WHY DO WE NEED TO THINK ABOUT VETERANS ?

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Outline

What is a Veteran?	Context	Structure / organisation of the Armed Forces
Military Culture and Values	Transition	Barriers to care /engagement
Mental health	Substance misuse	Physical health
Risk	Families	What you can do/resources

Who is a Veteran ?

Veteran

Anyone who has served one day in HM Armed Forces

+ Merchant Navy (on operations)
+ Former Polish forces under British Command

In 2016 there were an estimated 2.5 million UK Armed Forces veterans.

Almost two-thirds of veterans were estimated to be aged 65+ (63%)

- *Not all are combat veterans*
- *Issues with definition*
- *Future changes in age distribution*

Who is a Veteran?

The majority do well after leaving the armed forces

- with life opportunities improving due to service

E.g.

87.5% of those who left were in full-time employment

(Iversen 2005)

‘Veteran’ identification

- Veterans may also use other terms to describe themselves
- They may not identify as a ‘Veteran’
- Some do not want to admit they are a Veteran

- **Is the question important ?**
- **How do you ask the question?**
- **Recording the question**

The Covenant (2000- to date)

Service in the armed forces is different from other occupations.

- Relinquish some of their **civil liberties**

e.g. military law vs statue law

- **Uncertainties**

e.g. posting, deployments etc

- **Dangers**

Risk of death in the army overall is approx. 1 in 1000 per year

(approx. 150 x general working population.)

Because of this the Government promises to help and support people in the armed forces when they need it most.

What the covenant means

- ✓ **No disadvantage**
- ✓ **Continuity of public services**
- ✓ **Proper return for sacrifice**
- ✓ **Remembrance**

- Key areas for NHS
  - **Transition** into NHS Care (with Armed Forces)
  - **Prosthetic provision** for veterans
  - Implement **MH services** for veterans and families

- now in legislation

Priority treatment

Veterans should receive *priority treatment* for a condition that relates to their service subject to clinical need
- NHS England

'Those injured in service should be cared for in a way which reflects the nation's moral obligation to them , *by healthcare professionals who have an understanding of Armed Forces culture*'

- NHS England

NHS long term plan -

States:

'To ensure all GPs in England are equipped to best serve our veterans and their families, over the next five years we will roll out a veterans accreditation scheme in conjunction with the Royal College of GPs.'

Veterans accredited services

- Trusts – VCHA
- GP

GP Accreditation

- Accreditation lasts three years.
- Being accredited means that a practice can better identify and treat veterans, refer them, where appropriate, to dedicated NHS services and capture better epidemiological data to improve future health provision.
- It also means that the NHS is better able to meet the health commitments of the Armed forces covenant and priority treatment agreement
- Accredited practices are provided with an information pack to help increase their understanding of the health needs of veterans and services available to them.
- Accreditation is currently open to GP practices in England. We are working with the Devolved Nations to extend the programme.

Veterans friendly GPs

In summary the accreditation consists of five elements:

- Ask patients registering with the surgery if they **have ever served in the British Armed Forces.**
- **Code it on the GP computer system.**

The RCGP recommends using 'English' rather than Read codes as these vary according to which computer system is used. Having changed the Read codes available and removed derogatory codes such as 'dishonourable discharge', they recommend that the term 'Military Veteran' is used. It is therefore very simple.

- **Have a clinical lead on veterans** in the surgery. This should be a registered health care professional, but could be a nurse or paramedic, not just a GP.
- **This clinical lead is required to undertake dedicated training,** attend training events (RCGP or other provider), stay up to date with the latest research and innovations and ensure that the practice is meeting the health commitments of the Armed forces covenant . They should also be available to provide advice to colleagues, as well as possibly seeing veterans themselves.
- **Eligible practices should have a CQC 'good' rating or higher.**

Why is structure and organisation needed ?

- Function
- Chain of command
- Effective
- Efficient
- Layers of teams

'Life depends on it'

Reservists

Increasing reliance on reservists and increasing numbers

- Increase in numbers deployed
- Return to civilian employment
- Return to care of NHS not military healthcare
- Return directly to families/ not to unit
- Impact of redundancies of regulars – premature transition to civilian life with less preparation + loss of roles etc.

Consider the consequences of this

Military Culture and Values

Core values

Selfless commitment

Courage

Discipline

Integrity

Loyalty

Respect for others

Culture and values

- **Highly organised**
  - hierarchical, structured, layers of teams
- **Professionalism**
  - pride in efficiency, discipline, problem solving, high standards/expectations
- **Preparedness**
  - quick response, timekeeping
- **Macho**
  - consider females
- **Resilient/ stoic**
  - trained to face danger / cope
- **Team cohesion and leadership**
  - comradeship , mutual dependency / support, strong sense of 'family', being 'part of something'
- Eyewitness to the best and the worst (of humanity)

'Life depends on it'

Transition – issues

- **Mode of discharge**

e.g. medical, TU, SNLR, dishonourable …

- **Resettlement**
- **Support network** – loss/change
- **Adjustments to civilian life** –
  - pace
  - speed of response
  - different standards
  - attitudes
  - loss of military family
  - doing things that were previously arranged

e.g. housing finances, medical services

- **Transferrable skills** /lack of recognition of skills
- **Early Service Leavers-** vulnerable (see later)
- **Returning to environments**

may have joined up to leave

- **More time with families**/ in-laws
- **Trauma triggers**
- **Losses**
- **Dysfunctional coping mechanisms** – alcohol, aggression

Veterans' health

Barriers to care

Physical health

Mental health

Substance misuse

Risk

Other

-familes

- facitious etc

Barriers to care (part 1)

- **Stigma**(protective in the battlefield)
- **'Illness = weakness'**
- **'Help seeking = 'failure and weakness+ disloyal'**
- **Poor social and domestic support** / encouragement
- **Anger and fear of loss of control**
- **Guilt/ shame** and not being worthy of help
  incl survivor guilt
- **Protecting others** e.g. families from the things the have seen and done
- **Public perception** -' hero role ' ' unjust wars '
- **Recognising they have a problem** eg alcohol

Barriers to care (part 2)

- Poor knowledge of services and access
- Anticipate not being understood by health workers
- Hearing of colleagues failing- veterans talk to each other
- Self medicated alcohol use and its impact
- Perceptions of NHS Staff – expectations, dress code, attitude etc
- Auto Discharge on DNA /Opt in systems
- Multiple Assessments
- Not being given full plan of care and goal of getting better

Military Mental Health

Attitudes to mental health

Improving awareness

e.g. education, TriM, decompression etc

- Military held more **positive** attitudes about the **causes** of mental illness

('not due to weakness, LMF etc..)

- More **negative** attitudes relating to the **nature** of mental illness, compared to the general population
  - Widely-held belief that personnel with mental illness will experience career difficulties

(*Forbes et al 2013- serving personnel)*

Attitudes to mental health

- However majority from cohorts with differing exposure to education and attitudes
- Delay to access treatment reducing
  - was approx 15 yrs
  - now less than 12 yrs
  - but 2 yrs in Iraq/Afghanistan Veterans

Mental health issues in Veterans

The most common mental health problems in veterans, in approximate order of prevalence

- Adjustment disorders
- Alcohol misuse
- Depressive disorders
- Personality disorders
- Post-traumatic stress disorder
- Drug misuse

Iversen , Greenberg 2009

Risk factors for poor mental health

US study

-veterans more likely to have poor mental health if

- **female**
- **younger**
- **less educated**
- **single**
- **white**
- **short-term service enlisted personnel**
- **army personnel**

UK veteran population (smaller study)

-those most at risk of reporting mental health problems

- **army**
- **single**
- **lower ranks**

(Iversen 2005)

Risk factors for poor mental health

- UK and the USA studies;

Combatants who had **pre-enlistment/childhood adversity** were more likely to experience mental health problems on return from deployment

(Iversen ,Greenberg 2009)

Protective factors –mental health

Greater levels of (self reported)

- **unit cohesion**
- **morale**
- **perceived good leadership**

All associated with **lower** levels of common mental disorder and PTSD.

'May help to modulate the effects of combat exposure and the subsequent development of mental health problems'

(UK Armed Forces personnel deployed to Afghanistan -*Jones et al 2012*)

Reservists

- ‘

- ‘Higher rates of PTSD and CMD are also evident in deployed reserve personnel than regular counterparts
- suggesting that further efforts to improve reserve forces mental health may be warranted.’

KCMHR

Reservists vulnerability to mental health problems – factors

Deployed reservists are likely to

- **have different expectations of military obligations**
- **have different levels of preparedness and fitness**
- **be more likely to have been deployed as individual reinforcements**

On return from deployments

- **military social networks may be lost.**

(and replaced by civilian relationships, incl. employers and colleagues - may offer less understanding of and support for reservists' concerns)

- **may experience more exposure to decline in overall support for conflicts from the wider civilian society**

- can lead to an **increase in the risk of psychiatric injury**

(*Iversen ,Greenberg 2009*)

PTSD

PTSD is a problem for a minority of Veterans.

In 2014/16 rate of PTSD

serving regular **combat** personnel = 6%

in serving combat service **support** personnel =4%.

ex-service regulars who had not deployed =5.0%

ex service regular who deployed =9.4%.

Considerable differences in the rates of PTSD dependent on the **role** troops had in their last deployment before leaving service.

For those veterans whose last deployment had been in a combat role the rate of PTSD was 17%

compared to 6% among veterans whose last deployment was in a service support role.

PTSD

- The **complexity** of the disorder tends to be much greater in veterans.
- **Different themes** predominant

e.g. guilt, shame, responsibility etc rather than fear (see moral injury)

- Often occurs with other **comorbidities etc**
  - pain
  - disability
  - substance misuse, particularly alcohol misuse
  - other adjustments / losses/ transitional issues
  - pre-service vulnerabilities

PTSD

- Lower PTSD prevalence in British troops c.f US

Reasons include

- variations in combat exposures
- demographic differences
- higher leader to enlisted soldier ratios
- shorter operational tour lengths
- differences in access to long-term health care

Triggers

- Further traumatic experiences
- Bonfire night
- Remembrance / memorials / anniversaries
- Smells – meat, fire
- Ethnic minorities
- Built up areas , traffic jams etc
- TV news etc

Think about how to prepare the veteran to manage triggers

PTSD- treatment issues

- Due to comorbidities complexity and severity

  treatment sequencing is imperative

  - stabilisation, risk management, management of comorbidities, trauma focussed therapy etc

- Dementia and exacerbation of presentation - difficulties in management

Moral injury

An emerging/developing concept (not a diagnosis)

-the psychic fallout of

"morally injurious events such as perpetrating, failing to prevent, or bearing witness to acts that transgress [one's own] deeply held moral beliefs and expectations."

Examples

- *killing or harming others*
- *making decisions that affect the survival of others*
- *medics not able to care for all who were harmed*
- *freezing or failing to perform a duty during a dangerous or traumatic event (for example, falling asleep on patrol)*
- *failing to report an event that violates rules or ethics*
- *engaging in or witnessing acts of disproportionate violence*
- *feeling nothing or exhilaration while causing harm to or killing others*

Was it a factor in the increased alcohol misuse seen in veterans deployed to Bosnia?

Moral injury

- characterised by guilt, shame, disgust and self-condemnation
- Moral injury in PTSD increases severity of PTSD , secondary depressive features and suicidality
- to be considered in those who are difficult to treat with standard PTSD interventions
- because moral injury relates to ethical behaviour, the meaning attached to events and perceptions of the self,

moral philosophical and spiritual approaches could contribute to the design of treatments

Alcohol

- We are already in an area of high misuse rates!

Alcohol misuse in Veterans

The most common mental health problems in veterans, in approximate order of prevalence

- Adjustment disorders
- **Alcohol misuse**
- Depressive disorders
- Personality disorders
- Post-traumatic stress disorder
- Drug misuse

Iversen , Greenberg 2009

Risk factors for alcohol use related to occupation in general

Includes

- High stress
- Long irregular working hours
- High disposable pay
- Working away from home etc

Alcohol misuse in military personnel

The levels of drinking are higher in those who are currently serving or have served in the military c.f. gen popn .

Fear 2007

In both sexes, for all ages, the military have a higher prevalence of hazardous drinking.

AUDIT >8+

- 67% of men in UK Armed Forces (38% of men gen popn.)
- 49% of women in the UK Armed Forces (16% of women of Gen popn)

Alcohol use is seen as ‘ the norm’ for this group – misuse may not be seen by a veteran as problematic

Harmful alcohol use has decreased over the years, but still remains high and is now significantly increased in deployed reserves.

Heavy drinking in military men

Among military men, heavy drinking (AUDIT score 16+ harmful/dependent) was associated with

- **holding a lower rank**
- **being younger**
- **being single**
- **Navy or Army**
- **being deployed(to Iraq)**
- **not having children**
- **being a smoker**
- **having a combat role**
- **having a parent with a drink or drug problem.**

(Fear 2007)

Alcohol misuse- risk factors

- Higher levels of **comradeship**
- Deployment **alongside one's parent unit** associated with heavy drinking
- **factors acting to increase the bonding of troops also seem to act to increase the levels of alcohol use following deployment.**

(Browne 2008)

- Undertaking an **unfamiliar role** in theatre
- **Peacekeeping** specifically associated with increases in alcohol consumption (Wessley 2007)

Alcohol misuse- comorbidity

- 'Self medicating' for **PTSD** + other mental health symptoms eg sleep problems – maladaptive coping strategies

- New onset or persistent symptoms of probable PTSD was associated with an increase in AUDIT scores *(Thandi 2015)*

- 35% of PTSD cases had probable alcohol dependence

(Comorbidity in general popn approx. 30%)

(Iverson 2005)

- In 'self medication' with alcohol for **chronic pain** consider – assoc trauma , combination with pain medication, health rel to alcohol etc

- **Alcohol increases complexity and complicates management of comorbid physical /mental illness**

- treatment needs to reflect this

Alcohol – treatment implications

- Not seen as a problem
- Makes other symptoms worse
- Masking / misinterpretation
- Not moving people on/ access denied to services
- Maladaptive
- PTSD often predates the alcohol misuse/escalation in comorbidity
- Impact on PTSD - processing of trauma
- **Treatment for PTSD can improve their substance misuse** but if dependent then the substance misuse is the priority– implications for **sequencing** treatment
- Physical comorbidity – Korsakoffs – interpretation in past brain injury, PTSD etc
- Note most of the research concentrates around alcohol – consider other substance use

Risk – issues to consider

- **Suicide/ self harm and harm to others**

Ex-Service personnel reported a lifetime prevalence of self-harm **more than double** that of serving personnel (10.5%)

More likely to report **self-harming behaviour** if

- **younger personnel**
- **Shorter term of service**
- **PTSD**
- **those who had experienced more childhood adversity**

(Pinder et al)

(Macmanus 201

- Consider **access to weapons** , 'souvenirs', training in explosives, aggression/anger etc
- Higher risk in the two years post transition

- **Driving** and HGV risk incl dissociation and substance misuse
- **Radicalisation**
- **Ex-forces argued to be highest occupational group in UK prisons**
- **Reservists** – training / deployment, live arms access, risk to team , driving /operating equipment

Physical health

Physical health

Earlier onset of physical disorders due to military life

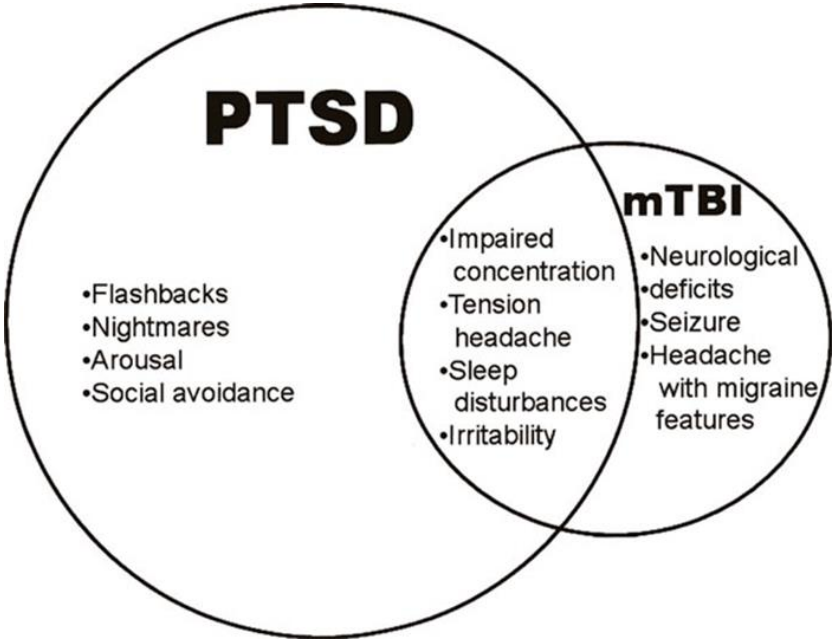
- Mainly orthopaedic, ENT, burns, chronic pain* deafness, blindness etc
- TBI/mTBI*
- Life-changing injuries
  - increased use of IEDs
  - limbs, perineal, facial etc
  - prosthetics (@ young age)
  - impact on MH
- Unexplained symptoms

e.g. Gulf War syndrome , conversion disorders etc.

Consider the impact on mental health

The relationship of mTBI and PTSD

- PTSD and TBI are often addressed together
- many people with TBI also have PTSD from same incident
- the symptoms may be similar/overlap - difficult to distinguish between the two injuries.



- Also significant **differences**

For example

- PTSD - trouble remembering the event, otherwise their memory and ability to learn is intact.
- TBI - preserved older memories, but may have difficulty retaining new memories and new learning

Chronic pain- considerations

- Substance misuse
- incl painkillers
- risk of use of painkillers in those drinking to manage symptoms
- compliance
- Reminder of trauma
- Limitations of physical activity
- central to identity =loss of role, self esteem, isolation
- Losses, adjustment etc
- Depression etc
- Physiological and mechanical impact of PTSD

Medically unexplained symptoms

Example

'Gulf war syndrome'

Soon after the end of 1991 Gulf War- reports of clusters of unusual illnesses occurring amongst Gulf War veterans.

Medically unexplained symptoms

UK cohort study;

No evidence that veterans of the Bosnia mission had any worse health than the rest of the Armed Forces, but that Gulf veterans were more likely to report each of the fifty symptoms that were asked about.

(Unwin et al., 1999)

Despite this evidence of poorer health amongst Gulf veterans, there has not been any accompanying increase in "hard" outcomes, such as death, cancer, or physical disease

(Gray & Kang, 2006).

1/4 million UK service personnel reported symptoms for Gulf war syndrome

The mortality rate of both US and UK Gulf veterans up to 2009 had not increased compared to non-Gulf veterans, with the exception of suicide and accidental death.

Medically unexplained symptoms

Postulated explanations of symptoms :

- anxiety regarding the genuine threat of chemical weapons
- exposure to burning oil
- exposure to depleted uranium
- use of organophosphate pesticides or nerve agents
- multiple vaccination
- use of Pyridostigmine ("anti-nerve gas") tablets.

The majority have been robustly disproven- controversy and uncertainty remain.

Recently a study concluded -

Gulf War syndrome is likely to be caused by destruction of Iraqi chemical weapons not uranium

Media reporting was likely to have influenced, and continues to influence the health of service personnel

(Greenberg & Wessley, 2008).

Question

From what you know about Gulf war syndrome Why as GPs in the current pandemic might you need to consider this population?

Gulf war (early 1990s) and vaccinations

Factitious veterans
'Walters and bloaters'

- Approx. 10% of those presenting to services are factitious
- Legislation has removed penalties
- Many stories will be richly embellished

Why ?

- Gains - status, sympathy, monies
- More 'acceptable' to have military trauma than childhood trauma

How to check ?

- Ask for help
- Note inconsistences – ask about role
- Check service number and how it is recalled
- Get consent to obtain full service records – contact disclosures

Families

Research suggests that **parental deployment** affects children's well-being and functioning

- increased stress on other parent
- impact on child of absence

+ anxiety of what may happen

- High freq domestic relocation
- Schooling disruption
- Taught drill , high expectations
- Impact of trauma on parent PTSD on child's behaviour
- DV
- Moral injury incl perpetration – impact on parenting

Veterans in the prison population

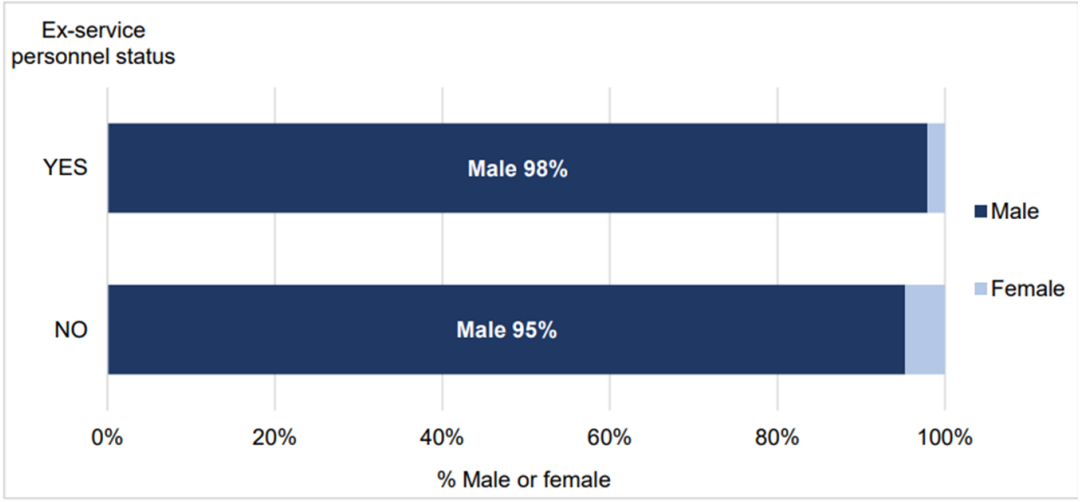
There is very limited data so it is difficult to draw any significant conclusions

An estimated 3.6% of the prison population in 2022 were ex-service personnel

Sex

- There is a higher proportion of males (98%) in the ex-service personnel cohort, than the non ex-service personnel cohort (95%)

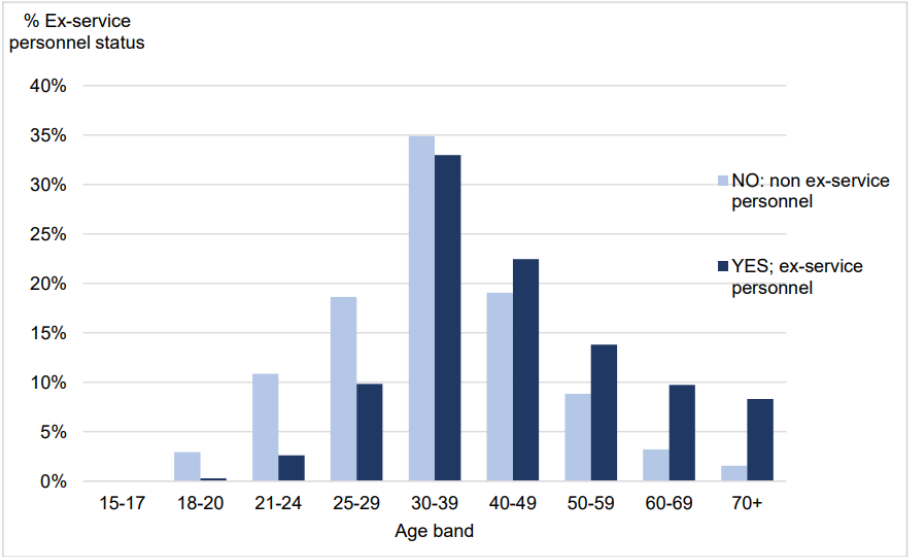
Figure 1: Matched prison population, by ex-service personnel status and sex



Age

- Those in the ex-service personnel cohort (mean age 45 years) are on average nine years older than those in the non ex-service personnel cohort (mean age 36 years).

Figure 2: Matched prison population, by ex-service personnel status and age group



Effect of National Service on age of population

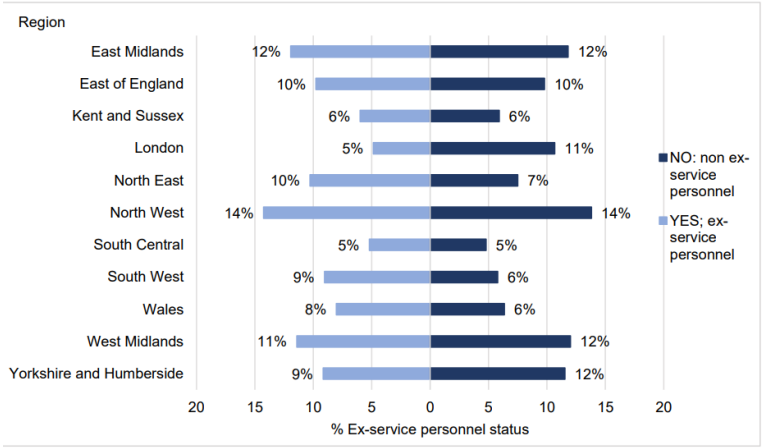
- The observed age difference is likely due in part to National Service.
- 1939 would have been in the eligible cohort for National Service in the UK (this equates to those aged 82 or over as at 30 June 2022).

- 2.7% of the ex-service personnel prison population group as at 30 June 2022 were born before 01 October 1939.
- This compares to just 0.1% of the non ex-service personnel group.

Prison region

- There is a difference in the distribution of ex-service personnel across the regions.
- The regions with the largest differences were London (5% of ex-service personnel and 11% of non ex-service personnel) and the South West (9% of ex-service personnel and 6% of non ex-service personnel).
- The larger representation of ex-service prisoners in the South West prisons may reflect veterans living close to large military locations (for example, the Devonport Naval Base and the Ministry of Defence Equipment & Support Headquarters are both in this area).

Figure 4: Matched prison population, by the percentage of ex-service personnel in each prison region



Specific prison distribution

- While across the whole prison estate, 3.6% of prisoners declare themselves to be ex-service personnel but some prisons have significantly more.
- The Verne, Haverigg, and Usk prisons have the highest proportion of ex-service personnel (12.1%, 11%, and 10.4% respectively).

This may reflect the specific functions of these prisons.

Offence type

- The 2010 DASA report found the most common offence type among veterans in prison to be violence against the person at 33%,
- followed by sexual offences at 25%
- and drug offences at 11%..

- Unfortunately, these offence types are not broken down into sub-groups, so limiting the understanding that can be gained from them

Offence type

- The DASA report provides a comparison by offence type of the general population against that of the Regular male veteran population aged 18-54.
- In almost every offence group, including violence against the person, the general population has a higher offending rate than the Regular veteran population.
- However, the one exception is with sexual offences where, adjusted for age, the latter has a 13% higher rate of imprisonment

Offence type

- The 2009 Napo report
- breakdown of types of offences of 90 case studies.
- The case studies are a non-randomised sample so any figures have to be treated with caution.
- The most common conviction was for violence in a domestic setting, featuring 39 times, with ‘other’ violence accounting for a further 18 cases.
- Approximately 11% involved an offence against a child and in most cases this was sexual.
- Napo reported five of the veterans were serving time as a result of serious driving offences.
- KCMHR found an increased rate of reporting of risky driving behaviour amongst those returning from Iraq.
- It is thought that this might be reflective of a general tendency for sensation seeking after the stimulation of deployment

Substance use

- Amongst the 90 case studies for the 2009 Napo survey
- 39 involved use of alcohol as a problem factor although not necessarily the direct reason for imprisonment.
- 13 cases, drug use was seen as a major issue.

Experience of combat

- There is sometimes an assumption that experience of combat increases the likelihood of violent behaviour post-Service.
- The available research on this provides little support for the assertion.

RBL

What to ask a Veteran

- Have you ever served in the Armed forces?
  - **Regular /Reservist**
  - **Service number**
  - **Who did they serve with?**
  - **Job/ trade?**
  - **Date joined and left** (why/how they joined/left)
  - What was their **rank** on leaving
  - **Deployments? Role** in deployment - combat role ?dual role ?Any particularly difficult events ?
  - Did they attend **DCMH?**
  - **Pre service vulnerabilities**
  - What **support** have they tried to get?
  - Request **consent** to get Military medical records

Resources- general

- Operation Courage
- Op Restore
- Op Nova
- Op Fortitude
- Op Prosper
- Royal British Legion- Gateway incl App
- Other charities -Combat Stress, Walking with the wounded etc
- Online – Togetherall

OpCOURAGE

THE ROYAL BRITISH LEGION

togetherall

COMBAT STRESS

WALKING WITH THE WOUNDED
Supporting Those Who Served