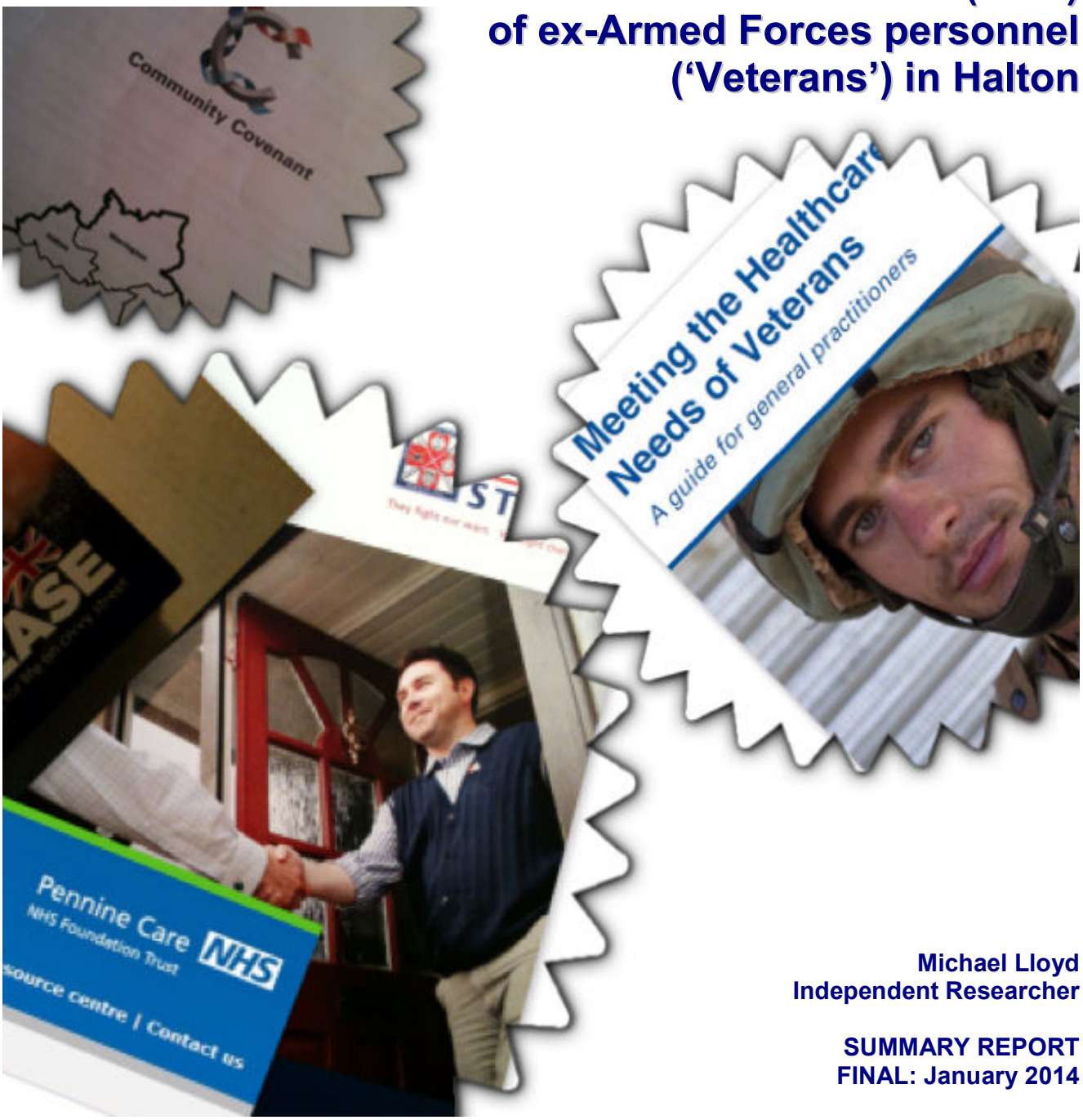
Health needs assessment (HNA) of ex-Armed Forces personnel ('Veterans') in Halton



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SUMMARY REPORT
FINAL: January 2014

Commissioned by
NHS Halton Clinical Commissioning Group (CCG)

NHS
Halton Clinical Commissioning Group

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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 UK*"[2]. 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 Paper[4] 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 Covenant[5]. 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 reports[6] 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

*"Veterans may have **health and helpseeking 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."*

'Meeting the Healthcare Needs of Veterans: A Guide for General Practitioners', RCGP, 2010

[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.
[4] Access here: https://www.gov.uk/government/publications/the-nation-s-commitment-cross-government-support-to-our-armed-forces-their-families-and-veterans--2
[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

least educated of the Armed Forces are disproportionately vulnerable to post-traumatic 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[8], 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.

[8] Access abstract of Harvey et al (2012) here: http://www.ncbi.nlm.nih.gov/pubmed/23186749

Approach and report structure

Primarily a qualitative assessment of need – gathering perceptions and feedback from strategic stakeholders and service users, and linking in localised secondary statistics

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.

[9] Access here: http://www.healthwatchhalton.co.uk/about-us/9-news/112-call-for-military-veterans-to-take-part-in-a-health-needs-assessment

[10] Access here: http://www.haltonccg.nhs.uk/news-and-events/Call_for_Military_Veterans.aspx

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.

Key Findings	*Halton-specific Recommendations*
H1. Defining the size of the local Veteran community ➢ 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: o around 200,000 Veterans are aged under 65 in the North West; o 3,406 Veterans are estimated to be aged under 65 in Halton (6,412 Veterans of all ages are Halton residents). ➢ 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. ➢ 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.	*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.*
H2. Service use and needs - recording of Veteran status on systems ➢ 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: o Keep consistent record of the numbers, to inform future strategic and resource decisions. 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). ➢ 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.	*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"***

➢ 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 locall**y** ➢ 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.	*H3.1 Work with the Armed Forces to explore possible ways to* ***further integrate the Community Covenant benefits into Service Leavers Packs*** *in 2014* *H3.2* ***Review Community Covenant marketing and communications****, and test the message with both Veterans and families.* *H3.3 Host a* ***Community Covenant Grant 'bidders day'****, that tackles the barriers and difficulties in accessing funds, tapping into the experiences of Halton agencies who have successfully and unsuccessfully bid to date.*
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.*