Views and experiences of using mental health services: feedback from veterans in Norfolk and Suffolk

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About this report

This report sets out the findings and recommendations that follow from talking to 30 veterans from Norfolk and Suffolk about their views and experiences of local mental health services provided by the NHS, as part of the Healthwatch Norfolk Veterans Project (April 2015-2016). This was not an academic study; rather the report is intended to help inform the delivery of services for local veterans in the future and to contribute to the wide body of work that is currently underway to improve mental health outcomes for veterans across the country.

A summarised version of our work with veterans is also available from our website (www.healthwatchnorfolk.co.uk).

Who is this report for?

This report is primarily intended for the commissioners and providers of NHS mental health services for veterans, specifically:

- The seven Clinical Commissioning Groups in Norfolk and Suffolk
- NHS England
- The Norfolk and Suffolk NHS Foundation Trust

The report may also be of interest to many other people and organisations, including but not limited to:

- Residents of Norfolk and Suffolk; members of the Armed Forces Community, including veterans and their families
- Third Sector organisations working with local veterans and their families, especially those that contributed to the study
- Norfolk County Council’s Community Covenant Board
- Suffolk County Council’s Community Covenant Board
- Healthwatch Suffolk
- Veterans First
- The Local Medical Council
- Health Education East of England

Acknowledgements

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Special thanks go to all of the people and organisations who worked tirelessly on our behalf to recruit veterans for this study.
Directory

Healthwatch Norfolk: the consumer champion for all publically funded health and social care provision in Norfolk. We are an independent organisation, with a statutory remit to use the views and experiences of local people as evidence to influence improvements in service provision.

Statutory organisations and programmes

(CCG) Clinical Commissioning Group: the organisations that commission (pay for) local NHS services, including mental health services. There are seven CCGs in Norfolk and Suffolk.

(CQC) Care Quality Commission: the independent regulator of all health and social care services in England.

(DCMH) Department of Community Mental Health: MoD organisation that provides mental healthcare to military personnel. Currently there is a national network of 16 DCMHs, although there are plans to reduce these numbers in the future. Norfolk and Suffolk are serviced by DCMHs at Merville Barracks, Colchester and RAF Marham, King’s Lynn. The DCMHs offer a range of outpatient services, supported by inpatient care provided by a consortium of eight NHS Trusts.


(DMS) Defence Medical Services: umbrella organisation that organises all medical, dental and nursing services within the Armed Forces.

(HEEofE) Health Education East of England: the regional arm of Health Education England (HEE), which is the part of the NHS that is responsible for providing education and training for health professionals.

(MoD) Ministry of Defence: the department of the British Government responsible for managing the Armed Forces.

(NCC) Norfolk County Council: provides various health and social care for residents of Norfolk. Responsible for supporting positive relationships between local Armed Forces and civilian communities through the Community Covenant Board.

NHS England: oversees the budget, planning, delivery and day-to-day operation of the commissioning (funding) side of the NHS. Commissions (pays for) a number of dedicated services for veterans, including a ‘national network’ of 12 mental health services.

(NICE) The National Institute for Health and Care Excellence: provides national, evidence-based guidance and advice to improve health and social care.
(NRP) **Norfolk Recovery Partnership**: statutory drugs and alcohol service for adults in Norfolk, delivered by NSFT in partnership with the Matthew Project and Rehabilitation for Addicted Prisoners Trust.

(NSFT) **The Norfolk and Suffolk NHS Foundation Trust**: the organisation that provides NHS mental health services for residents of Norfolk and Suffolk, including veterans.

**NSFT primary care mental health services**: delivered through the Wellbeing Services *(Norfolk and Waveney; Suffolk)*, which provide a range of support from group workshops to one-to-one therapy. For people with mild to moderate common mental health and emotional issues. Delivered in partnership with **Mind** and other organisations.

**NSFT secondary care mental health services**: provide more specialist support and interventions for people with moderate to severe mental health needs, either in the **community** or, if necessary, through **inpatient** facilities. Mainstream community services are supported by **acute services** including Crisis Resolution and Home Treatment. NSFT also provides a **Psychiatric Liaison Service** for patients in hospitals who have mental health issues or need mental health assessment.

**(PRU) Personnel Recovery Unit**: Army units for the command and care of wounded, injured and sick soldiers. There are 11 PRUs across the UK and Germany and soldiers can be transferred to one if their commander feels that they need more help than their current unit can provide. The nearest PRU to Norfolk and Suffolk is based at Merville Barracks, Colchester.

**(SCC) Suffolk County Council**: provides various health and social care for residents of Suffolk. Responsible for supporting positive relationships between Armed Forces and civilian communities in Suffolk through the **Community Covenant**.

**Veterans First**: Part of the ‘national network’ of dedicated services commissioned by NHS England. A specialist secondary care mental health team, staffed by a mix of MOD staff, veterans and civilians, providing holistic assessment and treatment programmes that are specifically tailored to the needs of veterans and their families and ensures collaborative working with the MOD and charities such as WWTW and the RBL. Accepts self-referrals and professional referrals across Essex.

**(VRMHP) Veterans and Reservists Mental Health Programme**: MoD programme for veterans and reservists, deployed since 1982, who are suffering from mental health problems as a result. Provides a full psychiatric assessment with guidance to GPs about follow-up care. Historically based at Chetwynd Barracks in Nottingham, as of 1 April 2016 veterans will be able to access the service from their nearest DCMH.

**(VSP) Veterans Stabilisation Programme**: 16 week, two hour a week, outpatient programme, offering mindfulness/CBT based self-help strategies to small groups of veterans with PTSD and other mental health conditions. Delivered by a senior clinical psychologist from NSFT, alongside the Founder/Director of the Walnut Tree Project, who is a veteran with lived experience of PTSD. At the moment, the VSP is
run on a small scale as part of NSFT’s mainstream community services, but NSFT is looking for funding to roll out the programme across Norfolk and Suffolk.

**Wellbeing Service**: see NSFT primary mental health services.

### Third sector and other organisations

**Access Community Trust**: works with disadvantaged communities in Norfolk and Suffolk providing support with housing, health, wellbeing, education and employment. Offers a range of therapeutic interventions (recovery groups, mindfulness, CBT, EMDR) for people, including veterans, who are suffering with PTSD and other mental health problems through **The Anchor**, which is managed by a senior mental health nurse with 25 years’ experience.

**Bridge For Heroes**: local charity offering special rest and recuperation for the whole Armed Forces community. Supports NSFT to provide mental health treatment from its base in King’s Lynn.

**Combat Stress**: the UK’s leading mental health charity for veterans, operating within a recovery framework to provide community and residential services, including; clinical assessment, welfare advice and signposting, diagnosis, psycho-education, occupational therapy and psychological therapy. Combat Stress has 15 Community Teams and three Residential Treatment Centres and is currently commissioned by NHS England to provide a six-week **PTSD Intensive Treatment Programme**, which is one of several residential treatment programmes. Combat Stress also hosts monthly support groups in Norwich and Ipswich.

**(FiMT) Forces in Mind Trust**: commissions (pays for) research to build an evidence base that will influence and underpin policy making and service delivery in order to enable veterans and their families to lead successful civilian lives. Recently commissioned a large piece of work around veterans’ experience of mental health services (FiMT, 2015), building on an earlier study (FiMT, 2013).

**Help For Heroes**: national veteran charity providing support to men and women who are wounded, injured or sick as a result of service.

**(KCMHR) King’s Centre for Military Health Research**: based at King’s College London, the leading civilian UK centre of excellence for military health research.

**Outside The Wire**: part of the adult team of the Matthew Project, a local charity that supports people with alcohol and drugs problems (partly through the NRP). Outside The Wire provides bespoke treatment for veterans with alcohol and drugs problems in Norfolk, Suffolk and elsewhere in England. Local support is provided through two recovery workers (both veterans) in addition to management support. Based in the Veterans’ Hub, Britannia House, HMP Norwich.

**(RBL) The Royal British Legion**: provides lifelong support (e.g. welfare) and representation for the whole Armed Forces family. Also the national custodian of Remembrance and key campaigner for veterans’ rights.
(SSAFA) **The Soldiers Sailors Airmen and Families Association**: national charity providing lifelong support (e.g. welfare) for the whole Armed Forces family.

**Stand Easy**: new local charity providing acupuncture to veterans with PTSD and other mental health problems. Based in Norwich.

**Turning Point**: a national charity. Part of the **Suffolk Recovery Network**, providing drugs and alcohol service for adults and young people in Suffolk alongside Suffolk Family Carers, Iceni and Air Sports Network

(WWTW) **Walking with the Wounded**: national charity with a base in Norfolk. Raises funds for the re-education and re-training of wounded servicemen and women. Provides mental healthcare for veterans through **Head Start** and works with veterans in custody through **Project Nova**. Project Nova is based in the Veterans’ Hub, Britannia House, HMP Norwich.

**The Walnut Tree Project**: local charity helping veterans with PTSD and other mental health conditions. Runs the VSP in partnership with NSFT. Based in the Veterans’ Hub, Britannia House, HMP Norwich.

Terms and phrases

**The Armed Forces community**: includes current military personnel, veterans, reservists (past and present) and their families.

(AFCS) **Armed Forces Compensation Scheme and the (WPS) War Pensions Scheme**: veterans who were injured in service on or before 5 April 2005 receive compensation through the WPS. Veterans who were injured in service after that date receive compensation through the AFCS.

(CBT) **Cognitive Behavioural Therapy**: a talking therapy used as a treatment for common mental health conditions and PTSD.

**Common mental health conditions**: a term to refer to the set of conditions that are most common in the general population, such as anxiety and depression.

(EMDR) **Eye Movement Desensitization and Reprocessing**: a therapy used to help reduce the long-lasting effects of PTSD.

(ESLs) **Early Service Leavers**: the name given to individuals who leave the military before the end of their minimum initial contract (typically 3-4½ years), as well as those who are compulsorily discharged and thereby lose their entitlements.

**Mindfulness based therapies**: mental health treatment that focuses on encouraging patients to become aware of, and accept, incoming thoughts and feelings as a way of managing their symptoms and learning to live with, if not overcome, their problems.

(PTSD) **Post-Traumatic Stress Disorder**: an anxiety disorder caused by very stressful, frightening or distressing events (e.g. combat).
Executive Summary

Background

A Healthwatch Norfolk scoping paper identified that a significant minority of veterans suffer from poor outcomes when it comes to mental health and alcohol misuse (2014). Some veterans may have slightly different needs to their peers in the general population and they may require a slightly different kind of service. This is reflected in a recent pledge by the British Government to support veterans through the Armed Forces Covenant (MoD, 2011a).

Aims

Little is known about how veterans would like to receive mental healthcare at a local level. The aim of this study was to talk to a sample of local veterans (30-50) in order to supply this information to the commissioners and providers of NHS mental health services in Norfolk and Suffolk (NSFT). We were also interested in exploring the work of Third Sector organisations supporting local veterans.

Method

Thirty (30) veterans from Norfolk and Suffolk were interviewed in a semi-structured format about their views and experiences of using local mental health services. This sample was purposively recruited and is not representative. The interviews were recorded and transcribed and qualitative analysis was conducted using Template Analysis, to identify key trends and themes in the data (transcripts).

Findings

The participants felt that they had been marked out as different from civilians by virtue of their service. The distinctive values of Armed Forces culture remained relevant once the participants had left the military, although these were more important to some than to others. Most found it difficult to adjust to life outside the Forces.

All of the participants were reluctant to engage with services, both inside and outside of the military. The apparent difference between veterans and civilians emerged as an additional barrier to care in Civvy Street and some participants preferred to receive specific treatment and support from the many veteran charities in the Third Sector.
Unfortunately, in some cases, partnership working between the NHS and the Third Sector, or between Third Sector organisations, was poor, to the detriment of veterans in need. Information about local support was not always easily accessible. The GP can be the key to navigating a complicated system but whilst there were some very positive stories, it was clear that more can be done to support GPs when treating veterans.

Twenty (20) participants had conditions with some symptoms related to service. These participants, especially those with combat related PTSD (13), generally found mainstream mental health services were ineffective at treating their underlying issues, although they praised individual staff members. Part of the problem seemed to be that PTSD is not well managed within mainstream services, but the military context meant that most participants preferred to receive treatment from professionals with an understanding of military culture.

The ten participants with conditions that were unrelated to service did not have as many issues using mainstream services and gave mixed reviews about the treatment they had received. Any problems they raised referred to general shortcomings in local mental health provision and had nothing to do with the fact that they were veterans.

The majority of participants, regardless of whether or not their conditions were related to service, were supportive of the idea of a dedicated veterans’ service for Norfolk and Suffolk.

Recommendations

NHS England currently commissions a network of 12 dedicated veterans’ services. The nearest service to Norfolk is based in Colchester. We believe that local veterans have just as much right to receive dedicated treatment as veterans from elsewhere and so this report will recommend that Healthwatch Norfolk uses the findings as evidence to encourage NHS England to consider commissioning a dedicated service to cover Norfolk and Suffolk in future funding cycles.

During the course of our work with veterans we have supported key stakeholders working to improve services for local veterans, most importantly HEEofE (primary care) and NCC’s Community Covenant Board (partnership working in the Third Sector) and the report also recommends that Healthwatch Norfolk continues to offer support to these stakeholders in the future.
1. Introduction

The aim of this study was to gather feedback from a sample of veterans from Norfolk and Suffolk about their views and experiences of using mental health services. Specifically, the primary objective was to find out more about what it is like for veterans to use local NHS services, as provided by NSFT, and to identify examples highlighting good practice and areas for future improvement. A secondary objective was to explore the work of Third Sector organisations providing support to local veterans with mental health conditions.

The decision to conduct a study around this issue was made on the basis of a three month scoping exercise (October-December 2014) looking at the health and wellbeing of veterans in Norfolk, which identified both that a significant minority of veterans have poor mental health outcomes and that there was an opportunity for Healthwatch Norfolk to make a difference (Healthwatch Norfolk, 2014).

The following section contains further information relating to veterans’ mental health needs and explains how Healthwatch Norfolk might be able to make a difference.

1.1 Veterans’ mental health

1.1.1 A general overview

The British Government defines a veteran as: “Anyone who has served for at least one day in the Armed Forces (Regular or Reserve), as well as Merchant Navy seafarers and fishermen who have served in a vessel that was operated to facilitate military operations by the Armed Forces,” (Department of Health, 2008, p.4).

Around 20,000 military personnel leave the Armed Forces each year, which is approximately 10% of its total operational strength (MoD, 2015a). Members of the Forces have their healthcare provided for them by the MoD through the DMS. Once they leave the military, the responsibility for their care returns to the NHS. It is thought that, generally speaking, there are no significant differences between the mental health of veterans and non-veterans (Woodhead et al., 2011a; Woodhead et al., 2011b) but not much is known about veterans’ specific needs.

The UK’s prolonged involvement in the conflicts in Iraq and Afghanistan has prompted a great deal of recent interest in the psychological (and other) effects of warfare upon members of the Forces. The prevalence rates of mental health (and other) conditions within the military are becoming increasingly apparent due to an ongoing cohort study involving more than 10,000 personnel, undertaken by KCMHR since 2003.

The KCMHR studies may offer a potentially revealing insight into the prevalence of mental health conditions within the veteran population, not least because, given the high turnover rate in the military, many of the individuals who served during the Iraq and Afghanistan conflicts will since have left service. It is not the purpose
of this report to comment in general on the findings from these studies, but the following three key messages have been highlighted as being of particular importance.

1. There is no evidence for an impending ‘tsunami’ and common mental health and alcohol misuse disorders are more prevalent than PTSD.

Contrary to sensationalist warnings in the national press, no evidence has emerged as of yet about the ‘toxic legacy’ of military service, or the supposedly impending ‘tsunami’ of veterans heading towards NHS mental health services as the effects of this legacy bear fruit for the men and women who served in Iraq and Afghanistan. According to MoD statistics, the numbers of personnel suffering from a diagnosed condition have been consistently low for the last few years (2015b), although these statistics may not be the most reliable because the issue of mental health is stigmatised in the military (on which more later), which means that there may be more personnel whose conditions are undiagnosed.

PTSD is widely seen as the quintessential service condition. Service in the military is a uniquely dangerous and demanding job and the most obvious risk to the mental health of personnel are traumatic experiences following deployment to a conflict zone. Nearly half of personnel (46%) deployed to Iraq and Afghanistan reported that they saw comrades wounded or killed (Fear et al., 2010). Over 6,900 military and civilian personnel were medically evacuated back to the UK and research shows that those who were evacuated due to (combat) injury have an increased risk of developing PTSD (Forbes et al., 2012).

With that in mind, it is perhaps unsurprising that PTSD tends to be prevalent among clinical samples of veterans. Most of the data comes from Combat Stress, where it has been estimated that as many as 70% of patients have PTSD (van Hoorn et al., 2013). However, high rates should be expected from services such as Combat Stress, which offer specific treatment for PTSD, and should not be taken to be representative of general prevalence (MacManus & Wessely, 2013).

Studies by KCMHR have consistently shown that there has, broadly speaking, been no deleterious effect upon the mental health of personnel deployed to Iraq and Afghanistan (Fear et al., 2010; Hotopf et al., 2006; Jones et al., 2013; Rona et al., 2009). This is not to say that deployment has no impact at all. Reservists and personnel who were deployed in a combat role have been found to be slightly more likely to develop PTSD, for example, but the prevalence is still fairly low; 5-7% compared to 4% for personnel generally and 3% in the general population (Fear et al., 2010). Deployment has also been associated with increased risk-taking behaviours, (Fear et al., 2008; Thandi et al., 2015) and anger (MacManus et al., 2015).

PTSD can be a very debilitating condition, but it is probably not the major issue facing the mental health of military personnel and, by extension, veterans. Rather, the evidence suggests that common mental health conditions, such as depression
and anxiety, and alcohol misuse are the most prevalent (Fear et al., 2010; Iversen et al., 2009; Murphy, Iversen & Greenberg, 2008). Alcohol consumption is a well-established part of Armed Forces culture and rates of harmful drinking are thought to be more than twice as high (67% vs. 33% for men and 49% vs. 16% for women) as the rates in the general population (Fear et al., 2007) with deployment linked to increased consumption (Browne et al., 2008; Hooper et al., 2008). This is particularly troubling given the established link between harmful drinking and numerous adverse outcomes (MacManus & Wessely, 2013).

Whilst the prevalence of common mental health conditions is generally thought to be similar in the military population compared to the general population (Fear et al., 2010), recent research has indicated that personnel who have been deployed may be twice as likely (18% vs. 9%) to suffer from these conditions (Goodwin et al., 2014). However, it should be noted that the authors of this study acknowledge that the difference might have been inflated by a specific limitation in their method.

The KCMHR studies are sometimes compared to studies from America, where the research tradition in military health and wellbeing is better established. Numerous studies have consistently shown much higher rates of PTSD amongst American personnel, both past and present (Sundin et al., 2014). The reasons for this are not yet fully understood. The discrepancy might have something to do with a difference between the coping strategies used by individuals from the two countries (Sundin et al., 2014). Alternatively, it might be due to practical factors, such as the fact that, under the MoD’s ‘Harmony Guidelines’, British troops tend to be deployed for shorter periods (National Audit Office, 2006). Whilst comparative studies make for interesting reading and investigation, they go beyond the scope of this study and the mental health of veterans outside of the UK will not be considered in the report.

2. The majority of service leavers transition well from the Armed Forces but a significant minority struggle badly in Civvy Street. This may not be solely the result of military experiences.

Most people who left the Armed Forces in recent years were fit and healthy, both mentally and physically (MoD, 2015c). Service in the military gives many young men and women access to opportunities that might otherwise have been impossible and the majority adjust well to civilian life, bringing with them the skills and values they learned from their time in uniform (Ashcroft, 2014; Iversen et al., 2007; MoD, 2015d). However, a significant minority of service leavers struggle with life in Civvy Street. These individuals are more likely to suffer from mental health conditions and wider social issues, such as homelessness or criminal behaviour.

This is particularly true in the case of ESLs, who make up approximately 40% (8,000) of all service leavers each year (Howard League for Penal Reform, 2010). Although they are known to have very poor outcomes on a number of measures (Buckman et al., 2012; Woodhead et al., 2011a), historically ESLs have been
provided with far less support than other service leavers who have enjoyed longer military careers. More recently, ESLs have been the subject of various specific interventions, most notably the MoD’s Future Horizons Programme, which focuses on helping ESLs to find long-lasting civilian employment (Career Transition Partnership, n.d.).

For a variety of reasons, reservists are more likely than regulars to find the transition to civilian life difficult and are vulnerable to developing persistent problems (Harvey et al., 2011; Harvey et al., 2012). This could be a significant issue in the future because recent conflicts have involved unprecedented numbers of reservists, and the Reserve Forces are expected to play an increasingly important role (MoD, 2013).

As already indicated, in some cases, deployment and subsequent combat exposure can be detrimental to the mental health of personnel. The importance of this link cannot be denied, but there is a growing appreciation that military experiences are but one of a number of factors. Even taking PTSD for example, it is estimated that only 50% of cases arising in currently serving personnel can be directly attributed to deployment (Jones et al., 2013).

Many of the factors that might have an effect on a veteran’s mental health relate to pre-enlistment vulnerabilities and may have nothing at all to do with their time in the military. It is important not to forget that the military attracts certain types of people and that veterans are part of a self-selecting community. For instance, all branches of the Armed Forces are renowned for recruiting disproportionately from disadvantaged areas, and the link between poverty and poor mental health outcomes is well established. In addition to suffering from worse outcomes after leaving the military, ESLs are more likely to report higher levels of childhood adversity, for example (Buckman et al., 2012).

Finally, it has been speculated that civilian attitudes towards the military can be an additional barrier for service leavers. Whilst public support for the military is generally very high, a recent opinion poll showed that more than 90% of the public thought it was common for individuals leaving the Forces to have some kind of physical, emotional or mental health problem (Ashcroft, 2012). This is patently untrue, but nonetheless the perception may hamper service leavers when they are looking to re-enter the civilian world.

3. Veterans with mental health conditions may have particular needs.

If it is true that the majority of service leavers adjust well to civilian life, then it also seems to be the case that the minority who struggle tend to have poor outcomes. For one thing, veterans (and military personnel) can be reluctant to seek help, partly due to stigma surrounding the issue of mental health, (Iversen et al., 2010, Iversen et al., 2011), although it is unclear whether they are worse than men in general (89% of veterans are male; RBL, 2014). When veterans do present to services, they often present late with considerable clinical complexity.
This may be due to a combination of the early life difficulties noticed above (Iversen et al., 2007; MacManus et al., 2012) with comorbidity such as substance misuse and anger issues (Murphy & Busuttill, 2015). Furthermore, veterans may slip through the cracks of mainstream mental health services; too complicated for primary care services but not considered serious enough to warrant the attention of secondary care services, which traditionally focus on more severe conditions like psychosis (MacManus & Wessely, 2013).

Whilst a veteran’s mental health condition may not necessarily be the direct result of their military experiences, these experiences may nonetheless provide some of the context for their presentation. Civilian mental health practitioners are unlikely to be familiar with the military way of life, which can be a barrier to care. It is widely recognised that the military has a distinctive culture, which is different from civilian culture. The MoD requires personnel to be able to execute uniquely dangerous and demanding tasks under intense pressure. In addition to the necessary skill set, military training is designed to equip newly recruited civilians with a set of values that will enable them to perform these tasks.

The MoD is very good at ‘militarising’ recruits and many veterans still relate to the military way of life years after leaving service. Anecdotally, it is thought that many veterans prefer to see professionals with an understanding of the military (Ben-Zeev et al., 2012) but to date the issue of how veterans would like to receive mental health treatment has been given surprisingly little academic attention, although the picture is changing. Recent national research by FiMT has reiterated the importance of the military context when treating veterans (2013; 2015).

### 1.1.2 The local context

At the time of writing, service leavers are not systematically recorded once they have left the military, and so it is impossible to know how many veterans there are in the UK and where in particular they may reside. The main source of information comes from a recent RBL Household Survey, which estimates that there are 2.931 million veterans in the UK, which is approximately 4% of the total UK population (2014).

The Household Survey does not provide specific information about the numbers of veterans living in Norfolk, but it is possible to extrapolate from the findings in conjunction with general population projection data (Norfolk Insight, 2015) and location data for veterans receiving pension and compensation payments (MoD, 2015e) to arrive at a rough local figure. Using this method, Healthwatch Norfolk estimates that there are between 43,000 and 63,000 veterans in Norfolk, which is between 5% and 7% of Norfolk’s total population. Further information about the methods used to arrive at this figure is provided in Appendix A.

It is important to note that the figure is tentative, and does not include ‘hidden’ veterans, such as those in prison or living on the streets, a community that has been estimated to number between 190,000 and 290,000 across the UK (RBL,
2014). It is also worth remarking that nearly two thirds (64%) of veterans are over the age of 65 and nearly half (46%) are over 75 (RBL, 2014). The veteran community has reduced significantly (by 44%) since 2005 and it is expected to continue to reduce in the future due to the high proportion of older members (RBL, 2014).

As the preceding section explained, the true scale of the mental health needs of veterans is difficult to estimate. If veterans have similar levels of mental health to non-veterans, then we might expect between 10,000 and 14,000 of local veterans to have at least one mental health condition at any one time (the 2007 Adult Psychiatric Morbidity Survey found a prevalence of approximately 23% for at least one mental health condition; NHS Information Centre, 2007). This figure is a very rough estimate and may be under-representative.

As indicated in the previous sections, veterans are known to be reluctant to engage with mental health services. The following information relates to the numbers of local veterans who have actually received treatment from the NHS:

- Of the 187,465 total referrals into NHS primary care mental health services across the Midlands and the East of England during the period 2013-14, 3,645 (2%) were veterans, of whom 51% completed their initial treatment course (Kirkham, 2015).
- Of the 4,002 triage forms completed by the Access and Assessment Team for Norfolk (NSFT) during the period February-October 2013, 143 (4%) were for patients who reported that they had served in the military (G. Hazelden, personal communication, February 26, 2016).

1.1.3 Mental health services for veterans

As part of a wider motivation to demonstrate support for members of the Armed Forces, both past and present, and their families, the British Government recently promised to ensure that the men and women returning from Iraq and Afghanistan, as well as other veterans, “should be able to access services with health professionals who have an understanding of Armed Forces culture,” if their conditions are thought to be related to their time in the military (MoD, 2011a, p.6).

This pledge was enshrined in the Armed Forces Covenant, which imposes a more general duty of care on the part of the state to ensure that members of the Armed Forces community (including veterans) face no disadvantage, health or otherwise, as a result of military service and that special compensation is awarded to those who have sacrificed the most in defence of their country (MoD, 2011a).

In order to make good on the promise to provide culturally sensitive mental health services, NHS England commissions 12 dedicated veteran services, which were set up following the recommendations made in a report by MP Dr Andrew Murrison (2010). Although these services are sometimes taken as providing a national network, in reality the coverage is patchy and the quality of care varies wildly
from county to county (Mercer, 2016). The nearest service to Norfolk is the award winning Veterans First, which is based in Colchester, and primarily provides care to veterans in Essex.

The dedicated services are complemented by the PTSD Intensive Treatment Programme, provided by Combat Stress from three Residential Treatment Centres and commissioned by NHS England. Veterans and reservists who have deployed since 1982 are also entitled to a one-off assessment by an MoD psychiatric consultant through the VRMHP. Otherwise, it is expected that veterans will use locally commissioned NHS mental health services like the rest of the population.

Outside of statutory services, there is a great wealth and variety of support for veterans in the Third Sector, arguably more than is available to any other group of people. Nationally, there are over 2,000 veteran charities with a collective net worth of more than £1.1 billion (Ashcroft, 2014). These charities employ a wide variety of different approaches, not all of which are evidence based or follow NICE guidelines and the lack of regulation by an independent body like the CQC has led to concerns about the quality of care that is provided to vulnerable individuals (MacManus & Wessely, 2013). Duplication of effort is a further problem, and it is unclear how successfully charities work in partnership with each other (Ashcroft, 2014). Finally, veterans report to being confused about where to go for help (MacManus & Wessely, 2013).

In the absence of dedicated funding, NSFT currently provides a veteran specific outpatient programme (the VSP), in partnership with a local veteran charity called The Walnut Tree Project, as part of its mainstream community services. At the moment, the VSP is run on a small scale, but NSFT is looking for funding to roll out the programme for veterans across Norfolk and Suffolk.

The principal mental health services available to local veterans are outlined in Figure 1 (p.15).

Before concluding this section it is worth briefly mentioning that healthcare for UK veterans is frequently compared (often unfavourably) to the system of provision in America, where all healthcare is provided by veteran specific services through the U.S. Department of Veterans Affairs (VA). The VA has a rich history - indeed it is the only part of the American healthcare system that has been consistently praised (VA, 2010) - and it is interesting to reflect that the organisation currently spends roughly the same amount of money as the entire NHS budget to provide services for 23 million veterans (MacManus & Wessely, 2013).

However, we should be cautious before reading too much into these comparisons. The American healthcare system is mostly private, whereas the responsibility for providing health and care to all British citizens, including veterans, ultimately belongs to the state. An overstretched NHS will never be able to be all things to all people, which means that an entirely distinct veterans’ service like the VA is always going to be impossible, if indeed such a service is to be desired.
If you have concerns about a veteran’s mental health there are specific statutory services offering support, in addition to mainstream services:

NSFT’s Veterans Stabilisation Programme (VSP): 16 week CBT/mindfulness based out patient programme. For PTSD and conditions where a veteran specific approach is preferred. Referrals made via Wellbeing. Veteran status must be identified. Also contact The Walnut Tree Project.
Tel: 0300 123 1503 (NSFT) / 07494 799 023
Further details: click here

Veterans & Reservists Mental Health Programme (VRMHP): Assessment by MOD consultant psychiatrist with treatment guidance. Based in Nottingham. For veterans & reservists deployed since 1982 whose mental health may have suffered as a result of service. GP referrals preferable.
Tel: 0800 032 6258
Further details: click here

If statutory treatment is not found to be suitable, there are several free and veteran specific resources in the Third Sector, in addition to wider mental health resources like Mind:

Step 1: Supportive online community where members can anonymously share their problems. Guidance from trained professionals 24/7. For mild to moderate common conditions.
Tel: 0203 741 8080
Further details: click here

Step 2: ‘Hidden Wounds’ provides support and self-help skills remotely or face to face. For mild to moderate common conditions, anger and alcohol.
Tel: 0808 2020 144
Further details: click here

Step 3: Up to 12 free sessions from a local, accredited psychotherapist. For mild to moderate conditions (usually common mental health). GP referrals preferable.
Tel: 01263 863 900
Further details: click here

Step 4: Bespoke alcohol and drugs service provided by veterans. Part of the Matthew Project and Norfolk Recovery Partnership.
Tel: 01603 626 123
Details: click here

A range of support via contact centres in King’s Lynn & Norwich. Treatment through the wellbeing service. For mild to moderate conditions.
Tel: 0300 111 2030
Details: click here

Veteran specific acupuncture and alternative treatments for PTSD. Based in Norwich. Especially suitable for those who don’t want talking therapies.
Tel: 01603 666 546
Details: click here

Figure 1. GP information resource about local mental health services for veterans.
1.2 The opportunity for Healthwatch Norfolk to make a difference

As explained in section 1.1.1, it is possible that some veterans with mental health conditions have slightly different needs and may therefore require a slightly different kind of service to what is typically provided by the NHS. We felt that this was an important opportunity for us to find out more about how our local veterans would like to receive mental healthcare, to enable commissioners and providers to make their services more effective. We envisioned that our study would complement wider pieces of national research, in particular by FiMT (2013; 2015).

As well as using feedback to improve services for local veterans, the scoping paper identified that there was also an opportunity for Healthwatch Norfolk to enable veterans from Norfolk and Suffolk to influence national commissioning arrangements. The contracts for most of the dedicated mental health services outlined in section 1.1.3 are due for renewal in September 2016. We understood that NHS England would be undertaking a review of the current model of service delivery in spring 2016, and we wanted to be in a position by this time to ensure that local veterans were able to contribute to the wider debate.

Finally, we felt it was important to give veterans the opportunity to comment about their experiences of the Armed Forces Covenant in action. As explained in section 1.1.3, the Covenant establishes that members of the Armed Forces community (including veterans) should never be disadvantaged and should sometimes receive special consideration when it comes to accessing health and social care. It is easy to pledge support on paper, but we wanted to find out more about the practical benefits for local veterans and so we decided to frame our work with veterans within the context of the Covenant.

The Covenant is enshrined locally by the Norfolk and Suffolk Community Covenants. A Community Covenant is a voluntary statement of mutual support between the local civilian and Armed Forces communities, bringing together statutory and Third Sector bodies under the auspices of the local County Council. April 2015 marked three years after the signing of Norfolk’s Community Covenant and it seemed like an appropriate time to review the progress that had been made by local health and social services to honour the terms of the agreement.
2. Method

This was a qualitative study involving a thematic analysis of transcripts from interviews with 30 local veterans.

2.1 Participants

Participants were selected using purposive sampling. In purposive sampling, participants are selected for their knowledge and/or experience of the area being investigated. The study was open to any veteran (as defined by the British Government) who lived in Norfolk or Suffolk and had used or tried to use local NHS mental health services, as provided by NSFT, since March 2012. This date was selected both because it was the month in which the Norfolk Community Covenant was signed and because it ensured that the participants’ stories would be recent and relevant.

Traditionally, our work to date has focused on service users from Norfolk, for whom we are the statutory representative. The decision to include veterans from Suffolk in this study was made due to the fact that NSFT provides services to both counties. Our work in Suffolk was supported by Healthwatch Suffolk.

The scoping paper had highlighted three groups of veterans as being particularly vulnerable to developing mental health problems, and we were especially interested in talking to these veterans (Healthwatch Norfolk, 2014). The groups were as follows:

- Reservists (past or present)
- ESLs
- Veterans who misuse alcohol

The aim was to recruit and interview 30-50 veterans. This target was primarily selected on practical grounds. Although the question of ‘how many interviews is enough?’ is a contentious one within qualitative research, it is worth noting that 30 interviews is widely considered to be a suitable number (National Centre for Research Methods, 2012).

The impact of service upon families is an area of increasing research interest (The Parliamentary Office of Science and Technology, 2016). For this reason, and others, we felt it was important to represent the views and experiences of families as well as veterans. To that end, where appropriate, the participants were asked if they would like to conduct the interview in the presence of their wife or partner.

2.2 Recruitment

The scoping paper had identified that veterans, especially those with mental health conditions, would be hard to reach, and we recognised that we would need to work closely with other organisations to meet the recruitment target. Eight
months were allocated to recruitment (April-November 2015). We contacted more than 200 organisations, most of which agreed to support the study.

A particular effort was made to recruit reservists by advertising through specific networks, such as those provided by the Reserves and Cadets Association for Norfolk and the 254 Medical (Reserve) Regiment. Veterans who misused alcohol were recruited by working with Outside The Wire.

We recognised that ESLs would be particularly difficult to engage with, but, given that they make up a large proportion of all service leavers each year, we hoped that we would be able to reach some through general recruitment.

30 participants had been successfully recruited by December 2015. More veterans had expressed an interest in the study, but by this stage we felt that the saturation point had been reached, and that further interviews were unlikely to yield more information that was instructive to the research aims.

Participants were primarily recruited from the beneficiaries of veteran charities. However, we wanted to be able to talk to as wide a variety of veterans as possible, and so we also worked hard to recruit participants through the following, non-veteran specific, channels:

1. From the previous patients of NHS mental health services (NSFT)
2. From the beneficiaries of other charities
3. From self-referrals

*Figure 2* (below) and Table 1 (overleaf) show the numbers of participants that were recruited via the four channels. Further details about the participants are included in section 3.
Table 1

*Number of referrals by veteran charity*

<table>
<thead>
<tr>
<th>Charity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combat Stress</td>
<td>4</td>
</tr>
<tr>
<td>Help For Heroes</td>
<td>4</td>
</tr>
<tr>
<td>Outside The Wire</td>
<td>3</td>
</tr>
<tr>
<td>Royal British Legion</td>
<td>1</td>
</tr>
<tr>
<td>Royal Naval Association</td>
<td>1</td>
</tr>
<tr>
<td>Stand Easy</td>
<td>3</td>
</tr>
<tr>
<td>Walnut Tree Project</td>
<td>2</td>
</tr>
</tbody>
</table>

Further details about our recruitment strategy and supporting materials may be found in Appendices B and C.

2.3 Interviews and questions

The data was collected using semi-structured interviews. In a semi-structured interview, the researcher prepares a general framework of key themes to be explored (an interview guide) with a list of questions to stimulate and focus the discussion, but the structure of the interview itself remains flexible and the participant is encouraged to dictate the flow of the conversation, going into detail about whichever themes are most important to them and exploring new areas of interest where appropriate.

The purpose of a semi-structured interview is to refine understanding. This type of interview is well suited to the kind of study we were conducting, where some themes had been identified as being of potential significance prior to data collection (i.e. via the scoping exercise), but where no fixed ideas about these themes had been developed.

The interviews covered a very broad period of time, from the participants’ time in the Forces (often many years ago; see section 3.3) through to the present day, although they focused on the period after discharge and recent experiences with NHS mental health services. More specifically, the interviews centred on the following themes:

- The participant’s military career
- Mental health support in the military
- Transition into civilian life
- Using mental health services (NHS)
- Using mental health support (Third Sector)
- The role of the GP
- The Armed Forces Covenant in action

A full interview guide is included in Appendix D. The guide was trialled with veterans at a meeting of the Norwich Combat Stress support group in May 2015.
The wording of the questions was amended as a result of feedback from this group, but the general structure of the guide was well received.

The interviews were conducted at a time and place of the participant’s choosing (usually their home) and participants were asked whether they would prefer to conduct the interview face-to-face or over the phone. Healthwatch Norfolk committed to paying for any expenses accrued by participants.

Twenty-nine (29) of the interviews were recorded for later analysis. In total, there were 31 hours and 12 minutes of recordings. Each interview lasted an average (mean) of 64.5 minutes. Two interviews were conducted over the phone and 28 were conducted face-to-face. Seven interviews involved the participant’s wife or partner and five were conducted in the presence of a member of staff from the referring organisation. Two interviews took place at a meeting of the Norwich Combat Stress support group.

2.4 Ethics

Ethics approval was granted by NSFT to enable us to speak to their service users (Appendix E).

2.4.1 Obtaining informed consent

Participants were asked to give explicit written consent to participate in the study. An information sheet providing details about the study was given to participants in advance of their interview, where possible at least one day before, so that they had time to make an informed decision about whether or not they wanted to take part. We went through the sheet again on the day of the interview to give participants the chance to ask any questions. The information sheet/consent form may be found in Appendix F.

Where interviews were recorded participants were asked to give consent to be recorded. Where interviews involved the participant’s wife or partner they were also asked to give consent. Verbal consent was obtained for the two telephone interviews.

2.4.2 Participants’ welfare

We recognised that this study would involve discussions about sensitive issues with vulnerable people, and there was a risk that the interviews could have a negative impact on participants’ mental health and recovery. The welfare of the participants was our highest priority from the outset and we sought to mitigate any risks by ensuring that:
• We worked closely with the organisations who were recruiting participants on our behalf to ensure that they only referred participants who were willing and able to take part (Appendix G).
• The researcher attended Mental Health First Aid training in advance of conducting any interviews (Appendix H).
• The participants understood that the interviews could take place in the presence of supporting staff, or, if necessary a qualified mental health practitioner.

Healthwatch Norfolk also committed to paying for up to a maximum of 6 sessions of counselling/therapy if a need was identified as arising from participation in this study but no such need was identified throughout the study.

2.4.3 Confidentiality and anonymity
Following each interview, the recordings were transcribed from audio to text format. The conversations were transcribed verbatim, i.e. word for word. The recordings and transcripts were stored on a password protected system for the duration of the study and they were accessed only by the researcher.

The study also involved the collection of personal information. Any sensitive or identifiable data was stored separately from the recordings and transcripts on a password protected system in compliance with the UK Data Protection Act (1998). All recordings, transcripts and personal data were destroyed immediately after the publication of this report in line with Healthwatch Norfolk policy.

No sensitive information is included in this report and we have taken all reasonable measures to mask any potentially identifying aspects within the participants’ stories. Pseudonyms have been assigned to all participants and we have not included the names of any individual staff members, except in cases where they were praised (with the written permission of the staff member.)

2.5 Quality assurance
Whilst this was not an academic study, we wanted to ensure that our work was of the highest possible standard. To that end, a Steering Group was established to monitor progress and provide guidance and advice (Terms of Reference, Appendix I). The group met four times on a bi-monthly basis from June-December 2015 and was composed of the following members:

Luke Woodley - The Walnut Tree Project
Rod Eldridge - WWTW
Andy Wicks - Outside The Wire
Kate Green - RBL
Carolyn Brown - Combat Stress

Gary Hazelden - NSFT
Caroline Money - NCC
Diane Palmer - Veterans First
Matt Fossey - Anglia Ruskin University
Alex Stewart - Healthwatch Norfolk
Ed Fraser - Healthwatch Norfolk

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Five further measures were taken to ensure that our work was of the very highest quality:

- The progress of the study was monitored from inception through to completion by the Healthwatch Norfolk Quality Control Panel, which consists of the Healthwatch Norfolk CEO and three members of the Board, all of whom are experienced health and social care professionals and one of whom is a qualified researcher.
- As mentioned in section 2.3, the discussion guide was trialled in advance of the interviews with veterans at the Combat Stress support group in Norwich. The guide was amended on the basis of the feedback that was received by members of this group.
- Members of the Healthwatch Norfolk team, in the company of a research consultant, assisted in the initial coding and analysis process and provided validation by offering independent scrutiny (section 2.6).
- Participants were given the opportunity to comment on an initial draft of the findings. In particular, we wanted to give them the chance to verify that their views had been fairly represented. Elements of the draft were amended on the basis of their comments before this report was published.
- The report was also shared in advance of publication with the organisations whose services featured in the participants’ feedback, to make sure that their services had been accurately represented.

2.6 Template Analysis

The data (transcripts) were analysed with the aid of NVivo v.10, which is a piece of qualitative analysis computer software. A method of thematic analysis was used called Template Analysis. This method was chosen because of its flexibility and its suitability to the size of the data set.

Template Analysis involves the development of a coding template, which summarises those themes in the data set that have been identified as being of importance and organises them in a useful and meaningful manner (University of Huddersfield, n.d.). Hierarchical coding is emphasised, with broad themes, such as ‘experiences of NHS mental health services’, encompassing successively narrower, more specific ones such as ‘experiences of the Wellbeing Service’.

As usual with Template Analysis, an initial template was produced based on a subset of the data set, which included five of the transcripts. As noted above, as a means of validating the initial coding and analysis, members of the Healthwatch Norfolk team were provided with the sample transcripts and were invited to scrutinise the template in a coding workshop, where the suitability of the template was discussed and revisions were made.

The refined template was used as a guide to code the rest of the data. Where data did not fit naturally with the template, the template was amended until a final template was produced. This template was used to support further analysis.
The final template consisted of eight hierarchical themes. These themes were initially conceived \textit{a priori} (before data collection) either because previous research had indicated that they may be of importance or because they formed part of the discussion guide (or both). Subsequent analysis showed that their inclusion was justified as they emerged to be of considerable significance to the participants. Whilst the hierarchical themes were conceived ‘top down’, they were not fleshed out in any detail until the analysis stage, and the sub-themes were very much developed in a ‘bottom up’ style on the basis of an analysis of the data set.

The first theme, \textbf{A. ONCE A SOLDIER, ALWAYS A SOLDIER}, was the most important. It was an integral theme, running ‘laterally’ through the participants’ stories and contextualising their experiences of using services, (themes B-E), which ran ‘horizontally’. This is shown by \textit{Figure 3}.

\textbf{Figure 3. Overview of themes.}

The final template was as follows:

\textbf{A. ONCE A SOLDIER, ALWAYS A SOLDIER}

1. The importance of the military bond
2. Issues with transition
   2.1 Institutionalisation and culture shock
       2.1.1 Attitudes towards work
   2.2 Losing the social network
2.3 Perceptions about MoD transitional support

3. The legacy of service
   3.1 Combat experiences
   3.2 Military training

4. Help seeking behaviours in the military
   4.1 Stigma
   4.2 Normalising problems
   4.3 Perceptions about attitudes towards mental health in the military

5. Help seeking behaviours in Civvy Street
   5.1 Desiring a veteran specific approach
      5.1.1 Or not...
   5.2 Lack of information as a barrier to care
   5.3 Coping
      5.3.1 Drugs and alcohol
      5.3.2 Working

B. MoD MENTAL HEALTH SERVICES
1. Views and experiences
2. Onwards liaison

C. VIEWS AND EXPERIENCES OF NHS MENTAL HEALTH SERVICES
1. Primary services (Wellbeing)
2. Secondary services
3. Veterans Stabilisation Programme
4. Veterans First
5. Wider psychiatric support
   5.1 Hospitals
6. Alcohol services

D. THE ROLE OF THE GP
1. Positive experiences
2. Lack of understanding about mental health issues
3. Veteran GPs and the importance of the military link

E. THIRD SECTOR SUPPORT
1. Combat Stress
   1.1 Residential facilities
   1.2 Community support
2. Outside The Wire
   2.1 The importance of the military link
   2.2 Personalised, holistic treatment
   2.3 Partnership working with The Anchor
   2.4 Family support
3. Stand Easy
   3.1 Transformative and restorative effects
   3.2 Helping with sleep
   3.3 Family support
4. Other charities
5. Partnership working

F. THE EFFECTS ON FRIENDS AND FAMILY
G. WIDER WELFARE ISSUES
1. Employment
   1.1 Support at work
   1.2 Job seeking
2. Housing
3. Benefits
   3.1 Military compensation

H. ARMED FORCES COVENANT AND THE CIVILIAN / MILITARY INTERFACE

Figure 4. Final template.
2.7 Strengths and limitations

The strength of a qualitative study is that it brings the researcher closer to the world of their participants by enabling a rich understanding of their personal experiences. Service user feedback is an important way to measure the effectiveness of any service and the advantage of an in depth approach is that it enables exploration of not just whether or not a service is working well for any particular individual(s), but also why this might be the case. We felt that this kind of approach would be particularly useful when it came to veterans, because previous research had indicated that some veterans may have particular needs that are different to the needs of other service users.

If the strength of a qualitative study is that it reduces the distance between the researcher and their participants, then one of the ongoing challenges of conducting this kind of research is to ensure that one’s own personal biases and beliefs do not unduly influence the findings. Arguably, it is impossible to completely guard against researcher bias, but it is quite possible to diminish its effects by being reflective and responsive to the threat, which is why we took great care to employ the quality insurance measures described in section 2.5.

It is important to recognise that, whilst service user feedback can be invaluable, it will only ever tell part of the story. This study was not intended to be a full evaluation of the quality of care provided by NHS and Third Sector providers. The findings reflect the views and experiences of a sample of local veterans. The sample was not representative of all veterans in Norfolk and Suffolk and as such the findings do not speak to the objective quality of services.

The method of sampling was the principal limitation of this study. In spite of our own recruitment efforts, the vast majority (26/30 = 87%) of participants were referred to the study from another organisation. This could be a problem because any organisation would be very unlikely to refer somebody who was going to give them a negative review; indeed all of the participants were almost exclusively positive about the organisations that had referred them.

Given that the main aim of this study was to find out more about how veterans experience, and would like to experience, NHS mental healthcare, the limitation is particularly relevant in the case of the five participants who were referred from the NHS. This issue will be returned to in section 4.5.

This issue was exacerbated in five interviews by the fact that a member of staff from the referring organisation was also in attendance, making the participant even less likely to want to speak negatively. However, in these interviews, the participant had requested that their interview take place in the company of their support worker and we felt that it was important to prioritise the welfare of our participants above all other concerns.

Whilst we tried hard to ensure that we were able to talk to as wide a range of veterans as possible, (section 2.2 and Appendix B), most participants (18/30 = 60%) came from the beneficiaries of veteran charities. We might expect these veterans
to be more likely to have had negative experiences with the NHS, hence why they looked for help elsewhere. This might skew the findings by painting a more negative picture of the quality of care provided by the NHS. It is also worth bearing in mind that this kind of study will always attract people with particularly strong views, which can also result in an exaggerated picture of reality. On a positive note we were able to talk to a group of veterans with a wide range of characteristics by most measures relevant to the research interests of this study (section 3).

In publishing this report, Healthwatch Norfolk is discharging a statutory duty set out in the Health and Social Care Act (British Government, 2012). Under this duty, we are required by law to gather the views and experiences of local people regarding their needs for and experiences of local health and care services. This legislation also requires us to gather experiences from people in Norfolk to whom services are being provided in any place.
3. Information about the participants

To facilitate in-depth analysis, information about the participants’ backgrounds and characteristics was collected during the interviews. With so few participants, there is little to be gained from comparisons with the wider veteran population, although any significant similarities or differences will be highlighted briefly in this section. Full comparisons with data from the RBL Household Survey (2014) and presentations to Combat Stress (Kaur, 2015) are included in Appendix J for further information.

3.1 Age, gender and ethnicity

All of the participants were white males. The veteran community is largely male (89%; RBL, 2014) and white (98%; RBL, 2014) but we were disappointed not to be able to speak any female veterans or veterans from a more diverse range of ethnicities, because these veterans may have very different needs having experienced military life in a white and male dominated environment.

The average (mean) age of the participants was 49 years. The oldest participant was 80 and the youngest was 23. The participants were younger than we might have expected, given what we know about the wider veteran community (Appendix J, Figure J1).

3.2 Location

The majority of the participants were from Norfolk (22/30 = 73%). Figure 5 and Table 2 show in which CCG area the participants lived.

Table 2

Numbers of participants by CCG

<table>
<thead>
<tr>
<th>CCG area</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Norfolk</td>
<td>3</td>
</tr>
<tr>
<td>West Norfolk</td>
<td>6</td>
</tr>
<tr>
<td>South Norfolk</td>
<td>7</td>
</tr>
<tr>
<td>Norwich</td>
<td>2</td>
</tr>
<tr>
<td>Great Yarmouth and Waveney</td>
<td>7</td>
</tr>
<tr>
<td>Ipswich and East Suffolk</td>
<td>3</td>
</tr>
<tr>
<td>West Suffolk</td>
<td>2</td>
</tr>
</tbody>
</table>

Figure 5. Location of CCGs in Norfolk and Suffolk.
3.3 Military career

Twenty-nine (29) participants had served in the UK Regular Armed Forces. One participant had served in the U.S. Air Force, which currently operates from RAF Lakenheath, Suffolk. This participant did not meet the inclusion criteria for the study but they were included anyway because it was felt that their story would serve as an interesting comparison.

Reservists were the first of the three groups of veterans that we were particularly interested in talking to. Unfortunately, in spite of a targeted recruitment effort (section 2.2 and Appendix B), we were unable to speak to any reservists, although several participants had served in the Reserve Forces after serving as a regular.

Nearly half of the participants (14/30 = 47%) had served in the Army (Figure 6). This is broadly reflective of the wider veteran community although it is not particularly representative of veterans seeking mental health support from Combat Stress (Appendix J, Figure J2).

![Figure 6](image)

*Figure 6. Information about the branch of the Forces the participants served with.*

On average (mean), participants left the Forces 19 years ago. The most recent discharge date was 2015 and the least recent date was 1975. The participants served more recently than we might have expected (Appendix J, Figure J3).

On average (mean), participants served in the Forces for 12.5 years. The shortest career was 3 years and the longest career was 26 years. The participants served for longer than we might have expected (Appendix J, Figure J4). ESLs were the second of the three groups of veterans that we were particularly interested in talking to. Five participants (16%) had a career that was no longer than 4 years, and might therefore have been ESLs.
Most of the participants (24/30 = 80%) had been deployed to at least one conflict zone. Almost half (14/30 = 46%) had been deployed to Northern Ireland. The figures are similar to the presentations seen by Combat Stress (Figure 7).

**Figure 7.** Theatre of operation: participants compared to Combat Stress data.

Most participants (27/30 = 90%) were from the ranks (Private or equivalent) or were Junior or Senior Non-commissioned Officers (NCOs) as shown by Figure 8. These figures are similar to what we might have expected (Appendix J, Figure J5).

**Figure 8.** Participants’ rank on discharge.
Most participants (18/30 = 60%) left the military voluntarily (*Figure 9*).

*Figure 9. Reason for discharge.*

### 3.4 Physical and mental health

Fifteen (15) participants suffered from PTSD (13 conditions were primarily related to combat) and 12 suffered from depression and/or anxiety, as shown by *Figure 10*. Some participants suffered from more than one condition.

*Figure 10. The participants’ mental health diagnoses.*
The diagnosis of PTSD was more prevalent than expected, but this might be due to the fact that participants were primarily recruited from the beneficiaries of charities working specifically with veterans who have PTSD (e.g. Combat Stress). It should also be noted that we did not have access to patient files and so we relied upon the participant to remember their formal diagnosis, which some participants found to be quite challenging. For these reasons, the figures should not be taken to be representative of prevalence amongst the general veteran population.

The majority of participants (20/30 = 67%) said that at least some of their symptoms related to their military experiences (e.g. flashbacks, nightmares, hallucinations, intrusive memories). Unsurprisingly, this included all of the (13) participants who had been diagnosed with combat related PTSD.

Nineteen (19) participants (63%) said that, on reflection, they had suffered from some symptoms when they were in the military. Of these, six had received mental healthcare from the MoD.

The problem of alcohol within the military has already been identified in section 1.1.1. It was not surprising, therefore, that alcohol featured strongly in the stories of nearly half (14) of the participants.

The majority of participants (19/30 = 63%) felt that they had a physical disability, and of these, most (17/19 = 89%) felt that their disability was service related. Again, these figures rely on self-reporting and should not be taken to be an indication of the general health of the wider veteran community.

As Figure 11 shows, half of the participants had received or were receiving compensation for (service attributable) physical or psychological illness or injury through one of the two MoD compensation schemes; the AFCS or the WPS. A further five participants were pursuing a compensation claim at the time of their interview:

![Figure 11. Numbers of participants receiving compensation for physical or psychological illness or injury.](image-url)
3.5 Usage of civilian services

Twenty-six (26) participants spoke about their experiences with their GP, who was the first port of call in most (22) cases.

Twenty-one (21) participants had used NHS mental health services since March 2012 (Figure 12). Nineteen had used mainstream mental health services provided by NSFT and three had used a dedicated veterans’ service (some participants had used both types of service). Three participants had received treatment from a specialist drugs and alcohol service (Figure 12).

![Figure 12. Types of services used by the participants.](image)

Six participants had not been able to use either mental health or drugs and alcohol services (Figure 12) for reasons that will be discussed in section 4.4.1. This included the participant who had served with the U.S. Air Force, who was still receiving his healthcare from America.

Combat Stress was the most used Third Sector service (14). Five participants had used Outside The Wire and five had received treatment from Stand Easy. Figure 13 (overleaf) shows a full list of all the services used by the participants, presented in a matrix format, where arrows show the direction of travel between the different organisations.
Figure 13. Matrix of the relationships between the organisations used by the participants.
3.6 Pseudonyms

1. Senior NCO (SNCO) Peterson, Army
2. Junior NCO (JNCO) Rogers, RAF
3. Senior NCO (SNCO) Matthews, RAF
4. Junior NCO (JNCO) Williams, RAF
5. Junior NCO (JNCO) Nelson, RAF
6. Officer Gibbs, Army
7. Private (Pte) Miller, RAF
8. Private (Pte) Taylor, Army
9. Private (Pte) Stevens, Army
10. Officer Perkins, RAF
11. Private (Pte) Reed, Army
12. Senior NCO (SNCO) Hyde, Navy
13. Private (Pte) Anderson, Marines
14. Junior NCO (JNCO) Middleton, Army
15. Officer Palmer, Army
16. Senior NCO (SNCO) Parker, Army
17. Senior NCO (SNCO) Anderson, RAF
18. Junior NCO (JNCO) Bateman, Marines
19. Private (Pte) Grant, Navy
20. Senior NCO (SNCO) Clark, U.S. Air Force
21. Senior NCO (SNCO) Chadwick, Navy
22. Senior NCO (SNCO) Martin, Army
23. Private (Pte) Jones, Army
24. Junior NCO (JNCO) Turner, Army
25. Private (Pte) Lewis, Army
26. Senior NCO (SNCO) Harris, RAF
27. Private (Pte) Hooper, Army
29. Private (Pte) Davies, Army
30. Private (Pte) Connor, Army
4. Findings

Traditionally, the purpose of a Healthwatch Norfolk project has been to gather feedback from local service users and to use this feedback as evidence to justify a set of recommendations for service improvement, made upon completion. As such, the following section outlines the key findings from this study, which will be used as evidence to support the recommendations in section 7.

This study additionally incorporated elements of a Participatory Action Research model (Bergold & Thomas, 2012), whereby, as far as possible, we took steps to work with key stakeholders to resolve issues as and when they were raised by the participants. Further details about Healthwatch Norfolk’s wider activities to improve services for veterans will also be included in this section.

The participants’ views and experiences have been reported exactly as they were told, to keep true to the essence of their stories. By consequence, some of the stories quoted in this section contain language that may be offensive to some people.

4.1 Once a solider, always a soldier

The majority of the interviews (27/30) began with questions about the participants’ military careers. It was apparent that service in the Armed Forces had had a profound effect upon the life of every participant:

“I can’t be the only one in the country that sits there on one hand knowing that you'll never be in the Army again, but on the other hand, waiting for a call... I guess - I guess - you’re actually hoping to get called up... You never actually forget the Army or forget your service,” JNCO Turner.

4.1.1 Armed Forces culture and the importance of the military bond

The unique nature of Armed Forces culture was discussed in section 1.1.1 and aspects of this culture clearly remained relevant to the participants, even those who had left the Forces many years ago. Sometimes, legacies from military life presented themselves in the smallest of ways:

“I got out [nearly 25 years ago] but I’ve still got such a military head on, and I feel everyone I meet still has... I still look smart when I go out, still iron all my stuff to a stupid level,” Pte Davies.

It was clear from the way in which the participants spoke that they felt they had been marked out as different to civilians by virtue of their service. The notion that ‘you can always spot a military person’ ran through the stories and the participants felt strongly that there is a special bond between individuals who serve or have served in the military, and who therefore share in the Armed Forces culture:
"I suppose it’s that whole kind of, ‘You can’t pick your family but you can pick your friends.’ And what the military family is; basically a very close-knit group of people that get each other,” Officer Perkins.

Teamwork is one of the key values of Armed Forces culture and it is strongly emphasised in training. Military personnel live and work side by side with their comrades, whom they ultimately rely upon for their survival. It can be difficult for civilians to understand the strength of a fellowship that has been forged in the crucible of combat:

“There’s something that goes with the territory about trust and honour and all these kind of terms that really need to have inverted commas like that around them which you just take as a given. You trust everyone and you expect everyone to trust you. It’s almost as though trust isn’t earned, it’s bestowed upon you, and then you’ve got to keep it. Rather than in Civvy Street where no one trusts anybody until you’ve done something outstanding to prove the point. It’s a different way of looking at it,” Officer Perkins.

Two participants shared interesting anecdotes, suggesting that the military bond is universal across individuals from different Armed Forces:

“If you’re military, you’ll talk to other military people then you’re just best friends off the bat... [Recently] I spent eight days [with a veteran charity]... I was riding with the Germans, the Norwegians, the Estonians, and it’s really amazing that even though we’re all from different cultures, saying you’re military off the bat, you just start to chat about life. We formulated that, and I’m not sure what it is, it’s not lingo, terminology. I think perhaps it’s just how we presented ourselves,” SNCO Clark.

“I did six months working with the Argentinian Army... it was a team of three nations working together: Germany, Argentina, and Britain. Good mixture. But in fact within two days, everybody understood each other. We’re all on the same side, so we bond together, and we [realise that] the Argentinians weren’t getting paid... What we did was, us and the Germans got extra money, clubbed it together, and gave it to the Argentinian guys, so they could all come out here still. We didn’t want it back, it wasn’t a loan, it was just, ‘Here you go guys, you spend that, that’s fine.’ Some of them wanted to send money home, so we gave them extra money, but that’s got nothing to do with Germany, Argentina, Britain; we’ve always been at war. And yet when you bring it together in that little culture, they’re in the same culture as us. The military one,” SNCO Martin.

Whilst every participant had been affected by their time in uniform, the military link was more important to some than it was to others. The majority felt that serving in the Forces was a way of life, not just a job, but not everybody agreed with that sentiment. In particular, one participant felt that the bond between veterans is similar to that between former co-workers from other professions:
“If you get a bunch of construction workers that have a conference, they can talk about what nail you use, what hammer you have... Same thing with military. It’s with everything,” SNCO Clark.

4.1.2 Transition

“I have to remind myself sometimes when I wake up. Sometimes I wake up looking for my kit,” JNCO Walker.

The enduring relevance of Armed Forces culture, as just described, is perhaps best demonstrated by the fact that so many participants found it difficult to adjust to life outside the Forces. In total, 28 participants spoke about the transitional period and only two of them said that they had faced no problems whatsoever.

On the face of things, this does not seem to be very revealing. After all, the majority of participants (19) left the military whilst they were already suffering from some symptoms and, given the challenges of life with a mental health problem, it was always likely that many of them were going to find it hard; indeed, neither of the participants who enjoyed smooth transitions were suffering from any symptoms at the time of discharge. However, whilst a few had quite clearly struggled with specific problems that were a direct result of their mental health, there was a general consensus that, these problems aside, adjusting to life outside the Forces could be difficult at the best of times.

As shown by Figure 9 (p.31), 12 participants left the military non-voluntarily, having left or been discharged for medical reasons. We might have expected these service leavers to have found the transitional period particularly hard, an expectation that would have been shared by two participants:

“I think [choosing to leave] is good for helping with readjustment. If they told you to leave or you finish, I think it’s hard. But if you say, ‘I’m leaving,’ I think that makes it easier. It’s just a general thing I’ve noticed for myself. If I’d have done my whole term, my whole life may have been different,” SNCO Martin.

“[It’s] more difficult if you’ve gone non-voluntarily, like I did. That wasn’t supposed to happen to me. I was supposed to stay in until my retirement age and have a career and all the rest of it. And that was quite quickly snatched away. So it’s almost like a bereavement type loss,” Officer Palmer.

Generally speaking, participants who left the military non-voluntarily, especially those who were medically discharged, did struggle to adjust to life outside the Forces. Three participants found it particularly hard to come to terms with the loss of what was supposed to have been a life-long career:

“I joined the Royal Navy when I was 15. I wanted to since the age of five... It’s in my blood... The other night I dreamed I was on a frigate... [When I was in the Navy] I used to do all the charts, the weather, astronomy. God, I loved it, loved every
minute. I still do the weather. I’ve got a weather station on my roof. I go to astronomy. I love all that and that was all due to the Navy. Yeah, that was my home...

When I left [the Navy], after being discharged... I cried me eyes out for ten minutes, and that’s the first time I’ve cried since I was a boy,” Pte Grant.

“I was absolutely heartbroken... what I always wanted to do as a little boy was be in the Army and be an infantry soldier. So yeah, it was quite devastating,” Pte Taylor.

“I’d joined up from boy soldier. I literally left school... and then joined the Armed Forces, and that’s all I ever knew,” Pte Lewis.

Interestingly, though, many service leavers who left voluntarily had similar problems:

Researcher: “You took voluntary redundancy. Did that make it easier to adjust to life outside the wire, or did you find it hard leaving?”

JNCO Turner: “I found it very hard... I guess you get institutionalised. I mean, I did 16 years in the Army and loved every minute of it. And if they were to turn around tomorrow and say... ‘Can you come back?’ I’d be there. I know I would.

“My life fell to bits when I left the Air Force. I walked straight into a different job in IT so it was really as if I was floundering around going, ‘I don’t know what I’m going to do with life... I’m still floating. I’ve tried various jobs around here, none of which are serious or could be a career... So the last seven years of my life just being in limbo, not knowing where I’m going,” Officer Perkins.

If it is fairly apparent why many of the participants who were ‘forced’ to leave the military might have found it difficult to adjust to life outside the Forces, it is not immediately obvious why those who left of their own accord should have struggled too. This finding may be partly explained by the fact that the term ‘voluntarily’ should be loosely defined. For example, some of the participants who left the Forces voluntarily did so for reasons such as wanting to save their marriage (four) and would ideally have preferred to stay in uniform. If they felt that they had no real choice in the matter, then it is more understandable why they would also have found it difficult to leave:

“My biggest regret in life is that I left the services,” JNCO Bateman.

A quick glance at some of the above stories should be enough to prove that this explanation is insufficient. Instead, the true explanation seems to lie in an observation noted in the previous section, namely that most participants viewed service in the military as a way of life, rather than just a job. This meant that,
regardless of how or why they left the military, ultimately they all faced the same challenge of having to adjust to a whole new way of doing things as a civilian:

“It’s not like changing your job. You’re changing your whole lifestyle and culture and the military culture is a lot different to civilian culture,” JNCO Rogers.

As JNCO Rogers hinted, the adjustment was complicated by the fact that civilian life was found to be governed by a very different set of values to military life. The issue was particularly relevant where participants tried to apply the lessons they had learned from their time in uniform at the civilian workplace:

“I had trouble adjusting to civilian life. That was very hard. It took about ten years to realize that people do things differently. They don’t commit as much... they look at a job and think, ‘Yes, it’s nearly home time.’ Whereas I would look at a job thinking, ‘We need to get this completed to the best of our ability quickly and so on and so forth.’ That was very hard to understand why people couldn't be bothered,” JNCO Middleton.

“I had an argument with one person [at work] once and he turned around to me, and said, ‘Well, you’ve got to understand [is that] not everything is black and white in life.’ And I said, ‘Look, I’m an ex-serviceman. Everything is black or white.’ He said, ‘No, there’s grey in between.’ And my friend come in... who’s an ex-Army guy, and I said to [him], ‘What’s life? Is it black and white or does it have areas of grey?’ And [he] turned around and said the same, ‘No, it’s black or white. This is what it says. This is what we do,’” JNCO Rogers.

“I struggled with finding a decent job... I think it’s because you’ve gone from having status and a way of life to working in Civvy Street. It was quite a change... I struggled with the transition in terms of people, how they dressed, not taking their time, going off sick for the earliest of excuses, not putting the clients first, it was all about them. I thought, ‘This is a different world.’ In the military where you worked as teams, you’d look to solve a problem. The mission was everything, and that mission will be achieved, then you worry about the other stuff after. It’s the opposite when you’re out-- look after number one, and if the client down the end who I’m visiting today gets me for an hour to have a coffee or a walk round town, then good,” Officer Gibbs.

Unable, or unwilling, to come to terms with life as a civilian employee, several participants drifted into professions that were similar to the military, such as security or policing. One actually went back to work for the Forces, having tried, and failed, to find meaningful employment elsewhere:

“When you think I was a chief... Top chief in the Navy, basically. And then I’ve come out and I’ve gone right down to ground level and that’s where I’m going to stay because I haven’t got the confidence to move on. And I don’t think there’s anything that would help me to move on...”
“I’m [now] working with the military so I’m back in an area that I’m familiar with. To this day, I couldn’t really work anywhere else because I just don’t know how to handle it,” SNCO Hyde.

The period of transition is well known to be an area of vulnerability for some service leavers. Outside of academic research, the historic trend has been to identify adjustment issues such as those just raised as being to a large extent the result of individuals being ‘institutionalised’ by service.

Military personnel live in a protected environment where all of their basic needs (food, housing etc.) are catered for. They receive their healthcare on base. They are surrounded by their comrades and closely monitored and managed by a rigid command structure, being told exactly what to do and when and so on. Individuals can enlist in the Forces from the age of 16 (with parental consent), and the worry is that the military way of life breeds a sort of dependency, which means that service leavers are unprepared for the harsh realities of life in the real world.

Four participants used the term ‘institutionalisation’ in their stories. More broadly, it was clear that, for a significant minority, part of their problems adjusting to life outside the Forces related to difficulties with the practicalities of everyday life as a civilian:

“You leave the Forces; nobody tells you anything about, ‘Have you got registered with a doctor?’ Nobody tells you what could happen. You could come out and you’re like a fish in a sea full of sharks because they’re all after your money,” SNCO Hyde.

“When you’re in the Army, if you get in trouble or whatever, you get to the barracks and the officers can drop the magic umbrella and sort out any your issues... Or bills or finance issues, or anything like that. But when you come out, you’ve got no magic umbrella to help you or protect from stuff,” Pte Taylor.

“You’ve been living in a nice little bubble where you’re protected. You’ve got free medical care, subsidized housing, you haven’t got to worry about anything if you’re single, your food, three meals a day are provided in the mess so you haven’t got anything to worry about. Basically, your money you can just go and drink it all or whatever. It doesn’t affect you,” JNCO Rogers.

The issue of institutionalisation as it relates specifically to healthcare, as mentioned by SNCO Hyde and JNCO Rogers, will be explored in more detail in various places later in the report because it may have implications for the way that some veterans behave as users of the NHS. Generally speaking, however, current thought on the matter is that institutionalisation is too simplistic an explanation for the wide range of issues faced by service leavers during the transitional period. Instead, recent researchers have preferred to think of institutionalism in terms of a broader model of culture shock (Bergman, Burdett & Greenberg, 2014).
The model of culture shock is instructive as an interpretation of the participants’ stories. Crucially, the issue was not so much that the participants had been rendered in some way helpless, or incapable of looking after themselves, as a result of their time in uniform; indeed, many of them would have argued the opposite:

“When I got out of the Army, I could completely look after myself, as I still can now. And I learned so much from being in [the Forces],” Pte Davies.

Rather, the reason why so many struggled to adjust to life outside the Forces seemed to be that the values of Armed Forces culture remained more relevant to them than the new values governing people in Civvy Street.

The ongoing relevance of Armed Forces culture is attested to by the fact even some of the (nine) participants who left service because they had had enough of military life still struggled to move on. Pte Davies, quoted above, had actually left the Army because he was being bullied nearly 25 years ago, having served for four years, but he explained how he was still finding it difficult to adjust:

“I’ve bounced around for ages not having a proper job, just getting temporary jobs. One minute I was bullied but an important member of team. I had a serial number, I knew where I had to be, every day, at what time. Now to someone who hasn’t been in the Forces, that might sound a bit crap. Christ, why would you want that? When you go in the Army... they rewire your brain so that in the end physical training is fun, and getting up at 6:00 o’clock is perfectly normal and that crazy stuff,” Pte Davies.

Pte Davies not alone in identifying the enduring effects of military training and the implications of training as a process of ‘rewiring’ will be explored in more detail in section 4.1.3.

Moving on, the participants’ troubles adjusting to civilian life were compounded by the fact that, generally speaking, people in Civvy Street were just as unable to understand life in the military:

“You feel lonely and vulnerable when you leave the Forces, because the safety net of what you do and what did and stand for is all gone, because I think people forget that the day you leave the Forces, you lose your job, your home, your income, your prospects... your role and your purpose in life... all in one day... on top of that, you then find that no one’s really interested,” SNCO Matthews.

In the most extreme cases, this ‘culture clash’ could lead to social exclusion, whether imposed or self-imposed, which is a known risk factor for poor mental health. The potential importance of the military/civilian interface will be explored in more detail in section 4.7.

With the above in mind, it is unsurprising that many participants missed the old camaraderie they had enjoyed when they were in the military:
“It’s very different when you come out. There’s no-one looking after you, no-one watching your back and so on,” JNCO Middleton.

“I’ve learnt [that] in Civvy Street in general - there isn’t anybody I would trust with my life. In the Forces, you do trust people with your life; you have to... And you work together. When you’re put in a situation [in Civvy Street] where there’s only you - you don’t have to depend on anyone; you don’t have to rely on anyone - it’s fine. There’s only me that I have to look after, and that’s how it is,” JNCO Turner.

One participant, who was discharged nearly 40 years ago having served for four years, explained with particular clarity how he was still affected today:

Pte Anderson: “When I left the Marines there was a period of time when it was such a shock being in Civilian Street, and things just didn’t seem the same, well they weren’t the same as far as interaction with people. That was difficult—”

His wife: “That was the most difficult time of our life, I think. When you left the Marines.”

Pte Anderson: “It was, yeah. There was a period of time when I was drinking heavily and stuff like that, which I know a lot of other guys have been in that situation, and it’s one of those things that you do it to numb the senses as much as anything else.”

Researcher: “What were you trying to numb the senses about?”

Pte Anderson: “Well I suppose it was that sort of feeling different, left out, odd. Just not having that connection with other people, and I think I’ve, since leaving the Marines, I’ve always been secluded. I’ve never-- I know a good number of people, but I don’t actually have friends, do I? I don’t go out drinking with people or whatever, I just keep myself to myself and do what I do.”

Whilst the vast majority of participants seemed to find it difficult to adjust to life outside the Forces because they were unable, or unwilling, to reconcile themselves with the fact that civilian life is ruled by a different set of values to Armed Forces culture, it must be acknowledged that two participants faced transitional challenges that had nothing to do with their time in the military. Indeed, one participant actually rejected the notion that adjustment issues had any sort of unique military flavour, and felt that the challenges he faced were typical to people leaving any profession:

“Obviously it’s like... teaching or the priesthood or whatever. It’s a vocation. And if you’ve done it for any length of time, then you have the normal adjustment problems that anybody gets when they leave a profession,” Officer Palmer.
Transitional support

With so many participants struggling in Civvy Street, the general consensus was that the MoD could have done more to help:

“The report that you got was almost similar to a school report... About five sentences, isn’t it... That’s your reference for the rest of your life,” the wife of Pte Anderson.

“It’s all designed just so that you can do the job at the end of the day. And you’re there to kill someone, and that’s what they fucking want you to do. And the consequences afterwards, they don’t give a fuck about that. They’re not interested. As far as they’re concerned, you joined the fucking Army in the first place. It’s your fucking fault that you joined. That’s the fucking attitude,” Pte Stevens.

For a few participants, this lack of support had soured their view of their service in the military:

Researcher: “Are you proud to have served in the military?”

[Silence]

SNCO Hyde: “I’d say no. Not now.”

Researcher: “Because of the way you feel you’ve been treated?”

SNCO Hyde: “The way I’ve been treated. I was very proud while I was in the Navy... but I wasn’t at all impressed how I left the Navy and the support once I got out of the Navy... There was no assistance from anybody... It’s like when you leave the Navy, you walk out that gate and a shutter comes down. Don’t want to know you anymore... 23 years of my life and then the rest of it could have gone down the pan and they wouldn’t have cared. That’s how it comes across to me...”

His wife: “We were on the bones of our arse, we didn’t have a penny, and we had water coming in through the roof... So what did you do? Sold his medals.”

Some participants would have liked some more emotional or psychological support:

“[It was] very hard. I wasn’t given much help. I wasn’t given any resettlement, any mental health training or anything to help me integrate back into civilian life,” Pte Lewis.

Others would have welcomed advice around practical matters, such as managing finances and paying bills:

“I spent a lot of time training to be a soldier, but there was no training to go back to being civilian,” Pte Taylor.

The MoD seemed to offer slightly more help when it came to education and training, which is important because the military has very low entry standards (in
terms of literacy, numeracy and so on) and individuals who do not rise up the ranks before they leave may struggle to demonstrate that they have gained any transferable skills or experiences, especially if they have served in a combat role, which can make it difficult for them to find a job in Civvy Street.

This issue is particularly relevant in the case of ESLs. We spoke to five participants who might have been classified as ESLs. Of the four who left the Forces from the ranks (Private or equivalent), three commented about the challenge of finding a job in Civvy Street:

“I came out and I had no real skills to use in Civvy Street, because of the regiment’s role as a combat role,” Pte Miller.

One ESL was still unemployed when we spoke to him, having left ten years ago:

“I’m not going to lie, I have no qualifications. I do have qualifications, but not qualifications, if you know what I mean,” Pte Connor.

Again, it was felt that support from the MoD had been inadequate:

“Again there wasn’t anything there. I had decided for myself that because I was leaving the Marines I wanted to get something there which I could use in civilian life… It’s no good going out to Civvy Street and selling, ‘well I’m a first class sniper’ or whatever, you know?” Pte Anderson.

As explained in section 3.3, the majority of participants left the Forces many years ago (mean = 19 years) and any comments about the quality and quantity of the support they received must be interpreted within this context. Of course it is highly unfair that a veteran should feel so poorly repaid by the country they risked their life to defend, regardless of when they served, but it cannot be denied that the MoD has taken steps to improve its transitional support in recent years (Ashcroft, 2014).

Of the seven participants to leave the Forces within the last five years, five said that they felt that they were offered a good deal of support:

“They do put a lot of provision into helping you. A lot more than anybody else would get in any other trade or job, so you’ve got to appreciate that,” Officer Palmer.

However, it was clear that there was still some way to go. More specifically, one participant was doubtful that service leaves took full advantage of the support:

“There’s lots out there. It’s quite bewildering, and I think people will clutch at straws… I always think a lot of people don’t use it as well as they should. They see it as a process that they’re entitled to at the end and they’ll use, but I don’t think they use it to the best effect,” Officer Gibbs.

Another felt that more should be done to tailor the support to the individual:
“When you leave the Forces... you have an employment consultant who rings you up every six months, but realistically these guys should be ringing you up every three or four days and they should be hammering you, ‘What are you doing? What are you doing?’ And they shouldn’t be recommending jobs to you that are 100-120 miles away. Why do you think some of these guys have left the Forces? To go home and what? Start working 150 miles away again? Some guys leave the military because they’re fed up of being away from home...”

“[It’s] all down to the infrastructure of how guys that are leaving the military, the process, it needs to be more informative. And that’s why... I personally think, in every county in Britain there should be somebody that is qualified, educated enough with the area, has links in the area say Norfolk, who deals with basically... possibly getting them back into education,” Pte Reed.

One participant was particularly negative about his experiences, feeling that he was ‘pushed out of the back door’, having suffered a neurological injury in service. This participant received treatment from MoD mental health services, as indeed did most of the recent leavers (6/7). Their stories will be picked up in section 4.3.2, where their views and experiences of mental healthcare in the military will be explored in more detail.

As explained in section 1.1.1, the latest research from KCMHR suggests that ESLs are the group of veterans who have the worst outcomes when leaving the Forces. This group has quite rightly been the focus of recent initiatives to ease the transitional process. The veterans who participated in this study served in the military for a disproportionately long time (Appendix J, Figure J4). It is potentially revealing that so many of them struggled to adjust, and we should not forget that some service leavers with longer careers can also find it hard.

Furthermore, it is possible that ‘career veterans’ face a different kind of challenge in Civvy Street. Whilst ESLs tend to struggle due to pre-enlistment factors (section 1.1.1) or problems finding employment outside of the military (previous page) - in other words, challenges that they would probably have faced if they hadn’t joined the military - we might think that service leavers who have had longer careers will be of higher rank and, therefore, a more established socio-economic position. Where they do develop problems, then, these problems may have a distinctly military flavour, such as those earlier described.

4.1.3 Combat and training

“We’re all shaped by our experiences... there is a price to pay for doing the things that you do... The vast majority [of what I took from my time in the military] is positive, is good but if I do attend to the horrible things that I’ve personally been involved in, or have heard... then it can become a bit dark and unpleasant. I think when you’re at your low ebb, that stuff sort of drifts through,” Officer Gibbs.
If the participants saw themselves as different from civilians by virtue of their service (4.1.1), which had implications in Civvy Street (4.1.2), then two elements of service appeared to have been particularly distinguishing. These elements were experiences of combat and the training process, which will now be discussed in turn.

Deployment and combat

For some participants, service in the Armed Forces had ongoing implications for their mental health. As mentioned in section 1.1.1, the most obvious potential risk to the mental health of military personnel are traumatic experiences following deployment to a conflict zone. Thirteen (13) participants said that they had been diagnosed with combat related PTSD (section 3.4). More generally, 20 participants presented with at least some symptoms that were related to their time in the military (section 3.4).

Perhaps unsurprisingly, the legacy of combat featured particularly strongly in the stories of 13 participants who had been diagnosed with combat related PTSD. All of these participants suffered from flashbacks, hallucinations, nightmares and so on:

“I was having the same nightmare almost every night... My nightmare was that there was gunmen outside the house trying to break down the door to come and shoot me, and my quandary was, do I send the family upstairs and offer myself to these guys and get shot and they’ll go away and leave the family, or will they shoot me and shoot the family as well? I would wake up screaming and shouting and what have you. But that’s been with me for now 40 years,” Pte Anderson.

Some participants found it difficult to adjust to civilian life having just returned from deployment:

“I should have stayed [at the Army’s decompression site] for three weeks and fucking readjusted, instead of just going straight home and having this fucking kid thrust in my hands. I mean, what the fuck? One minute I’m a soldier and the next minute I’ve fucking got this kid in my hands. What the fuck was that about? I didn’t have a fucking clue. Oh, fuck me,” Pte Stevens.

Researcher: “What did you find hard to adjust [to]?”

Pte Taylor: “Probably the fact that we’d gone on patrols into firefights and then in the States, and 48 hours I’m back in the U.K... And then it’s just... not having that sense of purpose. You’re just so busy out there all the time. You didn’t have time to grieve for the boys we lost and there’s no time to think about anything else. When you come back you haven’t got much to do, and all that thoughts and memories and grief all starts flooding back in.”

Others had long-term difficulties switching off:
“Still ‘til this day, if I go out to a pub or anything like that, I’ll sit with my back to
the wall so that I can see everyone and everything. It’s just some of the [training]
you get instilled into you. And you’re always aware of what’s happening around
you. It’s just ongoing,” JNCO Turner.

This kind of behaviour was very widespread through the stories. It was something
that the participants’ friends and family were not readily able to understand:

“I realised how crazy I’d got by the fact when I first met my wife… I said, ‘I’ll show
you my guns if you like…’ And I had pistols with live rounds and everything… and I
showed her. And then the look of horror on her face, that made me think, “Yeah,
I’m not normal, really.” She said, ‘Why do you keep a gun in your bedside
cupboard?’ And I said, ‘Well, in case.’ She said, ‘In case of what?’ ‘In case
someone attacks me,’” Pte Miller.

For some, the legacy of combat also manifested itself in other ways. As mentioned
in section 1.1.1, deployment can be related to increased anger and risk taking.
Several participants said that they had exhibited these behaviours:

“The thing is we have military as well because of the nature of the job, the
aggressiveness and the training and the discipline. If you’ve got a veteran that’s
suffering, he could do a lot of damage to himself or others, do you know what I
mean? He’s like a coiled spring,” Pte Davies.

“I was getting quite aggressive at that point… My flash to bang was much shorter,
so I remember being cut up [in a car] by some young lads… and I just got out of the
car and grabbed them. It was like, I could really do these guys some harm,”
Officer Gibbs.

“I kind of got involved in a lot of risk taking behaviour; riding fast motorcycles,
having lots of accidents, stealing cars, joy riding type things and things like that,
or to kind of get a bit of a thrill out of it, which never actually happened. I
remember once on this motorcycle, I was pulling a wheelie about 90 and the
person on the back was screaming to stop, and afterwards I just thought, ‘What’s
the big deal?’ I couldn’t really gauge danger any more. It didn’t really have an
affect on me, and I think I probably thought I was invincible. And I sort of steered
toward confrontation. I’d go into pubs and deliberately start a fight with more
than one person, just to kind of— because I felt so pent up and aggressive, so I got
myself in lots of trouble; lots of beatings and beat lots of other people…”

“I remember one guy in this fight, he pulled out a knife and I pushed him against
the wall holding him by the throat and he pulled this knife out and he said, ‘I’m
going to stab you,’ and I just stood there and said, ‘Go on, then.’ Because I really
believed that it wouldn’t happen to me, because I’d been through so many things,
close misses. [On mission a comrade] triggered a mine and there wasn’t much left
of him. And I was ahead of him, so obviously I stepped over that mine, but he
triggered it. So, things like that, and snipers, and-- I don’t know. I just thought, ‘Whatever happens, it can’t happen to me,’” Pte Miller.

SNCO Hyde: “I used to into pubs and there’d be six guys in the pub, and I’d say, ‘Who wants to fight?’”

His wife: “But the [mission] was like a suicide mission, really.”

SNCO Hyde: “[It] was a voluntary thing, and three officers tried to convince me not to go on it. In the end, I did go on it. And it’s funny, because there was [a small group] of us and we’re all of similar background, and we just didn’t care we were getting shot at every other day, and there was bullets whizzing around and-- yeah, it’s like we didn’t care we got shot or not.”

Researcher: “Why... didn’t you care?”

SNCO Hyde: “Don’t know. It’s like an adrenaline rush. You know when somebody runs away from something? We don’t; we went towards it.”

His wife: “When [SNCO Hyde] talked to me about it as well... he said he didn’t care because he’d got nothing to care for.”

Combat experiences are not the only risks to deployment and two participants had found other elements to be just as traumatic:

“[I was in] the rear party of my battalion when it went to Afghanistan. So I had to stay back, train people as replacements to go out to replace those killed and injured. And also to receive back the dead and injured and deal with their repatriations, funerals, treatment, and their families. That was quite demanding, and again, in a way that was in some ways more demanding than having to go out because there was no formal training for that and no emotional preparation for that, if you know what I mean,” Officer Palmer.

“I did a lot of operational tours... from high intensity war fighting to humanitarian peacekeeping operations. The latter actually are more disturbing often than the war fighting... What was key, I think [because of my role in the military] I actually listened to people’s accounts of their experiences on operations - it was vicarious trauma, if you like... Whilst not there, not directly in the threat, not really disgusted by what happened - you couldn’t smell it, touch it, hear it - but you’re hearing that account, and you’re seeing that effect on the individual,” Officer Gibbs.

It bears repeating that deployment and combat (and other military experiences) are not the only reasons why veterans may develop mental health problems (section 1.1.1). Even taking only the 20 participants who had some symptoms relating to their time in the military, at least five (25%) explicitly recognised that they had pre-enlistment vulnerabilities that might also have contributed to their problems.
Similarly, other participants found elements of their civilian lives were just as important as military factors when it came to explaining their problems. Some actually found their civilian professions to be more traumatic than their time in the military:

“I guess there was an element of my military service that was apparent in the nightmares. But I’ve been out of the military for a long time. And then suddenly, I’m starting to struggle with depression and I would argue that... carrying the grief and trauma of families [as part of my civilian job], I took that on board and absorbed all of that and maybe it got too much,” JNCO Bateman.

It is also worth remembering that PTSD is not unique to those who have served in the military; in fact, statistically, the condition is nearly as prevalent amongst civilians (as explained in section 1.1.1). Many participants felt that the unique nature of military life made combat related PTSD more complicated than other types of PTSD:

“You have [civilian] people with PTSD, but it’s not the same as PTSD from the military, because the fear is so much more intense, and the fucking aggression that is instilled in you,” Pte Stevens.

“I’ve known very good friends who were paramedics and firefighters and police officers who suffer from PTSD. The difference is when a copper, a paramedic, or a fireman goes out every day to work, he knows that he’s not going to be fucking shot at every day,” SNCO Peterson.

However, others disagreed:

“It could be childhood abuse, it could be a car crash, a fire, whatever... military trauma is just another type of trauma,” Officer Palmer.

A good deal of academic attention to date has focused on trying to identify ‘the cause’ of mental health problems amongst military personnel. A lot of financial and political currency currently rides on this issue. For one thing, if most conditions can be found to have been directly caused by service, then presumably the MoD, as the ‘guilty’ party, may be expected to foot the bill when it comes to veterans’ ongoing needs.

Human beings are complicated creatures, and it is perhaps unlikely that we will ever be able to isolate a single predominant cause. Whilst this pursuit is, of course, important, it was clear that the participants were more concerned with finding appropriate treatment so that they could move on with their lives, than they were with root cause analysis. Crucially, it seemed that most participants who presented with some symptoms relating to their time in uniform desired a slightly different, military sensitive, kind of treatment to what would typically be provided by the NHS. This issue will be explored in more detail later in the report, in particular in section 4.5.1.
Training

Not every participant had been deployed to a conflict zone (Figure 7, p.30) but they had all completed basic training. There is an emerging interest, especially abroad, in the effects of training upon the mind (Jackson, Thoemmes, Jonkmann, Lüdtke & Trautwein, 2012).

The enduring relevance of Armed Forces culture, and its implications for transition, have already been noted in sections 4.1.1 and 4.1.2 and training is the method by which the unique values of military life are instilled into newly recruited civilians. Unsurprisingly, given previous discussion, many participants had found training to be a transformative experience. In and of itself, this was not necessarily seen as a bad thing:

“You get kind of the chat on day one at various stages, and one of the first things in initial training was the next eight weeks in here will be bloody horrible, we’re just going to break you down and then build you back up where we want you. Which they did. By the end of it that whole thing about if someone says jump, you don’t ask how high, you just jump, and all the rest of that kind of thing. But you become at the end of it a different, probably better person,” Officer Perkins.

“We’re taught to behave ourselves,” JNCO Williams.

Indeed, training is an essential part of the process of remoulding newly recruited civilians into the type of people who will be able to execute the very unique tasks performed by the MoD:

“If you come up against a roll of razor wire and you’ve got to get across it, what we used to have to do, the first in would jump on top of the razor wire, and lie on it, all the other bods would run across that person’s back and then the last two people that had gone across you, would pick your legs up and peel you off the razor wire. But you do that because that’s what you had to do, you didn’t mind you got all cut up... If you’re under fire and you had to get across that barrier, that’s how you do it, and you expect your oppo to do it just as much as you would do it, for your oppo. You know what I mean?” Pte Anderson.

However, the fact that the participants had been ‘broken down’ and ‘rebuilt’ (in the words of Officer Perkins, above) by the military could potentially lead to problems if the process was not reversed when they left the Forces:

“The thing is in the military you’re programmed different. You end up being programmed virtually. You do not fail because you can’t fail in that sort of job. I mean, ultimately if you’re in a conflict situation and you fail, you’re probably going to end up [dead]. So the pressure is always there to succeed and that is brought in to you in basic training. They literally take you down from when I was 16. So I was very impressionable when I was 16... And the problem is when you leave what you need to do is literally come out a different person again,” JNCO Rogers.
It is possible that some of the transitional issues discussed in section 4.1.2, especially those relating to the civilian workplace, would have been ameliorated if the participants had been ‘de-militarised’ before discharge as skilfully as they were ‘militarised’ upon enlistment.

Transitional issues aside, two participants felt that training had had an especially detrimental impact upon their mind. Both of them had left the Forces over 20 years ago, but clearly felt that training was still affecting their attitudes towards everyday life in a way that was not conducive to good mental health in the long-term.

They used terms that conceptualised training as a process of ‘brainwashing’ or ‘conditioning’:

“You’re conditioned and you think-- because I don’t know if you know about military training, but what they do to you, they fucking get you thinking a certain way. And what it does, it makes you a perfectionist and you think about things before you do them so that you don’t make mistakes doing them. Which is unnecessary. You don’t need to fucking wash up worrying about what you’re going to do next in case you fuck up. You’re not going to get killed washing up, are you? But that’s what the fucking Army instils in you…”

“If they had done something to deactivate you, I’m sure that would have helped me. I’m fucking certain it would have, because half the problems I’ve got is based on the fact that I still think I’m a fucking soldier, which I’m not,” Pte Stevens.

The wife of Pte Anderson: “It’s hard, because I think the worst of it is the actual way they brainwash you, and it’s getting out of the brainwashing... He’d run 12,15 miles home, and like if we were in a traffic jam-- I remember going up to Grimsby once, we were in a traffic jam and he said, ‘Right I’m going to get out and run, you can pick me up in Boston,’ like that. And it was nothing for him to run 20, 25 mile, because that’s what he believed, keeping fit was the only way that kept him alive, when he got shot because he was at peak, so for him to be at peak it was like, the fitness all of the time, all of the time it was like…”

Pte Anderson: “I suppose that was in my defence in a way. That’s what saved me before... You don’t expect to get shot again, but--”

His wife: “It wasn’t just the running, it was everything. Like everything that was done has to be done to perfection and it has to be--”

Pte Anderson: “So working on cars and stuff like that, and I’d taught myself how to weld and all the rest of it, and at one stage I’d had nine cars.”

His wife: “And that’s how it went with everything. Cider making, he made for them cider, and that’s like he’s made seven presses now and he makes gallons of cider, he goes up and gets the apples from the Queen’s estate, and that’s what-- everything's got to be-- when people say, “Have you got any hobbies?” I think [laughter], “What’s it like to be bored?”
We might not expect that many civilian mental health professionals will be sensitive to the effects of military training, which could have implications when it comes to treating some veterans.
4.2 Seeking mental health support

“The easiest thing in the world is to ignore it, the hardest thing is to say you need help,” JNCO Bateman.

Generally speaking, the participants were very unwilling to seek support, as demonstrated by the fact that less than one in three (6/19) of those who acknowledged that some of their problems had started whilst they were still in the military had actually come forwards to receive treatment from the MoD at that time. Even these individuals had waited until they were nearing crisis before seeking help, usually at the behest of their friends and family:

Researcher: “When did you put your hand up and go and get some help for what you were experiencing?”

Pte Taylor: “It was more my family that said something about it, and then I got arrested one night, and obviously as soon as we get arrested or something whilst we’re on leave or something then the first port of call is to let your platoon commander know.”

“I was so ill when I presented that I had to be detained in a secure unit,” Officer Palmer.

Stigma was the major barrier to care, with participants being ashamed to disclose that they were struggling for fear that it would make them look weak. On the face of things, this finding should have been obvious: men from all walks of life are known to be bad at seeking help when compared to women (Galdas, Cheater & Marshall, 2005; Kingerlee, Precious, Sullivan & Barry, 2014) and all of the participants were male, as indeed are the vast majority of veterans. However, it seemed that the unique nature of military life had exacerbated the problem. This issue will now be considered in more detail.

4.2.1 Help seeking behaviours in the military

Given the nature of the profession, we might expect those who serve in the Forces to place additional emphasis on traditional male values such as pride. As has already been explained, personnel are required to execute demanding tasks under intense pressure and danger. In this kind of world, where the stakes are so high, it is understandable why the participants might have been even more reluctant to admit to anybody that they were struggling:

“Being in the Forces sort of… heightens [the stigma], because you don’t discuss with your fucking mates things like that. You just wouldn’t. You just don’t do that. Feelings? What the fuck are they? You don’t talk about feelings to your fucking mates,” Pte Stevens.
**Researcher:** “Did you find it hard to talk to your comrades about what you were feeling?”

**Pte Taylor:** “I wouldn’t talk to them about it... I was embarrassed. I think I had built up so much respect from my friends and I didn’t want them to think anything different of me. I didn’t want them to think that I was weak... From the day you join you’re pretty much told to suck it in and leave personal issues at home and stuff.”

“I was honest and looked at it, yes, I could recognise it, but I did nothing about it, because of the shame and embarrassment... I had a kind of persona within the unit because... I was usually very fit and very forthright. But for anyone like me to admit to having a problem is just too difficult,” **Officer Gibbs.**

Closer analysis indicated that the military way of life seemed to have introduced an additional layer of complexity beyond the standard issues of shame and male pride. Personnel rely upon each other for their survival in combat situations and the importance of teamwork is one of the core principles of Armed Forces culture. With that in mind, it is unsurprising that the desire to avoid letting down the team emerged as another reason for not raising concerns:

**Pte Lewis:** “You ask a group of 40 soldiers, ‘is someone suffering from a mental health problem? Have you seen something that you found so disturbing that you need to talk about it?’ Sorry, no one is going to say, ‘Yes.’”

**Researcher:** “Why not?”

**Pte Lewis:** “Because you’re around a group of lads you know and get on with, you’ve got to cover-- if I had to go into a battle with a guy who I thought was troubled, I’ll be more worried about him than myself... so you’re not going to put your hand up and say, ‘Yes, I’ve got a problem,’ because you want the guy next to you to look after himself and not worry about me. I saw that hundreds of times, hundreds of times. I saw guys shaking in their cots, and screaming at night because of things they’ve seen, things they’ve had to have done, but you just got on with it.”

This reluctance to seek help for fear of letting down the team was not necessarily confined to combat scenarios (although it might be exaggerated in that context), but extended to general tasks undertaken in uniform. It seemed to be part of the culture of working life in the military in a way that may not be the case for other, civilian professions:

“It’s just part of the culture in the military. So you don’t go sick, you man up, you cope... It’s ingrained in you culturally to have your shit squared away... your health and personal admin... so you’re not a liability to others and can become part of an effective team,” **Officer Gibbs.**
In some cases where the participants felt unable to come forwards, efforts had been made to normalise problems:

“I didn’t know at the time that I was ill. I just thought they were normal reactions and you just got to go with it. That’s the way an awful lot of us veterans look at it. We have these nightmares, flashbacks, and anxiety, depression, and things like that. We’re frightened of fireworks and bangs, and we don’t like crowds because crowds to us mean riots on the streets... That’s just the way we grew up. And even after coming out of the military, it was just the norm to avoid big crowds, it was the norm to avoid fireworks, it was the norm to avoid hostile scenarios, but you try and bottle things up. And there are time when you do, for example, you do self-medicate to help you sleep because you know you’re going to have these nightmares. But we just class it as normal behaviour,” SNCO Peterson.

Twelve (12) of the 19 participants whose symptoms began whilst serving said that they weren’t aware that there was a problem at the time. Denial is a common response when it comes to mental health, but it seemed that some participants were genuinely unaware that their symptoms were the result of a specific condition, as shown by their relief at diagnosis:

“I felt such a weight come off my shoulders at that stage [when I was diagnosed], and I thought, ‘Oh, it isn’t me. It is a problem, it’s actually like a disease or whatever.’ That felt good for a period of time,” Pte Anderson.

One participant, who had been diagnosed with PTSD in 2004, having left the Forces with some symptoms four years earlier, was still worried that he was wasting people’s time:

“And then you get the confidence thing again. Are you just messing people about or is it a genuine thing? But you have to ask other people for their assessment. The number of times I’ve asked [my wife], ‘Am I just messing people about or is this a real thing?’” SNCO Hyde.

This lack of insight and understanding was not explored in detail in the interview but it is worth noting that men in general tend to find it difficult to conceptualise and articulate their feelings (Kingerlee, Precious, Sullivan & Barry, 2014). It is also possible that, given the extreme professional requirements of the military, personnel are tempted to dismiss any problems as just ‘part of the job’:

“I think it’s instilled in you, in the military. Basically, when you sign up, you sign up for life or death. You know [that’s] a possibility and get on with it,” JNCO Turner.

Perceptions about how concerns would be received by superiors

For the vast majority of participants, the reluctance to seek help was compounded by perceptions about the attitudes towards mental health in the military.
First and foremost, some participants felt that there would have been no point asking for help because their concerns would not have been taken seriously by their superiors:

“There was a lot of bullying in general in the Army at that time... And it was the time when you wouldn't go to your commanding officer or your troop sergeant and say there’s bullying going on because they’d just probably punch you and say go on your way,” Pte Davies.

Another issue was that the command structure was felt to be unapproachable:

“You’re constantly worried there will be some kind of derogatory factor in what you’re hoping will be your career for the rest of your life, and anything that means that you’re not fitting in with the moulded individual that the Forces want you to be or what you think that they think you should be. That’s the key to it really, is that you’re taught to respect and almost fear senior officers, so you’ll do anything you can to avoid crossing them,” Officer Perkins.

There was a related perception that seeking help from superiors would involve harming future prospects in the military, which was shared all through the ranks:

“It’s an unwritten rule that you never, ever speak about mental health problems in the military. Because number one, that’s your career over with, and number two, you put the other three men in that brick on the ground... at risk if you’re not strong enough,” SNCO Peterson.

“I was worked constantly over a long period of time without anybody saying, ‘Actually, take a break.’ And I think I just burned out. But there was no sort of management or leadership structure in there... It’s a very difficult environment, a meritocracy, in which it’s too difficult to say, ‘Actually, I’m not coping. I need to stop.’ Because if you do that, you’re finished... you know, you wouldn’t be sacked but you certainly wouldn’t advance... I think that’s a cultural thing,” Officer Palmer.

“You certainly worry about how that might affect your career because as you’re going along, the carrot gets bigger and you’re drawn towards it. So for lots of reasons, and you don’t want to jeopardise your chances of getting on,” Officer Gibbs.

There were a few positive stories, where the participants felt that there was a supporting environment:

“You have... your rank structure [and] I do think take it upon themselves to have a duty of care, to look after the wellbeing of people below them,” Pte Reed.
However, there was a broad consensus that, when it came to mental health, there was a lack of general support outside of the specialist services provided by the DCMHs, which will be discussed in section 4.3.

Again, it is important to remember that the majority of participants left the Forces many years ago (section 3.3), having served in a period where mental health was not well understood both inside and outside of the military. The MoD has done a lot of work in recent years to try to destigmatise mental health and to encourage personnel who are struggling to come forwards. Preventative measures, such as decompression, and early identification methods, such as Trauma Risk Management, have been introduced with mixed success (Greenberg, Langston, Iversen, & Wessely, 2011; Greenberg, Langston & Jones, 2008).

Six participants left the Forces within the last five years, and their stories suggested that the MoD still has some work to do:

“I went and saw the padre and he said, ‘Oh, no. You don’t want to go down there [to see a doctor]. There are two routes you can do. You can just come and see me or whatever, or you can go down the doctor’s route... If you go down the psychiatric route, that’s your life over... nobody’s going to employ you again. You’re going to have all these mental health records on your file,’” Pte Taylor.

The two highest ranking participants, who left the military in 2012 and 2013 respectively, felt that, whilst things were getting better on the ground, the MoD as an organisation needed to change at the top level:

“If I’m honest... I work[ed] with senior commanders at brigade level who think this is all hogwash, it’s all pink and fluffy...”

“The bottom line is to achieve a mission, you want somebody who’s going to fight when you ask them to fight. A commander wants somebody who’s squared away, so therefore there’s little tolerance of anyone that isn’t...”

“They want people to get on with the job,” Officer Gibbs.

“I think the MoD itself as a corporate body hasn’t got anywhere near enough of a grip of it,” Officer Palmer.

Whilst the MoD obviously has a duty of care towards its staff, we should not be unsympathetic to the scale of the challenge it faces to reduce the stigma surrounding mental health. Military personnel are self-selecting, and the Forces attract a certain type of person; namely those who place a great deal of emphasis on traditional male values such as pride. Considering the requirements of the military, it is perfectly understandable why the MoD would want to foster such a culture.

Moreover, the ultimate goal of a military operation is to get the job done, and considering what this can sometimes require, we might think that part of the MoD’s duty of care would extend to ensuring that personnel who are struggling
with their mental health are not placed in situations that might cause them further harm, even if this means, as some participants feared, reassigning them to another unit or discharging them from the military altogether.

As society becomes increasingly open about the issue of mental health, the MoD faces a difficult balancing act to safeguard the welfare of its personnel whilst at the same time protecting the interests of the military. A few of our participants were aware of this challenge:

“[It’s] a tough one, because... there is a need for the [focus on the operational needs of the military] at certain times, and I don’t think you can switch that on and off. But... if you look after your soldiers well all the time, so you attend to their personal needs, their issues, financial, relationship, career, the more you invest in that person and give them time and support, the better they’ll be,” Officer Gibbs.

Touching on issues raised by Officer Gibbs, one participant had an interesting suggestion for how the MoD might be able to maintain this balance:

**SNCO Clark:** “You have the preventive health clinics on every installation. Instead of just being all negative, how about they use positive reinforcement? You can have like a martial arts part of mental health. You can have weightlifting mental... You can add people who want to work on their trigger time or their reaction time, then you can have the mental health side of that. It’s the same clinic where you can help with people with that, so there’s no stigma when people do enter [for treatment.]”

**Researcher:** “Rather than having it for sick people, you would have it for everybody?”

**SNCO Clark:** Right. And so you can tell people-- it would be one of those great things. Like, ‘What are you doing this afternoon?’ ‘Oh, I’m going for mental health.’ ‘Oh, what are you going to do there?’ ‘Like me, I’m going to work on my trigger time.’ Because now you have psychologists working on people’s adapt speeds or their reaction time to an emergency scenario. And so if someone can get it underneath five seconds-- a five second thought, that takes them 30 seconds, then you can see if that works out. That can be a lunchtime thing, and then it has a gym based scenario. If there’s people that want to talk about their reaction times, then that helps with the combat PTSD. Instead of speeding things up, you can now slow things down with the same type of psychology.”

**Researcher:** “It’s very interesting. And you can see operationally why it would be attractive for the MoD to be able to, like you said, reduce the trigger time because that’s going to make better soldiers or better airmen or better sailors.”

**SNCO Clark:** “And then you also do it into the physical adaptations also. People want to work on their run time, it’s mental. It’s a mental aspect. Because now you have the same doctor you can with for PTSD or kind of pick and poke, as like, ‘Why do you want to be faster?’ And it’s like, ‘Well, because I had a friend that bled to
death, and that really bothers me, so I want to make sure that I’m faster.’ ‘Okay. Then let’s start working that out. And then we’ll start working on your speed.’ Now you’re knocking out two birds with one stone. It’s preventative measurements.”

4.2.2 Additional barriers to care in Civvy Street

Given the already noted enduring relevance of Armed Forces culture (section 4.1.2), it is perhaps unsurprising that the participants continued to exhibit the same help seeking behaviours when they re-entered the civilian world:

“I first went to see my GP... after having been told by my new partner for 18 months that, ‘You’re unwell, you’re tired, you’re irritable, you’re not functioning at home, you’re non-existent, I can’t talk to you,’ all the usual things...”

“She said, ‘If you don’t get help, then you’ll destroy yourself.’ She said, ‘I can’t live with you like this,’ so she left. Because she left, I went to the doctor, if she hadn’t, I probably wouldn’t have come for the same reason all the other guys said. I guess a bit pride at having to go [and] concede defeat,” JNCO Bateman.

Nationally, the average length of time from symptom onset to a veteran seeking help is estimated to be around 11.8 years by Combat Stress, although this is thought to be much shorter for newer veterans from Iraq and Afghanistan (Murphy, Weijers, Palmer & Busuttil, 2015). Whilst the delay was not explicitly measured by this study, some participants said that they had waited 10-20 years and stories like this were all too common:

Researcher: “You mentioned you spiralled down... When did you go for help outside of the Forces?”

Pte Lewis: “Probably when I tried to commit suicide. And it wasn’t me, it was my wife... She made me an appointment with my local GP. I went kicking and screaming.”

It is worth repeating that men from all walks of life tend to be bad at seeking help. However, many participants felt that the fact that they were a veteran added a unique barrier to care in Civvy Street. Simply put, the issue was that some of them, especially, but not exclusively, those who presented with some symptoms related to their time in the military (and especially those with combat related PTSD), were reluctant to engage with civilian services because they felt that civilian professionals would not be able to understand them or respond to their needs:

“Soldiers in my eyes, the ones that [need the most help] probably feel like they’re wasting their time. ‘Why should I talk to a doctor... if he hasn’t been through what I’ve been through? You were never there when I was in Afghan, so why would I sit there and bother talking to you?’” Pte Reed.
For this reason, the participants generally felt that they were more likely to seek help from a dedicated veterans’ service. This issue has important implications when it comes to the discussion about the participants’ views and experiences of the NHS (sections 4.4.2 and 4.5.1).

Whilst the participants generally preferred to seek help from a dedicated veterans’ service, unfortunately not all of them had been aware that several such services existed in the Third Sector when they needed them the most:

“You think how many years I was in the wasteland there just not knowing. If I’d known about Combat Stress and things like that, and they would-- at one point, I’ve tried to commit suicide twice. I’ve been suicidal twice. Had I known about Combat Stress, the first one would probably never have happened because I’d have had another part of my network there. But I didn’t have any help. So, you get to the point, ‘Oh you think there’s nowhere to turn to.’ But there is. But I didn’t know about it,” JNCO Rogers.

As mentioned in section 1.1.3, there is a vast wealth and variety of support available to veterans in the Third Sector. With this in mind, it is disappointing that several participants reported a lack of information as a barrier to care. Some participants felt that this information should have been provided them by the MoD as part of the transitional process:

“[We need more] signposting through the whole system and I think that comes right back to when you leave the Forces,” JNCO Rogers.

“There’s so many agencies involved from the discharge perspective... you have the Veteran Agency who get involved on the financial side, but you have no one who gets involved for the medical side of things... I think if everything could be linked up, it would be fantastic,” SNCO Matthews.

Other participants said that they would have found it helpful if their GP had been able to point them in the direction of veteran specific support. The role of the GP will be explored in more detail in section 4.4.

The health and social care system can be difficult for anybody to navigate and the picture is complicated for veterans by the sheer number of different support services in the Third Sector. Whilst the model of interpreting transitional issues in terms of institutionalisation has fallen out of favour, there is something to be said for the idea that, when it comes to the NHS, veterans do not make for particularly ‘savvy’ service users because they have grown used to receiving their healthcare on base and consequently do not know where to turn in Civvy Street. This may be especially true for those who were recruited at a young age and have been in the Forces for most, or all, of their adult lives.
4.2.3 Coping

In the absence of professional help, the participants tried to cope with their problems alone, or with the support of their family. It is difficult to appreciate how difficult it can be to live day to day with a mental health condition:

“You manage. Cope is...you’re sort of forced to cope, rather than-- coping is a strong word, because you exist rather than cope. You do the bare minimum, so I would go out shopping, and for me, that would be at 4:00 in the morning when it’s quiet, or as soon as the shop was open. Then I’d come back and I’d do nothing else. That was my week. I would sit here, planted in front of the TV with my laptop, and that was it pretty much. It’s only over the last year that I’ve been able to get out a little bit more, so that was pretty much a limbo period for me, of just existing rather than living for lack of a better term,” SNCO Matthews.

Whilst it is easy to feel sorry for somebody with a mental health problem, most participants had no use for pity:

“I don’t want to live off handouts from the state,” JNCO Williams.

Instead, the overwhelming feeling was one of frustration as the participants struggled to come to terms with the fact that they were no longer able to operate at the same high levels as when they were in the military:

“I used to be a workaholic,” JNCO Williams.

Most participants were determined to get back to the way they were:

“I won’t ever give up no matter what. I just will not give up,” JNCO Walker.

Others had become more accustomed to their situation after years of dealing with their problems. As they saw things, they were not going to get better. A stoic theme ran through many stories:

“It’s just a part of life. We’ve had lots of things happen in our lives, like you do as you go along, and you manage it. And that’s all... But I think the hardest thing was we both held down, you as a manager and me as a manager, really responsible jobs but when you have had to get up in the night normally 3:00, 3:30 in the morning, make a cup of drink, sit there for an hour and then try and get back to sleep, you had to get up at 5:00 in the morning... I sometimes think now, how did we do it? Because now, we’ve retired early because of it, because you can only go for so long. It got to the stage [where] we just gave up our wages and said, ‘We can live on beans on toast. Let’s do this.’ And that’s what we’ve done, and we can get up in the night now and we can have a cup of tea and then we can not get up till 9:00 in the morning,” the wife of Pte Anderson.
Alcohol

As explained in section 1.1.1, alcohol is well known to be a major problem for the veteran community and it featured strongly in 14 stories. Twelve (12) participants had used alcohol as a form of self-medication and ten felt they had partly picked up this habit as a result of the strong drinking culture in the military:

“It’s a coping mechanism, it’s a way that you deal with problems. It’s putting the blinkers on and it’s the wrong way of doing it, but it is and historically has been the way to deal with issues. If a colleague has an accident, crashes, dies, everyone goes to the bar and they open their barber cup and go ‘Ay!’ and everyone just gets sh*tfaced at their bar,” Officer Perkins.

“I used drugs for a bit - LSD, amphetamines - but then I just stuck with the usual drug of choice for veterans, which is alcohol. And I found that work fairly well at managing sleeplessness, being hyper-vigilant, kind of nightmares,” Pte Miller.

“A few years ago, I knew there was a problem, I was waking up and I was putting fucking Vodka in my cornflakes. Really stupid stuff. I just fucking drink loads to get it all gone, just wanted it gone. Once I was drunk, totally drunk, I couldn’t remember nothing,” JNCO Walker.

Many participants had found that alcohol was a poor coping mechanism in so far as it gave them the courage to try to take their own life:

Researcher: When you were in the Navy did you find it easier not to think about what had happened before [a childhood trauma]?

Pte Grant: “Yes. Yes, I did. Yes, I did... because I could push everything to the back of my mind then, but then again a lot of it was due to alcohol. I remember the first time I was introduced to alcohol in the Navy. I wish I’d had a Coke. Of course, being with the lads, I drank more and more...”

“When I left the Navy, I even drank more than that because I was drinking every day. That lasted a long time... Then a couple of times after that I tried to kill myself... I gave up drinking after that. I’d really had enough because the drinking had given me the Dutch courage to try to commit suicide.”

Pte Hooper: “I don’t quite know how to explain this. I don’t know what, when or how I start to get depressed. It was a few years back... Obviously, the drinking got heavier, and I got involved with drugs. I got a load of money and decided to spend all that, and then I decided to end it all on the beach.”

Researcher: “Do you think the drinking and the drugs was a way of dealing with depression?”
Pte Hooper: “Could’ve been, but I was on a death wish. The idea was to blow all the money and end it at the end, which I would’ve done if it weren’t for a couple of dog walkers.”

Another way in which the participants sought to manage their symptoms was by throwing themselves into their work. Again, touching on some of the issues raised in section 4.1.3, this sort of coping mechanism was thought to be related to the military:

JNCO Bateman: “At work, I was functioning. So what I did was work harder which has made me more irritable at home, more physically exhausted, I guess. Looking back, I think, it’s a saving grace, I was never violent, my partner never argued. I didn’t lose my appetite, didn’t drink more, didn’t self-medicate with drugs or anything like that. I just threw myself completely and totally at work.”

Researcher: “Do you think that has something to do with the military?”

JNCO Bateman: “Yeah, definitely… in the work that I do now [with other veterans], I tell guys that, ‘You take forward good traits from the military, discipline, team work, the ability to work unsupervised as well as part of the team.’ All of those good character traits can also destroy you if you allow them to. And looking back now, I realized that that’s exactly what happened. Because the only thing that I was confident in was my ability to do a good job and so I worked harder. I wouldn’t take any time off. If I did take time off, I’d be on-call and go back in.”

4.2.4 The effects on the family

“It isn’t funny, but if you don’t laugh you cry,” the wife of Pte Anderson.

The effects of service, especially deployment, upon military families is an area of increasing academic interest. Several participants left the Forces for family reasons:

SNCO Harris: “I left for family reasons. We had moved, I think, a total of 19 times... Our only son... had, by his eighth birthday, been in six schools and was considered below par.”

His wife: “He was one confused little boy.”

SNCO Harris: “Absolutely, and I owed it to [my wife] - although she went everywhere that was required of her - I owed [her] something better.”

Most of the participants (20) were married or cohabiting. Family support emerged as a key protective factor:

“I’m very, very, very lucky in that [I have] a supportive family. But again, I know people that haven’t been that lucky,” Officer Palmer.
However, some participants felt that they had been so changed by their service that their families barely recognised them:

“My mum says, ‘I sent my son away and I don’t know what came back,’” JNCO Williams.

There is only so much support a family can give. With so many participants reluctant to seek professional help once they had left the military, there were always going to be knock on effects. Seven interviews were conducted in the presence of the participant’s wife or partner, and unsurprisingly the theme tended to come across particularly strongly in these interviews.

One of the more unpleasant statistics about people living with a mental health problem is that they are five to 15 times more likely to attempt to take their own life (Windfuhr & Kapur, 2011). Whilst suicide rates in the Forces are generally low, male personnel under the age of 20 are at greater risk than their peers in the general population, although this is thought to be mostly due to pre-enlistment vulnerabilities (MoD, 2014). Several of the participants had tried to take their own life, and unfortunately, some families had to deal with the threat of suicide on an ongoing basis:

“To be absolutely honest, I used to ask my son, ‘Keep an eye on him,’ because I used to walk out that door thinking, ‘I’m coming home to a body in the morning…’ And if he was that bad, I’d just… take annual leave because I wouldn’t leave him,” the partner of Pte Jones.

In other cases, participants were worried that they were more of a threat to their loved ones than they were to themselves:

“I remember arguing with my wife in the kitchen, and before I knew it she was someone else and it freaked the fucking shit out of me. I could have killed her. I was quite capable of killing her,” JNCO Walker.

Some participants said that their family members had developed problems of their own, as a result of supporting them:

“They are the victims. [My wife] was diagnosed years ago with PTSD as a result of me having PTSD… and my daughter’s the same as well. And that is the fallout… It is fucking horrible for the families; it is terrible. I count myself very, very lucky. I’ve been with [my wife] 18 years. And out of those 18 years, 10 of them have been with my official diagnosis of PTSD. Before then - and the kids will laugh about it; the kids will tell you the same - I was known as the grumpy… bastard because I’m a miserable git. Now we know why I have this misery and everything that goes on with it,” SNCO Peterson.

As explained in section 4.1.3, two participants had been very deeply affected by military training. This had some broad consequences for family life:
“That’s the hardest things for the families, is the fact that this person comes back and he’s fucking totally changed. He’s an aggressive fucking asshole, basically. He can’t control his fucking anger, and he’s fucking-- I mean, when I was fucking frightened at home, I used to make myself angry so that my kids couldn’t see me frightened. I didn’t want them to see my frightened. I was so ashamed of being frightened. What the fuck is that all about? I don’t need to be fucking ashamed that I’m frightened, for fuck’s sake. I never showed my kids any sort of love or anything…”

“My wife didn’t have a fucking clue. She didn’t know what the fuck was going on. I was fucking moody as fuck, changing moods all the time. One minute I was happy, the next minute I was fucking angry, the next minute I was fucking frightened. She didn’t know what the fuck was going on. And I think it’s harder for the fucking families, to be honest. Because they’ve got to fucking sit there and wait for their fucking loved ones to come back from war. She really found that hard, and I just feel so sorry for her,” Pte Stevens.

“We were up the beach one day with the girls, and a load of men got out of the truck in camouflage and he made us all lay down in the dunes and hide, and we had to stay there for ages, and you were trying to explain it to the girls, why have we got to do this? But that’s the kind of stuff that you have to go through... We’re just realising how much it actually must have affected [the girls] when they were young, because it’s like they never, ever told anybody, never spoke about it, because it was something that wasn’t spoken about, so they never ever told any of their friends that their dad had been shot or anything,” the wife of Pte Anderson.

Generally speaking, it was felt that there had not been enough support offered to families, or advice to help them understand what their loved one was going through:

The wife of Pte Anderson: “I’ve only just realised, there’s been nothing for me, because there hasn’t. I’ve had counselling before, for different things through work, obviously that happens and stuff, so I know how counselling works, but I just think sometimes it would have been nice to just ring somebody up and say, ‘Look I've had a really bad night’... That would have been good.”

Researcher: “So that could be a support group of other wives, other dependents, could it? Or would you want to speak to a professional?”

The wife of Pte Anderson: “No I think it could be a support group for families, children as well.”

Where support was offered, it was very gratefully received, as will become clearer in section 4.6.
4.3 Using MoD mental health services

As noted in section 4.2.2, the participants were reluctant to engage with civilian services once they had left the military, managing their problems for as long as they could before presenting to the NHS, often in crisis. Six participants had been diagnosed with a mental health condition whilst they were in the military and had received treatment from the MoD. Considering that they had entered the system before leaving the military we might have expected that these participants would have had an easier journey into civilian services. Unfortunately this was not always the case.

4.3.1 Information about mental health services in the military

As mentioned earlier, the MoD provides healthcare for all serving personnel through the DMS. Most services are provided on base but some secondary and tertiary care is provided by local NHS services. According to the DMS page on the British Government’s website, “The primary role of the DMS is to promote, protect and restore the health of service personnel to ensure that they are ready and medically fit to go where they are required in the UK and throughout the world, generally referred to as being ‘fit for task’,” (n.d.).

The DMS, therefore, are required to provide a far more occupational kind of service to the NHS. Military personnel are very valuable assets and the DMS need to be prompt and effective in order to enable wounded, injured or sick individuals to recover quickly and return to their unit.

4.3.2 Views and experiences of MoD mental healthcare

When it comes to mental health, the care is primarily provided through the DCMHs. All of the (six) participants who had received treatment from a DCMH when they were in the military had left the Forces within the last five years. Two participants were medically discharged, and four left for reasons at least in partly to do with poor health (either mental or physical or both).

The first participant received private counselling, which was paid for by the MoD, because normal treatment through the DCMH would have been inappropriate in his case. He found this to be useful:

“It was very good, very helpful. Didn’t really quite understand the military, didn’t quite—wasn’t military sensitive, but I knew, because of my background, actually whilst [that] would help, it’s not everything,” Officer Gibbs.

The second participant, who had served in the U.S. Air Force, had not found his treatment to be particularly useful. This was partly because he did not feel comfortable opening up, for reasons such as those described in section 4.2.1:
“I [did] the psychology side of things, just talk about my feelings. But to me that wasn’t really a treatment plan. It was just them digging on what’s wrong. But it wasn’t explained in any type of way, ‘the reason why we’re going to talk this is because’... [It would have been better] if they had said, ‘Hey, the treatment plan is for you to get better and for you to fly again.’ [As it was] I was thinking anything I do say can be held against me. If I say that I’m having daydreams of punching one employee, then they’ll be, ‘Okay then, you’re not safe to fly,’” SNCO Clark.

The third participant was very negative about his experiences with his DCMH. Most importantly, he felt that he should have been medically discharged, but that he had been pushed out of the military via the back door:

“What they’ve managed to do with me is they took me to Med Board, they took a ten year extension off me and said, ‘Thank you very much for your service.’ I don’t even think they went that far and that was it,” SNCO Chadwick.

The fourth participant told a similar story:

“I thought [the treatment I received] was effective. I thought it was very good. And actually, once what happened to me happened to me, the Army looked after me very well, I think. Better than I thought it would. I had various treatments. The problem I had with it was that it was all done to a timeline, and it was tailored to sort of finish as I left the Army. My discharge date was set and my treatment finished at the same time. And looking back, I clearly wasn’t treated. I wasn’t treated well enough anyway because some time later I had to get in touch with my doctor and go through the NHS for more treatment,” Officer Palmer.

Although the DMS is often thought to provide a more responsive service to the NHS (section 4.3.1), when Officer Palmer left the military he actually found that the treatment he received from the NHS was more effective:

“So I thought [the treatment I received from the DCMH] was effective, but perhaps since I’ve been through the NHS system I’ve realised it wasn’t as effective as I thought it was at the time,” Officer Palmer.

Indeed, Officer Palmer was so impressed with the NHS that he called for the DCMHs to be disbanded:

“If it was up to me, strategically, I would get rid of all the DCMHs and I would have the MoD pay the money to the NHS and contract it out to the NHS where it can be done properly,” Officer Palmer.

In addition to improving the quality of care, Officer Palmer felt that this would help with issues of stigma, as discussed in section 4.2.1:

“Just little things. DCMHs are on camps. Who wants to walk into a DCMH in front of all their friends? My DCMH was behind the battalion lines... I had to walk in there with my collar up so that none of my guys could see me walk in. Ridiculous,” Officer Palmer.
Officer Palmer’s experience with the NHS will be picked up again in section 4.5.1. To return to his experience with the DCMH, it was clear that, whilst he had been treated by a very competent individual, he felt that, structurally, the MoD needed to make some improvements:

“My individual therapist, when I was in the Forces and I was getting treated, was very, very good... She had a huge understanding of what was going on. She didn’t try to rush me. And she gave me treatment which she and I agreed was appropriate at the time. She was very, very good. And she managed to get me to a point where I felt that I could get better. I think perhaps if she had continued to be my therapist, I may have got to a better point than I did... [Unfortunately she]... went sick...”

“Once the link with that therapist was lost, I didn’t get followed up on as I should have. I didn’t get appointments for a long time. They said they’d tried to contact me. They hadn’t tried to contact me. If they’d tried to contact me there would have been evidence, i.e. phone calls, things like that. We’re in the digital age. You can’t hide an email. If I’ve received an email or a phone call, I can’t hide it. There were no emails and there was no phone call... And it wasn’t good enough, quite frankly,” Officer Palmer.

Once he left the military, Officer Palmer returned to his home in Norfolk/Suffolk. He found that there had been no liaison between the DCMH where he had served and local NHS services:

“There was no follow-up... My medical documents were sent to my GP, but there was no liaison as far as I know between the Ministry of Defence and my GP surgery. They just sent the notes. Because they discharged me. And when I say discharged, I mean they’d discharged me from their clinic. They classed it as treatment finished. It wasn’t ongoing, so it didn’t need to be handed over, which is quite a neat way of doing it,” Officer Palmer.

In an ideal world we would hope that the MoD would ensure that service leavers who have (recently) received treatment from a DCMH, even those not being formally medically discharged, were linked into local support services. After all, these are individuals whom the MoD knows may be likely to have ongoing problems in Civvy Street.

This has been acknowledged at the policy level. Under the Armed Forces Covenant, where an individual has been referred for treatment to a DCMH, they are entitled to access care from the MoD for up to six months after their discharge date (MoD, 2011b). Sometimes this care will be provided from the DCMH where they were based during their time in the military, but it may be from another DCMH if they have changed location since discharge.

It seems that this policy is not always being put into place by frontline staff. For example, the Officer Palmer had received no follow up support from his DCMH:
Officer Palmer: “I’ve never heard from anybody from the MoD since I left... But I think that perhaps could have helped. Even in a sort of morale boosting way, that somebody was actually bothered. Again, I’m probably a little naive there. I probably truly bought in to the whole if-you’ve-served-your-country-then-they’ll-look-after-you thing, which clearly isn’t true.”

Researcher: “So that contact might have helped?”

Officer Palmer: “It might have helped because if somebody had phoned after six months and said, ‘Are you okay?’ and I’d said, ‘Well, sort of,’ they might have said, ‘Well, go to your GP. We can tell that you’re not very well, so go to your GP.’ Because with mental health, people don’t know if they’re unwell. That’s the problem. So somebody else needs to say to them, ‘You might want to go, you know, have a chat with your GP.’”

When we explained to Officer Palmer that he should have been entitled to additional support he said that he felt it added some context to his story:

“Six months from my discharge date... I got a phone call asking me if I would go in to have my file closed. That was the only contact I had with them. Almost unbelievable that it was done to that point. Really, really bad. It didn’t make me feel great. And actually, it was them running around trying to tie their loose ends up. That’s how I felt. I felt like a loose end. Absolutely no time at all for the-- and when I think about some other guys who I know who’ve had similar issues to me, it’s horrific, really. I did think about writing and complaining, but I didn’t have the energy to, to be quite honest. And it wouldn’t change anything anyway,” Officer Palmer.

In their defence, it is possible that, having considered Officer Palmer’s treatment completed, his DCMH saw no need to offer follow up support. Even if we grant this concession, the fifth participant, SNCO Matthews, whose treatment wasn’t finished upon discharge, reported similar experiences.

Like Officer Palmer, SNCO Matthews had served away from the area during his time in the Forces. His initial experiences with his DCMH were very positive:

“When I first went [to the DCMH], I had a fantastic therapist... and he was serving in the military. He was superb, and he knew what deployments were about,” SNCO Matthews.

However, things went quickly downhill:

“Sadly, [my first therapist] left the Army, so my care went to another lady, and she-- I just didn’t get along with her at all. So, I said, ‘Look, I can’t work with you,’ so after two sessions, they put me onto a different therapist. She’d never deployed, never served, so that in itself-- she found some of what I was saying a bit difficult to understand and appreciate. So, it seemed after what I thought was a promising start, it didn’t progress that well,” SNCO Matthews.
The notion that some veterans may respond better to treatment from professionals with an understanding of the military, as mentioned by SCNO Matthews and Officer Gibbs (p.67), could potentially be of some significance when it comes to NHS mental health services, discussed in further detail in section 4.5.

To return to SNCO Matthews’ story, having been medically discharged from the military, he moved to Norfolk/Suffolk, where he came under the jurisdiction of a local DCMH. Unlike Officer Palmer, he had actually been promised some support:

**SNCO Matthews:** “There was a social worker who said when I was discharged that I would still have this and I would still have that, and it just didn’t really come to fruition. The Armed Forces Covenant said that I’d get another six months of treatment... I saw [staff from the local DCMH] three times in that six month period. There were no military men; I just saw three different people and told my story each time and actually got nothing. But the promised again. They said, ‘Oh, we’ll get this through to our social worker, we’ll do this for you,’ and none of it ever came.”

**Researcher:** “What support did they promise you?”

**SNCO Matthews:** “They promised that they would liaise properly with the NHS and get me on the books to have proper, regular treatment, but none of that came through; that they would continue through the first appointment that I had, that it would continue through the six month period with the treatment that I’d been receiving, but that never happened either. They’d phone up, book an appointment or change one, and then they just stopped taking my calls, so I just didn’t bother... I think their social workers - pardon my expression - need a good kick up the arse, to be honest. I don’t think either they know what to do or what services the NHS provide, or they’re unwilling to actually admit that guys in the services need help. I don’t know, but it seems to me that the link is broken between the two.”

Expanding on the above, it seemed that, again, there had been very little liaison between the two DCMHs and the NHS:

“The liaison between [the local DCMH] and my GP was negligible. I only just had to go and sort of sign up with my local GP. I left it for quite a while before I did, because when I left the military, they gave me three months’ worth of medication anyway, so I pretty much exhausted that before I went and sort of signed on as it were. But [the local DCMH], I have no idea what they liaised with and wrote, but I think it was minimal, because I don’t think they knew what to do with me or had any liaison with my previous DCMH to get sort of information from them, to be honest. I think because they were aware that they only had me for six months, and there’s not much that you can do in a six month period without doing something every day or every week, and they’re not going to invest time and money in someone that they’ve only got a limited amount of time with, so I think it’s a fairly lackadaisical approach,” **SNCO Matthews.**

SNCO Matthews felt that the pledge to offer six months treatment was only useful for those service leavers who remained within the region where they had served:
“I think the six months treatment post leaving the Forces would have been fine if you would have stayed within the region of which you were having treatment whilst in the Forces. But as soon as you move to a different area, which most people do... it becomes sort of more frenetic and difficult trying to find that aspect,” SNCO Matthews.

This is a particularly important point because veterans are known to be a transient community, and in many cases personnel do relocate after leaving the Forces.

Both SNCO Matthews and Officer Palmer later presented to the NHS requiring further support, following some time trying to manage in Civvy Street by themselves. As Officer Palmer was quick to realise, discharging vulnerable service leavers without taking steps to ensure that they are able to access ongoing care could have disastrous consequences for those individuals:

“In my case it was pretty sad. In other people’s cases that could lead to them killing themselves,” Officer Palmer.

If the above two stories indicate areas of service provision where there is room for improvement, then the sixth participant, Pte Taylor, showed what can happen when things work well. Pte Taylor had been based in Colchester where, in addition to the DCMH, he had made use of one of the Army’s PRUs, which is also based at Merville Barracks. Pte Taylor was very complimentary of the PRU:

“[The staff] were actually brilliant... It sort of helped being with some of the other lads that had the same issues, and that was quite calming,” Pte Taylor.

In a noticeable contrast to Officer Palmer and SNCO Matthews, Pte Taylor felt that his support had not been cut off after discharge:

“My recovery officer... would still be in contact with me all the time, even if it’s just for a chat. I can always give him a call. I could still go back up the recovery centre,” Pte Taylor.

Crucially, staff at the PRU managed to link Pte Taylor into some follow-up support in the NHS, notably Veterans First (Colchester), a service that Pte Taylor was very positive about (section 4.5.1).

In some ways we might have expected Pte Taylor, who was based in Colchester for the duration of his care, to have enjoyed a more positive outcome than SNCO Matthews and Officer Palmer, who moved to Norfolk and Suffolk having received treatment elsewhere. Colchester has a large military footprint, and there is an established network of support, from the PRU to Veterans First, which makes it easier for service leavers to make a smooth transition between the MoD and NHS (and other) services. Veterans living in and around Colchester also benefit from the presence of Chavasse House, which is a recovery centre run by Help For Heroes and supported by RBL. Pte Taylor had found Help For Heroes to be very helpful.
There is no reason why this kind of good practice cannot be repeated in Norfolk and Suffolk. Service leavers who are being discharged having (recently) received treatment from a DCMH, regardless of whether or not they are being medically discharged, should be regarded as vulnerable service leavers. Of course, some of these individuals will not want anything more to do with the military, and will refuse any support that is offered. However, where they do want further support, as in the cases of Officer Palmer and SNCO Matthews, we should take steps to make sure that they are linked in appropriately to local civilian services.

In response to the participants’ concerns, we have already taken steps to explore how Healthwatch Norfolk might be able to assist with streamlining the referral pathway between RAF Marham, the DCMH that services Norfolk, and NSFT, as detailed in Figure 14 (overleaf), but it is clear that there is much more to be done on both sides. The presence of a dedicated veterans’ NHS mental health service could go a long way to overcoming this problem.
Every year around 200 individuals are medically discharged from the military on the grounds of their mental health (MoD, 2015c). Many others leave for other reasons having recently received treatment from a DCMH. These are some of the most vulnerable service leavers. Under the terms of the Armed Forces Covenant, they are entitled to continue to receive care from the MoD and at the very least they should be linked into local support avenue as part of their discharge package. Unfortunately, most participants who left the Forces having been through a course of treatment with a DCMH had not been offered enough support, and had subsequently re-presented to the NHS (section 4.3.2).

What did we do?

We met with staff from the DCMH at RAF Marham to see if there was anything we could do to improve the relationship between the MoD and the NHS so that vulnerable service leavers who were based at Marham, as well as those relocating to Norfolk (who should come under the care of DCMH Marham for sixth months under the terms of the Covenant), who are in need of further support can be linked seamlessly into the appropriate level of care. To their credit, staff at the DCMH were very keen to make improvements. We also escalated this issue to the regional Quality Surveillance Group, which exists to ensure that different parts of the health and care system work together. Finally, we shared our information resource (Figure 1, p.16) with DCMH Marham so that they were aware of local support avenues for veterans in Norfolk.

What are the next steps?

It is clear that there is more work to be done to streamline the handover between the MoD and local NHS services. We will continue to look for ways to make improvements as part of our general work to support NCC’s Community Covenant Board, which is ultimately responsible for integrating the Armed Forces and civilian communities (section 7, recommendation 3).

Figure 14. Information about our work to improve MoD mental health services.
4.4 The role of the GP

For most people in this country, the first step to accessing help for any health problem would be to go to the GP. Twenty-six (26) participants spoke about their relationship with their GP and the majority (22) had approached their GP as a first port of call. As described in section 4.2.2, the participants had tended to wait until they were in crisis before seeking help:

“I went to the doctor and I said I was looking at rafters, thinking if that was going to hold me weight. I was on a suicide thing then... I was crying and shaking and I was obviously going back to the way that I was when I was in the Navy,” SNCO Hyde.

Given the manner in which they presented to their GP, it was very good to hear that they were generally positive about their experiences of primary care. For several participants, it was clear that their GP had become an instrumental part of their care package:

“I have an excellent relationship with [my GP]. He certainly [understands] me because... the last four or five times he’s been really concerned whether or not he’ll see me again. He’s always there making sure I’ve got the Crisis telephone number. And asking me, ‘Look, are you sure you’re okay.’ He was really making sure that I wasn’t going to be a stat,” JNCO Middleton.

Only six participants were entirely negative about their experiences of primary care. In total, ten participants highlighted areas for improvement, which will now be explored in more detail.

4.4.1 Lack of understanding about mental health

The most common issue for the participants was that their GP did not have a sufficient understanding about mental health problems, whether military related or otherwise:

“There was a decent doctor... and he was very sympathetic. But like I said, he didn’t know how to treat me... GPs just don’t have a clue, do they? They haven’t got a clue about that. Honestly, most GPs just don’t understand anything about PTSD,” Pte Stevens.

Four participants felt that they had been given anti-depressants and sent on their way, without being offered any further support (e.g. counselling/therapy):

“I went to the GP because I was getting very depressed... To be honest with you... I’ve got no faith in the GPs I’ve ever known. If you go and talk about depression, they give you pills, pat you on your head and tell you you’ve got low mood. And when you want to kill yourself like all weekend, someone telling you you’ve got low mood, I think that’s disgusting. I think that a terrible phrase,” Pte Davies.
“I went to my GP and he basically didn’t know how to deal with it, and just shoved me with shitloads of antidepressants and just said, ‘Take these and you’ll be okay.’ I wasn’t ever offered treatment. Never offered any counselling, nothing like that,” Pte Taylor.

“My GP, when I registered with him, he got all my medical docs, he got my listed prescriptions, he basically started me on [medication] and said, ‘I only need to see you if something new comes up,’ and that was it. And it was [Combat Stress] who referred me to the NHS [mental health services]... My own GP wouldn’t have done a thing I don’t think. To be honest, he seemed quite an ignorant man. That’s my impression,” SNCO Matthews.

“I need[ed] help, and [the GP is] like, ‘No, no, no,’ and I’m like, ‘I’m sitting here asking you help, man. I’m asking someone for help.’ [And I start thinking] ‘Well, I’ve asked the first time and I’ve asked once, I’m not going to ask again...’ because it’s basically giving you the hard shoulder. ‘It’s not my problem,’ basically. That’s what they’re saying... That’s how I felt,” Pte Connor.

One participant was signposted to Relate, which is a private marriage counselling service. Relate is now part of the Norfolk and Waveney Wellbeing Service, but it seemed that, at the time that he accessed it, the participant was expected to pay:

JNCO Nelson: “[My GP] felt that there was an underlying issue, so he prescribed me some meds, and then suggested I should talk to Relate and just send me on my way, really.”

Researcher: “So your GP didn’t recommend NHS services?”

JNCO Nelson: “No, nothing like that. Which I come away thinking, ‘Oh, that’s a bit strange.’”

Researcher: “What could have your GP have done... to make it easier for you?”

JNCO Nelson: “Certainly with hitting that depression, and as far as getting counselling and support, then yeah, certainly something that I didn’t have to pay through the teeth for.”

These kind of experiences were the principal reason why six participants had been unable to access mental healthcare from the NHS (section 3.5).

Pte Davies, quoted above, had an interesting suggestion about how primary care could be improved for people with mental health conditions:

“I think what they need to do, and again I understand they’re general practitioners, I know they can’t all specialise. I think you need someone who knows about mental health in every GP surgery. I know it ain’t gonna happen, but if you had a mental health expert that covered say, six GP surgeries, that would be absolutely fantastic because you could go in and see your GP, you say, ‘Look, I’ve
been running around wanting to die all weekend. What are you gonna do,’ they could get started on this person. Even if they’re covering other--I mean lets be serious, 20 GP surgeries, they’re gonna have plenty of time to go and see these individual people and they’re gonna pick them up, know what’s going on for them, and know where to put them and who to signpost them to…”

“I’ve been in a situation where I’m just barely hanging in there and I’ll go to the GP which is a massive task in itself for someone that doesn’t wanna leave the house and they go, ‘Take these, low mood, blah blah blah, come back in two weeks.’ Well two weeks to you fella might be all right but two weeks to me, an hour is a nightmare for me, it’s like a lifetime. Even a week is too long. Whereas if they said, ‘Look, we’ve got a liaison person, I’ll phone them now...’ Within say 24-hours, they’ll at least have made phone contact. That would be absolutely brilliant,” Pte Davies.

Whilst a lack of understanding of mental health will affect both veterans and non-veterans alike, it is possible that veterans may feel more keenly aggrieved, due to the fact that they may have higher expectations of the kind of support that an overstretched NHS can provide. As mentioned in section 4.3.1, the medical services in the military are highly responsive and a few participants found the NHS, with its targets and waiting times, to be rather disappointing:

“[Leaving the military] was a massive shock. Because you think that things will be similar. I mean, you don’t think that it’s going to be exactly the same, but you think that there will be some follow up. And certainly when those of us who are diagnosed-- not all of us have PTSD, but there always tends to be some sign of depression along with it, whether it be mild, Moderate, or severe. You would think just with that alone, that would be something your GP would need to see regularly. But it seems not...”

“I’d have liked [my GP] to just [say], ‘I understand you’re a veteran. I see you’ve got these mental health conditions, and these other conditions. It’s not common practise for us to do this, but even if I don’t see you once a week, I’d like to see you once a month. Just to say, ‘Is everything all right?’ [Because] if we do have a bad day, it’s a really bad day. So when no one’s following you up from having all this constant sort of care and attention whilst in uniform, I think it’s... you just feel like no one’s interested and you just become a forgotten afterthought,” SNCO Matthews.

It is important not to make too much of this point. For one thing, as already shown, one participant had actually found the NHS to be a more responsive service than the DCMH (section 4.3.2), although it is possible that his comments related specifically to mental healthcare provision as opposed to primary care (and other) services.
Experiences with medication

Whilst not every participant had been offered counselling/therapy on the NHS, almost all of them were given medication by their GP. There were mixed reviews, but on balance, the participants tended to find that medication was not particularly effective. Several found that their medication had undesirable side effects that outweighed any benefits:

SNCO Harris: “[My GP] said, ‘The only way that you can deal with it is to try drugs,’ so I thought, ‘Yeah okay.’ And he reassured me that they’d be short-term sort of thing... When I went back and said I’d had trouble with the first drug, [another GP] said ‘Well, try this one, this is a bit different.’ I did. I thought I was dying.”

His wife: “It was dreadful. Just dreadful.”

SNCO Harris: “It was totally wrong in every respect. I felt so ill, I just didn't know where I was. So I just had to stop them after taking about half-a-dozen of them.”

His wife: “Yeah, you couldn’t do that one at all.”

4.4.2 GPs who are veterans

Three participants had (or used to have) a GP who was also a veteran. Given earlier findings, it was not surprising that the military link was very important to them:

“It’s one of those things that my doctor at the time that I went to, because he was an ex-military chap, and again I had that sort of connection with him,” Pte Anderson.

“There just was something with my GP. My GP was ex-Forces. He felt confident, and I had full confidence in him,” Pte Jones.

Touching on issues raised in section 4.2.2, one participant found that having a veteran GP gave him more confidence to ask for help:

“I had the confidence in my GP because of his military background and his understanding of what makes servicemen tick... They won’t disclose immediately, you’ve got to ask them. You’ve got to push them and give them the confidence to tell you what’s wrong with them,” JNCO Bateman.

Three participants had (or used to have) a GP who wasn’t a veteran, but who had an understanding of the military and this link seemed to be important too, as indicated by JNCO Bateman’s story, following on from the above:

“When I learned that my [ex-Forces] GP was retiring, I was quite upset but on the first meeting with [my new GP], I was really quite encouraged... I remember she
said that she was particularly interested in the trauma that military people go through and the mental health aspects of it... she is very good... I have complete confidence in her,” JNCO Bateman.

As these stories indicate, the major advantage of having a GP who was a veteran, or a GP with an understanding of the military, was that they would be more likely to be able to understand and respond to a veteran’s needs, which were felt to be different to civilians, for reasons such as those discussed in section 4.1 and 4.2.

This issue, was particularly relevant when it came to mental health treatment, which will be explored in more detail in section 4.5, but it ran all the way through the system. The fact that they saw themselves as being different to civilians has already been identified as a potential barrier to care for some participants on Civvy Street (section 4.2.2). It seemed that having a military sensitive GP helped to remove part of this barrier.

For example, one participant preferred to see an English doctor, because foreign accents were one of his triggers for his PTSD as a result of the places he had been with the military:

“I’m not racist... I’ve never been racist. I have a problem with ethnic minorities - Europeans and languages: Irish, African, things like this. The thing is, I don’t always see what I’m seeing. It’s the accents,” SNCO Parker.

SNCO Parker also didn’t like crowded places, which is one of the classic symptoms of PTSD. Staff at his practice were very accommodating, and it was clear how much this meant to him:

“The nurse practitioners are stellar... I got a 20 minutes appointment, and they talked to me the first ten minutes about myself, what am I doing. ‘How’d you feel on the day? Is everything at home all right? Have you got any money worries you’d like to talk about?’ Doctors are the same; out-of-hours flu injections done after the queue with the rest of the people... so there will be hardly anybody there. They’re really good about it. And you can’t fault them... On one to ten, that would be ten, every time. Even the people in reception, brilliant,” SNCO Parker.

20-30 years ago, there would have been many National Service era veterans in clinical roles within the NHS (National Service ended in 1960). These days, we cannot expect there to be very many individuals with direct experience of the military working in primary care, which makes it all the more important to ensure that GPs are aware that veterans may need a slightly different approach and are able to adjust their practice accordingly.

One participant outlined two examples that illustrate both that veterans may sometimes have rather particular, and demanding, needs and also how much difference it can make if they are treated by a professional with a willingness to try and understand:
Best practice:

**SNCO Peterson:** “Whenever I’ve seen [medical professionals]... I’ve always gone through a simple quiz with them to find out if they know what they’re talking about. What’s a brick, what’s a Gympy? And if they don’t know the answers, they’re no fucking use to me because they don’t know what language I speak...”

**Researcher:** “Just out of interest, you say you put those two questions to test staff. Has anyone who didn’t know the answer ever rung you back or done the research, found out, and said, ‘Come back and I can tell you now?’”

**SNCO Peterson:** “One person. That’s my old GP. The first time she saw me, once we got over the initial crisis management... she turned around the said to me, ‘I know nothing at all about Combat Post-Traumatic Stress Disorder.’ And she asked me a question: ‘Will you help me?’ I said, ‘Yes, I will.’ So I pointed her in the right direction.... So, yeah, she knows what a Gympy is and she knows what a brick is... She saved my life countless times, and [my wife] will back that up. She was the best GP I’ve ever had. Unfortunately, I don’t come under her catchment area anymore...”

Room for improvement:

“When I first made an appointment to go and see [my new GP]... the first thing I asked her was, ‘Do you have any knowledge or experience of dealing with Combat Post-Traumatic Stress Disorder?’ Her answer was, ‘No.’ I said, ‘Well, in that case, you are going to be no good to me whatsoever.’ She said, ‘Why?’ I said, ‘Because I can’t talk to you.’ I said, ‘I need someone who understands where I’m coming from to be able to help me with my mental health side.’ Standard answer. Referral. Northgate. But we had to do that in the end. [We] had to follow that up because it just never happened from them...”

“I ended up with a second GP... He knows very, very little about mental health, but I’m in a situation where I’m stuck... They have three surgeries under their umbrella... And apparently, from all three of them, they have no one who has-- no GP who has specialised in mental health. So I’m stuck with a GP who I cannot talk to about my mental health.”

Another advantage of having a veteran GP or a GP with an interest in the military was that they were more likely to be aware of the wealth of support that is available to veterans in the Third Sector. A lack of information about local support services has already been highlighted a second potential barrier to care on Civvy Street (section 4.2.2) and it seemed that, in most cases, GPs were just as unaware about these services.

By means of example, of the 14 participants who had used Combat Stress, only three were referred by their GP, and in these cases the GP was either also veteran (two) or had a special interest in the military (one). These findings mirror the general picture, according to which only 7% of referrals to Combat Stress come from GPs or other health or social care professionals, in spite of the fact that
Combat Stress provides a commissioned service on behalf of the NHS (Simpson & Leach, 2015).

It is fair to say that, traditionally, primary care services have struggled to manage veterans (MacManus & Wessely, 2013). Whilst this is a national problem, recent figures suggest that the East of England performs particularly badly, as measured by the low numbers of veterans that have been identified by primary care staff and coded on clinical systems across the region (Kirkham, 2015). The participants were quick to understand that GPs are very busy people and cannot be expected to know everything. As has already been mentioned, several thought that the issue was bigger than primary care, and that there should be more signposting right the way through the system, starting with the MoD at discharge (section 4.2.2).

We have already taken some steps to improve signposting for veterans passing through RAF Marham (Figure 14, p.74) but we also decided to respond to the participants’ concerns by looking for ways to improve the primary care experience for veterans within the course of this study. Healthwatch Norfolk is currently undertaking another piece a work looking at the primary care system more generally. As part of this work, we have been asking staff from local GP practices (46 as of March 2016) what support they would like to help them when treating veterans. On the basis of their feedback, we put together some information resources, which we shared with all of the practices in Norfolk. In addition, we made the most of national policy drivers from the Department of Health (2015) to organise veteran specific training for 200 GP students across the East of England.

Further information about our activities to improve primary care services for veterans is detailed in Figures 15 & 16 (overleaf).
What did we do?

We spoke to several veterans who were working within primary care to ask them what we could do to help GPs when treating veterans. We supported one of them to produce a protocol for identifying and treating veterans in his practice (Appendix K). In addition, we produced an information resource for GPs about local mental health services for veterans (Figure 1, p.15). We shared both resources with all GP practices in Norfolk through the Local Medical Council and followed up by attending Practice Manager network meetings, where we also helped NCC to share GP waiting room posters aimed at veterans.

Why did we create a protocol and information resource?

Some veterans have unique needs, maybe as a result of their service. They have special entitlements on the NHS and there is also a great deal of veteran specific support available in the Third Sector. However, GPs, who are the key to accessing help, are not always aware of these things (section 4.4.2). GPs are busy people and so by helping to create a protocol and information resource we hoped that we would be able to make it easier for them to treat veterans appropriately.

What are the benefits for local veterans?

There is a wealth of support available to veterans in the Third Sector, but veterans are not always aware of this (section 4.2.2). The GP has the potential to play a key role in helping veterans navigate the complicated system. With our protocol and information resource, more GPs will be able to help veterans to access the right support.

What are the next steps?

We are currently doing a different piece of work talking to GPs and other primary care staff, in which we have been asking some specific questions about what their practices are doing to support veterans. As part of this project, we will continue to support GPs to treat veterans by sharing our protocol and information resource.

Figure 15. Information about our work with GPs.
What did we do?

Currently, HEEofE has a requirement to provide training in veterans’ health needs to GP students. At the start of this project, we approached local CCGs and HEEofE to ask them what they were going to do to meet this requirement (Appendix L). Our letters helped to speed along national action, leading to the appointment of a Veterans’ Lead within HEEofE. We brought this lead together with the MoD and supported them to plan four Veteran Healthcare Conferences. As a result of our input, this region is now a leading example of best practice for other areas in the country.

Why did we help to organise Veteran Healthcare Conferences?

The purpose of the conferences is to raise awareness about veterans’ health needs, entitlements and local support avenues in a way that will inspire the students to change their practice when treating veterans in practice. The conferences are run by a Lt. Col. who serves as a GP in the Royal Army Medical Corps. In the morning, local veterans from the Royal Anglian Regiment share their stories, and small groups of students talk to each veteran in a consultation style. In the afternoon, the format is repeated with representatives from national and local veteran agencies.

What are the benefits for local veterans?

The four conferences have reached 272 students, which is more than 1 in 4 of all the students in the region. The feedback so far has been extremely positive (Appendix M). Every student so far has said that they have changed the way they work with veterans as a result and we have received anecdotal examples of this happening in Norfolk.

What are the next steps?

We have completed an evaluation of the first two conferences (Appendix M). This report recommends that we complete the evaluation process to build an evidence base of the benefits of the conferences to local veterans and that we continue supporting HEEofE to provide this much needed training in the future (section 7, recommendation 2).

Figure 16. Information about our work with GP students.
4.5 Using NHS mental health services

As shown by Figure 12 (p.33), 21 of the 30 participants had used NHS mental health services and three had used drugs and alcohol services. Based on some of the findings reported earlier, we hypothesised that participants who had some symptoms relating to the military might have different views and experiences of NHS mental health services to those whose conditions were entirely unrelated to their time in uniform. For that reason, we divided the participants into these two groups in our analysis, and the findings will be presented in this fashion (sections 4.5.1 and 4.5.2).

Before beginning this section it is worth repeating that this study was not intended to provide an objective evaluation of NSFT’s services (section 2.7). Feedback from a sample of participants has been outlined to contribute to the evidence base about how veterans experience, and would like to experience, mental healthcare in Norfolk and Suffolk, but their experiences cannot be taken to be representative of the experiences of the wider veteran community (section 2.7).

4.5.1 Participants presenting with symptoms relating to the military

14/21 participants presented to services with at least some symptoms relating to their service, including 10/13 of the participants diagnosed with combat related PTSD. Nine of these participants used mainstream counselling/therapy provided through primary (Wellbeing) or secondary (community) services and seven received military sensitive treatment, either from a dedicated veterans’ service or from a mainstream professional with an understanding of the military (two participants received both military sensitive and non-military sensitive treatment). In almost every case, military sensitive treatment was felt to be the more effective.

In addition to the limitation outlined above, it is worth noting that 4/7 of the participants who received military sensitive treatment (2/3 who had made use of a dedicated veterans’ service) were referred to the study by the NHS, whereas almost all who received mainstream treatment (8/9) were referred to the study from elsewhere. Bearing in mind that the participants were largely positive about the referring organisation (section 2.7) it is possible that the fact that military sensitive treatment was felt to be more effective has something to do with the way in which veterans were referred to this study, rather than overall treatment quality.

This limitation is partly mitigated by the nature of the feedback; namely that the majority of participants clearly felt that military sensitive treatment was the more effective, regardless of whether or not they had actually received such treatment themselves.
Mainstream treatment (not military sensitive)

One of the nine participants with some symptoms related to the military who received treatment that was not military sensitive was completely satisfied:

“Yeah, I think for me personally, it’s been really good. Very good… Fast and effective,” SNCO Martin.

The other eight participants were not so positive and all told similar stories. Generally speaking, they were satisfied with elements of their treatment, and said that staff from NSFT had done their best to help, but ultimately they felt that their conditions were too complicated for the level of treatment they received.

For one participant, who had depression with some military related symptoms, the problem had nothing to do with the fact that he was a veteran. Rather, he felt that (what is now) the Norfolk and Waveney Wellbeing Service was not suitable for his needs:

JNCO Middleton: “[What is now] the Norfolk and Waveney Wellbeing Service] is a total waste of time. No disrespect to the girl. She probably knows what she did when she was on her course the week before. But I didn’t need the telephone conversation, I needed to see someone, and you have to go through all the hoops first, have your six telephone calls, fill in your questionnaires. I didn’t want that, that’s not what I needed. It was just a total-- someone to speak to over the phone, ‘How do you feel today?’ And it’s like, I’m of the age where you don’t speak to people like that over the phone. You don’t know who you’re talking to. You need to look at them and say, ‘This is the problem. Where do I go?’”

Researcher: “Did they offer [face-to-face appointments] to you?”

JNCO Middleton: “Well, they did, but you had to go through all the hoops first, and then the options were you go to a group session. I’m a private person, I don’t want to tell Joan Bloggs next door what’s wrong with my brain. I need to speak to someone, someone who’s qualified, who can look at me sympathetically and say, ‘Yeah, I understand.’ Well, not I understand because no-one understands, but, ‘This is what we need to do to get you out.’ Not cognitive therapy over the telephone.”

The other seven participants all had combat related PTSD and it seemed that the complexity of the condition itself, quite apart from the military context, had made it difficult for them to find a professional who was able to address their underlying issues:

“I went] to see a therapist [from the local community service] I’ve seen her twice. But at the end of those two sessions, I was basically told, in a nutshell, because my PTSD is complex, they haven’t got the resources or the speciality to treat me,” SNCO Peterson.
“[I] saw a therapist [through (what is now) the Norfolk and Waveney Wellbeing Service] who quite quickly said, ‘Look, I’m not treating your PTSD. That’s a very specialist area,’ which I kind of accept to a level... In fairness to that individual, being reasonable, she did say that, ‘The main feature of your presentation are depression, anxiety, and I can help you with that’... So yeah, they didn’t offer to send me to secondary psychological service or anyone within [NSFT] who could treat PTSD. For me, that was a little disappointing. It’s not the end of the world... I get the fact that she’s treating my presenting problems very effectively. It was good... I think some of that has sustained. That’s stuck with me. It’s helped me have a different appraisal on things,” Officer Gibbs.

The complexity of PTSD aside, there was a general feeling that the military context introduced an additional challenge, making it even harder for mainstream professionals to offer effective treatment:

“[My therapist] done his best to fucking help me, but he didn’t know himself. He had to go and ask someone else, because he didn’t know himself. He’d never dealt with a veteran before... They need to educate the fucking NHS, because they haven’t got a fucking clue how to deal with veterans in the Army. And you have people with PTSD, but it’s not the same as PTSD from the military, because the fear is so much more intense, and the fucking aggression that is instilled in you-- I mean, I was constantly doing this fucking bayonet drill. I don’t know if you know what that is, but that is fucking pure fucking aggression all the time. Control and aggression,” Pte Stevens.

One participant, who had found it particularly difficult to adjust to life outside the Forces, was disappointed that his treatment had not helped him to move on:

SNCO Hyde: “The therapy I’m getting at the moment [through the Suffolk Wellbeing Service] I feel has helped me to get over what was bouncing around in me head, but it hasn’t helped me to change my character or make me any better than what I am.”

His wife: “From my point of view, I won’t even go in when we have to go... I won’t even go in there anymore. She’s quite a young girl and from what I’ve-- I mean, I don’t sit in on it, obviously; I just sit and wait. But we’ve talked about it, and it sounds to me as if she’s fine with what she does as long as it goes by the list.”

SNCO Hyde: “A set criteria?”

His wife: “Yeah. As soon as [SNCO Hyde] asks a question that isn’t on this list, she doesn’t know how to answer, so her answer is usually, ‘Oh, you’ll have to see your doctor. You’ll have to see your doctor.’”

SNCO Hyde: “See, nobody’s ever told me whether [my condition] is a curable thing or not... I’m assuming it’s not, because it’s in me head and it’s always going to be there.”
A lack of understanding about the military context has already been identified as a potential barrier for some veterans within primary care (sections 4.2.2 and 4.4.2). Touching on issues raised by two participants in section 4.3.2, with reference to treatment they had received from the MoD, it seemed that a lack of understanding could also affect therapeutic experiences:

“It’s having the full military background of knowing what someone might have experienced... just have an understanding of how things are on an active deployment makes a huge difference, or at least know how the military family works. A lot of people who understand the military systems of moving every few years and being not just deployed makes a big difference, because you’re doing it with a backpack, sort of all ready to go on short notice, and you just put in a few last minute things, and you go. And having that understanding, you feel you’re more open to just say, ‘Oh, yeah. You know what I’m talking about.’ And if you have to try and explain in the first few sessions exactly what a deployment’s about, you feel like you don’t quite-- they don’t know what you’re talking about, so you don’t think they really understand you,” SNCO Matthews.

“A psychiatrist who’s never dealt with a combat veteran hasn’t got a clue how to treat a combat veteran... I’ve had a senior board [member] on a medical tribunal telling me that she wants me to see a psychiatrist [and I said] ‘Fine, okay, you get me a psychiatrist, but you get me one that is trained in how to deal with combat veterans.’ And when she turned around and said to me, ‘Oh, any psychiatrist can treat you,’ I turned around and I told her, ‘With all due respect, ma’am, you’re talking out of your fucking arse. You haven’t got a clue what you’re talking about. Because what you can do is you could put a veteran in front of a psychiatrist who’s never dealt with veterans before; he will open up boxes and then let a killing machine out on the street,’” SNCO Peterson.

For this reason, SNCO Peterson would have preferred to receive military sensitive treatment from a professional with an understanding of the Armed Forces:

Researcher: “[Do] you think it would make a difference to you if you knew that the person you were talking to at least had done some training or had some experience treating [veterans]?"

SNCO Peterson: “They have to, because otherwise bang come the shutters, they just come down, we don’t talk, we don’t open up... I’ve seen therapists [and] the first question that I ask them: ‘Right, before you take me on this journey of treatment, I’d like to ask you a couple of questions.’ And they said, ‘Carry on.’ And I said, ‘Right. What is a brick?’ And if they come up with a suitable answer, I will talk to them. If they tell me it’s something to build a house with, I’m likely to fucking punch them or just walk out, and I’ve done it. Because if they can’t tell me what a brick is... they can’t understand my language. They’ve got to be able to understand the military ethos with a veteran: the way we think, the way we talk, the way we act. And unless they can understand part of that, they have no chance whatsoever in getting us to open up our innermost secrets so that we can move
forward. And that’s one of the biggest problems we’ve got. We don’t trust people who haven’t got a clue what we’re talking about or can’t understand us."

The other participants who had received mainstream treatment for combat related PTSD were in agreement, although not all of them were as forceful:

“There’s things I’ve said and done... that I’d liked to have sat down with somebody who’s military-sensitive to say, ‘I want to’, as one of our colleagues used to say, ‘empty the vessel.’ I’ve got-- in me I’ve got a lot of pent-up experiences and thoughts around things that I’ve been involved in that I would love to air and maybe get somebody else’s perspective. Because I think my perspective, as with most people, is probably a little bit catastrophic, a little bit dark and not helpful. So if I had somebody in NSFT who would at least listen to my experiences in the military, God bless them, put up the sandbag and swing the bat, I think that would be hugely cathartic and probably would have been helpful,” Officer Gibbs.

One participant had actually asked for a military sensitive approach, but was told that it would not be possible:

“The first counsellor I saw [from the local community service], I could see on their face, sort of a look of horror. And I thought, ‘I don’t think I better say any more about that then’... [So] I said, ‘Would it be possible to see someone who’s got specific experience of PTSD?’ [They said] ‘Well, we can’t say really. You just have a counsellor appointed to you.’ He was [good], because he was... experienced. But... we didn’t talk about the combat, we didn’t talk about the flashbacks. We didn’t talk about anything to do with that. All he wanted to talk about was my childhood, and I had a happy childhood... And I was thinking, ‘Well, that’s not really addressing the issues.’ Again, it was a bit of a sticking plaster,” Pte Miller.

For two participants it was not so much of a problem that their underlying issues were not being treated by NHS mental health services, because they were also receiving some specialist support from elsewhere:

“[My therapist from the local community service] is superb... We try something new each time... I’ve told her that I’m a bit of a challenging case for her, so she’s under no illusions there. But yeah, she’s the sort of person that’s easy to talk to, which is great for me, because I do sometimes have barriers. And that’s the hardest thing, is if you have a therapist who you can’t get on with and you say, ‘I can’t work with you,’ and it’s difficult then, because you feel- I know that she would swap and get someone else, but it would then make it awkward again. But no, she’s been great...”

“The stuff that we’ve been discussing hasn’t really pertained too much to the military. It’s been more about my actual behaviour... about how I cope. [My therapist] knows it’s a stepping stone to get me towards the proper treatment, this specialist side of things. Which I think is difficult for the NHS to cope with... So, it’s proving beneficial for the aim of it, which is to be able to focus me to get to Combat Stress,” SNCO Matthews.
The partner of Pte Jones: “When I first met you, you used to see that young lass via [(what is now) the Norfolk and Waveney Wellbeing Service]... but the GP, as I recall, thought you were kind of a bit too much for her.”

Pte Jones: “Too much for her.”

His partner: “And that’s why we went in other directions.”

Researcher: “In what way were you too much for her?”

Pte Jones: “I think [my GP] felt - although he never expressed it - I think he felt that somewhere else [Combat Stress and The Anchor] were good enough. And it were.”

His partner: “I think he felt that his issues were too complex... and he needed like - because the Army - he needed a specific type of therapy.”

These two stories are great examples of effective partnership working between the NHS and the Third Sector, in this case Combat Stress. Unfortunately, it seemed that this kind of arrangement was not happening in every case. As a result, other participants were not so lucky:

SNCO Peterson: “As soon as Combat Stress were mentioned, the [local NHS] team weren’t interested.”

Researcher: “Why do you think that was?”

SNCO Peterson: “They said, ‘Because you’re now under the umbrella of Combat Stress, so we can’t actually jointly treat you.’”

To be fair, this part of SNCO Peterson’s story took place in 2005, but his more recent experiences suggest that not much had changed for him over the years. Having recently attended two sessions of therapy (p.85), which he did not find to be very effective, SNCO Peterson was offered an appointment to see a psychiatrist. Again, the fact that he was also being treated by Combat Stress seemed to have complicated things:

“This is part of the snag with Combat Stress: from the time you’re involved with Combat Stress... the psychiatrist down there has always said, ‘I am the only person that is allowed to play about with your psychiatric medication because I deal with combat veterans all the time. Whereas an ordinary psychiatrist in a mental health hospital who doesn’t deal with veterans on a daily basis hasn’t got the knowledge and experience to be able to prescribe the right sort of medication for you...’”

“So basically, [staff from the local community service] agreed that there’s nothing the psychiatrist can do apart from play about with my meds. And I’ll be honest, I wasn’t willing for that to happen, because I’ve been led to believe over the last ten years that only my psychiatrist at Combat Stress was allowed to play about with them. Because we rely so much on the professionalism of our psychiatrist at
Combat Stress.... So I didn’t end up with a psychiatric appointment to see a psychiatrist; it just dropped dead...” **SNCO Peterson.**

It is important to note here that none of the Combat Stress psychiatrists prescribe medication, but rather work with GPs or local psychiatrists. However, it is clear that SNCO’s perception was that his psychiatrist at Combat Stress took the lead when it came to managing his medication.

Although SNCO Peterson had a long history with Combat Stress, he had not found the treatment he had received over the years to be very effective, which meant he was in a position where he felt he was not receiving support from either Combat Stress or the NHS. SNCO Peterson’s experiences with Combat Stress will be discussed in more detail in section 4.6.1.

Aside from struggling to find an appropriate level of care from a mainstream professional who understood the military context, three participants raised issues with the early stages of their engagement with NHS mental health services:

“To be honest, I thought it was a very, very poor [initial] assessment, very unprofessional assessment. The guy seemed to be completely out of his depth when I started talking about some of the symptoms. He didn’t ask me about harm to others; he asked me if I was suicidal and I said yes... I’ve picked out a tree in the woods that I want to hang myself.’ And I said, ‘I keep feeling compelled to go there and do it. I keep trying to stop myself, because I’ve got my wife and I’ve got my dogs, and I don’t want to hurt other people.’ And I thought, ‘Are you not going to ask me am I having some thoughts about will I harm other people?’ No. So I thought, ‘Well, I better tell him.’ So I said, ‘Look, I had this incident where I hit my wife and I feel really awful about it... And again, ‘Well, what happened to your wife?’ I said, ‘She didn’t get hurt too much or anything.’ ‘Oh, well you could move to another bedroom.’ And that was again, quite dismissive of it...”

“I forget how he put it. He said, ‘Well, what we could do,’ he said, ‘We could pass you to one of our community teams.’ So I said, ‘Okay.’ He said, ‘Well, do you want to do that then?’ I said, ‘Well, yeah. I want some help.’ ‘Well, you’ll have to have another assessment for that.’ I said, ‘Another assessment?’ He said, ‘Yeah, you’ll have to have a face-to-face assessment before that can happen.’ So he’d almost promised it to me, and then sort of said, ‘Do you want to do that?’ And I said, ‘Yeah, I do,’ and it’s almost like you could feel the disappointment,” **Pte Miller.**

“[I] waited a long time for my appointment. One finally came through, then the therapist was changed three times in the space of a week, and the location changed a couple of times. So there were three different names, and then when I did finally think we’re getting close to the appointment, I’m going to see somebody, that then was cancelled...”

“It was disappointing that... To get three changes of therapist who I haven’t even met, just letters, and then getting yourself worked up and ready to go to an
appointment to be told a few days beforehand, ‘Actually, that person’s off sick,’ long term sick. It was due to stress. I thought, gosh, you know, that’s why I’m here... I know where they’re coming from, I can empathise with you. And you feel bad for the therapist, thinking, ‘[I’m] taking up your time,’” Officer Gibbs.

“I was seen twice for assessment... and then I went back on the waiting list until there was a spot available for me for treatment, and that was a couple of months later. Because once I had gone for the assessment, I thought, ‘Oh, great. It’s all starting,’ and then when I went back on the waiting list... it sort of took me back for a bit. So I thought once they had done the assessment that the treatment would begin and not have the waiting, but it would have sort of been nice for them to say, ‘We’ve got a space, we’ll do the assessment, and then you instantly come in.’ So, that would have been nice as a patient than to have the assessment and then wait,” SNCO Matthews.

SNCO Matthews was also disappointed to be told that he could only have a limited amount of sessions at the start of his therapy:

“The only thing which I know is difficult... to do is when I was told that there’s a finite number of sessions that you can have... you have to be sort of re-referred to then get another set of sessions. I think [my therapist] said 22 was the maximum that she could do, which is a lot... But it’s difficult for me to-- I think 22 session, my instant thing is negative, so I think I’m not going to be able to get to where I need to be in that number of sessions knowing how I’ve been with other treatments. So I was instantly thinking that I’m not going to have enough time. I know you can’t leave an open sort of chequebook with it, which is a shame,” SNCO Matthews.

Whilst we might expect these kind of experiences to be frustrating for any service user, several participants, including Officer Gibbs, quoted above, suggested that initial disappointment could be particularly deterring for veterans, touching on some of the issues that have been raised in various places around their expectations of the NHS having grown accustomed to receiving treatment from the DMS:

Researcher: “Do you think it’s particularly hard for people who’ve been in the military, who’re used to a different type of health system, to transition to the NHS where appointments do get changed, therapists get changed?”

Officer Gibbs: “Yeah. I think-- absolutely. The military’s very much an occupational service that needs people to be fit dentally, physically, mentally, to get on with the job, and therefore most formations who’re at the front line will get a very prompt and attentive service. Therefore leaving the military to get, in my case, three letters and then the fourth option too-- was cancelled at the last minute, is not acceptable in anybody’s book, military or not, but certainly you’re more sensitive having been in the military, because that’s not how you’re treated...”
“If I was of a different disposition, putting myself in the shoes of others, I would just tell [the NHS] to fuck off. I’d be just like, ‘Sorry, I’ve served my country, I’ve done my bit, and this is what you’re offering me?’ And for some—I’m not racist in any means, but three names on there were not English. They’re all different—some [veterans], because of where they served [will be] thinking, ‘Will they be able to understand me culturally? Will they understand—will they be sensitive to my military experience? Will they actually be against what I’ve done? Will they not agree with what I’ve done?’”

Another participant, whose condition was not related to service, made a similar comment, after nobody got in touch with him following his assessment with the Suffolk Wellbeing Service:

“Hour and a half I was assessed for and she goes, ‘You need this, I’ll send you over?’ And I waited and waited and someone said to me, ‘Well, why don’t you phone them?’ And I said, ‘No, they phone me.’ Come back to the military mentality, why should I chase somebody and tell them to do their own job? No one would do that to me,” Pte Davies.

Military sensitive treatment:

The above stories reflect findings from recent national research by FiMT, which suggests that that some veterans desire and respond better to a military sensitive approach (2013; 2015). In recognition of this fact, NSFT has recently invested in some veteran specific training for over 20 therapists who primarily sit within the Wellbeing (primary) services.

Four of the participants had used mainstream services where they were treated by a therapist with an understanding of the military, although, as it happened, none of the therapists had actually attended the NSFT training. In sharp contrast to the previous stories, all of the participants were extremely positive about the treatment they had received:

“So I rang the number [for the Suffolk Wellbeing Service]... They got back to me really quickly and they spoke to me, I think, within a couple of days, and spent a long time on the phone to me. They were very, very helpful. They were very sympathetic, and listened to me without bias or a blame, and told me that they thought I needed an appointment with a mental health specialist...”

“I don’t really know what else to say about the treatment I had from the NHS other than that it was fantastic. It was effective. It was delivered professionally. You know, mental health is a really difficult issue, especially for the person that it affects. You kind of lose your self-esteem and your dignity. That was fully recognised, and everybody who I dealt with was as sensitive, I think, as they could be. Very quickly I was given treatment...”
“For the first time for a long, long time I feel back to normal, completely well, with having gone through CBT and being given tools to deal with my issues, and prevent them happening again, which is the most important thing. And I don't really know how my therapist did it, but she’s clearly very, very, very good at what she does because she’s managed to hugely improve my quality of life. And not only that. Without being dramatic, perhaps even save my life because I don’t know where it would have ended had I not had that intervention. So I’ve got nothing but good things to say about it,” Officer Palmer.

Whilst all four participants felt their therapists’ ability and personality were important factors to their successful treatment, for three of them it was clear that the fact that their therapist understood the military context was also of some significance:

“[My therapist from the local community service] was absolutely brilliant partially because she comes from a service background that she could actually understand that the things I was telling her about, [she] thought, yeah my ex-husband done that. My father-- so she understood the culture. So that did help because the worst thing is now for a lot of servicemen I think they send you to see someone like a counsellor. And she’s dealing with somebody who’s getting upset because their washing machine keeps breaking down or something. Then you get a veteran come in who’s seen God knows what, people’s limbs blown off and everything else and then they’re not coped to deal with it. I think we need to get more specialized people who specialize in military...” JNCO Rogers.

JNCO Turner: “This is going to sound daft, but had Maria [my therapist at the Suffolk Wellbeing Service] had me as her first-ever patient, client, whatever, then it probably would have been a problem. She’s been doing it for I don’t know how long, but she’s had other clients that she can relate back to you, do you know what I mean?”

Researcher: “Do you mean other veteran clients?”

JNCO Turner: “Yes. Yeah.”

Researcher: “Yeah. So really, it’s the experience she has in treating veterans that matters?”


Pte Miller, who felt that he had ‘horrified’ his first counsellor and subsequently asked for a veteran specific approach (p.88), eventually managed to find somebody he could talk to, a full year after first presenting to the NHS. This was solely through his own perseverance, but the effort paid off in the end:

“I saw [my therapist from the local community service] for about 21 or 22 sessions that we had eventually. And it’s fantastic. Really great treatment, and came out feeling very well. He’d got a lot of experience in treating combat PTSD, and had
The fourth participant who had military sensitive treatment from a professional working within mainstream services disagreed that the military context was important:

“I think it’s better that the therapist has no knowledge of the MoD whatsoever. And that might sound a bit mad, excuse the pun. But... I don’t see how that’s relevant because a qualified therapist is going to deal with people who’ve had trauma from a variety of sources. It could be childhood abuse, it could be a car crash, a fire, whatever. And military trauma is just another type of trauma,” Officer Palmer.

Officer Palmer had also experienced mental healthcare in the military (section 2.3.2, pp.68-69). As has already been explained, he found that the NHS compared very favourably. He particularly valued the person centred nature of his treatment, and the fact that, unlike SNCO Matthews (p.91), he had not been made to feel like there were any financial or time restraints:

“I think what the main difference was that the MoD were trying to fit a particular therapy to me, and they were trying to fit me to a timeline that coincided with my discharge. Well, mental health doesn’t work like that. It can’t be budget led or time led. It’s like cancer. It’s very different in every single person. And some people will respond to some treatments and others won’t. And I think rather than trying to make something fit me, which is what the MoD did, with the best intentions I’m sure, the NHS provision that I had was built around me. Because there wasn’t - or if there was I wasn’t made aware of it - a budgetary or time constraint on my treatment, the therapist was able to take the time. And that’s the crucial bit. It takes time. She was able to take the time to get to know me well enough and get to know my problems intimately enough that she could tailor an appropriate treatment to me rather than fixed one to me. You know?” Officer Palmer.

The limitations with this study notwithstanding (p.84), these stories offer great cause for optimism, and the fact that NSFT has provided veteran specific training to some of its therapists is obviously a very important first step. However, it should be recognised that findings from FiMT research suggest that upskilling mainstream staff is not the best way of providing an effective service for local veterans (2013). Apart from anything else, as long as veterans continue to use mainstream services, where some therapists do understand the military context and some therapists do not, there will inevitably be discrepancies in standards of care, as reflected in the feedback above.

There is a wider point here. As mentioned in section 4.2, men from all walks of life are known to be more reluctant than women to engage with mental health services. There is an emerging interest in this area, with recent studies suggesting that the difference may have a basis in meaningful gender differences (Kingerlee,
Precious, Sullivan and Barry, 2014). As such, it is possible that men may respond better to male-specific psychotherapies (Peterson et al., 2012). If we apply this to the issue of veterans’ mental health, it is possible that male veterans may respond better to dedicated veterans’ services.

Dedicated veterans’ services

As mentioned in section 1.1.3, NHS England currently commissions a national network of 12 dedicated services for veterans. Three participants had received treatment from a dedicated service. Two of them had used Veterans First, which is based in Colchester. Veterans First is an award winning service, and so it came as no surprise that it was highly praised:

“Veterans First were absolutely phenomenal,” Pte Taylor.

“Veterans First is absolutely amazing... I thought they were absolutely fantastic... If they said to me, would you come back and stand out in front of a 100 people, even though I’m not the most confident person in the world, would you stand up in front of a 100 people and tell them how good we were, I’d be there straight away. They’re brilliant. I will be indebted to them for a long time. Forever,” Pte Davies.

For one participant, it seemed that the veteran focused nature was the most important element of the service:

“Not trying to sound elitist or anything, you've probably heard of this before, but once you’ve been in the Army, it’s always you. And soldiers relate to other soldiers. Even if it was 20, 30 years ago, soldiers will relate to soldiers. There’s always a thing about soldiers and civilians,” Pte Davies.

Interestingly, Pte Davies had not really enjoyed his time in the Army, having left because he was being bullied. He had only served for four years and his condition was not related to the military, yet the ongoing effects of his time in uniform upon his attitudes as a service user were all too clear:

“It’s a bit hard to explain. Obviously I can’t speak for everyone but from my experience, in the Army, if someone says something’s going to happen at 12:00 o’clock, it happens at 12:00 o’clock... You get out of the Army from being in a real structured routine and suddenly - no disrespect to [the NHS] - but you’re dealing with civilian firms who go, ‘Yeah, yeah, we’ll call you tomorrow,’ and they don’t. And then they’re on holiday and they don’t call you. And then someone else doesn’t call you. And then someone turns up late or on the wrong day. And because you have been in that structured disciplined environment and I’m speaking from my own point of view but also from speaking to other lads, you lose faith in people. And you start thinking, ‘I should be back in the Army... because then you knew what was going to happen and when it was going to happen...’ And then you’ve got veterans with mental health. They’ve lost their faith in civilian
firms, maybe the NHS. They’re on a slippery slope, they really are. Sorry,” Pte Davies.

Within this context, it is easy to see why a dedicated veterans’ service was so attractive to him:

“So when I was scooped up by Veterans First… I thought, ‘Excellent, I’m back in with squaddies.’ And if they told me they were going to phone me, they’d phone. If they said they were going to do this, they’d do it. And I thought, ‘This is brilliant. That’s what I’m used to. I’m back to what I’ve experienced in the past. This is what life should be like,’” Pte Davies.

This kind of responsive service was particularly important to Pte Davies, because he felt he had been let down in this regard by Suffolk Wellbeing Service (p.92). Some staff at Veterans First are themselves veterans and the importance of this military link was clear:

“There was the banter. He took the pee out of my regiment. I took the pee out of his regiment. And we argued about what regiment was best. And already you’re starting to develop a rapport. Whereas to a civilian if you said, ‘I was in [this regiment],’ they’d go, ‘All right. Okay.’ But if I said it to him, he goes, ‘They’re a lot of rubbish. You should have joined my line.’ There’s the rapport there,” Pte Davies.

Pte Davies was also very positive about the way in which Veterans First was run, and its holistic approach to care:

“Basically, I’d got to the point where I couldn’t leave the house. I wasn’t going shopping. I was relying if someone popped in I’d get them to go to Tesco’s for me. So Veterans First come along and they were like advocates. They’d say, ‘Look, we’ll make a list of things you need to do. If there’s things you can’t do, we’ll help you do them, we’ll help you write letters, we’ll help you,’ because I’m a bit dyslexic as well. ‘We’ll help you write letters. If we can’t help you, we’ll sign post you to an organisation that can’”...

“They were a very self-motivated organization. And they helped me with so much. Not with my health as such but with other things that were going on in my life. [They gave me] financial advice because I was getting in debt. They helped me with that and they signposted me to the British Legion who were absolutely fantastic,” Pte Davies.

The second participant who had received treatment from Veterans First was not as interested in the military bond:

“Some of the people who I’ve had treat me at Veterans First, they haven’t served themselves, but the way that they approach you and the way that they are with, it’s so understanding and it’s almost—they’re so good that you really start to build up a friendship rather than just somebody that helps you,” Pte Taylor.
Like Pte Davies, Pte Taylor really appreciated that Veterans First was able to tailor their services around his needs, offering a holistic approach:

“They fully take on board what you’re saying and they’re never quick to mug you off, ‘Right. Just go get tablets’ or, ‘Go to your doctor’ or whatever. If I wasn’t up to going out they would come around to see me. If I was up to going out I’ll go see them. We’d sit down, just have a chat about what’s going on. You can really get out everything and they’d say, ‘Right. Okay. These are our options. What do you want to do? We’ll be there every step of the way.’ When I couldn’t leave the house, they would actually try and come with me to appointments, trying to get me out of the house. They’d say, ‘Right. Okay. I’ll come with you to walk your dog,’ and we’d gradually do stuff that’s more, and more, and more, to a point where I could go out on my own,” Pte Taylor.

In some ways, this was like the kind of support offered by the military:

Pte Taylor: “They also helped when I had [an] absolute nightmare [with my housing]. So Veterans First were on the phone with the council and anybody just try and see if they can get this moved on.”

Researcher: “I suppose in some ways that’s what you had in the military?”

Pte Taylor: “Yes. That’s exactly right.”

Pte Taylor had recently finished receiving treatment from Veterans First and he praised the way the organisation had tied him in to local support services:

“Veterans First also sorted out some medication for me, and then they had also got me onto a little program called Head Start [WWTW]... so I’m now having counselling treatment around my local area. And Combat Stress. So now looking after my medication needs and anything like that,” Pte Taylor.

For the above reasons, Pte Taylor felt that having a service like Veterans First in every county would be a great way to support veterans like him:

Pte Taylor: “I shouldn’t have really been with Veterans First [because I don’t live in Essex] but there’s actually absolutely nothing around [where I live] so they took me in.”

Researcher: “Do you think a Veterans First in each county would be a good thing to have?”

Pte Taylor: “I would think that would be absolutely phenomenal. I’ve spoken to some of my colleagues and they say the same thing. They know what I got from Veterans First and they ask me how they can get in contact with them.”

The third participant who had used a dedicated veterans’ service, Pte Stevens, had received treatment from NSFT’s VSP. Pte Stevens was one of the participants whose life had been fundamentally altered by his time in the military, in particularly by training (p.52). Having struggled with his problems for several
years, he had tried a range of services, including mainstream NHS mental health services (p.86) but had not found them helpful. It wasn’t until he started attending the VSP that he felt as though he was making progress:

“I can’t reiterate how fucking good it’s been… It’s done a world of good… It’s been life changing. I would recommend [it] to anyone,” Pte Stevens.

One of the reasons why Pte Stevens had found the VSP to be so useful was that he was not required to talk about his experiences, as he had previously tried CBT and had not found it useful:

“I fucking hated talking about my experiences. What the fuck do you need to do that for? That is not the way to treat PTSD. No way. Not with me anyway. Some blokes like talking about it, but not me. I mean, if I can’t tell my own fucking grandfather, how the fuck do you expect me to talk to some stranger? That just doesn’t happen. I mean, you brought up the fucking, ‘Oh, you’re a man. You don’t have fucking emotions. You don’t fucking cry,’ and it’s all fucking bollocks, isn’t it? Because sometimes crying is good for you, but when you cry, you feel ashamed that you’re fucking crying. What the fuck is that about?” Pte Stevens.

Whilst veterans attending the VSP can be linked into one-to-one therapy (CBT and EMDR) through NSFT, the programme itself primarily focuses on stabilisation and self-help strategies and so emotional disclosure is not necessary, but a matter of personal choice. This may potentially be of great significance when it comes to providing effective treatment for veterans, because men (veterans or otherwise), as intimated by Pte Stevens’ story, are thought to be less able or willing than women to articulate their feelings and consequently may not respond particularly well to treatment that relies upon emotional disclosure (Levant et al., 2009; Levant et al., 2006).

The nature of the treatment aside, according to Pte Stevens, the most important positive aspect about the VSP was that, in addition to being veteran focused, it was delivered, in part, by a veteran:

“The hardest thing really is to get the blokes to trust you enough to listen to what you fucking say… Roger [the NSFT clinical psychologist from the VSP] is brilliant. I wish I’d met Roger before. [But] if [he] had just been there on his own, it wouldn’t have mattered how good or how nice he was to me, I would have just fucking left. It was the fact that Luke [the veteran who co-delivers the course] was a veteran that made me trust him, and I was so impressed by the way Luke was, that I thought I want to be like that,” Pte Stevens.

As well as breaking down the initial barrier to care, the fact that the programme involved a veteran who was managing to successfully live his life with PTSD was also a source of great inspiration:

“I don’t know how Luke has fucking done it, but he’s fucking changed his life and he seems so positive and he’s inspired me. The man has inspired me, and I want to
be like Luke at some stage in my life... And if I could help someone else, that would give me some form of...a feeling that my life is worthwhile, because at the moment, I just don’t feel like my life is worthwhile,” Pte Stevens.

Pte Stevens was in no doubt about what the NHS could do to help veterans:


It should be noted that Pte Stevens had been referred to this study by the VSP and he had requested that his interview take place alongside Luke for support. As such, we might have expected him to be positive. The limitation with his testimony is in part mitigated by comments from other participants. Whilst we did not typically solicit opinions specifically about the VSP, several participants described something that sounded very like the VSP in response to the question ‘what can the NHS do to better support veterans?’ and in these interviews we did explain about the service and ask for their specific comments. The feedback was overwhelmingly supportive:

“That [sounds] really good... That’s definitely something we need but on a far larger scale,” Pte Reed.

More generally, the majority of participants indicated that they felt that a dedicated service would be a very good way of providing mental healthcare to local veterans (especially those with symptoms relating to the military). Like Pte Stevens, many felt that veterans should be involved in the delivery of this service:

“Veterans get on better with veterans... You need to employ someone who’s a veteran who’s got PTSD, who understands it, who’s got it under control, who can talk to some of these lads to help them through the stages,” Pte Davies.

SNCO Peterson: “From my personal experience, the NHS needs to build on programmes that are designed to assess and help the veterans with their mental health problem... The NHS needs to widen, to build a huge programme based on evidence-based programmes that work. Now, I’ve seen over the last ten years different programmes and schemes coming in through the NHS and not working, and they’ve failed in certain areas, because they haven’t supported and they haven’t had the input of the right people.”

Researcher: “Who do you think the right people are?”

SNCO Peterson: “Number one, veterans.”

However, not all veterans felt that a dedicated veterans’ service was such a good idea, particularly not one where treatment was provided for veterans alongside other veterans. This was for reasons such as stigma, as discussed in section 4.2.1:

SNCO Hyde: “I don’t think you’d be able to get a group thing with a lot of servicemen... It’s the stigma, isn’t it? That’s bred in us. Yeah. You find it very hard
telling a serviceman, another serviceman, that you’ve got post-traumatic, because in their eyes, ‘Oh, you’re a wimp.’ Probably getting better now. It’s like my son is in the Army; he’s just come back from Afghan: his third tour. But he’s oblivious to it, isn’t he?”

**His wife:** “Yeah.”

**SNCO Hyde:** “He doesn’t understand and doesn’t see post-traumatic. To him, it’s a weakness.”

Another participant made an interesting comment about a potential side-effect of providing specific treatment for veterans alongside other veterans:

> “A lot of [veterans] think they should see only people who understand the military when in fact I think that would be dangerous... Because you may end up falling back into your [old habits],” **SNCO Martin.**

It has already been shown that some veterans find it difficult to adjust to life outside the military, partly due to the enduring relevance of Armed Forces culture (sections 4.1.1 and 4.1.2). With this in mind, it is vital that veterans are encouraged to move on from their time in uniform as part of their treatment. Whilst some participants felt that one of the advantages of a dedicated service was that it was like being back in the Forces (e.g. Pte Davies, p.96), we must be careful not to let this prolong adjustment issues.

This issue will be discussed again in relation to residential treatment provided by Combat Stress (section 4.6.1).

### 4.5.2 Participants with unrelated conditions

Seven of the 21 participants who used NHS mental health services presented to services with conditions unrelated to their service. All of them had used a variety of mainstream services provided by NSFT and one of them (Pte Davies) had also used Veterans First (as outlined in the previous section).

There was a fairly even mixture of positive and negative reviews. As hypothesised, there was a difference between the views and experiences of this group of participants compared to those participants who had symptoms that were in some way related to service. More specifically, unlike before, any problems encountered by the participants had little to do with the military context, apart from in the case of Pte Davies.

**(What is now) the Norfolk and Waveney Wellbeing Service**

Two participants had attended Wellbeing workshops in Norfolk. One participant was positive about his experiences:
“I went along for a taster session. It was quite good. It was really interesting. So I thought, ‘Well, I’d give it a go.’ So I did the basic thing which four weeks... I thought it was good, that one. Things they told us, I’ve used. It’s very handy,” SNCO Anderson.

The other participant, who attended a number of workshops with his wife, was less enthusiastic:

The wife of SNCO Harris: “I think I’d already picked up as much as I could from reading books... I found that the young lady who presented [the session], she couldn’t seem to express herself properly, and it was pretty ineffectual, wasn’t it?

SNCO Harris: “It was. I felt sorry for her.”

His wife: “She kept on saying ‘kind of’ this and ‘kind of’ that... She was filling in for what she really didn’t know what to say, ‘kind of’ - I thought, ‘No, no, no’. And really, only reading from a book and putting it on a screen for us to look at. I thought, ‘No, no, this is not too good.’”

SNCO Harris: “I looked around the room and I thought, ‘There’s some quite sick people here.’”

His wife: “I think there were 40 people, easily. And just looking along the rows, you think, ‘My gosh, that person’s in a bad way.’ You could just see it in their body language, in the expression on their faces. And I think not many probably found anything in it to really help them.”

SNCO Harris: “I think probably basic is the best way to put it. When you came home you’d say, "Well, all they did was read off a relaxation thing which you could actually put on a CD and just listen to yourself.”

His wife: “But you were frustrated. Yeah, you were.”

SNCO Harris: “Yeah, just frustrated. They didn’t seem to be able to expand on the stuff that was on the board. There were one or two interested people that asked questions and I thought, ‘Well, you’re not really answering that very well.’ And it was interesting, too, that when I went to the first session there must have been about 20-odd people there, and the very next week there were eight.”

In addition to not finding the workshops helpful themselves, SNCO Harris and his wife felt that such a service wasn’t appropriate for veterans in need:

SNCO Harris: “Well, the last [workshop] I went on was something to do with a worry workshop and something like that, and they had sent this young ex-Army man... who had been through the wars in firstly Iraq and then Afghanistan. Poor guy had been blown up, he’d been through the wars mentally in that direction, you know, and he had been left behind by the Army. The regiment that he was with went off [to be based somewhere else in the Country]. And one thing about the Army, they look after their people - or I thought they looked after their people - like a great, big family.”
His wife: “Because they’d moved away, he was left here, isolated.”

SNCO Harris: “He’d been discharged because of his health condition - mental condition, I suppose, to bring it down to the basics - so he was left isolated in Norfolk without his Army backup. They had seen fit that he wasn’t fit for service... He hadn’t a job to go to and he was now unemployed, not being able to get a job.”

His wife: “And he was just 30 years old.”

SNCO Harris: “He was 30 years old, and I got chatting to him outside after one of the sessions there, and I was able to empathize with him because of the shared military background, you know. Because whatever it is you’re in - Army, Navy, or Air Force - the rules are roughly the same. And I felt really sorry for this guy because he broke down in front of me and he said... ‘I’m 30 years old and I feel that my life is over.’”

His wife: “Yeah. Dreadful, wasn’t it? And he wasn’t in the right place. Those young women...”

SNCO Harris: “They had no answer to his problems.”

His wife: “They had no experience of anything like that.”

SNCO Harris: “They couldn’t identify with what he’d been through.”

His wife: “No, and he needed much more treatment, much more depth, didn’t he? And you came home, you were so upset about it. You said, ‘Well, he’s not going to get anything he needs there.’ He sounded almost suicidal to me... Dreadful. But he deserved better, didn’t he; better than being abandoned like that?”

One participant had received counseling/therapy through (what is now) the Norfolk and Waveney Wellbeing Service, which he found very helpful:

“I had a regular one-on-one with someone for about two hours every week, and that was brilliant. I’d go there, off-load all my worries, all my problems, get back in my car, go for a couple hours’ drive to calm down, and then go home again. That would be a regular thing every week,” Pte Lewis.

However, his mental health had suffered when the service had suddenly been withdrawn:

“But then, I don’t know what happened to her... So then, I kind of just fell through the crack... I didn’t hear nothing from the men at mental health, or anything. No, didn’t hear nothing. Spoke to my doctor about it, and she said, ‘Well, I will send documentations off to them.’ Which, I believe she’d done on three separate occasions, still hadn’t heard nothing from them. My mental health kind of went downhill big time,” Pte Lewis.
Crisis Resolution and Home Treatment

Pte Lewis was also disappointed with the treatment he had received from Crisis Resolution (Norfolk):

“On my third suicide attempt - my doctor contacted the mental health crisis team. Who, to be honest, I nearly chucked one of the gentleman out of the top window... They knew about my anxiety and everything, but they still sent someone different every time. Every time they came up with the same questions, ‘Why are you like this? How come? Please tell me about your history?’ Over and over and over again. [One day] the bloke turned up. He came upstairs and the first thing he said to me was, ‘How’ve you been feeling?’ ‘Well to be honest man, I don’t particularly want to be here.’ He goes, ‘What do you mean by that?’ ‘Well, I physically don’t want to be living any more. I’ve had enough, I’m having my eldest son and my wife drag me up some stairs just so I can go to the toilet properly.’ He goes, ‘Oh, oh we can sort you out a commode.’ I said, ‘I’m not sitting on some pissing commode’…”

“And he says, ‘Oh, you do realise if you commit suicide there’s a good chance one of your kids are going to.’ So, I do not know where I got the strength from, but I pinned that guy against the wall and I said to him, ‘You say one more thing, mate, and you’re going out this top window.’ After that I never saw him again. And that was my example of Norfolk Mental Health. They’re supposed to have been getting a-- I can’t think of what they’re called-- psychiatrist. Which is still never come around, which is now about three-and-a-half years…”

“I think they were undertrained. I think they were up their own arses. I think they didn’t know what they were doing to the point of-- all they kept saying to me is, ‘Well, you need to breathe. You need to stop thinking about this.’ How can you say to a guy who’s thinking about killing himself, ‘Stop thinking about it’? Seriously. And just keep shoving pamphlets at me and shoving pieces of paper at me, which to be honest I just ripped up and chucked away.... It was like a hassle to them. It really was, it was like a hassle. It was like, ‘No, I don’t really want to be here.’ I hated it,” Pte Lewis.

Another participant had phoned Crisis Resolution (Norfolk) after drinking one night because he was worried that he was going to try to take his own life. He had a swift response and was taken to hospital before he had a chance to follow through with his intention.

This participant was also receiving ongoing Home Treatment (Norfolk). He was very positive about his experiences:

Researcher: “Do you find [the treatment] helpful?”

Pte Grant: “She’s lovely. Yes, I do. She is really good... She’s very pleasant. She understands everything. I can tell her everything I’ve told you. They really are looking after me.”
Pte Davies, who was complimentary about his time with Veterans First (pp.95-96) but who had not had a good experience with the Suffolk Wellbeing Service (p.88), was also receiving Home Treatment (Suffolk) and was very positive:

“[My GP] realised the urgency of the matter. And he said, ‘Someone will be in touch with you in two weeks.’ And I thought, ‘Yeah, right, that’ll be that for another six months.’ Literally, within two weeks I’ve been assessed, I’ve been put in touch with the home treatment team, I had people coming round to see me, my meds were changed, I had people phoning up just to see how I was getting on with my new meds, I had visits from people, and it got to the point where I said, ‘Look, actually I don’t need the regular phone calls. I don’t need people coming round. I’m feeling all right about things.’ I’d like to have a number so if I feel bad I can call it rather than go through the whole GP thing again...”

“And I’ve started to pick up and I’ve ended up being seen once a week... I cannot fault this service at all. They’ve been absolutely 100%... I’ve got to the point where I know my illness now and I know the warning signs and I know how far it will go and I know how I’m gonna feel when it starts kicking off and I’m starting to really get used to it. So I don’t need somebody constantly saying, ‘Are you all right? Are you all right?’ Because I know now I can go then when I’m not all right, but seeing [my therapist] once a week is brilliant because questions pop up about my meds. Questions pop up--I will say to her, ‘I’ve been feeling very angry lately. Is that the start of something else?’ And she’ll say, ‘No, it’s just a continuation of this.’ And she explains things which makes it easier for me to take things on board and understand myself better,” Pte Davies.

The stories that have been outlined in the previous two sections highlight examples of excellent practice, as well as examples of how mental health services might be improved for veterans in Norfolk and Suffolk. It is worth remembering that this study was not designed to provide an evaluation of services provided by NSFT and the feedback from the participants does not necessarily speak to the objective quality of these services (section 2.7).

Whilst the main purpose of this study was to contribute to the evidence base about how veterans experience, and would like to experience, mental healthcare in Norfolk and Suffolk, we were also conscious of national developments in the area of veterans’ mental health, in particular NHS England’s review of their 12 dedicated services. Over the last year, we have taken various steps to make sure that local veterans were able to contribute to the wider debate, as detailed in Figure 17 (overleaf).
Primary Care (GP students)

Used participant feedback to support NSFT as they looked for long-term funding for the VSP.

Made sure that local veterans were able to participate in the NHS England review about the future of dedicated mental health services for veterans in this country.

Chaired a meeting between NHS England and local veterans and professionals.

Supporting NSFT:

Many participants felt that a dedicated veterans’ service would be a very good way of treating veterans with mental health problems, especially those with symptoms relating to the military (section 4.5.1). NSFT is currently providing such a service on a small scale through the VSP and we have already been using participants’ feedback to support them to find long-term funding to expand the service across Norfolk and Suffolk.

The NHS England review:

NHS England provides a ‘national network’ of 12 dedicated mental health services for veterans. Our nearest service is based in Colchester, which is too far away for most local veterans. We believe that veterans in Norfolk are just as entitled to receive treatment from a specialist veterans’ service as veterans elsewhere in the country. Ensuring that local veterans are able to contribute to the debate is an important part of our role to use local service user feedback to influence improvements in health and social care.

NHS England is currently reviewing whether this method of providing care is effective (section 1.2) before they recommission the services next year. In December 2015, we worked with NHS England to shape their review. We helped advertise the review at a local level, inviting all of our participants to contribute. We also organised and chaired a meeting where veterans and professionals working with veterans were able to talk to commissioners from NHS England about their views and experiences of mental health services.

We will continue to work with NHS England to make sure that they consider funding a dedicated service for veterans, like the VSP, in Norfolk and Suffolk in future funding cycles (section 7, recommendation 1).

Figure 17. Information about our work to improve mental health services for veterans.
4.5.3 Broader psychiatric support

Four participants commented on the broader psychiatric support they had received whilst in hospital. One participant was given an assessment from Psychiatric Liaison when he was admitted to a local hospital having tried to take his own life under the influence of alcohol. He did not find this service very useful but did admit that there was very little that staff could have done to help him, because he was so determined to leave:

“There’s no way I should’ve been discharged [but] I hate the fucking [the local hospital] with a passion... I was adamant I was coming out of there,” Pte Hooper.

Pte Hooper was offered follow up support:

“I got a letter from them to go see [NHS mental health services]... She asked me a load of questions, which I can’t remember. But the one question I can remember, she said to me, ‘Do you feel you’ll commit suicide again?’ And I said, ‘I think that once the thought of suicide’s in your head, you never lose it,’” Pte Hooper.

Even though Pte Hooper had declared that he was still suicidal, he was not offered any further support for his mental health:

“She palmed me off on Turning Point, which I didn’t quite understand, but there you go,” Pte Hooper.

Pte Hooper’s views and experiences with Turning Point will be discussed in the next section. In terms of his mental health, it seems that this might have been an example of a missed opportunity for the NHS to offer support to a vulnerable veteran.

Another participant had been admitted to a local hospital several times over the past few years having tried to take his own life, again under the influence of alcohol. The first time he was admitted, about ten years ago, he felt that he was treated appallingly, by staff who did not understand what he was going through. He said that he thought things had improved on his most recent visit (within the last two years), but that there was still some way to go to improve understanding of mental health issues and suicide amongst hospital staff:

“They still could treat you with a bit more compassion because they don’t know the reason that you’ve done that... Nobody smiled. Nobody really talked to us or anything like they did the other patients, so they still think, I think, somebody who’s trying to commit suicide and don’t actually do it, that they’re wasting their time... [There are] people coming in there who are dying and having heart attacks and then they have to deal with somebody who’s perfectly healthy and trying to take their own life and they don’t like it. They don’t like it at all. I can understand it but they don’t know the reason why and I suppose if they knew the reason why, which I wouldn’t tell them, they might be a bit more sympathetic... If they knew what you’d gone through, they’d treat you with a bit more respect I think,” Pte Grant.
The link between physical and mental health is well established, and often problems with the former can affect the latter (and vice versa). In particular, two participants found that their PTSD ‘kicked in’ when they were admitted to hospital with physical problems, and they spoke about their experiences trying to find staff who would understand what they were going through:

The wife of SNCO Parker: “I said to the head nurse, ‘My husband’s got PTSD. Can I just run through a few things, just so you know and you’re aware of the situation and what it entails’... And she was like, ‘Oh yeah, don’t worry, we know about PTSD.’ And I was like, ‘I appreciate you’re busy, but are you proper sure you know the reactions?’ She—‘Yes, yes, we’ll be fine. You go home, don’t worry. It’ll be fine.’ Well, I got back the next day at 10:00 and... everyone went, ‘He’s only just got to sleep five minutes ago!’ Because he’d been up all night. Yeah, the guys on the ward with him, all night, ‘Oh he’s had a dreadful night.’”

SNCO Parker: “The PTSD kicked in. First thing I do, I start having flashbacks, you know... I thought I’d been shot. I could feel the burning in my leg, I could see the blood running down... And then they came across... and they tried to give me one of my tablets. And of course you can’t get things down my neck, it just couldn’t happen. My hypervigilance had kicked in horrendously.”

His wife: “I’ve presumed, as standard, that if you-- well, the nurse should come up on the records when they go in the computer-- but as soon as you let the nurses know, shouldn’t they have a psyche person-- ?... Shouldn’t that be an automatic response?”

SNCO Parker: “A nurse came across and slapped me for about ten minutes, she was saying, ‘Look, calm down, calm down.’ I said, ‘I can’t fucking calm down, I got to get out of here now! Don’t you fucking realize?’ That’s when the nurse said to me, ‘I think you really ought to go for a fag.’ They took my drip out and let me go outside for a fag and tried to calm meself down. Because I was literally getting flashback after flashback after flashback. I could smell burning. I could smell explosions. I could hear the gunshots.”

His wife: “It’s the hustle and bustle of the war; hospitals are busy places. You don’t expect special treatment, but it’s more for other people’s safety.”

The wife of Pte Anderson: “[You were at the hospital] to get your hip done, and you were so worried about [it], because you jump around in the night, and he was worried about having the aesthetic, so he told the doctor, he put that down, that he’s got post-traumatic stress and he told the doctor and everything, didn’t you? But then a male nurse came into his-- they put him into a private... room so that if he did jump around he wouldn’t wake everybody up, and they started talking about guns in New York, didn’t they?”

Pte Anderson: “Weaponry and stuff like that... Really the last thing I wanted to be talking about.”
His wife: “Why did we write this down if they’re going to do that, because once you start-- we don’t watch the news late at night, because if there’s something on there I know we’re going to have a really bad night, so we try not to watch violence, and then I had to leave him like that with this doctor talking about guns, and I thought, ‘Oh no.’”

Pte Anderson: “I’m going to jump out of my hip.”

His wife: “Yeah, it was really bad.”

In both cases, the participants recognised that hospital staff are not experts in mental health and they were quick to compliment them for how they handled their physical problems. Whilst fewer participants spoke about their views and experiences of using secondary care services, and subsequently this was not one of our priority areas, we did undertake some work to try to respond to any concerns that were raised during the course of this study. Our activities to improve wider psychiatric support for veterans are detailed in Figure 18 (overleaf).
Letters to local hospitals:

Veterans have special entitlements on the NHS under the terms of the Armed Forces Covenant. The Covenant was the starting point for our work with veterans and we wrote to our three local hospitals to make sure that they were honouring the terms of the agreement. We received a full response from the Queen Elizabeth Hospital, which is currently putting in place an action plan to ensure veterans are treated appropriately.

Going into hospital can be a vulnerable time for anybody and veterans are no different. By making sure that hospital staff are aware that some veterans may have particular needs and entitlements we hope that we will have minimized the numbers of veterans who have to experience issues such as those raised by some of participants in section 4.5.3.

Sharing our information resource with hospital staff:

Several of our participants had been admitted to A&E, having tried to take their own life. Not all of them were smoothly referred onto mental health services (section 4.5.3). Most hospitals in Norfolk and Suffolk have a Psychiatric Liaison Teams, who work with patients who may have mental health problems. We met with these teams, who were very receptive, to share our information resource about local support avenues (Figure 1, p.15) in the hope that vulnerable veterans will be able to access appropriate treatment sooner.

Giving a presentation at University Campus Suffolk:

We were invited to give a presentation about veterans’ mental health to student nurses at University Campus Suffolk as part of their Wellbeing Week. We presented alongside the Founder/Director of the Walnut Tree Project. The students were very attentive and we hope that we helped to raise awareness about veterans’ mental health so that they will change their practice when treating veterans as fully qualified nurses.

Figure 18. Information about our work to improve wider psychiatric support for veterans.
4.5.4 Drugs and alcohol services

As explained in section 1.1.1, alcohol is well known to be a major problem for the veteran community and alcohol featured prominently in the stories of 14 participants (section 4.2.3).

Three participants commented in detail about their experiences with drugs and alcohol services. One participant had received treatment in Norfolk and two had recently received treatment in Suffolk.

None of them were very positive. Drugs and alcohol support is generally group based, and the main concern seemed to be that this format was not very suitable:

“I’m beginning to question the logic behind this whole thing... We sit there and tell our stories for the week. My story [is] nothing really because all I do is just go to bed, mainly. Then I have to listen to everyone else’s struggle through alcohol, this, that, and the other. I think, ‘Is that doing me any good, listening to other people’s woes?’ ... I’ll tell you an example. This chap, he was coming up to his ten-month anniversary of not drinking, and the anniversary at ten months was the time where he relapsed before. That is negative to me because I’m thinking by the tenth month, I should be getting towards home and dry. And the worst thing is the next time I go, no one know where he is. So whether he’s relapsed again I’m thinking, ‘Do I need to hear all this shit?’ ... And he’s still struggling. I’m thinking, ‘Oh, shit. Is it no end to this?”” Pte Hooper.

Pte Connor: “They want me to go sit in a room with a crowd of people. I can’t... Not with the people around here. They’re all smackheads. Like, I walk in there and there’s probably two Army people in there, and the rest are smackheads, or crackheads, or heroin addicts or something... I’m not going to go in there, because then if I start talking him then we might get pal-y, and then he’ll come to my house, and then before you know it he’s on drugs.”

Researcher: “So sort of group sessions like that aren’t a good idea with you?”

Pte Connor: “It’s not a good idea, no, because you’re in one frame of mind if you’re on drugs, and that’s just, ‘Where is my next fucking hit?’”

Pte Connor felt that he would respond much better to group therapy that was specifically to veterans, in contrast to the comments reported earlier from SNCO Hyde (pp.99-100):

Researcher: “Would you feel more comfortable [receiving treatment] in front of a group of Army guys [rather than civilians]?”

Pte Connor: Yeah, 100%.

Researcher: “Why’s that?”

Pte Connor: “Because we all know. We know each other. We don’t know each other, but we all know what we’re coming from. If you speak to a Civvy, they don’t
know what they’re talking about. They’re like, ‘What experience have you got?’ And you tell them and they’re like, ‘Well, why [inaudible].’ ‘Well, have you ever experienced anything like that?’ ‘No.’ ‘Well, you don’t know what we’re on about then do you?’”

Indeed, all three participants had received veteran specific support from Outside The Wire, which they had found much more useful. The military link was very important, even though their conditions were unrelated to their service. Their views and experiences of Outside The Wire will be explored in more detail in section 4.6.2.
4.6 Using Third Sector services

“Even though the military hadn’t been a good experience for me, I felt safe, I suppose, meeting up with other veterans and that,” Pte Davies.

As explained in section 4.2.2, due to the enduring importance of Armed Forces culture and the military bond (sections 4.1.1 and 4.1.2), many participants preferred to make use of the wealth and variety of veteran specific support in the Third Sector, either in addition, or instead of, the NHS, although some of them found it hard to initially access this support (sections 4.2.2 and 4.4.2).

It is worth mentioning that veterans, like the rest of the general population, are perfectly entitled to receive support from non-veteran charities. The wider work of Third Sector organisations was not the focus of this study and will not be discussed here in the interests of space and time. Instead, this section will focus on the participants’ views and experiences of using Third Sector mental health support, in particular from Combat Stress, Outside The Wire and Stand Easy, which have been selected because they were the most commonly used charities.

4.6.1 Combat Stress

Combat Stress was the most used charity, with 14 participants commenting on their services, four of whom were referred to this study by the organisation itself. Generally speaking, the feedback fell into two categories. Those who had received treatment from one of Combat Stress’ three Residential Treatment Centres were negative about their experiences, whilst feedback about the support provided by the Anglia Community Team was generally very positive.

Poor experiences of residential facilities

Five participants commented in detail about their experiences of Combat Stress’ residential facilities. None of these participants were referred to the study by the organisation. Three participants last received treatment between nine and 19 years ago and so their feedback has not been included because it is unlikely to be reflective of current provision.

Combat Stress has undergone a significant review of its residential provision over the last five years, and now offers phasic treatment based on the recovery model of mental healthcare. Further details are available from the organisation’s website (Combat Stress, n.d.). Two participants had received treatment under the current treatment model. The first participant, SNCO Peterson, had a long history with Combat Stress. He had attended several two week courses since 2005 and he did not find the treatment he had received over the years to be very effective:
SNCO Peterson: “I ended up under Combat Stress’s umbrella, and I’ve now been with them ten years, and I can honestly state I am no further forward in 2015 than I was in 2005 in respect to my involvement with Combat Stress.”

Researcher: “So you don’t find them an effective service?”

SNCO Peterson: “No. They keep you on this roundabout. From 2005, I was supposed to have three admissions a year, two weeks at a time... That was verified by Combat Stress on my first admission... Now, as time has gone on, as the years have gone on, and the workload of Combat Stress has gone up, that has deteriorated. Those inpatient visits have deteriorated in frequency to the point where I ended up with a four-year gap between admissions. And my last admission was [towards the end of] last year, when I spent two weeks there.”

Researcher: “When you were there, did you find it useful?”

SNCO Peterson: “Treatment-wise, no. Because they’ve tried CBT... but we found out the CBT treatment didn’t work because for CBT to be effective, it has to be conducted on a very regular basis, for example, every week. Now, if you’re in Combat Stress for two weeks, I might be lucky and have one or maybe two sessions with a therapist, of CBT. Then I could be waiting 6, 9, 12, 18 months for my next session. So anything that we’ve started to work on has totally and utterly unravelled by the time I get back in there. And basically, what they do is, they give you this supposed treatment in Combat Stress, then they just leave you out in the big wide world. You don’t have any support out away from the centre, from the inpatient clinic. You’re left on your own in the big wide world.”

As outlined in section 4.5.1 (pp.89-90), SNCO Peterson’s predicament was compounded by the fact the NHS did not seem to be working very effectively with Combat Stress, which meant that he felt he was in a position where he was receiving no treatment from either organisation. His story contrasts with the experiences of SNCO Matthews (section 4.5.1, p.88). In SNCO Matthews’ case, staff from Combat Stress’ Anglia Community Team (on which more below) had been able to work very well alongside the local NHS to provide an effective care package.

The second participant had received treatment from Combat Stress’ PTSD Intensive Treatment Programme (ITP). For this participant, the issue was not so much that he had found his treatment ineffective, but that he had found it to be very intense:

“At the time it was brutal. I was coming out of those sessions with major headaches, really bad headaches, really confused, trying to put the whole jigsaw together all at once where I could only find two corners, only part of the jigsaw, and I can’t find the rest of it, I’m trying to fill in the rest. And of course I can’t,” JNCO Walker.

For that reason, he felt that there should be more support for veterans before and after attending the PTSD ITP:
“[The treatment] smashed the hell out of me...”

“I don’t feel they’ve shut all the doors down. They’ve opened you up, they’ve made you remember a lot of stuff that you can’t even remember before you went there, and then they chuck you back in. I don’t understand all this...”

“There should be an interim thing before people go down there like I say. Before you go to Combat Stress you should have a couple of weeks somewhere, not six weeks bloody intensive programme,” JNCO Walker.

It should be noted here that Combat Stress recognises the importance of providing ongoing care for vulnerable veterans, both before and after they attend the PTSD ITP. For example, a two-week Stabilisation Programme was introduced in 2014, partly as a means of preparing veterans in advance of the PTSD ITP. Veterans are also followed up at six weeks, six months and one year after attending the PTSD ITP.

It is possible that JNCO Walker attended the PTSD ITP after the introduction of the Stabilisation Programme (we did not ask him to provide the exact date that he received his treatment). Follow up support has been provided to veterans who attend the PTSD ITP since its inception in 2011, but it is clear from JNCO Walker’s testimony that his perception was that, in his case, he had not been able to make use of this support:

“There was no follow up support. None whatsoever really. I got told I’d get a phone call, go see your vicar. Not a lot of support at all,” JNCO Walker.

JNCO Walker felt that the PTSD ITP may be more effective for more recent veterans who haven’t been struggling with their problems for so long:

**JNCO Walker:** “It’s not suitable for everyone. It’s suitable for people who have bang come straight out of Afghanistan.”

**Researcher:** “Not suitable for chaps who have had it probably for a while?”

**JNCO Walker:** “No. That’s my opinion anyway. And everybody else’s who’s down there. So you speak to every veteran, that’s exactly what they’ll say I think. People that have just come out of Afghanistan, perfect for them. People who have had it manifested for this long, you can’t sort it out in six weeks. That’s impossible.”

Touching on an issue raised by another participant in section 4.5.1 (p.100), he also made an interesting comment about the potential side-effects of providing treatment for veterans alongside other veterans:

“You get institutionalised so quick because you’re ex-military. Before you know it you’re folding your socks the same way you used to. ‘What the fuck am I doing?’ do you know what I mean? Because you’re in that environment. Before I knew it I was spitting polish on boots while I was doing it...”
“That was funny, I was looking at myself thinking, ‘What the fuck am I doing?’ And of course you get in that mind-set because everyone’s the same... everyone’s a veteran. So everyone’s pretty much cleaning shoes and everyone’s pretty much clean shaven - yeah, it’s really fucking weird. It’s like, ‘Am I really out of the Forces, or am I in some fucking type of programme?’ It gets you that way, do you know what I mean?” **JNCO Walker.**

Two other participants, who had received residential treatment from Combat Stress several years ago (nine and 19), made similar comments. As previously explained (section 4.5.1), the notion that a veteran can become ‘institutionalised’ by being surrounded by other veterans in a therapeutic setting has very important implications when it comes to dedicated veterans’ services. Some veterans struggle to adjust to life outside the Forces (section 4.1.2) and we must be careful to ensure that they are encouraged to move on from their time in uniform as part of their treatment.

It is worth repeating that it was not the purpose of this study to provide an objective evaluation of the services provided by Combat Stress, or indeed by any organisation (section 2.7). None of the five participants with whom we spoke were very positive about the treatment they had received from the residential facilities, but this feedback should not be taken to be representative (section 2.7), and it is not to say that other veterans do not find the treatment valuable. Indeed, Combat Stress have recently published a peer-reviewed paper, which shows that 87% of 246 veterans attending the PTSD ITP between late 2012 and early 2014 reported a reduction in symptoms at six months post discharge (Murphy et al., 2015).

**Positive experiences with the Anglia Community Team**

Combat Stress’ Residential Treatment Centres are complemented by 15 regional Community Teams. Five participants spoke about their experiences with the Anglia Community Team and all of them were very positive:

“I doubt very much I’d still be here if I hadn’t had it. It’s as simple as that. I value it that much,” **SNCO Matthews.**

SNCO Matthews felt that one of the important benefits of the Community Team was that it could offer a tailored treatment that would not be possible on the NHS:

“I mean, some of the problems that we have as veterans... is that it’s difficult for us to plan, because if we’re having a bad day-- I might say to Carolyn [the Community Psychiatric Nurse], ‘I’m really struggling today. I can’t meet you out for what we planned to do.’ That really throws a spanner in the works when you guys have got appointments and things to do; whereas Carolyn is flexible and can come to the house and things like that. That’s something that is obviously not achievable through the NHS side of things. But for people who do struggle, obviously that would be in an ideal world, that a therapist would be able to say,
‘Okay, we’ll reschedule, but I’ll try and make it to your house,’ type thing,” SNCO Matthews.

Another benefit was the support that was provided for the family:

“It’s not just the treatment that I get. It’s the fact that Carolyn took time to speak to my family and my mum and dad about things, because for them, somewhat having your family understand the illness that you’re going through... having a professional actually say, ‘This is what he struggles with and this is how you can help,’ really does make a difference to them, because they’re lost, because no one gives them the support or part of the support in their work. And that chat that they had with Carolyn, it was invaluable to them, because they had an understanding of what my limitations were. Because they see you still as the person you used to be a few years ago, and when you’re not... And I think that that is something that you wouldn’t get elsewhere from Combat Stress, as well,” SNCO Matthews.

It must be noted that this participant was referred to us by Combat Stress and he had requested that his interview take place alongside his Community Psychiatric Nurse for support. As such we might have expected him to be positive. That said, other participants who were referred from elsewhere were equally effusive:

“It was just a breath of fresh air. It was just amazing. Without her I would have been swinging on a tree... She was always on the end of the phone. If I needed anyone to talk to, she was there. And if I needed her to come over, she was there. If she couldn’t come over she would make sure there was someone coming over,” JNCO Walker.

JNCO Walker was very negative about his residential experiences, which makes his testimony about the Community Team even more compelling.

The wife of SNCO Parker, the participant who had had some traumatic experiences at the Norfolk and Norwich hospital (section 4.5.3), echoed JNCO Walker’s view and valued the support she had been offered after the event by her husband’s Community Psychiatric Nurse:

“Carolyn said afterward [that] we should have phoned her straight away, so she’d have found the hospital, gone in the hospital and seen me... She said next time he goes in, again, just phone her and she’ll phone the nurses and explain,” the wife of SNCO Parker.

The only negative comment about the Community Team was that it had taken a while for one participant to access their services:

“Because they were chock-a-block, they called in two months. But what they wanted to take place didn’t happen for another six months at least,” Pte Jones.

Once he had entered the system, however, Pte Jones had received a very responsive service from his Community Psychiatric Nurse, who had been able to
refer him for appropriate treatment from another local charity (The Anchor, section 4.6.2):

“Combat Stress, can’t fault them. They’ve picked [me] up and given me somewhere to hang on,” **Pte Jones.**

During the past year, Combat Stress has been reviewing its Community services in order to increase access to treatment in view of growing demand. As a result, four participants felt that they had lost their Community Psychiatric Nurse:

“I’m just scared that I’ve not got Combat Stress as a link now,” **Pte Jones.**

JNCO Walker, whose concerns about a perceived lack of support following his attendance at the PTSD ITP were reported earlier (pp.114-115), was particularly disappointed:

“I couldn’t believe they got rid of Lizzie, I just couldn’t believe it…”

“Without her it’s just gone impossible now…”

“What the fuck? What a waste of two years. That feels like it’s a total waste of two years. Because I’ve got this far and now I’m just going to go straight down again. That’s how I feel,” **JNCO Walker.**

**Local support groups**

Finally, five participants commented about the Norwich support group, which is hosted by Combat Stress alongside other veteran charities. All of the comments were very positive. The participants found it particularly helpful to be able to socialise with other veterans with similar problems:

“It’s the group of friends that you chat with. We’ve all got different problems. None of us judge each other. We just talk as normal folks, because many of us struggle with going out and doing other things. I don’t go to the pub or anything, so it’s nice to have a few hours of just total switch off and relaxation. And we’ll discuss other things, we do discuss our problems every now and then, and things we’ve done, treatments we’ve had… It’s a couple of hours of being normal for lack of a better term. No one’s judging you, and I think that’s the biggest things,” **SNCO Matthews.**

The Norwich support group is often attended by other charities offering support to veterans, such as the RBL, Stand Easy and WWTW. It was clear that having access to this wide range of support was another big positive:

“As I say, I’m quite lucky through Combat Stress because they’re part of my support group now... Because also when you’re a member of Combat Stress, you've got access to Rethink, telephone access, 24-hour counselling which again a lot of people haven’t got have they? But you’ve got to find out about these initial things before you can then start finding out, accessing, things like—it’s like me, accessing
acupuncture [from Stand Easy] and things like that... If I hadn’t of found Combat Stress, I wouldn’t have known," JNCO Rogers.

4.6.2 Outside The Wire

Five participants spoke about their experiences with Outside The Wire, three of whom had been referred to the study by the organisation itself. Three of these participants had received treatment from statutory alcohol and drugs services, about which they were fairly negative (section 4.5.4), but they were all very positive about their experiences with Outside The Wire.

The importance of the military link

As with many veteran charities, the staff at Outside The Wire are themselves veterans, and the military link was identified as a major reason why the participants preferred to receive treatment from the charity as opposed to statutory services, even though only one of them suffered from any symptoms that were related to their time in uniform:

Pte Hooper: “I think [the member of staff at Turning Point] is a nice chap and all that, but I don’t relate to him. Like Phil [from Outside The Wire] has done everything I have done really, probably more.”

Researcher: “So the fact that you guys have [both] served [is] important to you?”

Pte Hooper: “Yeah. I already know that if I had a problem which I couldn’t mention to anyone else, I probably could with [Phil].”

“For the first time, I felt like I could say what I felt rather than what was either expected of me or what I wanted them to think of me if that makes sense... It’s silly little things like when I met Andy [from Outside The Wire], we arranged a meeting [in a café], and he walked in the door and I was like, ‘That’s him.’ Because you can spot military, and he kind of looked around and went towards me, and it wasn’t like I had given him directions to my seat or anything like that,” Officer Perkins.

The military link was important for fostering a sense of shared respect, trust and understanding:

“I think certainly from a Forces point of view, and you’re doing it for a veteran’s thing, I think just there was an implicit trust or a believed awareness that if these people are doing it, they’re doing it for the right reasons...”

“[It was] that kind of understanding of what you’ve potentially been through, and if you haven’t been through it you signed up for it... gives a huge, huge amount of mutual respect. You just understand. And provided you’ve not been in for basic
training on day one, you've been through it and you know what is expected of you, how to act…”

“I’d still say that we’ve got a professional client relationship, but there’s tons of banter, there’s lots of reciprocal piss taking… Just crap like that that is often linked around Forces,” Officer Perkins.

“The person that helped me was Andy. But that’s because he was a Sergeant Major, he’s done it, he’s been there. He doesn’t make you feel awkward like when he talks to you he has a laugh which is good… He’ll talk about his military past [and] I spoke about my military past… He understands. It’s the most vital point in the whole process, the fact that he can have a laugh with you, he understands… I still meet Andy now for a coffee now and then. It’s like having a friend, someone you can call, there’s someone in the background,” Pte Reed.

“I can talk to Phil, and I feel he knows and understands from my Forces bit things that we’ve done and shared. So I can feel comfortable with him. I suppose when you get talking, it must be perhaps a thing of Forces that there must be some similarities… So I’ve had somebody that I can talk about Forces,” Pte Jones.

“Phil understands. He’s been there himself. He’s been through half the shit that I’ve been through… There’s no point putting a Civvy person to deal with ex-Forces,” Pte Connor.

Personalised, holistic treatment

Whilst the military link was one important reason why the participants preferred to receive treatment from Outside The Wire, it was not the only reason. More specifically, the participants found that staff at Outside The Wire were able to offer a treatment that was more tailored to their needs, really getting to the cause of their problems, rather than just treating the effects:

“[The NHS was] totally focused on alcohol. Completely... Andy had a much more... informed view of what had put me in the situation I was in, or am in, which I think generally within the NHS isn’t the case. Everyone is stereotyped and you’ve got your boxes, ‘Oh okay he’s had a marriage breakdown, he’s turned to drink,’ and everything is very, very black and white whereas the Outside the Wire thing was a lot more thoughtful... It was kind of, ‘Let’s look beyond just the definition of what it is, therefore you fit that category,’” Officer Perkins.

“Andy came and saw me, he done an evaluation, he has a pie graph and then he evaluates everything on-- so from fitness to finances, to wellbeing, to hygiene,” Pte Reed.
This kind of personalised care was felt to be much better than the group therapy provided by statutory drugs and alcohol services, as described in section 4.5.4.

**Partnership working**

Another advantage of Outside The Wire was that staff at the charity seemed to be very effective at partnership working, liaising with other organisations in the Third Sector to create a multi-agency support package for their clients:

“It’s not just [Outside The Wire]. They’ve given us a whole network of help... They’ve also pointed us in other directions if we need help financially... because we’re now just on benefits basically,” **the partner of Pte Jones**.

In particular, Outside The Wire worked well with The Anchor (Access Community Trust Suffolk). Three participants lived in Suffolk and had received treatment from The Anchor in conjunction with Outside The Wire. All of them were very positive:

“I did go with [Pte Jones] to his first session because he didn’t want to go on his own. And it’s perfectly clear to me that boy [Mark from The Anchor] really knows what he’s talking about,” **the partner of Pte Jones**.

It didn’t seem to matter that staff at The Anchor weren’t veterans themselves because the quality of the therapy was of such a high level:

**Researcher:** “Mark’s not a serviceman is he?”

**Pte Connor:** “No, he’s not, but he’s on the level. He’s really intelligent, that man... He pulls things out that-- he pulls everything out. Like, I always think about it but never talk about it. He always...”

**His partner:** “Gets things out of you that you don’t talk about, yeah.”

**Researcher:** “And you find that useful as a way of processing it?”

**Pte Connor:** “It’s not inside me, do you know what I mean? It’s not eating me. It’s basically out in the open. I can talk to him about it... He’s a brilliant man, honest to God. The way he talks to you, and the way-- he doesn’t look at you like you’re some sort of fucking piece of shit.”

All of the Suffolk participants attested to the value of the close working relationship between Outside The Wire and staff at The Anchor:

“They’ve encouraged me... I know I’ve got destructive stress, but they kept me motivated to do things, which I’m doing better... Mark and Phil have been there for me this year... And I know they talk. I know Phil and Mark must have some-- I don’t know if it’s in the care plan or what. I’ve never really seen a care plan. But I think they must talk to each other and say, ‘We’ll keep an eye for this’... I just get that impression that everybody seems to
know where I’m at. I think I were falling through now, it’d be picked up by now,” 
**Pte Jones.**

Indeed, the support he had received from the two organisations meant so much to Pte Jones that he worried what would happen if it was taken away from him:

“I was frightened and scared because I keep thinking that Mark will say, ‘Right. You’ve had as much as we can afford,’ because I know they’re expensive. And Phil with charity, if they say, ‘Sorry, I’ve got too many people; I can’t afford to see you,’”  
**Pte Jones.**

**Family support**

Two participants were interviewed alongside their wife or partner and it emerged strongly from these interviews that another positive of Outside The Wire is that it provides support to the whole family:

**The partner of Pte Jones:** “Phil is brilliant. We love him. He’s welcome here any time.

**Pte Jones:** “I don’t think I’d be where I am now [without him].”

**His partner:** “He’s a great comfort to me as well. I’ve got his number... He is the first person I would turn to... It’s comforting to know, should we get into trouble I can say to Phil, ‘We really need some help here, pal.’ And I know he’d do anything he could to help us or put us in touch with whomever could help us... Personally, and [he’s] not there for me per se, I can’t praise [him] highly enough. Because although [he’s] predominantly there for [Pte Jones], I know [he’s] there for me as well to help him.”

**Pte Connor:** If I’ve got a problem I’ll ring Phil up and he’ll be here in 10 minutes... [My partner] will ring him going, ‘Oh, [Pte Connor is] flipping out and he will be here.”

**Researcher:** “So it’s nice for you to have someone you can talk to as well?”

**The partner of Pte Connor:** “Yes, because what other people don’t understand is I know [Pte Connor] isn’t a horrible person... but then there has been times where we have had arguments, and he’s gone mad and chucked things around the house, and it’s not always for the police to come, is it? It’s a nightmare. I know he’s okay, and I know I’m not going to be hurt or anything, so I ring up Phil, and then [he] comes and calms him down and it’s good. He’s there for us for anything.”

**Wanting an earlier intervention**

Given all the advantages of Outside The Wire, it is not surprising that the participants wished that they had been able to access the service sooner. Pte Reed
had first come into contact with Outside The Wire when he had come into problems with the criminal justice system and was picked up by Project Nova (WWTW).

Pte Reed was very glad that he had been picked up by Project Nova and referred onto Outside The Wire but felt that it would have been better if he had been made aware of the charity before he got into trouble:

“The thing with Walking with the Wounded is I didn’t find out about him until it was too late, when I got taken into custody. What good is that? Too late. Too late. It’s no good getting taking into custody and then find out about them. What’s that? A slap on the wrist? Thanks a lot. You could’ve known about me six months ago and I probably never would have been in this situation in the first place,” Pte Reed.

Touching on suggestions made by other participants in section 4.2.2, Pte Reed felt that there needed to be more information and signposting about support for veterans right the way through the system, starting with the MoD:

“In the military all they’ve got to say is, ‘Do you want Walking with the Wounded to not get in touch with you?’ Or you can have the option do they get in touch with you, a phone call or at least just know about your details,” Pte Reed.

Two other participants had been referred to Outside The Wire having been through statutory drugs and alcohol services. Officer Perkins felt particularly strongly that his recovery may have been a lot faster if he had just been referred to Outside The Wire from the very beginning:

Researcher: “[How] did you come to Outside the Wire?”

Officer Perkins: “By mistake really.”

Researcher: “Would you have preferred for them to say you’re at the point that you came into the service, ‘look there’s a similar service for veterans by veterans, you might be interested in it?’”

Officer Perkins: “Definitely. But I think to get to that stage, there would have needed to have been a much more in depth interview with somebody in what medical role they would be I don’t know, but just talking through and getting to not the bottom of problems, but at least identifying issues that I might have had.”

Researcher: “Did they ask you if you were a veteran as part of the [initial assessment]?”

Officer Perkins: “No... Well, I don’t think they did, I think probably it came up in conversation.”

It is worth noting that Officer Perkins’s journey with statutory drugs and alcohol services took place before the formation of the NRP. Now that The Matthew Project, if not Outside The Wire itself, is linked in with NSFT, we would hope that any veterans who want a veteran specific service will find it easier to access Outside The Wire.
4.6.3 Stand Easy

Four participants had received acupuncture from Stand Easy, all of whom were referred to us by the organisation itself (one participant was also referred through Combat Stress). The feedback was very positive:

“This really, really has helped me... I couldn’t recommend [the treatment] highly enough,” JNCO Rogers.

“I didn’t know that sticking a few pins in you could create such a different person... After the first session, my mood was lifted. After the second session, I was a different person... I just can’t believe how a few pins can make all that difference,” JNCO Middleton.

“The best way I’ll describe that first session is I left, walked back to the car... I just had a spring in the step, had almost like a burst of energy... I just felt totally relaxed and at ease, more so than I had done in a long time,” JNCO Bateman.

The positive effects of the treatment are perhaps best demonstrated by the story of Pte Anderson, who had been struggling with his problems for a very long time without finding successful treatment from the NHS or Combat Stress:

“I feel the best I’ve felt for forty years... I can do this, I can do that and my confidence is there... Lots of my symptoms have either decreased or gone... I walked out there like a new man... If I had this treatment when I left the services... I would have had, and [my wife and children], would have had a different life,” Pte Anderson.

One of the most important beneficial parts of the treatment was that it seemed to help with sleep. Four of the participants had conditions with some symptoms that were related to their time in the military. Prior to using Stand Easy, all of them complained of suffering from disturbed sleep on a nightly basis (due to flashbacks, nightmares etc.) but they found that this was helped by the treatment:

“What I’ve found most of all is that when I’ve had acupuncture I get a really, really good night’s sleep... If you can get a restorative sleep that is really good because that calms you down and your systems all start kicking in... It normally relaxes me for two or three days,” JNCO Rogers.

“For years, I have trouble sleeping and nightmares and stuff like that. That’s almost completely gone... I sleep from the moment my head hits the pillow to my alarm in the morning... On the whole, I just sleep right through with no dreams, no nightmares,” JNCO Bateman.
As explained in section 3.4, the majority of the participants felt that they had some degree of physical disability. Two participants appreciated the fact that the treatment helped to ease their pain:

“[The acupuncturist] was able to tell I had a problem with my back... and he said ‘This’ll stop that,’ and when I walked out of the place I felt like I could run down the street. I gone in there with a backache, and now I was feeling I could... jump a wall,” Pte Anderson.

The participants were very complementary about staff at Stand Easy:

“[The acupuncturist] has been good in as much as if I want to say something I know I can say it and he’ll listen, and he’ll have compassion and he’ll understand,” Pte Anderson.

As noted on the previous page, Pte Anderson was particularly impressed by the treatment. He spoke at length about his experiences with Stand Easy in his interview, describing how the treatment had given him his life back:

“My memory’s coming back. I had lost my sense of smell [but] I just feel as if that’s starting to return...”

“I’ve always been interested in music... And I got up and sang in front of the whole garden full of people, strangers. And I know I would never have been able to do that before. I’d want to do it, but I’d never have been able to do it,” Pte Anderson.

His wife added:

“I’m actually feeling like I am on tenterhooks, because it seems too good to be true... I think it’s the first holiday that we’ve been on that [my husband] actually taken charge of the money, and I haven’t had to go and buy drinks or buy meals, and it’s just like being taken out compared to what it used to be... He actually drove into a carpark the other day. Normally, all my life, he’s been reversing into spaces so that you can get out quick, and the other day he drove in...” the wife of Pte Anderson.

Pte Anderson and his wife really valued the fact that Stand Easy had offered support to the whole family:

“[At Stand Easy they realise] that it’s not just the ex-service person... but it’s their partner, families and other people around them that are affected as well,” Pte Anderson.

The fact that these participants found acupuncture so useful is particularly interesting when viewed in the context of earlier comments about the ineffectiveness of anti-depressants:

“[When] I look back and think of all the money that’s been spent on me on antidepressants, and then I look at the sessions that I’ve had [at Stand Easy],
which if I was paying for, would be a fraction of the cost of the antidepressants...
Personally... I’d be putting a study in there, like getting x amount of people, and start at the beginning, see what they’re like, and then look at them at the end. The cost of that is nothing, is it? If three quarters of those come off antidepressants, it’s paid for himself,” JNCO Middleton.

Whilst stories like these are encouraging, it is important to note that all of the veterans whom we spoke to about Stand Easy were referred to us by the organisation itself, which makes it unlikely that they would give anything other than a glowing recommendation. Acupuncture is not particularly well evidenced as a treatment for mental health conditions in this country, although some studies have been conducted abroad, especially in America (Hollifield, Sinclair-Lian, Warner & Hammerschlag, 2007). In particular, there have not been many controlled comparisons with established treatments like CBT or EMDR and there is a lack of information about acupuncture’s long-term efficacy.

The lack of evidence may make NHS professionals reluctant to refer veterans into Stand Easy:

“When I had an appointment with a doctor on Friday... he said, ‘How are you?’ and I said ‘I feel the best I’ve felt in 40 years. I’ve got rid of this, got right of that, got rid of that. I’m not taking this tablet, not taking that tablet, and I just feel so much better.’ ‘Oh that’s good,” he said. But that was it. But for me, it’s such a life changing thing that’s happened. But it was again just as if, ‘I didn’t really hear that,’ ‘I don’t really want to know that,’ or whatever... I came out of there feeling really down,” Pte Anderson.

Of course it is important for GPs to be cautious when advising their patients to receive treatment that does not follow NICE guidelines. That being said, and the limitations with this study notwithstanding, our participants quite clearly valued the treatment they had received from Stand Easy, and there is no reason why the organisation should not make up one part of a more general package of support for local veterans. Crucially, it is another option for those veterans who feel that they aren’t able to benefit from the kinds of talking therapies that are offered on the NHS:

“I must admit, I don’t want to talk to people. I just put it in a box and leave it at the back,” JNCO Middleton.

4.6.4 Partnership working

We hope that this section has made clear that there is a lot of good work going on for veterans in Norfolk and Suffolk. In the interests of space and time, we have chosen to focus on three charities, but we might easily have spoken at length about many more.
Whilst the participants were very grateful for the support they had received in the Third Sector, and some examples of excellent partnership working have already been outlined, several participants raised concerns about how well the various organisations worked together and how well they worked with the NHS.

As a potential solution to the problem, a few participants felt that there was an opportunity for the NHS to take the lead:

“[What] I don’t understand is there’s all these charities that are set up now to help veterans... but there’s no real link between that and the NHS. Surely it would make a lot more sense if the NHS was to say, ‘Right, start here. See if that works. If that doesn’t work, then go there.’ It’s all like through one organization rather than having to go yourself going through all different organizations,” JNCO Middleton.

Our GP information resource (Figure 1, p.15) tied the various organisations providing mental healthcare to veterans in Norfolk into a stepped care model. Unfortunately, this is not always how it tends to work in reality. The issue of poor partnership working between veteran charities is widespread across the country. There are longstanding problems with the duplication of effort and there have been calls to consolidate the number of charities in recent years (Ashcroft, 2014).

At a local level, NCC’s Community Covenant Board has been trying to facilitate more effective working relationships between our local veteran charities (and the NHS) and we have been supporting their endeavours. Pockets of effective partnership working have already emerged and will continue to develop with the opening of the new Britannia Veterans’ Hub (section 4.7.3).

Information about our work with Third Sector organisations to date is detailed in Figure 19 (overleaf).
Promoting the good work of veteran agencies:

It was clear that the support they had received from veteran agencies in the Third Sector was very important to the participants (section 4.6). It was also clear that GPs and other professionals were not always aware of local support avenues (section 4.4.2). We took every opportunity possible to promote the good work of local veteran agencies. We gave The Walnut Tree Project and Outside The Wire, as well as local representatives from national charities like RBL and WWTW the opportunity to present their work to GP students from Norfolk and Suffolk (Figure 16, p.83), which led to some new referrals for these charities. We also promoted local agencies to qualified GPs (Figure 15, p.82) and other professionals (Figure 14, p.74; Figure 18, p.109) through our information resource (Figure 1, p.15).

Supporting Stand Easy:

Four participants were particularly impressed with the treatment they had received from Stand Easy (section 4.6.3). Stand Easy is a new charity and we were happy to help them become more established. Whilst recognising the limitations of this study (section 2.7) and that the purpose of our work was not to champion individual causes, we produced a feedback report for Stand Easy, which they used as evidence to gain some additional funding so that they could continue treating veterans.

Facilitating partnership working:

Whilst there were some very positive examples, several participants raised concerns about partnership working between local veteran agencies (section 4.6.4). This issue has been picked up by the NCC Community Covenant Board, and supported them by hosting two meetings bringing the charities together to discuss how they could better work in partnership. This report recommends that we continue to support this endeavour in the future (section 7, recommendation 3).

Figure 19. Information about our work to support local charities.
4.7 Wider welfare issues and the military/civilian interface

It is widely established that individuals who have mental health problems also tend to have attendant social and welfare issues, and veterans are no different. In the case of this study, 14 participants went into some detail about some of the difficulties they had faced around issues like employment, benefits and housing. Often, their stories involved wider comments about the integration of local Armed Forces and civilian communities. This section will present a brief summary of the key findings.

4.7.1 Employment

Support at work

Seven participants felt that they had been offered very little support by their employers when it came to their mental health:

“The biggest thing that still plays on my mind at the moment is what happened over the past few years in my work situation. As happens over periods of time, workforces get dwindled and ask you to do more and cover this and cover that... Where there used to be a team of five people covering the county, and management above that and support staff, we’d been dwindled to two... I said to them at the time, ‘There’s no way that we can really get through this, it’s just too much of an ask’ [and] because I knew I wasn’t going to be able to do the job the way I wanted to do it, I ended up with stress. Went to the doctor and they put me off work for a week or whatever it was, and I went back to work and said, ‘This is what the situation is, why I’ve been off,’ and said, ‘I’m finding it difficult to cope with this amount of work,’ [and I] asked them for assistance. It was never given. All they said was, ‘If you’re feeling bad, take time off.’ But I said, ‘So, how can I take time off and then come back to a workload that’s built up? I’m going to feel even worse.’ But they wouldn’t understand that,” Pte Anderson.

Where support was offered, it was felt to be very tokenistic:

JNCO Bateman: “If I’m honest, I got absolutely no support from [my employers] at all, none whatsoever. I went to occupational health, was dispatched off to a counsellor which was-- it was rubbish, frankly.”

Researcher: “Why?”

JNCO Bateman: “For me, it didn’t address my needs. It was to tick a box, quite frankly.”

Experiences at the job centre

As noted in section 4.1.2, several participants had struggled to find gainful employment once leaving the military. One participant had found it particularly
He spoke at length about his experiences at the job centre:

**Pte Connor:** “You walk in and it’s like, ‘Fucking hell.’

His partner: “It’s kind of like-- I found when you went in there they kind of laugh at you. Not laugh at you, but look down at you because he’s ex-service. I don’t know. It’s a bit weird.”

**Pte Connor:** “It was just like, ‘Well, you should have a job. What are you here for?’”

His partner: “‘Well, you should still be in the Army then if there’s not a problem’ kind of thing.”

**Pte Connor:** “They look at you as if to say, ‘You’re ex-Forces. You’re not entitled to nothing.”

Job centres in Norfolk and Suffolk (and elsewhere) have Armed Forces Champions, who sit on the Community Covenant Boards, but Pte Connor was not aware of this and he had never seen his champion, although, to be fair, the champion is not necessarily supposed to be a client facing role.

### 4.7.2 Military compensation

As indicated by Figure 11 (p.32), most participants were either already receiving compensation from the military for a service related illness or injury (13), or were in the process of making an appeal (five). Invariably, appealing for any sort of compensation is going to be long and complicated. The MoD has a dedicated agency called Veterans UK, which is supposed to offer welfare advice to veterans, but, generally speaking, the participants felt that they had been left to manage the process by themselves:

**JNCO Walker:** “I haven’t got a fucking clue mate. I have not got a clue. All I know is I take loads of paperwork… what we can find and what we can find out and just take it there. I don’t know.”

**Researcher:** “Did someone… help you with it all or did you do it by yourself?”

**JNCO Walker:** “I pretty much found out most of the information myself, apart from some people who I met, obviously I found other information off of them. But I haven’t got a clue what’s going on really. I’m really confused.”

Some participants saw this as another example of poor follow up support from the MoD (section 4.1.2):

“While you’re in the Forces, you’re the best person in the world and they’ll do anything for you. Soon as you leave, bang. They don’t take any responsibility for it. And to get your War Pension sorted out once you’ve left is very, very hard work,”

**JNCO Rogers.**
The participants did not appreciate being made to feel as though they were asking for charity, when they believed that all they were looking for was fair compensation for illnesses and injuries suffered in the line of service:

“At the appeal, I went in on my own, and I had to sit there and answer all these questions and dig up the past, and when I come out, I was in a mess. It was like, ‘What do you want? Why have we got to give you-- what you after?’ So you didn’t feel like—it’s like putting out a begging bowl... It’s intimidating because you get rows people right in front of you, and you’ve got the MoD spokeswoman, who’s there to say, ‘No, we’re not doing this. We don’t agree with that.’ And then you’re sat there going, ‘Oh, crikey, what am I doing here?’…

“When I got sunk, I can remember coming back and we had a board of inquiry, and you had to go in and sit in front banks of microphones with all these officers or admirals, and you’re sat there on your own, and it was question one, two, three, four; where were you when this happened? Question one, two, three, four, five; what did you do? And it was like they were trying to pin the blame. Now, part of my post-traumatic is I feel very guilty that it was my fault. I should have done better and my nerves took over... so I’ve always felt that guilty about that,” SNCO Hyde.

As SNCO Hyde’s story indicates, some participants, especially those pursuing claims for mental health problems, found the compensation process to be a degrading and emotional experience:

“Then you went for a medical... didn’t you, to make a claim? I think it was SSAFA that helped us with that? ... It’s so degrading, so degrading... crawling round on the floor in front of all these medical professionals, and I thought, you wouldn’t do that to an animal, but I would imagine they still do it,” the wife of Pte Anderson.

Several participants weren’t happy with their original awards. Given the above, it is perhaps unsurprising that some decided against making an appeal:

“To be honest with you, the stress of going to an appeal was making me ill at a time that I didn’t need to be ill. So I left [it],” Officer Palmer.

In the absence of advice from Veterans UK, some participants had turned to other charities like RBL and Combat Stress for help. For example, Officer Palmer got in touch with the RBL before he decided to withdraw his appeal:

“I did get in touch with the Royal British Legion because I was trying to appeal my Armed Forces Compensation Scheme award... That was the only time I needed to contact with the Royal British Legion, and that was a positive experience. They were very knowledgeable,” Officer Palmer.

Several participants felt that the compensation process was not fit for purpose:

Officer Palmer: “The system’s very flawed.... And it’s interesting, [when it comes to] mental health... very, very, very few people get a GIP [Guaranteed (monthly)
Income Payment]. Most compensation is given [as] a one-off payment and off you go... And the two common things - noise induced hearing loss and mental health - are the two things that people don’t get very much money for. And call me an old cynic, but it strikes me that actually being discharged from the Army for a mental health condition is way more debilitating in terms of your future earning ability, your likelihood of full recovery, of sustained recovery, it just strikes me that they are the very people that would need some sort of income on a monthly basis rather than some of the injury that do seem to attract it... Lots of people get discharged from the military for it. But not a lot of people get a GIP.”

Researcher: “Why do you think that is?”

Officer Palmer: “It’s all done on how long you’ve been suffering for. So they will only assess you - and this is where it’s really unfair - from the time that you presented. If you’re a soldier you suffer for a long, long, long, long time before you present. That’s the nature of a soldier... They go on as long as they can, getting worse, becoming more ill, and then when they do present they’re already usually very ill. And so the Armed Forces Compensation Scheme clock starts ticking from that point, not the point you were ill. And even though in my medical report from my medical professionals, it said that my symptoms were likely to have started many years before, my compensation was only counted, really, from the date of diagnosis. So that’s a huge-- I think it’s a miscarriage of justice. Anyway, I think it’s horrendous. I can see why they do it, and I can see how it’s legal, but whilst it’s legal it’s probably not legitimate. And I think it’s an easy get-out for the MoD.”

“I reckon... we’re fucking throwing a shit load of money and not getting anywhere because it’s just not suitable. The worst thing about it when it first came in is people who are having massive injuries that were life threatening, they were getting a massive payout because it wasn’t their fault, they were coming home, can’t work anymore so then go to the council [for ongoing social care needs] and then [the Council says] ‘you’ve got 250 grand in the bank, we’ll have that. Thank you.’ [And then the veteran says], ‘Hang on, you’ve just given me that 250 grand.’ ‘Ah, no, that was the government, we’re the council,’’” SNCO Chadwick.

SNCO Chadwick alluded to a very real and widespread problem where veterans in receipt of compensation through the older WPS are having to use their compensation to pay for means tested social care, even though the money was never awarded with that purpose in mind. This puts them at a disadvantage when compared to veterans in receipt of the (newer) AFCS, whose compensation money is not included in means tests, and also individuals who have been awarded compensation for illnesses or injuries suffered at the civilian workplace. This kind of disadvantage runs against the very spirit of the Armed Forces Covenant.

The issue is currently the subject of a national campaign (RBL, 2013). During the course of this study, we contributed to this campaign locally and are happy to report that, in July 2015, Norfolk became the first Council in the country to
formally end the discrepancy between the WPS and the AFCS. Further details about our work around this issue are detailed in Figure 20 (p.139).

The feedback about the military compensation schemes was perhaps the most disappointing part of the entire study. Listening to the participants’ stories, it was clear that the issue was about more than just the money. Above all, the participants wanted fair recognition for what they had sacrificed for their country, something which they were never going to get through the formal process, where they felt that they had been forced to fight the MoD for every penny they had received:

“[Right now] I’m not classed as a war pensioner... So I’m a nobody again... Just if I had a war pension... If I had a war pension, it gives you the sense of security... Because it opens those doors again, you know? ‘Oh, he’s a war pensioner. Right, he’s entitled to this, that, and the other.’ They don’t have to pay me a [GIP], but if I had a war pension [certificate]...” SNCO Hyde.

Other benefits

Military compensation aside, some participants were receiving other forms of benefits (e.g. Disability Living Allowance). Again, this process seemed to be unnecessarily complicated and distressing:

Pte Taylor: “They really do make it an absolute nightmare... I mean, it’s made my life a living hell... It’s a trial, firstly to get it, but then once you do get it they hassle you on a phone [and] they make you feel like a fraud.”

Researcher: “What do they make so hard for you?”

Pte Taylor: “They phone you every day [saying] ‘you need to renew it. You need to this,’ and when you’re in a situation where you don’t want to talk to people, they just put that pressure on you. They’ll send you letters, ‘You need to do this. You need to do this,’ and then they’ll go-- for instance, my colleague has literally just won his case to get his benefits. Now, he was in a position where he couldn’t even leave the house, and they made him go through all his stuff that is causing him hell for them to believe it. And he’s already posted off forms of full diagnosis from the Army and they still don’t believe him, and they don’t see it as a disability. When you can’t leave the house because you’re having flashbacks and you can’t go and socialize, I think it’s just as debilitating as any other disability... Again, mental health issues are not considered.”

Pte Taylor had also found that mental health was not treated in the same way as psychical disabilities when it came to housing:

“[It is important that] the councils have a full understanding of what’s going on. There’s guys coming up, leaving the Forces or going through these issues who have no home, they might not have family or friends around. Just to help with the housing issue. So many people I know went through or are still going through the
battle that I had to go through just to get appropriate housing because the councils don’t look at a mental health issue as a disability, so they won’t prioritize you over somebody had one leg or if somebody had a limb lost or anything like that. They just don’t see it like that,” Pte Taylor.

The issue was picked up by other participants:

“Anything that you can’t see is far easier to just be ignored... My mate, he had a aneurysm [and] he’s having to fight everything... to sort things out. And he said, quite rightly, that there’s a lass we met that had her leg blown off, she’s got five or six legs that are worth 40 grand a piece... Which is amazing service for her but he came out with his injury [or] illness and he paid the price. When you seem to have a decent head injury or head condition, you always seem to pay a price for it,” SNCO Chadwick.

“If I’d been in Afghanistan and lost a leg on a land mine, they wouldn’t have been able to do enough for me. That’s a visible illness; it looks good to the public,” JNCO Williams.

4.7.3 The recovery model

As these stories, and others reported earlier, attest to, people who are struggling with mental health can often face a variety of other challenges that need to be overcome in order for their treatment to be effective. For that reason, there has been a step towards the recovery model of mental healthcare, where treatment is offered as part of a holistic model of care that responds to all of a patient’s needs. The significance of this issue has already been identified in wider research (FiMT, 2015).

In the case of this study, several participants highlighted that it was important for them to have their wider needs addressed as part of their treatment:

“We should have a little bit of support first, get the veteran sorted out financially, help with all the bills, getting all that crap in his head... I should think if you want to get them veterans back to normal, they’ve got to sort out their finances first before they put them anywhere near [intensive mental health treatment]... Because all you’re thinking of when you’re there is, ‘Fuck, I don’t know what’s happened about the rent this month. What about the gas bill? What about the electric?’ I know they’re only little things but it weighs heavily on a veterans mind because they’ve got other things to contend with, not only their bills,” JNCO Walker.

Typically, of course, it is not possible for NHS mental health services, which are already overstretched, to address wider issues outside of treatment. In the case of veterans, however, the situation is rather different. As mentioned several times in this report, there is a vast amount of support available to veterans in the Third
Sector. This means that, by working collaboratively with veteran charities (and the wider Third Sector), the NHS has an opportunity to deliver mental health treatment as one part of a holistic care package.

Both of the participants who received care from Veterans First were quick to praise the organisation’s holistic attitude to care (section 4.5.1). Locally, the VSP is also starting to provide such a service, by working in partnership with the Walnut Tree Project and two other veteran charities at the new Britannia Veterans’ Hub to provide a tailored package of care, ranging from welfare issues such as housing, benefits and social exclusion (The Walnut Tree Project), to drugs and alcohol (Outside The Wire), to employment and problems with the criminal justice system (WWTW).

The Hub aside, there are a number of other charities – both veteran specific and general - that provide wider welfare support to local veterans. The participants particularly spoke about the help they had received from RBL and SSAFA:

“\[SSAFA\] sorted all my artwork out… And they helped to fund my trip to the Falklands. I went back to the Falklands this year in February… Unreal… We’re planning on a trip again next year…”

Researcher: “So it sounds like SSAFA was very helpful for you.”

JNCO Walker: Very helpful. Very, very good… [They] said, ‘If you need help in the future doing this, not a problem mate, give us a ring.’”

Not all of the participants were so positive, however:

“The worst thing about the RBL is that they’re this massive organisation that takes a shit load of cash in. Now if I ring them up asking them for help with something specific [with my mental health] I’ll get no assistance whatsoever… But if I ring them up and say I need a dishwasher or a washing machine, I’ll have it delivered before I even get back. That is the difference of level. They’re only good at what they can cover,” SNCO Chadwick.

SNCO Chadwick’s comment reinforces the importance of local charities working together, an issue that was raised in section 4.6.4.

4.7.4 Community integration and the Armed Forces Covenant

It has already been shown that the participants felt that they were different to civilians by virtue of their service (4.1.1), which had implications for transition
(4.1.2). Generally, the participants were proud to have served their country, and they were disappointed to find that people in Civvy Street did not tend to understand or show an interest in their military history.

As explained in section 4.1.2, for some participants, the lack of understanding had further hampered their transition:

**Pte Stevens:** “My wife’s fucking parents, what the fuck? ‘Oh, you’re back now?’ ‘Oh, yeah. I’ve just been down the fucking road. I’ve been fucking working two weeks.’ What the fuck? So, they didn’t have a fucking clue, and they still don’t.”

**Researcher:** “Does that make it harder that people at home don’t understand?”

**Pte Stevens:** “Oh, yeah. It does make it harder. When I was talking with her parents, they just drove me insane, I tell you. They haven’t got a fucking clue. No idea whatsoever. Fucking hell.”

One participant felt that more needed to be done to encourage civilians to take an interest in the military:

“**When you see all these old guys and their guns - and ladies - and they’ve done this, that and the other, but people don’t want to listen, do they? I think it’s about having a listening thing, and maybe it’s good to set up reminiscence and stuff like that. Maybe for some people that can talk now, because as you get older, you can talk, and to reminisce and try to get it straight in your mind,**” the wife of Pte Anderson.

Interestingly, some reminiscence work is already taking place in Norfolk through Veterans Recall, which brings older veterans from Age UK Norwich together with younger veterans from WWTW’s Project Nova programme.

Moving on, a few participants, and their wives or partners, felt that they had been judged for their service in the Forces:

“Oh still think there’s people out there that—there’s a lot of people that are anti-war, aren’t there? And those people, they’re judgmental... Because my husband was in the Marines, [people at work] were judgmental towards me, because it was like that, because they couldn’t see why that happened. You do get judged, yeah,” the wife of Pte Anderson.

As explained in the introduction, public opinion of the military is very misguided (section 1.1.1). According to a recent poll, more than 90% of the public thought it was common for individuals leaving the Forces to have some kind of physical, emotional or mental health problem (Ashcroft, 2012). This is not surprising; not many people have direct experience of the military and the media tends to focus on extreme cases, painting a picture of veterans as a group of people who are all ‘mad, bad and sad’ (RBL, 2014).

Several participants found that these misconceptions had directly hampered their transition into civilian life:
“I get the impression - and maybe because I’m quite a large guy anyway and quite well-built - but I get the impression that anyone who hasn’t got experience of working with combat PTSD, or experience of ex-military or veterans, etcetera, that they have a fear that you’re going to be out of control, you might be a risk; not to yourself, but to others, etcetera,” Pte Miller.

“Everybody says that squaddies [with] PTSD are violent and actually I said, ‘I think you’ll find what it is, is people get scared, and scared makes you violent.’ Even a civilian who’s been in a traumatic event... and there’s no friendly faces around, [they’ll] back like a rat. The problem is if you start going into try [and talk to them] and they don’t understand, then they’ll attack. I think [all] people with PTSD do that if - or any mental health - if they’re backed into a corner,” SNCO Martin.

The Armed Forces Covenant

The NCC Covenant Board is responsible for fostering links between the local Armed Forces and civilian communities. One of the key mechanisms for doing so is through the Armed Forces Covenant, which is enshrined at a local level through the Community Covenant. Again, the Armed Forces Covenant states that:

“Those who serve in the Armed Forces, whether Regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of public and commercial services. Special consideration is appropriate in some cases, especially those who have given most such as the injured and the bereaved,” (MoD, 2011a, p.1).

The NCC Board has been very active since its conception in March 2012 (NCC, n.d.). During the course of this study we have supported these efforts in a number of ways, which are detailed in Figure 20 (p.139).

Unfortunately, in spite of these efforts, the participants were overwhelmingly negative about the Covenant:

“[The Armed Forces Covenant is] about as much use as a piece of fucking bog roll,” SNCO Peterson.

Part of the problem seemed to be that the Covenant was not well understood, by veterans and civilians alike, which sometimes led to unreasonable expectations:

“If I wanted a house now and I went to the council... They wouldn’t give me a house,” SNCO Hyde.

Of course such misunderstandings are entirely forgivable because the Covenant is so loosely worded that it is not particularly clear who is entitled to what:

Pte Stevens: “What is the Armed Forces Covenant? Because I’ve been seeing a lot on news recently about people not living up to the Armed Forces Covenant, and I
think there’s a couple of lines that I have seen in the [Covenant] about how no soldier and their family should be at a disadvantage.”

Researcher: “That’s right.”

Pte Stevens: “So what does that mean? No families are disadvantaged. So if a soldier who lives at home is single, is going through massive massive massive depression, is heavily into drugs, and he’s probably on the edge of a cliff, maybe going to commit suicide and then this affects his parents, do the parents get care? Because they’re family aren’t they?”

The feeling was that the Covenant is a nice idea but it is ultimately useless in practice, because it is not legally binding:

“The Armed Forces Covenant’s not really worth the paper it’s written on... I think that it was a nice thing to do, but it’s like an unenforceable law. It’s like people talking on their mobile phones in their cars when driving. How many people get in trouble for that? Not many, because unless a police car happens to see you, people are going to get away with it,” SNCO Matthews.

Another reason why the Covenant wasn’t felt to be useful in practice was that, generally speaking, front line staff did not seem to be aware of it:

Researcher: “You say you tell your GPs ‘I’m Armed Forces.’ Do you expect that to make a difference to the way they treat you?”

SNCO Peterson: To be honest, no. Because half of them doesn’t even have a clue what that phrase entails. Not that I’ve served, but the fact that I’m a War Disablement Pensioner means there is a thing called the [Armed Forces] and the Community Covenant... I’ve mentioned the Covenant... to both my GPs and they haven’t got a clue what it’s about. They’ve never heard of it.”

One participant had found that the Covenant wasn’t widely known about even in the military:

“I don’t think many people even know about it. In services, they don’t know that Armed Forces Covenant is. The Armed Forces don’t follow it, so if the Armed Forces aren’t following it, I don’t think you’re likely to get everyone else following it, sadly. You’d like to think with military base being so close and so many people living nearby, that they would, but I don’t think it’s actually that well known,” SNCO Matthews.

Those few participants who managed to speak to a professional who was aware of the Covenant had found that, even then, the Covenant was not applied. For example, SNCO Matthews had been promised support by under the terms of the Covenant, but that support had never materialised (section 4.3.2, pp.71-72).

Overall, there was a concern that local commissioners and providers were using the fact that they had signed up to the Covenant as an excuse for offering a poor service to local veterans:
“I think it’s just a name that people use to big themselves up and say, ‘Oh, we’re part of this,’ but I’ve never known them do anything to support it,” SNCO Hyde.

“Yes, [the Covenant is] all fine and dandy when it’s on paper and people talk about it, but when it comes down to the mental health treatment of us lot, there needs to be more money, more resources pooled into it, into Norfolk and Suffolk, so that we can get the help we need,” SNCO Peterson.

As explained earlier, ‘no disadvantage’ and ‘special consideration’ are the two main principles underpinning the Covenant. Whilst all the participants felt strongly that they should not be disadvantaged compared to civilians, generally speaking, they did not want to receive special treatment:

“I don’t think you should necessarily receive special treatment, but I do think you should receive treatment that’s on a parity with everybody else... I don’t know if I was put to the top of any queue. I’d actually hope not, because mental health, having experienced it, it wouldn’t matter what your background was, you need to be treated. So I hope I didn’t jump any queues,” Officer Palmer.

“When you’re in the military, all that [the Covenant] means nothing to you, and I wasn’t aware of it when I left, and I wouldn’t use it as a flag... saying, ‘I’m entitled to this. I served. I’ve got medals... I deserve better.’ I would never do that because if somebody is equally in need, in uniform or not, they should get that help,” Officer Gibbs.

On this subject, we must be wary not to deepen the distinction between the Armed Forces and civilian communities in our efforts to bridge the gap. By defining individuals in terms of their involvement in the military, not only are we reinforcing the difference, but we are also regarding veterans as being one and the same, as though the military context is the most important part of a veteran’s identity. The reality is that the term ‘veteran’ covers a diverse group of people with a range of characteristics and needs. Some service leavers may want nothing more to do with the Forces and those who do may not identify themselves as ‘veterans’, preferring to use the term ‘ex-service’ instead.

Several participants pointed out the difference between veterans from different eras, as well as those who had served in different branches and roles. When it comes to the NHS, we should not assume that all veterans would like to receive the same kind of treatment. Whilst there may be some for whom a veteran specific approach is desirable (section 4.5.1), others may prefer to engage with mainstream services. As ever, when it comes to mental health, there is no such thing as a ‘one size fits all’ treatment (MacManus & Wessely, 2013), which is reflected by the wide range of sometimes conflicting preferences expressed in this study. The important thing is to ensure that veterans are offered a choice (Greenberg et al., 2003) and that organisations work together to deliver a holistic package of support.
### What is the issue?

Veterans who were injured in service on or before 5 April 2005 receive a War Disablement Pension and are known as War Pensioners. Veterans who were injured in service after that date receive compensation through the AFCS. It is not the purpose of the basic War Pension or the AFCS to cover the costs of care needs (RBL, 2013). According to national guidelines, which are followed by the majority of councils, should a War Pensioner have social care needs, they will find that all but the first £10 per week of their compensation will be taken to cover the costs, even though a veteran with a similar injury who was injured on or after 6 April 2005 is able to keep all of their payments (RBL, 2013). In addition to the unfair discrepancy between veterans under the different compensation schemes, these arrangements put War Pensioners at a disadvantage when compared to civilians who have been awarded compensation for workplace injuries, because their compensation may be placed in a trust fund, which is disregarded as income when it comes to social care (RBL, 2013). This runs against the very essence of the Armed Forces Covenant.

### What did we do?

RBL was leading a national campaign, called 'Insult to Injury', on this issue (RBL, 2013). We contributed to this campaign by writing a formal letter to Norfolk County Council (Appendix N). We also supported Healthwatch Suffolk to make a similar approach in Suffolk and escalated the issue to Healthwatch England, because we felt that the real problem lay with the national charging guidelines, as set by the Department of Health. We linked Healthwatch England up with RBL but Healthwatch England did not think it was suitable to take the issue any further.

### What are the benefits for local veterans?

In July 2015, Norfolk County Council voted to become the first county in the country to formally disregard the national guidelines and stop the discrepancy between the different compensation schemes, which means that about 100 of our most vulnerable veterans will no longer have to pay over the odds for their social care. In the most recent Budget, the British Government has pledged to end the discrepancy at a national level (2016).

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**Figure 20.** Information about our work to around wider welfare issues.
5. Other outputs

As mentioned in section 2.4.2, we had identified that one of the risks of this study was that it could have a negative effect on the participants’ mental health and recovery. For that reason, we were glad to find that participants were generally very positive about their involvement. As SNCO Matthews explained:

“Thank you so very much for coming today, I found it very insightful and valuable the work that you are doing and I hope that it proves fruitful for changes to the current system... It’s difficult in the time I’ve been out. You don’t feel like you serve much of a purpose, so it’s nice to feel like you’ve done something,” SNCO Matthews.

5.1 Information and signposting

One of Healthwatch Norfolk’s five priorities is to demonstrate how we have improved local information and signposting services and we work hard to ensure that all of our projects have a discrete information and signposting output. As noted throughout this report, there is a lack of understanding amongst veterans about what support is available and how to access it. We therefore felt it was particularly important in this study to make sure that the veterans who participated were aware of local support services. To that end, we signposted to the following organisations (Table 3):

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Number of participants</th>
</tr>
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<tbody>
<tr>
<td>Adventure Quest</td>
<td>1</td>
</tr>
<tr>
<td>Healthwatch Suffolk</td>
<td>1</td>
</tr>
<tr>
<td>Norfolk Wellbeing Service</td>
<td>2</td>
</tr>
<tr>
<td>Outside The Wire</td>
<td>3</td>
</tr>
<tr>
<td>Stand Easy</td>
<td>4</td>
</tr>
<tr>
<td>Suffolk User Form</td>
<td>1</td>
</tr>
<tr>
<td>Remploy</td>
<td>1</td>
</tr>
<tr>
<td>The Walnut Tree Project</td>
<td>7</td>
</tr>
<tr>
<td>WWTW: Head Start</td>
<td>7</td>
</tr>
</tbody>
</table>

We also took advantage of opportunities to spread information about support services to local veterans, for example when we gave a talk to the Norwich branch of the Royal Signals Association (February 2016).

Finally, our work with veterans has prompted us to develop our internal practices. Where appropriate, when fielding enquiries from service users we now ask whether they have served in the Armed Forces so that we can ensure that they are able to access veteran specific support, if they so desire.
5.2 A summary of all of our work to date

As explained in the introduction to section 4, this study incorporated elements of a Participatory Action Research model, whereby we took steps to resolve issues as and when they were raised by the participants. Information about our activities was included throughout section 4, and all of our work to date is summarised in Table 4 (overleaf).
Table 4

_A list of Healthwatch Norfolk’s actions to improve health and social services for veterans_

<table>
<thead>
<tr>
<th>Issue</th>
<th>Completed actions</th>
<th>Page</th>
</tr>
</thead>
</table>
| Mental health services (MoD)  | 1. Met with staff from DCMH Marham to discuss improving the handover from the MoD to the NHS.  
2. Escalated our concerns to the regional Quality Surveillance Group.  
3. Shared our information resource about local mental health services for veterans in Norfolk.                                                                                                                                                                                                                                      | 74   |
| Primary care                  | 4. Helped create a veterans’ protocol, which we shared with GPs in Norfolk.  
5. Produced a resource about veterans’ mental health services and shared it with all GPs in Norfolk.  
6. Approached local CCGs and HEEofE leading to the appointment of a Veterans’ Lead within HEEofE.  
8. Evaluated two of these conferences for HEEofE, which were a great success.                                                                                                                                                                                                                                             | 82/83|
| Mental health services (NHS)  | 9. Used participant feedback to support NSFT look for funding for the VSP.  
10. Made sure that local veterans were able to contribute to NHS England’s national review.  
11. Organised and chaired a meeting between NHS England and local veterans and professionals.                                                                                                                                                                                                                                      | 105  |
| Wider psychiatric support     | 12. Wrote to local hospitals about their plans to treat veterans under the terms of the Covenant.  
13. Gave a talk about veterans’ mental health to student nurses at University Campus Suffolk.  
14. Shared our information resource with Psychiatric Liaison Teams in hospitals in Norfolk and Suffolk.                                                                                                                                                                                               | 109  |
| Third Sector support          | 15. Promoted the work of local veteran charities to contacts in the NHS.  
16. Produced a feedback report for Stand Easy, which was used to secure funding.  
17. Supported NCC’s Community Covenant Board to facilitate partnership working between charities.                                                                                                                                                                                                  | 127  |
| Wider welfare issues          | 18. Wrote to NCC urging them to support RBL’s ‘Insult to Injury’ campaign.  
19. Supported Healthwatch Suffolk to approach Suffolk County Council about this issue.  
20. Escalated the issue to Healthwatch England to ask if they would pick it up at a national level.                                                                                                                                                                                                                          | 139  |
| Information and signposting   | 21. Provided participants with information about local support services.  
22. Gave a talk to the Royal Signals Association about veterans’ mental health and local support.  
23. Modified Healthwatch Norfolk’s information and signposting practice.                                                                                                                                                                                                                                                | 140  |
6. Discussion

6.1 Key findings and recommendations

April 2016 brings an end to eighteen months of Healthwatch Norfolk activity around the issue of veterans' mental health. When we began scoping this work in October 2014, the British Armed Forces were preparing to withdraw the last few troops from Afghanistan following a 13 year war. The media trumpeted dire warnings about the psychological (and other) burdens of recent conflicts upon the men and women returning home to civilian life, and threatened the NHS with an impending tidal wave of veterans with PTSD. With a well-publicised shortfall in mental health provision across the country and our own Trust (NSFT) in special measures, perhaps we can be forgiven for expecting an uphill struggle as we sought to find ways to improve services for local veterans.

All of our work with veterans has been framed within the context of the Armed Forces Covenant (section 1.1.3). Again, amongst other things, the Covenant imposes a moral obligation upon statutory services to ensure that veterans face no disadvantage compared to other citizens when accessing health and social care, receiving special consideration where appropriate (MoD, 2011a). Whilst the intention behind the Covenant is laudable, the document is not legally binding, and the extent to which its terms are implemented by local services varies wildly across the country. As the dust settles in Afghanistan and public interest in the military begins to wane, it can be difficult to imagine what comfort such a small piece of paper could possibly bring to those veterans with long-term needs, both new and old, for whom the fighting has not ceased along with the guns.

Most of the veterans with whom we spoke said that they were yet to see the results of the Government’s pledge to support the Armed Forces community through the Covenant with their own eyes (section 4.7.4) and it is clear that there is a long way to go on this front. The Norfolk Community Covenant Board has been striving admirably to make a difference in this space since its conception in March 2012 and the local NHS has recently begun to shoulder some of the responsibility, for example through the work of HEEofE. During the course of this study, we have helped these two organisations to initiate a variety of initiatives to improve health and social services for veterans (Figures 16 & 19) and we think it is important that we continue to offer support in the future (section 7, recommendations 2 and 3).

When applied specifically to mental health, the Covenant establishes that veterans whose conditions are attributable to service should be able to receive treatment from professionals with an understanding of the military. This pledge is based on the notion that some veterans may have different needs as service users, a notion that is supported by this study (sections 4.1, 4.2, 4.4.2 and 4.5.1).

NHS England currently meets this requirement by commissioning 12 dedicated veterans’ services. As noted in section 1.1.3, these services are sometimes taken to provide a ‘national network’, but in reality coverage is patchy and the quality of care varies wildly from county to county. Our nearest service is Veterans First, which is based in Colchester. Veterans First was highly praised by two participants
but it is primarily commissioned to provide care to veterans in Essex. In the absence of national funding, NSFT has taken the initiative to provide a small scale service in the form of the VSP. We spoke to one service user, who found that the VSP had had a transformative effect on his life (section 4.5.1).

We believe that veterans in Norfolk and Suffolk have just as much right to be able to access a (fully funded) dedicated service as veterans from elsewhere in the country. Moreover, we feel that the findings from this study show that there is a real desire for such a service at a local level. The majority of the participants (20/30) suffered from at least some symptoms that related to their time in uniform. Those who were able to access military sensitive treatment (seven) tended to have much better experiences than those who used mainstream services (nine), for which their conditions were found to be too complicated, although they were quick to praise individual members of staff (section 4.5.1). More generally, most participants felt that a dedicated service would be a good way of treating veterans with mental health problems, especially those with symptoms relating to the military (section 4.5.1).

At the time of writing, NHS England is reviewing the effectiveness of the current dedicated services. We have already been working with them to make sure that they are aware of all the positive activity going on for local veterans (Figure 17), and we will be using this report as evidence to ensure that they consider providing a dedicated veterans’ service in Norfolk and Suffolk in future funding cycles (section 7, recommendation 1). The fact that NSFT has already made great headway in developing such a service through the VSP, establishing key links with a number of local veteran charities to provide a holistic package of support based on the recovery model of mental healthcare (section 4.7.3), means that Norfolk and Suffolk will be well prepared to take advantage of dedicated funding if and when it arrives.

Dedicated services aside, some participants, especially those (ten) whose conditions were unrelated to their service, raised concerns about their treatment that had nothing to do with the fact that they were a veteran, but rather related to broader issues with the current system of mental health provision in Norfolk and Suffolk (section 4.5.2). All concerns and compliments will be shared with NSFT and added to our Feedback Centre as part of our growing evidence base about local people’s experiences of health and social care.

Before concluding this section, we must repeat that we are fully aware of the limitations of this study (section 2.7). This report was not a service evaluation and it does not speak to the objective quality of services provided by the NHS or Third Sector. For that reason, the report should not be considered in isolation and any findings must be interpreted within the wider body of literature around the issue of veterans’ mental health, especially recent national research by FiMT (2013; 2015).
6.2 Final thoughts

This summer marks the centenary of the Battle of the Somme. As we prepare to commemorate all the hundreds of thousands who lost their lives facing the barrels of German machine-guns, it is easy to overlook the 306 British and Commonwealth soldiers executed behind-the-lines after courts-martial for desertion and other ‘acts of cowardice’ during The First World War. Vilified and shamed at the time, court transcripts, made public 75 years after the events, suggest that some, at least, of these soldiers had exhibited symptoms of what would today be diagnosed as PTSD (The National Archives, n.d.). Several were also underage; boys with dreams of defending their country, they could scarcely have imagined the horrors that lay in store for them in the muddy battlefields of France and Belgium. Not traitors or cowards, then, just ill young men who had had enough of war.

We have come a long way since those dark days, but not, perhaps, as far as we would like to think. PTSD was only recognised as a condition in 1980. The British Government steadfastly refused to give a posthumous pardon to the men and boys it had put to death during the War, finally relenting in 2007, almost 90 years later. It is little wonder that mental health remains stigmatised in British society; a source of shame to many young men, for whom, quite unconscionably, suicide is the greatest killer (Office for National Statistics, 2013).

There stands before us now an opportunity to make a real statement of intent to do better. Veterans with mental health problems are known to be reluctant to engage with the NHS (section 4.2.2). The fact that they may tend to consider themselves to be different to civilians (section 4.1) has traditionally been regarded as a barrier to care, but, by providing a dedicated service that is veteran specific, we believe that we can use the enduring relevance of Armed Forces culture and the importance of the military bond as an incentive to encourage more veterans to come forward for help sooner (sections 4.2.2, 4.4.2 and 4.5.1).

In addition to saving the NHS money in the long-term - it is widely accepted that patients who present earlier to services generally require less time and resources to treat - this could lead to crucial improvements in patient outcomes, not just for veterans, but for men from all walks of life; for if we can encourage our veterans to come forwards, arguably the most reluctant men of all, then who knows how many others may follow?

In closing the discussion, we would like to once again stress that, whilst the report makes for rather bleak reading when it comes to the psychological consequences of service in the Armed Forces, the vast majority of service leavers enter Civvy Street fit and healthy, having benefitted from their time in uniform (section 1.1.1). When these individuals go on to develop problems, whether mental or physical, there is no reason why, in most cases, these problems cannot be managed perfectly effectively within mainstream NHS services.

Of course, the media likes to focus on the extreme cases, painting a picture of veterans as a group of people who are all ‘mad, bad and sad’ (RBL, 2014). Meanwhile, hidden beneath the rhetoric, a small but significant group of
individuals continue to suffer, all too often in silence. If we really want to help our veterans, a good way to start would be to dispel some of the myths currently surrounding the military. The widely held notion that individuals leaving the Forces are likely to have some kind of physical, emotional or mental health problem is not only untrue but unhelpful to service leavers looking to re-enter the civilian world.

In the last century, civilian and military communities were brought together by two World Wars but the gap has widened considerably with the passing of time. Members of the Armed Forces community are very much in the minority today and the ways of military life are not widely understood by those in Civvy Street. In a recent article, Professor Sir Simon Wessely, Co-Director at KCMHR, whose work has been referenced extensively in this report, described the problem as follows:

“We fall back on the easy clichés of seeing them as either heroes or victims. Both views are anathema to military culture, and both serving and ex-serving personnel are uncomfortable with either label. Most prefer to see themselves as professionals, doing a difficult job well,” (2016).

Echoes of these words run through the stories presented in this report. Used to pushing themselves to their very limits, the veterans who participated in this study saw no purpose for pity. Neither heroes nor victims, they were proud to have served their country, but, for the most part, they sought no special treatment (section 4.7.4). Whilst some of them may have entertained unrealistic expectations of what the NHS could provide, ultimately they wanted only what anybody would want if they had lost their way: to be treated with respect and understanding by professionals with the skills and experience to help them to get back on their feet.

In a society where so many people remain reluctant to talk about mental health, our participants demonstrated great courage in putting themselves forwards on behalf of their comrades. It was our privilege to work with each and every one of them.
7. Recommendations

This report has presented the key findings from a year-long study talking to veterans who had used NHS mental health services in Norfolk and Suffolk since March 2012. Following on from the findings presented in section 4 and the discussion in the previous section, this report makes three recommendations for future work.

The recommendations were selected on the grounds of their achievability and likely impact for local veterans (*Figure 21*).

![Figure 21. Prioritisation quadrant.](image)

The three recommendations are outlined in order of their priority in Table 5 (overleaf).
### Table 5

**Recommendations from the Healthwatch Norfolk Veterans Project**

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Recommendation</th>
<th>For</th>
</tr>
</thead>
<tbody>
<tr>
<td>A significant number of participants, especially, but not exclusively,</td>
<td>1. NHS England to consider commissioning a dedicated veterans’ service in</td>
<td>NHS England</td>
</tr>
<tr>
<td>whose conditions related to their service, wanted to receive treatment</td>
<td>Norfolk and Suffolk as part of their national review of dedicated services for</td>
<td></td>
</tr>
<tr>
<td>from a dedicated veterans’ service (4.5.1). Such a service is currently</td>
<td>veterans.</td>
<td></td>
</tr>
<tr>
<td>funded in 12 locations across the country but not in Norfolk or Suffolk.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This kind of post-code lottery is unfair.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is well recognised that there is more that can be done to support</td>
<td>2. HEEofE continue to deliver veteran specific training to healthcare</td>
<td>HEEofE,</td>
</tr>
<tr>
<td>veterans within primary care (section 4.4). Healthwatch Norfolk has</td>
<td>professionals.</td>
<td>Healthwatch</td>
</tr>
<tr>
<td>already helped HEEofE to provide four veteran specific training events to</td>
<td></td>
<td>Norfolk</td>
</tr>
<tr>
<td>272 GP students across the East of England. Delegate feedback from an</td>
<td></td>
<td></td>
</tr>
<tr>
<td>evaluation of the first two events has been overwhelmingly positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Appendix M). It is important that HEEofE is able to build on the success</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of these events in the future.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some participants raised concerns about partnership working between</td>
<td>3. Healthwatch Norfolk to support NCC’s Community Covenant Board as they work</td>
<td>Healthwatch</td>
</tr>
<tr>
<td>veteran charities in the Third Sector (section 4.6). They also felt that</td>
<td>to foster positive relationships between the local Armed Forces and civilian</td>
<td>Norfolk</td>
</tr>
<tr>
<td>the Armed Forces Covenant was not being put into practice at a local level</td>
<td>communities and to help ensure that the terms of the Armed Forces Covenant</td>
<td></td>
</tr>
<tr>
<td>(section 4.7).</td>
<td>are implemented by local services.</td>
<td></td>
</tr>
</tbody>
</table>
7. References


9. Appendices

Appendix A: information about the statistics used in section 1.1.2

Table A1

*Estimation of the numbers of veterans living in Norfolk using the RBL Household Survey (2014) and Office for National Statistics (ONS) 2012-based population projections*

<table>
<thead>
<tr>
<th>Step</th>
<th>Figure</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adult ex-service community in the UK</td>
<td>4,921,300 (nearest ‘00)</td>
<td>RBL Household Survey (2014, p.74).</td>
</tr>
<tr>
<td>5. (Total) adult population in Norfolk</td>
<td>730,422</td>
<td>ONS 2012-based population projections for July 2014 (Norfolk Insight, 2015).</td>
</tr>
<tr>
<td>8. Number of veterans living in Norfolk</td>
<td>43,200 (nearest ‘00)</td>
<td>14.98% of 288,388 = 43,200</td>
</tr>
</tbody>
</table>
Table A2

*Estimation of the numbers of veterans living in Norfolk using the RBL Household Survey (2014) and MoD data concerning the location of Armed Forces pension and compensation recipients (2015e)*

<table>
<thead>
<tr>
<th>Step</th>
<th>Figure</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total veterans claiming pensions or compensation in UK</td>
<td>374,750</td>
<td>MoD pension and compensation location data (2015e).</td>
</tr>
<tr>
<td>2. Veterans claiming pensions or compensation in Norfolk</td>
<td>8,355</td>
<td>MoD pension and compensation location data (2015e).</td>
</tr>
<tr>
<td>3. % of total veterans in UK claiming pensions or compensation who live in Norfolk</td>
<td>2.23%</td>
<td>8,355 / 374,750.</td>
</tr>
<tr>
<td>4. Total number of veterans in UK</td>
<td>2,835,000 (nearest ‘000)</td>
<td>RBL Household Survey (2014, p.5).</td>
</tr>
<tr>
<td>5. Number of veterans in Norfolk</td>
<td>63,200 (nearest ‘00)</td>
<td>ASSUMPTION: if 2.23% of UK veterans claiming pensions or compensation live in Norfolk then a similar proportion of UK veterans in general (both those who are and aren’t claiming) live in Norfolk. 2.23% of 2,835,000 = 63,221.</td>
</tr>
</tbody>
</table>
Appendix B: list of the organisations approached to assist with recruitment

<table>
<thead>
<tr>
<th>Key:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful recruitment channel</td>
</tr>
<tr>
<td>Assisted with recruiting participants (but unsuccessful)</td>
</tr>
<tr>
<td>Did not participate</td>
</tr>
</tbody>
</table>

**Veteran Charities**

- ABF - The Soldier's Charity
- Adventure Quest
- Blesma
- Bridge For Heroes
- Combat Stress
- Help For Heroes Store (Norwich)
- Help For Heroes Store (Ipswich)
- Help For Heroes: Chavasse House
- Help For Heroes: Hidden Wounds
- Outside The Wire
- PTSD Resolution Suffolk
- RAF Benevolent Fund
- RAF Association Dereham and Swaffham
- RAF Association Great Yarmouth
- RAF Association King's Lynn
- RAF Association Norwich
- RAF Association Thetford
- RAF Association Wymondham
- ReOrg
- Reserves and Cadets Norfolk
- Royal Naval Association Cromer
- Royal Naval Association Dereham
- Royal Naval Association Norwich
- Royal Naval Association Swaffham
- Royal Naval Association Thetford
- Royal Naval Association Wymondham
- Royal Air Force Cadets
- Royal Anglian Regiment and Association
- Royal Artillery Association (Norwich)
- Royal Artillery Association (Fakenham and Norfolk)
- RBL
- Royal Marines Association
- Royal Signals Association
- SSAFA Norfolk
SSAFA Suffolk
SSAFA Waveney
Stand Easy
The Walnut Tree Project
Veterans First
Veterans Norfolk
Veterans UK
WWTW: Head Start
WWTW: Project Nova

**Military Organisations**

Army Reserves: 254 Medical Regiment
DCMH Marham
1st The Queen’s Dragoon Guards (Robertson Barracks)
Marham HIVE/HUB
Wattisham HIVE
Woodbridge HIVE

**Statutory Bodies**

Air Ambulance
James Paget Hospital
Norfolk and Norwich Hospital
Norfolk Community Health and Care: Bowthorpe
Norfolk Community Health and Care: City Reach
NRP
NSFT
Patient participation Groups: Great Yarmouth and Waveney
Patient participation Groups: North Norfolk
Patient participation Groups: Norwich
Patient participation Groups: South Norfolk
Patient participation Groups: West Norfolk
Queen Elizabeth Hospital

**Other Charities**

Access Community Trust (Suffolk): The Anchor
Alcoholics Anonymous (Fenlands)
Alcoholics Anonymous (Norfolk and Suffolk)
Big White Wall
Cotman Housing
Job Centre Plus
Julian Support
MIND: Great Yarmouth and Waveney
MIND: Norwich
| MIND: Suffolk                  |
| MIND: West Norfolk            |
| Norfolk Carers Council        |
| Norfolk Personalisation       |
| Rethink                       |
| Salvation Army (Aylsham)      |
| Salvation Army (Briston)      |
| Salvation Army (Dereham)      |
| Salvation Army (Great Yarmouth)|
| Salvation Army (North Walsham)|
| Salvation Army (Norwich Citadel)|
| Salvation Army (Norwich Dussindale)|
| Salvation Army (Norwich Mile Cross)|
| Salvation Army (Sheringham)   |
| Salvation Army (Snettisham)   |
| Salvation Army (Thetford)     |
| St Martins Housing Trust     |
| Stonham Home Group            |
| Suffolk Family Carers         |
| Suffolk Rural Caravan         |
| Suffolk Turning Point         |
| Suffolk User Forum (NSFT)     |
| The Purfleet Trust            |
| Together UK (Norfolk Support) |
| Voiceability                  |
| YMCA                          |

**Other Routes**

<p>| 13 Parish Councils            |
| 15 Parish Councils            |
| Dereham Library               |
| Dereham Town Council          |
| Great Yarmouth Borough Council|
| Great Yarmouth Library        |
| HWS Suffolk Engagement Team   |
| Interview on BBC Radio Norfolk|
| King’s Lynn Borough Council   |
| King’s Lynn Library           |
| Norfolk and Suffolk veterans league|
| Norwich City Council          |
| Presentation at World Mental Health Day |</p>
<table>
<thead>
<tr>
<th>Shared Veterans Norfolk tent at Norfolk Show</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Forum Library</td>
</tr>
<tr>
<td>Thetford Library</td>
</tr>
<tr>
<td>Thetford Town Council</td>
</tr>
<tr>
<td>University of East Anglia</td>
</tr>
<tr>
<td>Veterans With Dogs</td>
</tr>
</tbody>
</table>
Appendix C: recruitment flyer

Calling ex-members of the Armed Forces

Have you served in the Armed Forces, Regulars or Reserves?
Do you live in Norfolk or Suffolk?
Have you used or tried to use NHS mental health services since March 2012?

It doesn’t matter why you left the Forces or how long you served for... if the answer to these questions is YES, then Healthwatch Norfolk would like to hear from you.

Healthwatch Norfolk is the independent consumer champion for local users of health and social care services. We are here to make your services better by listening to your experiences.

Throughout 2015 we will be talking to ex-service personnel about their views and experiences of local NHS mental health services to see how these services can be improved.

This is your chance to have your say and help us make sure that every member of the ex-service community across Norfolk and Suffolk receives the treatment that they deserve.

If you would like to be involved then please get in touch with Edward Fraser for an informal chat (everything you tell us will be treated in the strictest confidence and we will never share your details with anyone).

edward.fraser@healthwatchnorfolk.co.uk

01953 856 029
Appendix D: interview guide

Healthwatch Norfolk military career question sheet
Veterans Project 2015

Before we start the interview proper, I would like to ask you 12 short questions about your military career. This is to help me understand about your life in the Forces before we talk about your transition from the military to Civvy Street.

You do not have to answer these questions if you do not want to. Your responses will be kept in confidence and your personal information will never be shared outside of Healthwatch Norfolk.

1. When did you enlist? ____________________________
2. When were you discharged? ____________________________

3. Which branch of the Forces did you serve with?
   - [ ] Army
   - [ ] Navy
   - [ ] RAF
   - [ ] Other (please specify): ____________________________

4. Regular or Reserves?
   - [ ] Regular
   - [ ] Reserves

5. What was your role? ____________________________

6. What was your rank on discharge? ____________________________
7. Where were you deployed?

☐ World War Two (1939-45) ☐ Iraq [Op Granby] (1990-91)

☐ Other (please specify):

☐ Humanitarian aid (please specify):

8. Why were you discharged?


9. Are you in receipt of a military pension?

☐ AFCS ☐ Decision pending
☐ WPS ☐ No pension

10. Do you have a physical disability?

☐ Yes
☐ No

11. Is your disability related to your service?

☐ Yes
☐ No

12. Were you receiving mental health support in the military?

☐ Yes
☐ No

Military career v.2 (6/8/15)
### Healthwatch Norfolk interview guide

**Veterans Project 2015**

<table>
<thead>
<tr>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Thoughts about life in the military</td>
</tr>
<tr>
<td>• Did you enjoy your time in the military?</td>
</tr>
<tr>
<td>• If you had your time again, would you join the military?</td>
</tr>
<tr>
<td>• If not, why not?</td>
</tr>
</tbody>
</table>

| 14. Developing a mental health condition |
| Noticing the symptoms & seeking support: |
| • When did you first notice the symptoms? |
| • How did you manage your symptoms as they developed? |
| • Where did you go for help? |
| • How long did it take you to seek support? |
| • What stopped you from seeking support sooner? |

**Do you think your condition is Service related?**

| • Why? |
| • What about your life before the military? |

| 15. Accessing mental health support (military) - if applicable |
| • Ease of access |
| • Information & signposting |
| • Barriers to services |
| • How effective were the services at meeting your needs? |
| • How could these services be improved? |
| • Is there any additional support you felt you needed but didn’t receive? |
### 19. The role of the GP

Include other needs - e.g. physical health

**Registering with a GP:**

- When you left the military, how long did it take you to register with a GP?
  - What stopped you from registering sooner?
- When you registered with your GP did they ask you if you were a veteran?
  - If not, did you tell them that you were a veteran?
  - If not, why not?

**GPs and the Armed Forces Covenant:**

- Does your GP know you are a veteran now?
  - If yes, do you think it has made a difference?
- Has your GP been able to support you?
  - Is your GP culturally aware of Armed Forces issues?
  - Has your GP informed you about your rights according to the Armed Forces Covenant? **Do you know about the AFC?**
- What more could your GP do to make your life easier?

**Other experiences of the Armed Forces Covenant**

### 20. Closing thoughts

- What more could be done to help veterans in your position?
Healthwatch Norfolk personal information question sheet
Veterans Project 2015

That concludes the interview proper. Thank you very much for supporting my project. Before we finish, I hope you won’t mind answering six final questions. These questions are all about you.

I am asking these questions because it is important for Healthwatch Norfolk to know how far we have reached veterans across Norfolk and Suffolk and how effective we are at representing all sections of the veteran community.

You do not have to answer these questions if you do not want to. Your responses will be kept in confidence and your personal information will never be shared outside of Healthwatch Norfolk.

<table>
<thead>
<tr>
<th>Referring organisation:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Would you like to be involved with this project in the future?

<table>
<thead>
<tr>
<th>Email:</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21. The first half of your post-code:

<table>
<thead>
<tr>
<th>22. Your age: ____________________</th>
<th>23. Your gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Under 25</td>
<td>☐ Male</td>
</tr>
<tr>
<td>☐ 25-44</td>
<td>☐ Female</td>
</tr>
<tr>
<td>☐ 45-64</td>
<td>☐ Transgender</td>
</tr>
<tr>
<td>☐ 65+</td>
<td>☐ Prefer not to say</td>
</tr>
<tr>
<td>☐ Prefer not to say</td>
<td></td>
</tr>
</tbody>
</table>

24. Your marital status:

<table>
<thead>
<tr>
<th>☐ Married / civil partnership</th>
<th>☐ Widowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Cohabitating</td>
<td>☐ Single (never married)</td>
</tr>
<tr>
<td>☐ Divorced / separated</td>
<td></td>
</tr>
</tbody>
</table>
25. Ethnicity:

White:
- English
- Welsh
- Scottish
- Northern Irish
- British
- Irish
- Gypsy or Irish Traveller
- Any other White background, please describe:

Mixed / Multiple ethnic groups:
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed / Multiple ethnic background, please describe:

Asian / Asian British:
- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background, please describe:

Black / African / Caribbean / Black British:
- African
- Caribbean
- Any other Black / African / Caribbean background, please describe:

Other ethnic group:
- Arab
- Any other ethnic group, please describe:
Appendix E: service evaluation application form for NSFT

NSFT Research/Project Brief Template

Title of Project
Mental health provision for military veterans in Norfolk and Suffolk.

Main Aim of Project
The aim of this project is to understand what it is like for a sample of veterans to use mental health services in Norfolk and Suffolk, their views and experiences of these services, including examples of what works well for them and what they think could be improved.

Background to Project/Rationale
The Healthwatch Norfolk scoping paper (December 2014) into the health and wellbeing of Norfolk’s veterans estimated that there may be as many as 90,000 veterans in Norfolk, which is more than 10% of the county’s population.

One of the best ways to measure the standard of a service is to speak to the people who use it. However, veterans are acknowledged to be a largely under-represented group and not much is known locally about their views and experiences of mental health support once they have left the Forces.

There is a real need, therefore, to collect feedback that can be used as evidence of what is currently working well for veterans, and what could be improved.

In addition, whilst the majority of veterans enjoy the same levels of mental health as the general population, some have very poor outcomes (e.g. alcohol, suicide in young men). A small minority of these veterans may have particular needs arising from their Service history and they may therefore respond better to a slightly different kind of service.

Proposed Participant Group
Describe who will be approached & involved and how will they be identified & recruited from NSFT services.

This project will involve a sample of veterans (30-50) from Norfolk and Suffolk who have used NSFT services since March 2012, including those still in treatment.

Where possible, Healthwatch Norfolk would like to involve dependents too.
It is hoped that NSFT will be able to identify and approach suitable participants from their patients on behalf of Healthwatch Norfolk.

Additional participants will be sourced from Third Sector organisations like Combat Stress, The Royal British Legion and Mind.

How will confidentiality and personal data be protected? Who will have access to data?

Any personal data that is collected by this project will remain confidential; it will be stored on a password protected computer system and it will be accessed only by the Healthwatch Norfolk Project Lead.

A written report of findings will be published, but all the information in this report will be anonymised and no person identifiable information will be released.

Once the project has been completed, all personal data (as well as research notes, recordings etc.) will be destroyed.

What risks/benefits are there for participants to take part? What if something goes wrong during an assessment/interview? Are there any risks to researchers? i.e. lone-working.

Participants will not directly benefit from this project. However, this is their chance to have their say about their mental health services, so that their feedback can be used to help commissioners and providers improve services for veterans across Norfolk and Suffolk.

The interviews will inevitably involve discussions about traumatic events and so the risk to the participant is that these discussions may have a negative impact on their mental health and recovery.

The researcher will seek to mitigate this risk in the following ways:

- By attending mental health first aid training
- By ensuring that the interviews can take place in the presence of a qualified mental health practitioner, if necessary

Healthwatch Norfolk has also committed to paying for up to a maximum of 6 sessions of counselling if a need is identified as arising from this project.

Proposed Methodology – what you intend to do: interviews, assessments, follow-ups, intervention provided etc. how will it be analysed? What are your primary outcome measures?

It is anticipated that most participants will prefer a face-to-face interview format.
Focus groups will be conducted with those participants who may find a face-to-face interview intimidating.

Remote interviews (e.g. telephone, online) will also be offered.

If possible, follow-ups will be conducted to test and validate findings.

The interviews/focus groups will be semi-structured, following a set of questions based around the participant’s:

- Military career
- Transition into civilian life
- Views & experiences accessing and using mental health support (NSFT)
- Views & experiences accessing and using mental health support (Third Sector)
- Views & experiences registering with a GP
- Views & experiences of the Armed Forces Covenant in action

The interviews/focus groups will be recorded (with the permission of the participant) and these recordings will be transcribed to facilitate analysis. The researcher will then conduct a thematic analysis to identify key trends and themes.

The primary outcomes will be to capture:
1. The experiences of veterans using mental health services
2. Examples of elements of services that veterans think are working well
3. Examples of areas that veterans think could be improved

Proposed Outcomes to be Measured and How – Clinical Outcome measures (extra or routinely collected data?), questionnaires (quantitative?), interviews (semi-structured) etc.

This study will measure patients’ experiences accessing and using mental health support in Norfolk and Suffolk (since March 2012).

The evidence will be mostly qualitative, arising from semi-structured interviews based around questions that have been designed to capture the requisite information for the primary outcomes (see above).

Potential Impact of Study on Clinical Delivery – how could the results of your project be used to inform and improve clinical practice, whether positive or negative?

One of the best ways to measure the standard of a service is to speak to the people who use it.
This project will collect feedback from a sample of veterans that can be used as evidence of what is currently working well for veterans, and what could be improved. The feedback will be shared with local commissioners and providers so that they can adjust their practice accordingly.
Appendix F: information/consent form

Healthwatch Norfolk Veterans Project

Project Lead: Edward Fraser

Part 1: Information Sheet

About Healthwatch Norfolk

Healthwatch Norfolk is the independent consumer champion for anyone in Norfolk who uses health and social care services. Our role is to capture the views and experiences of local people and use this as evidence to influence the people and organisations who pay for and provide your health and social care.

Healthwatch Norfolk Veterans Project

Healthwatch Norfolk is currently undertaking a project to gather the views and experiences of military veterans who have used mental health services in Norfolk and/or Suffolk since March 2012. The purpose of this project will be to use feedback from local veterans to identify aspects of these services that are currently working well, and to highlight areas for improvement.

Participating in the Veterans Project

You are being asked to consider taking part in the Healthwatch Norfolk Veterans Project. This will involve talking to our Project Officer, Edward Fraser, about your views and experiences of mental health services in Norfolk and/or Suffolk. The conversation will last about an hour and it will be conducted at a time and place of your choosing. Healthwatch Norfolk will pay for any expenses that might arise.

You will be asked to give permission for the conversation to be recorded, so that detailed notes can be taken later. Edward will be asking you some personal questions about your military career and some equal opportunity questions (your age, gender, ethnicity, marital status). You do not have to answer these questions if you do not want to. Edward is required to protect your privacy. Your personal information and any identifiable information will be kept confidential and will not be shared outside of Healthwatch Norfolk.

During the project, any recordings and research notes will be kept securely on a password protected system and they will be destroyed once the project has been completed. We will be publishing a written report of our findings so that we can share the results with the people and organisations who pay for and provide your health and social care. When this report is published your identity will not be revealed and nobody will be able to identify who said what.

Participating in this project is entirely voluntary. You may choose not to take part or you may change your mind at any time. Once the project is written and published, however, it will not be possible for you to withdraw your permission. The project is all about your views and experiences. You are the expert and it is important that you feel comfortable and understand that nothing you say can be wrong. Participating in the project will not affect the quality or nature of any care or support that you are currently receiving. If at any point you are not happy with the questions that you are being asked, you would like to take a break or stop the conversation entirely, please let Edward know.
Your initials and signature below mean that you have read the above information about this project, that you have had a chance to ask questions to help you understand how your information will be used, and that you give permission to allow your information to be used in this project.

If you have any further questions please contact Edward Fraser on 01953 856 029 or by email at edward.fraser@healthwatchnorfolk.co.uk.

Part 2: Consent Form

Please Initial Each Box

1. This project has been fully explained to me and all of my questions have been answered to my satisfaction.

2. I give my permission for this conversation to be recorded.

3. I understand that my confidential information will not be accessible by anyone except the Project Lead.

4. I understand that any information given by me may be used in future reports, publications, articles or presentations by Healthwatch Norfolk.

5. I have been informed of the risks and benefits, if any, of allowing my information to be used in this project.

6. I have been informed that I do not have to participate in this project.

7. I have read each page of this form.

8. I have agreed to participate in this project.

______________________________  ______________________________  ________________
Name of Participant                  Signature                     Date

______________________________  ______________________________  ________________
Name of Project Lead                Signature                     Date
Appendix G: partnership working arrangements

Healthwatch Norfolk
Veterans Project Brief

Project title: Mental health provision for veterans in Norfolk & Suffolk
Project lead: Edward Fraser, Healthwatch Norfolk Project Officer
Project duration: April 2015-16

What is the purpose of this project?

The purpose of this project is to capture the views and experiences of a sample of veterans who have recently used mental health services in Norfolk and Suffolk, including examples of what is currently working well and examples of what could be improved in the future.

What is the rationale for this project?

The Healthwatch Norfolk scoping paper (December 2014) into the health and wellbeing of Norfolk’s veterans estimated that there may be as many as 90,000 veterans in Norfolk, which is more than 10% of the county’s population.

One of the best ways to measure the standard of a service is to speak to the people who use it. However, veterans are acknowledged to be a largely under-represented group and not much is known locally about their views and experiences of mental health support once they have left the Forces.

Furthermore, whilst the vast majority of veterans enjoy similar levels of mental health to the general population, a significant minority suffer from significantly poorer outcomes.

Who will this project involve?

This project will involve a sample of veterans (30-50) from Norfolk and Suffolk who have used NHS mental health services since March 2012, including those still in treatment.

Where possible, Healthwatch Norfolk would like to involve dependents too.

How will the participants be recruited?

It will primarily be the responsibility of partner organisations, who are working with veterans in mental health, to identify suitable participants for this project from their beneficiaries/patients.

Partner organisations will make the first approach and will pass on contact details of potential participants (with their permission) to the Healthwatch Norfolk Project Lead. The Project Lead will then contact potential participants with further information about the project.

Where a person is interested in being involved with the project, the Project Lead will organise a time and place to conduct the study. This will be...
arranged entirely at the participant's convenience and Healthwatch Norfolk will pay for any expenses that arise. The Project Officer will share a written information sheet/consent form with the participant ahead of the day so that the participant has time to understand what the project involves and ask any questions.

Healthwatch Norfolk understands that, in some cases, it may be appropriate for participants to be supported by a member of staff from the partner organisation. This decision will be made by the participant and/or the partner organisation.

**How will this project be conducted?**

It is anticipated that most participants will prefer a face-to-face interview format. Focus groups will be arranged for those who would prefer a group format. Telephone interviews will also be offered.

The interviews/focus groups will be semi-structured, following a set of questions based around the participant's:

- Military career
- Transition into civilian life
- Views & experiences accessing and using mental health support (HSFT)
- Views & experiences accessing and using mental health support (Third Sector)
- Views & experiences registering with a GP
- Views & experiences of the Armed Forces Covenant in action

The interviews/focus groups will be recorded (with the permission of the participant) and these recordings will be transcribed to facilitate analysis. The Project Lead will then conduct a thematic analysis to identify key trends and themes.

The primary outcomes will be to capture:
1. The experiences of veterans using mental health services
2. Examples of elements of services that veterans think are working well
3. Examples of areas that veterans think could be improved

If possible, follow-ups will be conducted early in 2016 to test and validate findings.

**Ethics:**

**How will confidentiality and personal data be protected?**

Any personal data, notes, recordings etc. collected by this project will remain confidential; they will be stored on a password protected computer system and will be accessed only by the Healthwatch Norfolk Project Lead.
A written report of findings will be published in Spring 2016, but all the information in this report will be anonymised and no person identifiable information will be released.

Once the project has been completed, all personal data, notes, recordings etc. will be destroyed.

What risks/benefits are there for participants to take part?

Participants will not directly benefit from this project. However, this is their chance to have their say about their mental health services, so that their feedback can be used to help commissioners and providers improve services for veterans across Norfolk and Suffolk.

The interviews will inevitably involve discussions about sensitive issues and so the risk to the participant is that these discussions may have a negative impact on their mental health and recovery.

The Project Lead will seek to mitigate this risk in the following ways:
- By attending mental health first aid training
- By ensuring that the interviews can take place in the presence of a qualified mental health practitioner, if necessary - in most cases this will be a member of staff from the partner organisation

Healthwatch Norfolk has also committed to paying for up to a maximum of 6 sessions of counselling if a need is identified as arising from this project.

What is the potential impact of this project?

This project will collect feedback from a sample of veterans, which can be used as evidence of what is currently working well for veterans as well as what could be improved.

The feedback will be shared with local commissioners and providers so that they can adjust their practice accordingly.

The feedback will also be shared with NHS England, commissioner of national specialist mental health services for veterans, so that veterans from Norfolk & Suffolk can contribute to the wider debate.

Further details:

For further information about this project, please contact Edward Fraser by emailing edward.fraser@healthwatchnorfolk.co.uk or ringing 01953 856 029.
Appendix H: Mental Health First Aid training certificate

MHFA
mental health first aid Standard

CERTIFICATE OF ATTENDANCE

Edward Fraser

has attended the MIHA England Standard course.
This course teaches skills for providing initial help to people experiencing emotional and mental health problems such as depression, anxiety disorders and psychosis.

Completed the MIHA England Standard course on: 17/07/2015

Penny Jemson
Chief Executive Officer

MHFA was developed by Betty Kitchener and Professor Anthony Jorm at the centre for Mental Health Research at ANU, Canberra, Australia.

We help to improve services and achieve better outcomes for children and families, adults and older people including those with mental health problems, physical or learning disabilities or people in the criminal justice system.
Appendix I: Steering Group Terms of Reference

Veterans Project Steering Group

Terms of reference

The Veterans Project Steering Group has been established to oversee the delivery of the Healthwatch Norfolk Veterans Project to ensure that the best interests of patients, service users and the public of Norfolk are kept foremost in mind at all times.

1. Membership

The steering group will be comprised of:

- Luke Woodley, Founder & Director, The Walnut Tree Project
- Rod Eldridge, Programme Lead, Head Start, Walking with the Wounded
- Carolyn Brown, Community Psychiatric Nurse, Combat Stress
- Kate Green, Area Manager (East Anglia & Essex), The Royal British Legion
- Andy Wicks, The Junction Team Manager, The Matthew Project
- Diane Palmer, Area Team Manager, Veterans First
- Gary Hazelden, Senior Operational Team, Norfolk & Suffolk Foundation Trust
- Caroline Money, Senior Planning and Partnerships Officer, Norfolk County Council
- Matt Fossey, Director, Veterans and Families Institute, Anglia Ruskin University
- Edward Fraser, Project Officer & Veterans Project Lead, Healthwatch Norfolk
- Alex Stewart, CEO, Healthwatch Norfolk

At its first meeting the group shall elect a chair.

2. Frequency of meetings

The group will convene in June 2015. The group will usually meet on a bimonthly basis and a quorum at each meeting will be two members plus the Project Officer. The meetings will last for a duration of approximately one and a half hours. The group may exceptionally have to deal with business by e-mail.

3. Record of meetings

An agreed record of decisions and actions at each meeting will be prepared by the Project Officer. Agendas will be prepared by the Project Officer and circulated around the group one week in advance of the next meeting.

4. Reporting

The Project Officer will report to the Healthwatch Norfolk Quality Control Panel in September 2015 and produce a Final Report of the project in March 2016.
5. Functions of the Group

To use specialist knowledge and expertise to support Healthwatch Norfolk to deliver the aims and objectives of the Veterans project as set out in the Project Initiation Document and agreed by the Quality Control Panel (17th December 2014) by:

- Providing guidance and overseeing delivery of the Veterans Project, including monitoring and reviewing progress
- Acting in an advisory capacity to assist with the development of an appropriate method to deliver the aims and objectives of the Veterans Project
- Helping to identify and recruit specific groups of service users to participate in the project, “opening doors” to engagement opportunities where appropriate
- Ensuring that Healthwatch Norfolk conducts engagement and research with service users in a sensitive, appropriate and effective manner
- Acting as a source of specialist knowledge and expertise on the Armed Forces community and the policy context regarding the Armed Forces Covenant and the Armed Forces Community Covenant (Norfolk)
- Facilitating linkages with related initiatives & networks, ensuring that the project runs without duplication and competition
- Promoting the project where appropriate with clear linkages to the wider Armed Forces agenda, e.g. the Norfolk Community Covenant
- Assisting with the planning of any public and/or stakeholder events relating to the project

6. Remuneration

All travel expenses will be paid in full by Healthwatch Norfolk. Refreshments will be provided at all meetings.
Appendix J: information about the participants

Figure J1. Age: participants compared to RBL data.

Figure J2. Branch of Forces: participants compared to RBL and Combat Stress data.
**Figure J3.** Years since discharge: participants compared to RBL data.

**Figure J4.** Length of service: participants compared to RBL data.
Figure J5. Rank on discharge: participants compared to RBL data.
Appendix K: Military Veterans’ Treatment Priority Protocol

Military Veterans’ Treatment Priority Protocol

Introduction

In June 1987 the NHS published guidelines relating to the priority treatment of war pensioners, and this was updated in December 2007. From 1st January 2008, all service veterans should receive priority access to NHS care for any condition which is likely to relate to their military service. This is also subject to fair treatment of all other patients based on clinical needs.

The British Government defines a veteran as: “Anyone who has served for at least one day in the Armed Forces (Regular or Reserve), as well as Merchant Navy seafarers and fishermen who have served in a vessel that was operated to facilitate military operations by the Armed Forces.” There are an estimated 40,000 veterans in Norfolk (Healthwatch Norfolk, 2014).

The purpose of this protocol is to raise awareness of the requirements in relation to veterans and to summarise the DoH guidance on the subject.

Many conditions do not become obvious until after a veteran has left military service, therefore all GPs should be aware of the government wish to prioritise care of this nature and consider the military aspects of a condition when diagnosing and referring to secondary care.

The July 2015 update to the NHS Constitution ensures that, in line with the Armed Forces Covenant, military veterans are supported, treated equally and receive the same standard of, and access to, healthcare as any other UK citizen in the area they live.

For those with concerns about their mental health who 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. Veterans who have lost a limb(s) as a result of their service will be able to access prostheses that reflect their clinical need. Veterans receive their healthcare from the NHS and are encouraged to identify themselves to their GP as member of the Armed Forces Community.

Most Frequent Conditions
- Audiology – noise induced hearing loss. There has been a lack of compensation in the past and little understanding in relating to this problem. It is possible therefore that cases may present now which have been symptomatic for some time.
- Mental Health – may present some years after military discharge. PTSD is not the biggest issue (4%), usually common mental health problems and/or alcohol misuse.
- Orthopaedic – may arise sometime after discharge but be related to in-service activity.

Required Action
- Where a known veteran is referred check with the patient that they are willing for the referral to show that they are a military veteran.
- Where consent is given by the patient the referral can state they are a veteran, and the clinician should give a clinical opinion within the referral as to whether the condition (or request for further investigation) is likely to relate to the period of military service, indicating the issue of priority treatment.
- Where consent is refused by the patient the information should not be included.
- The secondary care provider clinicians are responsible for prioritisation, taking into account the relative priorities of other patient groups based on clinical need.
- When using Choose & Book, GPs should select the correct priority of the referral based on clinical need or clinical guidelines only. Where veterans’ details are
included within the referral then the secondary care service is responsible for military prioritisation, and they will assess other demands on their limited resources based on clinical priorities.

Sample Text for Referrals

“As this patient is a military veteran and his/her current condition may be related to military service, this referral should be considered for priority treatment under the rules set out in the Commissioning Board mandate and Armed Forces Covenant.”

Identifying Ex Military Personnel

It is important that ex-military personnel are identified, not only so that patients can be referred appropriately within the NHS, but so that they can have access to the wide array of local support in the Third Sector. Further information about this support accompanies this protocol.

To aid with the identification, the Practice will add to its patient registrations leaflet the following two questions:

- Have you previously served in any of the military services?
- Are you content that this is annotated on your medical record?

Other identification tools have been or will be promulgated by the Practice – they are:

- Posters in the waiting room
- Notices in Parish Magazines
- Patient Newsletter

Clinical System

The following Read Code will be used for all known veterans in the Practice:

<table>
<thead>
<tr>
<th>Military Veteran</th>
<th>13j (EMIS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Served in the Armed Forces</td>
<td>U060T3 (SYS1)</td>
</tr>
</tbody>
</table>

This will be coded regardless of referral activity where it is known that the patient is an ex-serviceeman/servicewoman and entered in the Active Problem list.

Where a veteran considers that the arrangements for priority treatment have not been properly considered or fulfilled they are able to use the NHS Complaints Procedure to have the matter investigated.

Resources

NHS Choices Veterans healthcare


Appendix L: Healthwatch Norfolk’s letter to local Clinical Commissioning Groups re: veteran champions

7th September 2015

Dear XXX

Re: Your preparations for the Health Education England 2014-15 mandate to provide local support for veterans

I am writing to inform you that Healthwatch Norfolk recently published a scoping paper taking a first look at the health and wellbeing needs of Norfolk’s military veterans. The work was undertaken in-house by our Project Officer from October to December 2014, and it involved an extensive literature review of national research supported by qualitative information supplied by a sample of local commissioners, providers, professionals, advocates and service users (veterans). The paper is available at healthwatch_norfolk_veterans_scoping_paper_web.pdf.

The scoping paper made three recommendations for future work, all of which were endorsed by the Healthwatch Norfolk Board and form part of our strategy for 2015-2017. The project ‘Improving health and wellbeing outcomes for veterans in Norfolk’ commenced in April of this year. One of the objectives of this project is to: work with key stakeholders to ensure that the terms of the Armed Forces Covenant are being met by local health and social care services.

I was delighted, therefore, to see the Department of Health’s commitment to the Covenant reflected in Health Education England’s 2014-15 mandate to:

“Provide support for veterans by ensuring a specialist GP in every CCG trained in physical and mental health needs of armed forces by summer 2015.”

Now that the summer has fully arrived, it seems like an appropriate time to enquire about the status of your preparations for this mandate. If you have already identified a specialist GP within your CCG, trained in the physical and mental health needs of the armed forces community, I hope that you will be happy to make their contact details available so that Healthwatch Norfolk and other stakeholders can link up to discuss how best to work together to improve the lives of our local veterans.


healthwatch_norfolk_veterans_scoping_paper_web.pdf
If you have not yet identified a specialist GP, I would be grateful if you would provide an update of your preparations to date and advise me as to when you expect to have successfully met the conditions of the Health Education England mandate.

As you are aware, Healthwatch Norfolk is the consumer champion for all health and social care provision in Norfolk, with a statutory role to represent the voice of service users, patients, carers and the public. I would appreciate your initial response within 20 working days in accordance with the Healthwatch regulations 2012, which require a response to Healthwatch Norfolk.

I look forward to hearing from you soon.

Alex Stewart
Chief Executive

Healthwatch Norfolk
Suite 6, The Old Dairy
Elm Farm, Norwich Common
Wymondham
Norfolk NR18 0SW
Tel: 01953 856029
Email: alex.stewart@healthwatchnorfolk.co.uk
www.healthwatchnorfolk.co.uk
Registered company 8366440
Charity registration 1153506
Appendix M: evaluation from Norwich Veteran Healthcare Conference

Veterans Healthcare Conference
Wednesday 14th October 2015
Dunston Hall

Snapshot of event feedback
Healthwatch Norfolk
Edward Fraser, Project Officer
December 2015
About this paper

This paper presents a summary of the feedback submitted by 28 GP students from Norfolk and Suffolk who attended a Veterans Healthcare Conference at Dunston Hall (Norwich) on the 14th October 2015.

The paper is not a full event evaluation and there will be no discussion of findings, method or limitations. Rather, the paper is intended to provide a snapshot of how well the events were received by the students, which may be useful for Training Programme Directors and other professionals involved in the training of GP students in Norfolk and Suffolk.

The Huntingdon Veterans Healthcare Conference was part of a wider initiative launched by Health Education East of England, in partnership with Healthwatch Norfolk and the Ministry of Defence, to deliver four Conferences for GP students across the East of England in the following locations:

Norfolk & Suffolk - Norwich, 14th October 2015
Cambridgeshire - Huntingdon, 4th November 2015
Hertfordshire & Bedfordshire - venue TBC, 27th April 2016
Essex - venue TBC, 28th April 2016

These events were organised in order to meet the Health Education England 2014/15 Mandate, which includes the responsibility to “design a training programme/ e-learning module for Veterans’ Health Champions, aimed at training health professionals to recognise, and raise awareness of, veterans’ health needs across primary, secondary and community care settings.”

Healthwatch Norfolk will publish a full evaluation of the four Conferences once they have all been delivered (Summer 2016).
Summary of findings

61 GP students attended the event. This is 1 in 4 (25%) of all students in Norfolk & Suffolk (243).

84% (51) students remained until the end of the day.

28 students (46%) took part in the survey.

93% of survey respondents (26/28) said that the event had met or exceeded their expectations. Two respondents did not specify.

A thorough and helpful insight into the lives of veterans...

...and the organisations available to support them.

Before the event: on average (mean), respondents rated their awareness of Armed Forces/veteran issues at 4.1/10. The most commonly selected score (mode) was 2 (selected by 28%) and 18% gave themselves a score of 7 or higher.

After the event: the average awareness increased to 7.9/10. The most commonly selected score increased to 8 (selected by 39%) and 96% rated their awareness at 7 or higher.

All of the respondents said that the day would make a difference to their practice.

25 comments were particularly informative. Of these...

10 related to increased confidence and awareness of ONE of the following: the importance of identification, referrals and support and specific health needs.

10 related to TWO of these issues.

1 related to THREE of these issues.

3 were general comments.
Norwich Veterans Healthcare Conference - snapshot of event feedback

The respondents most frequently identified the following aspects as being the most useful parts of the day:

1st
- Interacting with veterans (14/28, 50%)

2nd
- Information about local support (12/28, 43%)

3rd
- Information about specific health needs and how GPs can help (6/28, 23%)

This ‘cloud’ shows the words that the respondents most frequently used to describe the event (the larger the word, the more times it appeared in the survey responses):
When asked how the event could be improved in the future...

7 respondents would have welcomed representation from the wider military family...
3 felt that the day was too long...
3 wanted specific information about referral guidelines...
7 made comments about the organisation on the day or the venue/catering...
1 wanted some more pre-course support...
And 3 felt the event was good as it was.

And finally...

14 respondents elected to leave further feedback...
1 said there was too much repetition
1 made a comment about the venue
1 wanted to see some more women present
11 said thank you for a great event

Thank you for an enjoyable and informative day. It is always a real pleasure to listen and talk to current and ex-servicemen.

Thanks for letting us know about this important group of patients that unfortunately I have never thought about their needs.
# Appendix

The feedback was collected through an online survey hosted by Survey Monkey. The questions were as follows:

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In which region did you attend the event?</td>
</tr>
<tr>
<td>2. Did you achieve what you hoped by attending today?</td>
</tr>
<tr>
<td>3. To what extent do you think what you have learned today will make a</td>
</tr>
<tr>
<td>difference to the way you do your job?</td>
</tr>
<tr>
<td>4. What do you think were the 3 most useful aspects of the day?</td>
</tr>
<tr>
<td>5. What do you think would improve this event next time?</td>
</tr>
<tr>
<td>6. On a scale of 1-10, please rate your knowledge of Armed Forces/veteran</td>
</tr>
<tr>
<td>issues AFTER attending the event*</td>
</tr>
<tr>
<td>7. Any other feedback?</td>
</tr>
</tbody>
</table>

*All students were also asked to rate their knowledge of Armed Forces/veteran issues on a scale of 1-10 BEFORE attending the event at registration on the day.
Appendix N: Healthwatch Norfolk’s letter to Norfolk County Council re: social care costs for War Pensioners

Rex Parkinson-Hare
Chair
Norfolk County Council
County Hall
Maritime Lane
Norwich
Norfolk
NR1 2DH

28th May 2015

Recommendations from Adult Social Care Committee to Full Council regarding changing current charging policies affecting war veterans

Dear Cllr. Parkinson-Hare,

As you know, Healthwatch Norfolk is the consumer champion for all health and social care provision in Norfolk and we have a statutory role to represent the voice of service users, patients, carers and the public.

I am writing to advise you that we recently published a scoping paper taking a first look at the health and wellbeing needs of Norfolk’s war veterans. The work was undertaken in-house by our Project Officer from October to December 2014, and it involved an extensive literature review of national research supported by qualitative information supplied by an anonymous sample of local commissioners, providers, professionals, advocates and service users (veterans). The scoping paper is available for download at healthwatch.norfolk.gov.uk/veterans/scoping-paper.pdf.

The scoping paper made three recommendations for future work, all of which were endorsed by the Healthwatch Norfolk Board in March 2015 and are now being undertaken as part of a full project (April 2015-16) looking at improving health and wellbeing outcomes for veterans in Norfolk.

One of these recommendations was to:

Work with the Norfolk County Council, the Norfolk Armed Forces Community Covenant Board and other key stakeholders to support the Royal British Legion national campaign ‘Insult to Injury’ regarding ending the current disparity between the charging policies for the War Pension and the Armed Forces & Reserve Forces Compensation schemes.

We were delighted, therefore, to see this matter discussed by the Adult Social Care Committee in March 2015, and we would strongly urge you to endorse the recommendations made by the Committee that:

• “Relevant council policy be changed in this cycle to grant the request put forward by the Royal British Legion in respect of charging policies in force affecting war veterans.”

• “In the interim, P&R committee officers bring forward to that committee urgently options to find within this financial year and beyond the £400,000 per annum which is estimated to be the cost of the change.”

I am certain that you will already be aware of the arguments that were put forward most persuasively by the Royal British Legion in favour of these recommendations and so I will not repeat them in full here. Suffice it to say that the amount of support we offer to our
injured war veterans should not depend on the period in which they were injured. Veterans in receipt of the older War Pension Scheme should not be obliged to use the money they received as compensation for injuries or illnesses suffered in the protection of their country to pay for their ongoing care, most especially when their comrades in receipt of the newer Armed Forces & Reserve Forces Compensation Scheme and their civilian peers who have been awarded compensation for workplace injuries can rightly expect to have the costs of their ongoing care met by the Council.

This last point undermines the very spirit of the Armed Forces Covenant; that Service personnel, veterans and their families should face no disadvantage compared to other citizens as a result of Service. I fear that the current charging policies must call into question all of the good work that the Norfolk Community Covenant Board has done to help local war veterans and the wider Armed Forces Community over the past three years.

I am not insensitive to the restrictions, financial or otherwise, within which the Council is obliged to operate. I also respect that the Council’s current charging policies already follow national guidelines and that neighbouring councils are not planning on changing their own policies. However, in the absence of national leadership, I hope that the Council will agree with me that we should be looking to act independently to put an end to the disparity between our charging policies for the War Pension and the Armed Forces & Reserve Forces Compensation schemes. I further hope that, by endorsing the recommendations submitted by the Adult Social Care Committee, Norfolk will be able to act as an example of fairness and best practice for other councils around the country.

I await the Council’s decision on this matter with great interest and look forward to hearing from you soon.

Kind regards

Alex Stewart
Chief Executive