are currently estimated to be living in the community in England. Regionally, a report produced in October 2011 by NHS Wirral\(^\text{26}\), extrapolating ONS 2007 population estimates, reveals that:
   - “There are an estimated half a million Veterans living in the North-West.
   - The majority are aged 65-plus.
   - Around 200,000 are estimated to be aged under 65.
   - Around 20,000 of them have received an injury in service significant enough to warrant receipt of a War Pension Scheme or Armed Forces Compensation Scheme, which could indicate potential health and social care need”.

\(^{26}\) Access here: [http://info.wirral.nhs.uk/document Uploads/angela
denny/armed%20services%20Personnel%20Estimate%20NW%2007%2011.pdf)
3.1.4 That same report provides a local level estimate of the number of Veterans as being 8,870, however that figure covers both Halton and St Helens. A January 2014 update from the NHS Wirral team for this project, reflecting recently released Census statistics, apportions estimates accordingly: 3,406 Veterans are estimated to be aged under 65 in Halton (of the 6,412 Veterans of all ages who are Halton residents). However it must be noted that the estimation methodology deployed is crude.

3.1.5 In addition to dated ONS population estimates, there are other data sources that could indicate potential health need amongst the Veteran community – including Armed Forces Pension data, supplied by DASA. Statistics on the number of people in receipt of an occupational pension under the Armed Forces Pension Scheme (AFPS), the number in receipt of ongoing pensions under the War Pensions Scheme (WPS) and the number awarded compensation under the Armed Forces Compensation Scheme (AFCS) is summarised in the table that follows:

<table>
<thead>
<tr>
<th>Area</th>
<th>AFPS total</th>
<th>Recipients of ongoing War Pensions under the War Pension Scheme (WPS)</th>
<th>All AFCS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>All WPS</td>
<td>In-Service</td>
</tr>
<tr>
<td>England Total</td>
<td>283,496</td>
<td>119,740</td>
<td>10,815</td>
</tr>
<tr>
<td>Cheshire East</td>
<td>1,130</td>
<td>875</td>
<td>15</td>
</tr>
<tr>
<td>Cheshire West and Chester</td>
<td>1,785</td>
<td>920</td>
<td>75</td>
</tr>
<tr>
<td>Halton</td>
<td>465</td>
<td>465</td>
<td>5</td>
</tr>
<tr>
<td>Warrington</td>
<td>775</td>
<td>435</td>
<td>20</td>
</tr>
<tr>
<td>Knowsley</td>
<td>345</td>
<td>690</td>
<td>5</td>
</tr>
<tr>
<td>Liverpool</td>
<td>775</td>
<td>1,855</td>
<td>35</td>
</tr>
<tr>
<td>Sefton</td>
<td>925</td>
<td>1,165</td>
<td>16</td>
</tr>
<tr>
<td>St Helens</td>
<td>475</td>
<td>435</td>
<td>15</td>
</tr>
<tr>
<td>Wirral</td>
<td>1,285</td>
<td>1,200</td>
<td>30</td>
</tr>
</tbody>
</table>

Table source data: Taken from the latest update from DASA, for 2011/12.

3.1.6 There are huge caveats associated with using these datasets to estimate Veteran populations and need, including:
- The AFPS data is likely to underestimate the total number of Veterans as only those who complete at least two years of service are eligible for AFPS, and numbers for those who leave with less than two years service are not accessible.
- The WPS and AFCS datasets are made to Veterans injured during service (WPS for injuries prior to 2005; AFCS for those injured post 2005), and therefore give an indication of the Veterans with acute health and social care needs.
- Individuals can be in receipt of awards under more than one scheme simultaneously. DASA are currently working on an updated set of tables.

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where the AFPS, WPS and AFCS datasets will be merged to provide a single value for the known veteran population in a given location.

3.1.7 Local support agencies and charities have generated their own estimates of Veterans (and the wider population that includes family members of Veterans, in some cases). The result is a confusing mass of unofficial estimates.

**Future projections and demand for services**

3.1.8 Nationally, the Veteran population is projected to decline by around 50 percent between 2007 and 2027 due to re-organisation within the Armed Forces, population changes and a decline in the cohort that completed National Service. Every year approximately 20,000 UK personnel leave the Armed Forces, however the latest re-organisation within the Forces has also seen three tranches of redundancies, with over 11,000 personnel selected for redundancy in 2011, 2012 and 2013. A fourth tranche is expected to be announced in early 2014, whose main impact will be on the Army.

3.1.9 How many ex-Armed Forces personnel return to Halton is unknown, however as each tranche of redundancy is implemented, DASA will have access to postcode level data that could be aggregated to local authority level without jeopardising any data protection rules. Further lobbying of DASA is needed to free up more data on the Veteran population.

3.1.10 An example dataset that would be particularly relevant to healthcare commissioners relates to the Veterans Information Service (VIS). The 2013 Service Leavers Guide forewarns service personnel of VIS and how they will be contacted as follows: "Veterans, who initially require no assistance adjusting back into civilian life, do sometimes go on to experience difficulties. Dr Andrew Murrison MP’s ‘Fighting Fit’ report recommended that all veterans should be contacted 12 months after leaving Service to ensure that health monitoring of Service personnel continues after the end of their Service. The Service Personnel and Veterans Agency (SPVA) and the Department of Health are working together to implement an initiative known as the Veterans Information Service (VIS). Contact will be made with all UK based Veterans approximately 12 months after leaving Service”.

3.1.11 This contact is reliant on Veterans having recorded an e-mail or postal address on JPA (the Armed Forces Pay and Personnel Administration system for all Service personnel) prior to their discharge. They will then receive a letter 12 months after leaving the Forces. Working with the DASA/MoD to access aggregated address level data from JPA would be one action for commissioners; another would be to ensure healthcare providers are aware of the local findings from the VIS project.

3.1.12 In tandem with putting pressure on DASA to release more detailed local authority level statistics, commissioners should consider the merits of procuring a local population model, asking Experian and other similar consultancies to scope and cost for the provision of Veteran population estimates that use a robust methodology and can withstand external scrutiny. A Cheshire-wide approach might generate procurement cost savings, if County-wide demand exists for this type of population data.

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3.2 Veterans’ health service use and monitoring

Key findings:

1. Not being able to accurately gauge the scale of the population is one hindrance to any commissioning plans – another is the inability to accurately monitor service use.

2. Where systems are already in place to record Veteran status (for example, the efforts already put in place to use ‘Read Codes’ in GP surgeries, and the recording of Veteran status by Cheshire Probation trust (CPT) staff when dealing with offenders), a renewed impetus is needed to encourage recording, so as to:
   a. Keep consistent record of the numbers, to inform future strategic and resource decisions.
   b. To support the signposting of Veterans to the ex-service community agencies (including charities and specific health referral options, like MV IAPT).

3. Of course, an important consideration is how to make the recording process more effective and gain buy-in from those recording? Explaining why Veterans should be treated as a ‘special group’ is an important message to get right – with strategic stakeholder interviews revealing a general confusion and scepticism about this perceived preferential treatment.

4. It should be noted that the use of recording systems, including Read Codes, is limited not only by awareness of the existence of the system and use by staff, but critically by the willingness of Veterans to identify themselves as such. When asked if they disclose their service history to GPs and other health professionals, several Veterans said they did not want to be seen as ‘jumping the queue’ or different.

5. Registering leavers directly with primary care providers was suggested by a handful of strategic stakeholders. However, the Veteran interviewees revealed that GP registration didn’t appear a problem (albeit with the usual caveat that it was a very small group interviewed), so there is not enough evidence to warrant this as a recommendation.

3.2.1 Whereas serving personnel have their every exercise tracked and recorded, Veterans are a largely hidden population. Being able to disaggregate the service use of ex-Armed Forces personnel from the general public requires two critical success factors: firstly, the user being willing to declare themselves as a Veteran; and secondly, adequate recording systems and processes being in place to allow this classification of user to be recorded and tracked.

3.2.2 The recording of Veteran status is considered from the perspective of two community ‘environments’ or settings in this section of the report, namely
   ➢ NHS Commissioned Support Services.
   ➢ GP practices.

NHS Commissioned MV Support Services

3.2.3 The number of Halton residents using NHS commissioned MV support services appears to be low. A key question has to be: does the small number of referrals to these support services reflect a small population in Halton (and ‘at risk’) or does it reflect an inability of referral agencies and organisations to identify Veterans and therefore ‘signpost’ adequately?
3.2.4 Two NHS commissioned services are the focus of this section of the report: Live at Ease and MV IAPT.

3.2.5 The October 2013 ‘Independent Return on Social Investment Review’ report of Live at Ease reveals the following service user statistics:

<table>
<thead>
<tr>
<th>Live At Ease referrals from:</th>
<th>Clients received between October 2012 and August 2013 - number</th>
<th>Clients received between October 2012 and August 2013 – percentage of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Halton</td>
<td>6</td>
<td>1.5%</td>
</tr>
<tr>
<td>All NW authority areas</td>
<td>402</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table source note: Data extracted from ‘Appendix 1: The number of clients by CCG area and recipients of AFPS by former PCT areas’ in Anglia Ruskin University report (October 2013) titled ‘An Independent Return on Social Investment Review of Live at Ease’.

3.2.6 In addition to the six Halton referrals received in the 11 month period up to August 2013, there were three referrals from Runcorn custody suite. Since that report was published, the number of clients identified and worked with from Runcorn custody suite has increased to 13.

3.2.7 Referrals to this service from across the North West varies – see map that follows:

Map source: Taken from Anglia Ruskin University report (October 2013) titled ‘An Independent Return on Social Investment Review of Live at Ease’ - p13, Figure 2 ‘Map of the number of referrals from each CCG area between October 2012 and August 2013’.

29 Further information on what each service offers is contained in sections 3.4.4 and 3.8.2 of this report.
3.2.8 A similarly small percentage of Halton referrals are recorded for the MV IAPT service. The August 2013 evaluation\textsuperscript{30} of the MV IAPT service reveals the following volume of referrals for the 20 months up to the end of March 2013:

<table>
<thead>
<tr>
<th>MV IAPT referrals from:</th>
<th>Clients received between September 2011 and March 2013 - number</th>
<th>Clients received between September 2011 and March 2013 percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Halton</td>
<td>16</td>
<td>1.7%</td>
</tr>
<tr>
<td>All NW authority areas</td>
<td>952</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Table source note: Data from PSSRU “Final report of an independent evaluation to Pennine Care NHS Foundation Trust” (August 2013) - p52, Table 4.1 ‘Referrals from Commissioning Groups’*

3.2.9 Whether the low number of referrals is proportionate to the Veteran population in Halton is unclear. Armed Forces Pension Scheme data, summarised in the previous Chapter, would indicate that less than 2 percent of the North West AFPS recipients are based in Halton, therefore referral rates of less than 2 percent could be reflective of this low ‘at risk’ population. As stated earlier, a better estimate of the population is required before judgement can be passed as to the adequacy of the scale of support service referrals.

**GP practices.**

3.2.10 The 2010 Royal College of General Practitioners / Royal British Legion / Combat Stress report ‘Meeting the Healthcare Needs of Veterans: A Guide for General Practitioners’\textsuperscript{31} remains a key reference point for those inexperienced in dealing with the various elements of Veteran healthcare: introducing the concept of priority treatment; outlining process guidance on prosthesis replacement; signposting to networks and information on mental health and post-conflict syndromes; and advising on full Service record requests where necessary and procedures for dealing with Veteran medical records.

3.2.11 Regarding the latter point, there is no national agreement on which Read Code to use but Xa8Da is advocated by the Department of Health and cited in guidance to GPs. Halton CCG should continue to stress the importance of recording Veteran status, and promote the use of Veterans codes to GP Practices.

3.2.12 Outside of primary care, recording of Veteran status for all referrals to secondary care for conditions relating to military service should be encouraged. This information plays a key part in determining population-level health and social care needs. Likewise, encouraging the recording of Veteran status on registers of partner organisations, such as identifying Veterans on homeless acceptance registers, would enable better estimation of the number of homeless Veterans - thereby improving understanding of the burden of need on housing services and related services. This would help Halton to fulfil its lead requirement on the housing pledges in the Community Covenant.


\textsuperscript{31} Access here: [http://www.britishlegion.org.uk/media/1163063/veteranshealthcareneedsgps.pdf](http://www.britishlegion.org.uk/media/1163063/veteranshealthcareneedsgps.pdf)
3.3 Community Covenant awareness

Key findings:

1. Strategic stakeholders interviewed were aware of the local Community Covenant, but many were critical of how widely publicised the benefits were being broadcast across Halton, and most think more needs to be done. Veterans interviewed hadn’t heard of the Covenant or were aware of its implications.

2. In 2014 the Covenant ‘message’ needs to be passed to Veterans in new and creative ways, to highlight the benefits of disclosure of their service history to agencies when health conditions may be related to their military service. Families have a critical role to play – wives and partners of Veterans were referred to in several interviews as being key success factors in linking health services to Veteran needs, overcoming a common reticence to seek attention. Marketing and communication messages have to be targeted at the families as well as Veterans.

3. The Community Covenant has funds attached to it – in the form of the £30 million Community Covenant Grant scheme, which is assigned by a regional bid review team and allocates sums from £100 to £250,000. Local third sector and not-for-profit support groups, in particular, need further guidance on how to navigate the bidding process. It is recommended that the equivalent of an Invitation To Tender ‘Bidders Day’ is held, when successful and unsuccessful bidders could be asked to share their experiences, and practical advice distributed on how best to access funds.

3.3.1 There are five clear pledges documented on page 5 of the Cheshire Community Covenant:

- “We will ensure that all parts of the NHS community will offer support to the local Armed Forces community and make it easier for Service personnel, ex-service personnel, families and veterans to access the services, help and support which will be available in a timely and appropriate manner in order to maximise their potential to achieve good physical health and positive mental health and wellbeing. Accordingly, service members and their families required to move or relocate will maintain their position within a hospital waiting list and in accordance with clinical priorities.

- Regardless of changes to NHS structures and delivery we will aim to ensure that there is a commitment to service user led design in order that the health care needs of veterans are recognised and met.

- We pledge to raise the awareness among healthcare professionals about the needs of veterans so that these needs are met. To this end Hospital and GP records will indicate that a patient is a current/former service member. The identification of an individual as a former service member may help identify vulnerable individuals who can then be brought to the attention of supporting agencies.

- In line with the establishment of pilot schemes by Central Government we pledge to improve veterans’ access to Mental Health Services.

- The NHS/Primary Care Trust (PCT) pledges that in the provision of prosthetic limbs the NHS/PCT will as a minimum match the standard provided by Defence Medical Services.32

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3.3.2 Strategic stakeholders interviewed were aware of the local Community Covenant, but many were critical of how widely publicised the benefits were being broadcast across Halton, and most think more needs to be done. Veterans interviewed hadn’t heard of the Covenant or were aware of its implications.

3.3.3 There remains work to do to promote the Covenant and benefits, both within community settings and when personnel are serving. With regard to the latter, this is illustrated by the latest Tri-Service Families Continuous Attitude Survey (FAMCAS)\(^{33}\), produced by MoD Defence Statistics and released in September 2013, which assesses and monitors the views of spouses and civil partners of Service personnel. For the first time, questions on the Armed Forces Covenant are included. When it came to awareness of the Covenant, the majority (53%) of those interviewed are not aware of the role of the Covenant in addressing disadvantages. The tables below are taken from the latest FAMCAS report:

**Table E.7.3 To what extent are you aware that, under the Armed Forces Covenant, the Government is working to address disadvantages faced by Service personnel, families and veterans? [F_Cv001]**

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
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<tr>
<td>Total</td>
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<tr>
<td>Fully aware</td>
<td>%</td>
<td></td>
<td></td>
<td>10</td>
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<tr>
<td>Somewhat aware</td>
<td>%</td>
<td></td>
<td></td>
<td>37</td>
</tr>
<tr>
<td>Not at all</td>
<td>%</td>
<td></td>
<td></td>
<td>53</td>
</tr>
<tr>
<td>Unweighted count</td>
<td>(%)</td>
<td></td>
<td></td>
<td>5,300</td>
</tr>
</tbody>
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*Table source note: Taken directly from FAMCAS report (September 2013)*

**Table E.7.30 Which, if any, of the following areas do you feel you as a Service spouse have a disadvantage compared to the general public? [2] Healthcare**

<table>
<thead>
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<th>2010</th>
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<td>Total</td>
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<tr>
<td>Ticked</td>
<td>%</td>
<td></td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>Not ticked</td>
<td>%</td>
<td></td>
<td></td>
<td>81</td>
</tr>
<tr>
<td>Unweighted count</td>
<td>(%)</td>
<td></td>
<td></td>
<td>5,300</td>
</tr>
</tbody>
</table>

*Table source note: Taken directly from FAMCAS report (September 2013)*

3.3.4 In 2014 the Covenant ‘message’ needs to be passed to Veterans in new and creative ways, to highlight the benefits of disclosure of their service history to agencies when health conditions may be related to their military service. Families have a critical role to play – wives and partners of Veterans were referred to in several interviews as being key success factors in linking health services to Veteran needs, overcoming a common reticence to seek attention. Marketing and communication messages have to be targeted at the families as well as Veterans.

3.3.5 Finally, the Community Covenant has funds attached to it – in the form of the £30 million Community Covenant Grant scheme, which is assigned by a regional bid review team and allocates sums from £100 to £250,000. Local third sector and not-for-profit support groups, in particular, need further guidance on how to navigate the bidding process. It is recommended that the equivalent of an Invitation To Tender ‘Bidders Day’ is held, when successful and unsuccessful bidders could be asked to share their experiences, and practical advice distributed on how best to access funds.

3.4 Mental health

3.4.1 Whilst only a minority of Veterans experience mental health and social problems, those that do often have acute problems and constitute an important minority. And there are particularly vulnerable groups within the Veteran community. For example, there is a growing research base that identifies young infantrymen as being particularly at risk to mental health problems. This may relate to both pre-service vulnerability as well as exposure to high levels of direct combat. In addition, the mental health effects of warfare can be delayed, sometimes for many years (for example, delayed-onset PTSD), contributing to the higher prevalence figures for veterans who have returned to civilian life.

3.4.2 Several Veterans interviewed were reluctant to talk about mental health issues and reticent to access care. Comparative research suggests that this hesitancy appears more pronounced among those with a Service background than the general public.

3.4.3 A detailed literature review conducted as part of the independent evaluation of the MV IAPT service reveals:

- “The predominant mental health problems include depression, anxiety, PTSD and substance misuse.”

Key findings:

1. Access to appropriate mental health services is important. Some Veterans interviewed were reluctant to talk about mental health issues and reticent to access care. Comparative research suggests that this hesitancy appears more pronounced among those with a Service background than the general public.

2. Nationally, organisations including the Service Personnel and Veterans Agency, Combat Stress, the Royal British Legion and the Sailors Soldiers and Airmen and Families Association (SSAFA) are trained to signpost to relevant health services. Local and regional agencies (like Sanctuary For Veterans, Runcorn Veterans Association and Live At Ease) also support Veterans in finding adequate care options, however each may have their own approach and philosophy rather than specialist expertise or medical training.

3. The present mix of support options available to local Veterans with mental health problems appears to meet a diverse range of needs, with the combination of clinical expertise via MV IAPT and more general ‘wrap-around’ support through Live At Ease being a popular and tested combination.

4. The mental health of Veteran ex-Reservists and early leavers, in particular, need to be explored more fully. Research suggests Reservists are particularly at risk of mental illness, as many return to normal life without the support structures in place at a base and without the peer support of others who have gone through the same experience. An interview with a Halton Veteran diagnosed with PTSD highlights the often unique pressures that Reservists are under – in this particular case, trauma experienced on a back-to-back tour of Iraq created the initial stress, that was exacerbated on return to the UK when difficulties accessing specialist support outside of the North West were pivotal in him ‘falling through the cracks’ in terms of the support offered by the Army. The 13 weeks supervision from Live At Ease and referral to MV IAPT is an important support mechanism for him.
Those veterans that experience problems are ill-served by existing mental health and therapeutic services. Once mental health problems are recognised, which represents an issue in itself, veterans tend not to receive extensive treatment for their mental disorder.

There are very few services designed exclusively for veterans, which focus on the mental health and social needs of this specific population.  

3.4.4 So what are the NHS commissioned support services available to those with concerns about their mental health? Three stand out:

- **Big White Wall**
  Big White Wall is an online early intervention service for people in psychological distress. It is provided in partnership with the Tavistock and Portman NHS Foundation Trust. Big White Wall combines social networking principles with a choice of clinically informed interventions to improve mental wellbeing. It can be accessed 24/7 and has staff (Wall Guides) who ensure the full engagement, safety and anonymity of all members. Big White Wall is a community of people who are experiencing common mental health problems who are supported to self-manage their own mental health. According to members, one of the most important elements of the service is the ability to talk freely, whilst remaining completely anonymous.

- **Military Veterans’ Service Improving Access to Psychological Therapies (MV IAPT)**
  The Military Veterans’ Service IAPT service is a psychological therapies service for veterans and their families across the North West. They are part of the Improving Access to Psychological Therapies (IAPT) programme and can support people with mild to moderate mental health difficulties.

- **Live At Ease**
  Running in parallel to the MV IAPT service, Live At Ease is a regional non-clinical service set up in summer 2012 to meet the welfare needs of military Veterans and their families. At the time of writing, funding had not been secured beyond 2013 to keep the service running.

3.4.5 With regard to the MV IAPT support service, psychological therapy for military veterans is a significant component in the care package offered to Veterans locally – and as the Integrated Commissioning Strategy 2013-15 states: "The NHS Outcomes Framework 2012-13 placed a duty on the NHS to improve psychological support for military veterans. All CCGs in the North West are making a financial contribution to this service. NHS Halton CCG’s share is £20,000."  

3.4.6 Nationally, organisations including SPVA, Combat Stress, the Royal British Legion and SSAFA are trained to signpost to relevant mental health services. Local and regional agencies (like Sanctuary For Veterans, Runcorn Veterans Association and Live At Ease) also support Veterans in finding adequate care options, however each may have their own approach and philosophy – particularly towards mental health problems. The approach of smaller ex-service agencies is sometimes governed by their own members service experiences rather than specialist expertise or medical training.

3.4.7 Looking ahead to future demands for service and research gaps, the mental health of Veteran ex-Reservists and early leavers, in particular, need to be explored more fully. Research suggests Reservists are particularly at risk of mental illness, as many return to normal life without the support structures in place at a base and without the peer support of others who have gone through the same experience. An interview with a Halton Veteran diagnosed with PTSD highlights the often unique

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pressures that Reservists are under – in this particular case, trauma experienced on a back-to-back tour of Iraq created the initial stress, that was exacerbated on return to the UK when difficulties accessing specialist support outside of the North West were pivotal in him ‘falling through the cracks’ in terms of the support offered by the Army. The ‘pathway’ via Live At Ease and referral to MV IAPT is an important support mechanism for him.

3.4.8 A further area to explore locally is the mental health needs of families and dependants – and understanding their experiences whilst associated with a serving member of the Armed Forces will be essential to appreciate behaviour and ways in which they interact with services in the community. As mentioned in the previous section of this report, the 2013 Tri-Service FAMCAS report monitors the views of spouses and civil partners of Service personnel in key welfare areas, including healthcare – to inform, amongst other programmes, the Armed Forces Covenant. One question has been asked in each of the last two surveys – relating to access to mental health support. The response percentages are replicated in the table that follows. 10 per cent (almost 500 respondents) were not able to access all of the mental health support they required whilst a partner was in Service – and this experience will, in some cases, not only have a detrimental effect on their health but also impact upon how resilient they are in seeking help in future when back in civilian settings.

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<th>Total</th>
<th>2010</th>
<th>2011</th>
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<tr>
<td>Yes</td>
<td>%</td>
<td>12</td>
<td>14</td>
<td>10</td>
<td>11</td>
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<tr>
<td>No</td>
<td>%</td>
<td>76</td>
<td>76</td>
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<tr>
<td>Umy family was not looking for service in the last 12 months</td>
<td>%</td>
<td>4,722</td>
<td>4,881</td>
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</table>

Table data source Taken directly from FAMCAS report (September 2013).

3.4.9 In summary, the present mix of support options available to Halton Veterans with mental health problems appears to meet a diverse range of needs, with the combination of clinical expertise via MV IAPT and more general ‘wrap-around’ support through Live At Ease being well thought of by several strategic stakeholders and receiving positive feedback in the MV IAPT evaluation: “On the whole, those receiving a ‘combined’ service – the clinical MV IAPT and the social care Live at Ease – did better, in terms of reduced depression, anxiety and social maladjustment, than those who received the clinical service alone”.

3.5 Veteran behaviours

Key findings:

1. Helpseeking behaviours can be linked back to how Veterans were accustomed to interact with health services when in the Armed Forces. There are conflicting messages from those stakeholders experienced with Veteran health needs, when it comes to generalising about Veterans ability to seek help – some are accustomed to seeing Veterans adopt the ‘soldier on, regardless’ attitude to seeking help; others refer to Veterans surprise at the lack of attention they get in the community, following years of being regularly checked over and assessed. Stakeholders noted that differences can be seen between generations of Veterans, with younger people generally being more proactive in seeking help.

2. Health behaviours are often influenced by a Veterans experience in the Forces. For example, alcohol misuse was cited in interviews with the majority of Veterans as being a common way to relieve stress, both when in Service and at home - a key ingredient for group bonding during social events, with binge drinking playing a part in many Veterans ‘decompression’ following a period of deployment. Add in the relative cheapness of alcohol when serving abroad, and alcohol misuse is an important element to focus upon in Veteran health checks.

3. Interviewees were asked when and why they would seek help, and the majority believed they were quite open when it came to talking about and seeking help for health concerns. However several remarked on being most comfortable when they were receiving medical attention from someone with an experience of the services or at the very least someone who “could speak their language”. Research suggests many Veterans prefer to see clinicians with an understanding of and sensitivity towards military life and culture.

3.5.1 Understanding fully the behaviour of Veterans when interacting with health service providers in the community will often require an in-depth knowledge of that individuals Service history. The 2010 Royal College of General Practitioners report ‘Meeting the Healthcare Needs of Veterans: A Guide for General Practitioners’ summed this up neatly: "Veterans may have health and help-seeking behaviours that are influenced by their experience in the Armed Forces. Consultation rates while serving are about twice the non-military average, partly due to a greater rate of musculoskeletal injuries and partly because in the Armed Forces they are not able to self-certify sick leave".

3.5.2 Health behaviours are often influenced by a Veterans experience in the Forces. For example, alcohol misuse was cited in interviews with the majority of Veterans as being a common way to relieve stress, both when in Service and at home - a key ingredient for group bonding during social events, with binge drinking playing a part in many Veterans ‘decompression’ following a period of deployment. Add in the relative cheapness of alcohol when serving abroad, and alcohol use is an important element to focus upon in Veteran health checks.
3.5.3 When it comes to seeking help, the majority of Veteran interviewees stated that they were quite open when it came to talking about and seeking help for health concerns. However several remarked on being most comfortable when they were receiving medical attention from someone with an experience of the Services or at the very least someone who “could speak their language”. Research suggests many Veterans prefer to see clinicians with an understanding of and sensitivity towards military life and culture.

3.5.4 There are conflicting messages, from strategic stakeholders experienced in dealing with Veteran health needs, when it comes to generalising about the Veteran community's ability to seek help – some are accustomed to seeing Veterans adopt the 'soldier on, regardless' attitude to seeking help (or avoiding help); others refer to Veterans surprise at the lack of attention they get in the community, following years of being regularly checked over and assessed. Stakeholders noted that differences can be seen between generations of Veterans, with younger people generally being more proactive in seeking help.

3.5.5 Veterans and strategic stakeholders interviewed perceived that civilian healthcare staff lack knowledge and understanding about military cultures and this was cited as a potential barrier to accessing services. Halton CCG should promote the importance of publications (such as the GP guidance referred to earlier in this section) amongst all primary healthcare staff. In addition, a review of the training needs of all staff likely to come into contact with Veterans (such as GPs, community and secondary care mental health staff) is recommended.
3.6 Veterans in the criminal justice system

Key findings:

1. Referrals of Veterans from the three Cheshire custody suites via Live At Ease (and, in turn, onto local service charities and groups, or regional expertise such as MV IAPT) became fully active at the start of October 2013. At the time of writing 13 referrals of Halton residents who are ex-Armed Forces have been made since then, and two of those were interviewed for this project.

2. The present mix of health ‘pathway’ options available to the local Veteran offender cohort appears to meet a diverse range of needs – i.e. specialist health referral pathways where needed (for example, clinical support via MV IAPT) together with more general ‘wrap-around’ options for the wider determinants of health (for example provided by agencies like Live At Ease).

3. Identifying offenders who are ex-Armed Forces personnel, at all stages of the criminal justice system, remains a problem. Further impetus is required to enhance recording systems and processes.

3.6.1 Statistics vary greatly on the exact numbers of Veterans in the criminal justice system – for example, official figures from the DASA estimate 3.5 percent of prisoners are Veterans, whilst others put this at 9% or above. Similar variation exists on the number of Veterans going through custody suites – a high estimate presented in the media in 2012 put this figure at 100,000, with low estimates being below 70,000.

3.6.2 Sourcing Halton-level estimates of the Veteran offender population is very difficult. Locally, across Cheshire, statistics vary on the number of Veterans who are also offenders in the community. For example:

- From the launch of the Cheshire Probation Veteran Support initiative in November 2010 to the end of 2012, CPT identified 109 military Veteran offenders.
- A 2011 DASA report estimated 125 Veterans who were offenders in the community.
- A recent request for more up-to-date statistics revealed 60 offenders in the community across the whole of Cheshire were recorded as being ex-Armed Forces, taking a snapshot in November 2013. However there were concerns expressed as to whether the data was being recorded properly given an IT system change recently.

3.6.3 In summer 2013 Astral Advisory released a report, commissioned by Central and Eastern Cheshire PCT, investigating the health needs of Veterans in custody across Cheshire and Merseyside. Within that report is a summary of the findings from a CPT survey conducted in summer 2010. This reveals:

- “a return rate of 80% with 66 Veterans completing their survey.
- 44% of Veterans had been convicted of a violence crime (GBH, assault and child cruelty), 17% for burglary / fraud / theft and 9% for a sexual offence.
- 89% had been in the Army; 75% had served for less than 6 years
- 39% had experienced combat.”

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37 Access here: http://www.express.co.uk/mentalhealth/349129/100-000-veterans-falling-foul-of-police-the-price-of-battlefield-trauma
3.6.4 Referrals to support groups and agencies are low from criminal justice agencies. Whether this accurately reflects the volume of service users who are Veterans is extremely hard to determine. A positive development in recent months, however, is the Veteran referrals system initiated in the three Cheshire custody suites by Live At Ease (who, in turn, refer or signpost onto local service charities and groups, or regional specialist clinical expertise such as MV IAPT). This referral pathway became fully active at the start of October 2013. At the time of writing 13 referrals of Halton residents who are ex-Armed Forces have been made since October, and two of those were interviewed in Runcorn for this project – mirroring the strategic stakeholders interviewed, all were complimentary about the support they are receiving.

3.6.5 Further impetus is needed to identify offenders who are ex-Armed Forces personnel, at all stages of the criminal justice system. If there is a risk that combat history could influence violence or a particular type of crime, then accurate recording of service history is important. For example, The Howard League for Penal Reform report of the independent inquiry into former armed service personnel in prison found that Veterans are twice as likely to be convicted for sex offences than the general population and more likely to commit violent offences. More recently, findings from KCL research, widely publicised in the media in March 2013, reveal that young, male military Veterans are almost four times as likely to have committed a violent offence than men of the same age in the general population. The KCL research findings include:

- Men who had been exposed to more traumatic events during deployment or misused alcohol after deployment were at increased risk of committing violent offences, as were men with aggressive behaviour and PTSD.
- Offences were most common in the post-deployment period (12.2%), than in the pre-deployment Service period (8.6%) and pre-Service period (5.4%).
- Serving in a combat role was associated with an increased risk of offending (6.3%) compared to being deployed in a non-combat role (2.4%).

3.6.6 At the time of writing, the future funding of Live At Ease beyond 2013/14 is in doubt. Interviews with strategic stakeholders and service users indicate that this is a valued service. Amongst other things, Live At Ease provides a gateway to the MV IAPT service for a cohort of Veterans who are identified when in crisis at custody suites, signposting to support and advice. Commissioners are encouraged to work with partners in the criminal justice system to explore funding avenues for the continuation of this service.

“On the whole, those receiving a ‘combined’ service – the clinical MV IAPT and the social care Live at Ease – did better, in terms of reduced depression, anxiety and social maladjustment, than those who received the clinical service alone”.

PSSRU Independent Evaluation of MV IAPT (Aug 2013)

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3.7 Understanding service user diversity

Key findings:

1. The make up of the Veteran community is complex and heterogeneous. Unfortunately the depth interviews in this study only provided insight into the needs of male, white British Veterans. This was not the outcome of any selection bias – most interviewees came forward after a press release, and no pre-selection criterion was used in recruitment. Future exercises need to include a more diverse range of interviewees – to reflect, for example, specific gender-related health issues.

2. Segmenting the diverse Veteran community, to adequately target health promotion and interventions, is recommended. The term ‘Veteran’ relates to all ex-military servicemen and women, 60% of whom are aged over 65 years old - largely explained by the high number conscripted during World War Two and National Service. Accounting for such a high proportion of that generation, elderly Veterans can hardly be described as having distinctive health needs.

3. Future health needs assessments should focus on more recent veterans - the group with the most distinctive needs, and where interventions and alterations to services are most likely to have a beneficial impact on long-term health outcomes.

3.7.1 Appendix A1, in the accompanying Appendices document, summarises key characteristics of the stakeholders taking part in this study. In terms of the Veterans:

- All six Veteran interviewees in this study were male and white British - four of whom responded to a press release, whilst the other two were put in contact with the researcher via local support groups.
- Interviewees were of a variety of ages – two under 40 years of age, two aged between 50 and 60; and the other two over 60 years of age.
- They served across many different decades of conflict – with service history ranging between three and 32 years.
- Two were ex-Reservists.
- The two most elderly Veterans served in the 1950's/60's (interestingly, including one of less than 3000 surviving Veterans of nuclear tests conducted in the South Pacific), whilst the two youngest had experienced a period of intense combat in Iraq. All apart from one served in the Army (one was Royal Navy).

3.7.2 The lack of detailed statistics on the Halton Veteran population, as outlined in Chapter 3.1, makes it impossible to judge what interview sample would be representative of the local ex-Armed Forces community. However national statistics would indicate that white British males remain the predominant cohort, though there are some gradual changes in the composition of the Forces. Official statistics released in October 2013 on diversity in the Armed Forces reveals that:

- “The overall female representation of the UK Regular Forces at 1 October 2013 was 9.8 per cent; this is a slight increase compared with 9.7 per cent at 1 October 2011 and 1 October 2012.
- BME personnel comprised 7.2 per cent of the UK Regular Forces, continuing a long term gradual increase in the proportion of BME personnel. This differs for officers (2.4 per cent) and other ranks (8.2 per cent).

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3.7.3 Of course the socio-demographic composition of the outflow from the Forces in 2013 and of recent additions to the Veteran community will contrast greatly with the Armed Forces over past decades and elderly Veterans. For example, prior to 1999 the proportion of BME personnel was approximately 1 per cent, whereas now it is 7.2 per cent. The age distribution of the current Veteran population is skewed towards older ages compared to the general population — primarily due to National Service and the volume of Armed Forces personnel in the 1950s and 1960s (see Chart that follows). As documented in Chapter 3.1 of this report, the predicted decline in the Veteran population may mean that fewer resources are required to support them. However, as the Veteran population will comprise a greater proportion of younger people, their needs will differ from the majority of Veterans today. For example:

- Veterans of different conflicts are likely to have different needs due to the diverse nature of each conflict and the contexts in which they were fought.
- Veterans are more likely to seek help for mental health related issues due to current and ongoing initiatives in the UK Armed Forces that attempt to reduce the stigma associated with mental health and treatment seeking, and therefore demand for Veteran-specific mental health care may increase.

3.7.4 It is recommended that future Veteran needs assessments include a diverse range of interviewees, to reflect for example gender issues. Research should also focus on more recent veterans - the group with the most distinctive needs, and where interventions are most likely to have a beneficial impact on long-term health outcomes. The Appendices that accompanies this report includes the interview ‘proformas’ and research resource, enabling consistent replication of this qualitative work. The addition of quantitative surveys to any future research programme would extend the evidence base considerably.

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3.8 Support group diversity and clarity of ‘offer’

**Key findings:**

1. Locally, there are a myriad of third sector and not-for-profit support groups accessible to Halton Veterans seeking advice and ultimately solutions to problems relating to health, wellbeing or wider determinants of health (such as poor housing).

2. However a clearer ‘offer’ from each is required to highlight specialisms and areas of strength, particularly relating to health issues, to aid more effective signposting / referral.

3. Whether these community support structures can present a coordinated network of options to meet the health and wellbeing needs of Veterans is questionable – at present there is a rather disjointed system of support available, with duplication in places. Without effective signposting to expert advice and services, there is a danger that some support groups will try to extend beyond their expertise ‘comfort zone’.

### 3.8.1 Locally in Halton there are a myriad of third sector and not-for-profit support groups that have been established in the last few years, alongside more established national and regional ‘brands’ such as the Royal British Legion and Combat Stress, which deliver Veteran-specific care and support to the ‘Veteran community’. This has created a plethora of different approaches, interventions, philosophies and procedures – many of which impact on how a Veteran is able to seek advice and solutions to problems relating to health, wellbeing or wider determinants of health (such as poor housing).

### 3.8.2 Five interviews were conducted with stakeholders from support groups, including representatives from Runcorn Veterans Association, Sanctuary for Veterans, Halton Royal British Legion and Live At Ease. Each of the interviews provided telling insight into the way in which the representative approached Veteran health needs and the service philosophy – with each offering a different mix of support options:

- **Sanctuary for Veterans** targets injured Veterans, and the mission statement for S4V is “to offer veterans and their families respite and rejuvenation at a relaxing retreat”. Run by an injured ex-Forces local man, there are two distinct service elements – a Widnes drop-in centre which offers support, advice and information to veterans on a wide range of topics including employment, training, health and housing; and a proposed £3m ‘sanctuary’ development that includes 30 lodges for Veterans, their families and widows/widowers, and service facilities that include “holistic therapies, mentoring, counseling, workshops and well-being services”.

- **Live At Ease** provide a social ‘wrap around’ service to Veterans and their families “who require Non Clinical interventions such as; Employment, Housing, Family, Debt Management and support to those within the Criminal Justice System”. The representative interviewed specialises in managing the gateway service for Veterans in the Cheshire custody suites, linking them through to support services including MV IAPT and Runcorn Veterans Association. Live At Ease provides 13 weeks close support to service users, signposting to initial support services - which can include debt advice, relationship counseling, MV IAPT (if they have PTSD, for example), or the Big White Wall. Critically, the

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44 Access here: [http://www.sanctuaryforveterans.co.uk/about-us/](http://www.sanctuaryforveterans.co.uk/about-us/)

experienced advisor gains an understanding of the service user through a detailed assessment, at various stages of the process – and together with knowledge of the approaches adopted by the Halton support groups, he would then signpost according to service user personality, needs and service compatibility. Training for Tascor healthcare and Police staff at custody suites, together with awareness raising presentations to health professionals, appear to create a well managed pathway for Veterans entering custody.

- **Halton Royal British Legion**\(^{46}\) is the local branch of the charity that provides welfare, comradeship, representation and remembrance for the Armed Forces Community. The Runcorn branch is open to all Veterans and families, however elderly Veterans have been traditionally catered for and still appear to be the main service users – though managers at the centre are keen to open the facilities further to younger members of the local community. Interviewees identified the Legion as a place that develops community spirit, erodes the isolation that some Veterans experience and helps to identify Veterans in need. The Legion's new 'pop in' Advice and Information Centre to serve the Cheshire & Merseyside area, opened in Liverpool in December 2013\(^{47}\).

- **Runcorn Veterans Association**\(^{48}\) seeks to help and assist in the transition from military to civilian life in a number of ways. Their website promotes four main support services: IAPT health services; the Runcorn foodbank voucher scheme; Open Mind mental health services; and the 'Who is Veteran' campaign, to raise awareness of the diversity in the age and composition of the Veteran community.

3.8.3 The scope of the project meant that it was impossible to visit all of the services on offer to Veterans. Locally, other well publicised support groups and services include Combat Stress and Blue Apple Heroes (offering combat stress related services). As discussed in the previous section of this report, a diverse range of support options reflects the diverse range of people who are in the Veteran community (for example, needs vary according to age, gender, socio-economic classification, rank, combat history, etc) and can be seen as a positive feature – as long as the overarching service ‘offer’ in Halton is co-ordinated and clearly understood. At present there appears to be a somewhat disjointed system of local support available to Halton Veterans, with duplication in places.

3.8.4 Whether these community support structures can present a coordinated network of options to meet the health and wellbeing needs of Veterans is questionable. Without effective signposting to expert advice and services, there is a danger that some support groups will try to extend beyond their expertise ‘comfort zone’. For example, a local support group worker alarmingly stated during interview that: “if someone comes to me and says they have PTSD I just say ‘you've not got PTSD – don’t be daft’ and we move them onto other things”. In the absence of a national regulator of service quality and standards, it will ultimately come down to local health bodies having to keep a watching brief on the support agencies – to ensure they do not cross the fine line between support and treatment.

3.8.5 If resource allows, mapping out the specialisms and areas of strength in the local Veteran support groups and networks is recommended. Once a list of health-related services is generated from the support groups, it might then be a case of developing an accredited local training programme, or ‘kite’ marked service standard, for adoption locally.

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\(^{46}\) Access here: [http://www.haltonrbl.co.uk/](http://www.haltonrbl.co.uk/)


\(^{48}\) Access here: [http://runcorn-veterans-association.co.uk/demo/1/](http://runcorn-veterans-association.co.uk/demo/1/)
# References

Note: Hyperlinks may require copying and pasting into your web browser.

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<td>Ministry of Defence web pages relating to the armed forces covenant. Access here: <a href="https://www.gov.uk/the-armed-forces-covenant">https://www.gov.uk/the-armed-forces-covenant</a></td>
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29 N/A – clarification note

30 See reference 25 - above


32 See reference 16 - above


34 See reference 25 - above


37 Express website (30th September 2012) ‘100,000 veterans falling foul of police: the price of battlefield trauma?’ Access here: http://www.express.co.uk/mentalhealth/349129/100-000-veterans-falling-foul-of-police-the-price-of-battlefield-trauma


44 Sanctuary for Veterans website. Access here: http://www.sanctuaryforveterans.co.uk/about-us/


46 Halton Royal British Legion website. Access here: http://www.hallonnbl.co.uk/


48 Runcorn Veterans Association website. Access here: http://runcorn-veterans-association.co.uk/demo/1/
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