Kent Joint Strategic Needs Assessment (Kent JSNA)

Kent 'Veterans' JSNA Chapter Summary Update '2014/15

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Kent Veterans ‘ex-military’ Needs Assessment JSNA Chapter Update 2014

Introduction

Military personnel put themselves in harm’s way in the service of their country. They risk injury or death in the course of their duty and successive governments have recognised the debt society owes to its Armed Forces, their families and veterans. Society’s obligations were recently set out in the *2011 Armed Forces Covenant* [i], a framework for the duty of care Britain owes its Armed Forces. In terms of healthcare, the key principle is that they experience no disadvantage in accessing timely, comprehensive and effective healthcare and that they receive bespoke services for their particular needs or combat-related conditions including, for instance, specialist limb prosthesis and rehabilitation.

Recent Ministry of Defence (MOD) reviews of ex-service personnel suggest the majority of personnel do make a successful transition to civilian life, although a small percentage struggle. [ii] These reviews describe the general position as follows:

a. Veterans are generally robust people who are likely to suffer the same range of health/welfare issues as the general population. [iii]
b. The vast majority of Service Leavers’ (SL) housing needs are met on transition to civilian life and the majority of SL obtain gainful employment.
c. A small minority of veterans do experience difficulties post-Service, these tend to manifest themselves on average 10 years after discharge.
d. The adverse outcomes (common mental health problems, unemployment, social isolation, encounters with the criminal justice system) present at a rate less than that in the general population.
e. Adversity is more common in the untrained and Early Service Leavers (ESL) cohorts. Vulnerability is associated with pre-service adversity (childhood disadvantage, history of anti-social behaviour) rather than a consequence of service life or combat experience.[iv]

Serving personnel have their every exercise tracked and recorded, veterans can however be a largely hidden population. A significant number of those who have served in the UK armed forces would not even identify themselves as veterans. This Needs Assessment draws from the research set out in the Kent and Medway Veterans Needs Assessment and is targeted at the younger veteran (ex-military) population involved in the conflicts occurring post 1990, principally the Gulf Wars, Iraq Conflict and Afghanistan. It will describe the health needs of veterans under 65 years old (from the Falklands War onwards). [v]

Key Issues and Gaps

There are significant problems with estimating the size of the veteran population. There is no single reliable data source, and the best estimates based on surveys can only state that the figure is likely to be four million in England.[vi] Kent and Medway have strong military links and include bases that are home to a significant number of serving personnel. Local modelling suggests there are approximately 130,000 veterans in Kent and Medway, with the highest density in Thanet, Dover, Shepway, Swale and Medway. The armed forces recruit heavily from deprived communities, veterans are known to have lower than average household incomes, and in Kent and Medway the areas with the highest prevalence of veterans are also some of the most deprived.

Who's at Risk and Why?

A veteran or service leaver (ex-service personnel) is defined as anyone who has been a member of the serving Armed Forces for at least a day and all should be registered with an NHS GP Practice. [vii] [viii]

The Level of Need in the Population

There are approximately four million veterans in England. No reliable evidence as to the long-term physical effect of military service exists. It has been theorised that for many individuals military service is, at least in the short-term, a positive intervention. Certain standards of fitness are required prior to recruitment, and these are then maintained throughout service. A physically active job, regular balanced meals, and regular health checks mean that routine service can contribute towards a healthier lifestyle than many would have experienced in civilian life. The alternative perspective acknowledges the 'toxicity' of war. Military personnel are exposed to extreme conditions, chemicals, and trauma: both mental and physical.

For the large cohort of elderly veterans, their significant physical health problems are likely to be age-related rather than due to their previous service. The usual cross-section of the chronic diseases of old age will be represented in this veteran population.

For younger veterans, it is very difficult to unpick whether military service has contributed to any observed ill-health. As previously discussed, recruitment is disproportionately from individuals with deprived backgrounds and poor educational achievement. Both these factors are independently associated with poor health and lower life expectancy. The majority of young men are recruited into the infantry and have an average service career of 3.7 years and as such, early service leavers receive limited support and there is a risk they do not register with a GP.

Population demographics

At present, there is no database of the location of UK veterans. The MOD holds data on recruitment locations, but does not hold information on where

personnel go on leaving service, or where they subsequently move to. This means that attempts to 'count' veterans can only be a best estimate, based on surveys and modeling of the past, current and future military population. National surveys suggest that in the region of 9-10% of the 16 and over UK population are veterans. [ix]

The Royal British Legion (RBL)/Experian mapping includes estimates of the numbers of veterans by local authority. Here, we have translated this into a percentage of the 16 and over population to allow direct comparison and ranking of Kent local authorities by veteran density.

Table 1: Geographical Distribution of Veterans

Area	Estimated number of veterans (2010)	Estimated % of 16 and over population who are veterans
Kent	129,700	9.5
Thanet	14,768	13.7
Dover	11,064	12.5
Shepway	10.051	12.0
Swale	12,382	11.6
Ashford	8,926	9.7
Gravesham	7,555	9.3
Dartford	6,883	9.0
Canterbury	10,537	8.3
Tonbridge and Malling	6,754	7.1
Maidstone	8,298	6.8
Sevenoaks	5,419	5.9
Tunbridge Wells	4,584	5.3

Source: RBL/Combat Stress/Experian Mapping [x]

The figures from the Experian mapping in Table 1 suggest that the proportion of veterans in the Kent and Medway population is in line with the national average. The county-wide estimate that 9.5% of the 16 and over population lies between the national averages of 9.1% and 10% estimated by the RBL and Woodhead et al studies respectively.

The local authorities with the highest estimated veteran populations are Thanet, Dover, Shepway, Swale and Medway; these are all areas with strong serving military connections (eg Folkestone Barracks, Chatham Royal Naval Barracks).

Army 2020

Army 2020 is the transformation of the British Army for the 2020s and beyond, in response to the strategic challenges it is likely to face in the future.[xi] It will, for the first time, fully integrate Regulars and Reserves within a whole force, consisting of some 82,000 Regular personnel and 30,000 trained Reserves – ie an integrated Army of around 112,000.

Reserves will be used routinely, rather than in extreme circumstances, for defined tasks including providing troops for lengthy stabilisation operations and Defence Engagement overseas. It is too early to establish how this new programme will impact on the health of reservists and their ability to access support.

Black and minority ethnic (BME) veterans
There is a smaller percentage of BME population in the armed forces than in the UK as a whole. However, in Kent we have a very important BME population. Kent is home to the 2nd Battalion Royal Gurkha Rifles, based at Shorncliffe, Folkestone, and nearly half of the soldiers from the Maidstone-based 36 Engineers Regiment are Queen's Gurkha Engineers. Families can join serving Gurkhas in Kent (an estimated 200 families have moved to the Shorncliffe area), and these communities are likely to make the area more attractive to Gurkha veterans choosing to make the UK their home following discharge. There are potential, but as yet unclear, risks to these units in the Army 2020 programme. [xii]

Current Services in Relation to Need

The Defence Medical Services (DMS) run the Defence Medical Rehabilitation Centre (DMRC) at Headley Court which cares for 6,500 patients per year. It aims to return injured or seriously ill personnel to full physical and psychological fitness. DMRC is specialised in the treatment of orthopaedic and sports injuries, spinal injuries, neurological rehabilitation (head & brain injuries) and rheumatic disease. It also hosts the Limb Fitting and Amputee Centre which enables military personnel to quickly receive prosthetic limbs and to have them expertly fitted.

Each year 24,000 individuals leave the Armed Forces. Of these, 10,000 have served in recent operations. Whilst most achieve a seamless transfer to civilian life, for a minority the experience is traumatic [xiii]. It is crucial that individuals who have sustained physical injuries, or developed psychiatric illness, in the line of service continue to have their needs met once care is transferred from DMS to the NHS. To that end transition services are in place, for example, those with a medical discharge on mental health grounds. Military social workers work with veterans for up to 12 months after discharge to help them access the right NHS services.

The majority of individuals leave the armed forces in good health, and the challenge for them is to ensure that they link into the NHS system through a GP so that any future needs are met. There are a number of reported problems inherent in this system:

- a Few veterans register with a GP until they are ill or need a prescription.
- b When they do register, many do not see the relevance of or choose not to disclose, their veteran status.
- c If veteran status is disclosed GPs do not always have a system for recording it on the veteran's NHS record.

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d The lag between leaving service and registering means few veterans give GPs their FMed 133 which records their military medical history.
e GPs are not always aware that they can call down the veteran's medical record from DMS or how to do so.

Evidence of What Works

Physical health

As with mental health discharge, those discharged with physical injuries sustained on military service have dedicated case workers who assist their transition.

The Medical Assessment Programme is an example of a successful intervention providing a general medical examination for veterans of:

- the first Gulf war 1990-91
- Porton Down
- the war in Iraq from 2003 (Operation TELIC)
- the war in Afghanistan from 2001 (Operation HERRICK)

The aim is to identify any sequelae from exposures linked to military service in these conflicts. This allows monitoring of any emerging trends and, on an individual level, also allows prioritised referral to the appropriate NHS service should the referring clinician consider the health condition is related to patient's military service.

Mental health

There are currently no specialised services for veterans in Kent beyond the Medical Assessment Programme. Primary Mental Health Care in Kent and Medway includes **Improving Access to Psychological Therapy** (IAPT) services, which offer Cognitive Behaviour Therapy (CBT), the intervention that **National Institute for Health** and Care Excellence (NICE) Guidance recommends for Post Traumatic Stress Disorder (PTSD). Veterans with a range of mental health problems including depression and anxiety can self-refer to IAPT, or be referred through a GP or other health professional.

User Views

It was not possible to gain local veteran feedback during the timeframe of this health needs assessment. We recommend regional qualitative research to allow the veteran voice to influence mental and physical health services and fully map and integrate mental health provision for veterans.

Unmet Needs and Service Gaps

A 2009 report on IAPT services [xiv] for veterans identified gaps that may exist amongst current IAPT providers in their ability to meet the needs of veterans.

It noted they:

a Do not identify veterans – maybe due to time constraints, lack of awareness about the needs of veterans, not being required to record or collect data relating to veterans.
b Lack knowledge and understanding of veterans and the armed forces.
c Are not aware that veterans may have specific needs because of past military cultures.
d May lack confidence in working with veterans, or perceive them to have special needs which they can't meet.
e May be fearful that veterans can be violent.

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

a Believing that mental health problems are shameful and so deliberately hiding symptoms from health professionals.
b Believing that NHS professionals will not understand them/their service history.
c Believing that the effort, stigma and shame will outweigh the benefits of asking for and receiving help.
d Self-medicating with alcohol in order to mask their moods or problems, and stop them being detected.
e Believing that psychological therapies are not effective for veterans.
f Being dis-enchanted by previous exposure to mental health services in the military or NHS.
g Having difficulty accessing general health services in the first place - especially for those who are socially excluded.

A 2015 Health Equity Audit of IAPT services which are commissioned by Clinical Commissioning Groups (CCGs) across Kent does not flag concern about access by veterans with common mental health problems or their experience of the service.

Recommendations for Consideration by Commissioners

1. Mental health services for veterans should provide both assessment and treatment. Where highly specialist treatment (eg alcohol detox) cannot be provided by the veterans' service then the priority for veterans should be invoked in order that there is no further wait for specialist treatment.

2. It is essential that services be staffed by people with experience of working with veterans and knowledge of the culture of the forces. Where practical it would be desirable for veterans to have the choice of being seen by veterans.

3. Services must have strong links at strategic level (board/chief executive) with other statutory and voluntary agencies, forces' charities etc. This should then be reflected at operational level with provision of services/advice on housing, benefits, employment, joint clinics etc.

4. Groups for veterans were a cost-effective way of seeing larger numbers, and were highly regarded by veterans as a source of companionship and solidarity. All services should consider group work as an option to offer veterans.

5. Mental health services for veterans should routinely access service records of veterans to gain the full picture of the client's service history. This would also serve as a check on the occasionally reported instances of fabrication.

6. A common minimum data set should be established so that clear comparisons can be made across services. Financial support for the services should be dependent on effective systems being in place and data should be co-ordinated by an independent research group (ie a practice research network focusing on veterans).

7. Now it has been shown to be possible, routine pre- and post-treatment outcome data should be collected for all clients seen. This should become standard practice across services and a basic expectation of funders and commissioners.

8. Mental health services for veterans should accept self-referrals, with GPs being involved after referral rather than as gatekeepers. (Experience with IAPT has shown no inappropriate use or 'flooding' of services.)

9. Transition from The Defence Medical Services (DMS) to the NHS – CCG commissioners should facilitate GP registration prior to discharge and improve awareness of DMS.[xv]

10. Target improving the pathways of support for young service leavers identified to be at higher risk of mental health problems.

11. Regional qualitative research to allow the veteran voice to influence mental health services and fully map and integrate mental health provision for veterans.

12. CCGs should build local representation on the South East Coast Armed Forces Forum Mental Health Working Group and review exploratory work with KDAAT about service accessibility for veterans with alcohol problems.

Further Needs Assessment Required

Qualitative research would ideally identify:

- current opinions about mental health services from a younger service leaver perspective (under 30)
- barriers to use of current mental health services
- features that veterans feel are key to an effective mental health service
- the best way to raise awareness of available services within the local veteran community
- work with the local Nepalise population with the aim of estimating local numbers of Gurkha veterans, and any specific cultural or language barriers they face in accessing services.

Key Contacts
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References

[i] 'The Armed Forces Covenant,', MOD, 2011
http://www.mod.uk/DefenceInternet/AboutDefence/CorporatePublications/PersonnelPublications/Welfare/ArmedForcesCovenant/TheArmedForcesCovenantDocuments.htm
[ii] Universities of Salford and Chester commissioned by Comd 42(NW) Bde and NHS NW.
[iii] Prof Sir Simon Wessely King's Centre for Military Health Research – KCMHR 2013
[iv] The Mental Health Of Armed Forces' Veterans, Headquarters Support Command Letter 8 Jan 2014

[v] Veteran Health Needs Assessment for Kent and Medway Dr grace Howarth Public Health Registrar, October 2011
[vi] **Securing excellence in commissioning for the Armed Forces and their families** First published: March 2013
[vii] http://www.england.nhs.uk/wp-content/uploads/2013/03/armed-forces-com.pdf
[viii] Veterans – *"those that have served in HM Armed Forces for at least one day, either as a Regular or Reservist"* Armed Forces Covenant
[ix] Population Trends No. 138, Winter 2009 (Pdf 1523Kb) Woodhead et al., An estimate of the veteran population in England: Based on data from the 2007 Adult Psychiatric Morbidity, ONS, Population trends 138, Winter 2009
[x] 2010 RBL Projections (2005 RBL Orange Report) extrapolated to local Kent and Medway RBL/Combat Stress/Experian mapping from 2009
[xi] http://www.army.mod.uk/structure/33449.aspx
[xii] National Audit Office report on Army 2020 June 2014
[xiii] The Murrison Report, Fighting Fit: Fighting Fit: A mental health plan for servicemen and veterans, DH, 2010
[xiv] Improving Access to Psychological Therapies (IAPT) report (Veterans' Positive Practice Guide, March 2009)
[xv] Securing Excellence.