

## **Veterans' Health and Lifestyle Survey**

- Veterans who had served in and left Armed Services in 1970 or afterwards.
- Likely to be biased group with more health problems than Veterans in general, because Veterans with health problems more likely to volunteer to take part in survey than those without problems if they feel they have issues that are not been addressed, etc. 53 questionnaires completed late 2009, and 16 in-depth interviews conducted.
- In relation to the analyses of the questionnaires:
  - Only a half of Veterans (48%) knew about the 'fast-track' service.
  - Overall, 43% felt they did not have access to all the services they needed and 14% stated that they were reasons why they might not want to engage with local health services mainly as civilians did not understand (although total numbers not wanting to engage very small). There were comments about the delays in receiving care, and a hope that this would not be 'just another survey'.
  - Just under a half stated that they had depression or anxiety and the majority (87%) of these stated that this was related to their service.
  - Around one in four stated they suffered from post traumatic stress disorder (PTSD) and all thought this was related to their service.
  - One-quarter had problems controlling violence with the majority (83%) of these stating it was related to their service.
  - One-third had difficulty obtaining or maintaining a job and the majority (63%) of these stated that this was related to their service.
  - One in six stated they smoked too much, drank too much alcohol or ate unhealthily to help deal with stress and the majority of these felt that this was related to their service
  - Two-thirds had physical health problems (but this could be associated with age for many), and 79% of these with health problems stated that they felt these problems were related to their time in the Armed Services.
  - Overall, of the 51 Veterans answering these questions, 10 (20%) stated that they did not have any of the above health or lifestyle issues and 11 (22%) stated that they had "physical health problems" but none of the health or lifestyle issues.
  - Similar percentages attributed these health and lifestyle issues to other people they know who used to be in the Armed Services with the exception of lifestyle issues with much higher percentage attributing these factors to others.
  - All were registered with a GP and many had used local health services within the last year; 94% had seen a GP, 62% a practice nurse, 23% a community psychiatric nurse, 26% attended physiotherapy, 38% attended counselling, 31% attended a psychologist appointment, 71% attended a dental appointment, 19% had been to A&E, 53% had had an outpatient appointment, 39% a daycase appointment and 19% had been an inpatient.
  - Veterans were asked if they had sought help or advice from a professional within the last year or more than a year ago with regard to the various health and lifestyle issues above. Within the last year, 61% had sought help or advice for physical health problems, 36% for depression or anxiety, 33% for PTSD, 23% for problems controlling violence, 13% for employment problems, 23% for problems with family relationships and few had sought help or advice for lifestyle issues.
  - 53 completed questionnaires for post-1970 Veterans with wide age range (23 to 88) with mean age of 54 years, serving between 1-38 years (mean 16 years).
  - Compared to similarly-aged local health and lifestyle survey responders, much poorer general health and mental health status for Veterans, but similar prevalence for 5-A-DAY and alcohol although 17% stated that a relative or friend, or a doctor or other health professional has been concerned about their drinking or suggested they cut down. Fewer Veterans smoked and a higher percentage of Veterans exercised to national guidelines compared to the health and lifestyle survey responders.

## **Veterans' Health and Lifestyle Interviews**

**Learning Point 1:** Responses from Veterans and professionals suggested that the survey results might not be an accurate representation of the proportion of ex military personnel actually suffering from the physical impacts of military service due to the sample profile. Whilst there was overall recognition of the association of drinking, smoking and poor diet with the lifestyle of service personnel, this was thought to be countered to some extent by the fitness regime that existed in the services.

**Learning Point 2:** Alcohol (and drug) misuse was attributed throughout by Veterans and professionals alike to the cultural pressures of service life and to the alleviation of stress suffered when military service was at an end. There is a need for health professionals in primary healthcare to recognise that such behaviour or symptoms may well be masking other much deeper serious problems. There is an immediate need for the development of improved education (about the long-term physical effects of heavy consumption) and accessible (prompt) counselling to assist Veterans using alcohol and other substances to alleviate stress and anxiety, this should be a priority.

**Learning Point 3:** The impact of military service on family life was widely acknowledged. Assimilation into the family was often a problem after long absences and behavioural problems and unrealistic expectations exacerbated difficulties. There appears to be a general need for family counselling facilities and speedy access (particularly for partners) to advice and guidance at the point when difficulties arise. An information pack for families and a help-line number should be considered.

**Learning Point 4:** The need for resettlement advice, particularly in respect of employment and training was expressed frequently. Preparation for employment and civilian responsibility appears to be absent from the experience of most Veterans. There is a need for more support for those seeking employment, advice and guidance might be encompassed within a counselling service.

**Learning Point 5:** These two points alone (and there are others) show that the health needs of Veterans are not simply a health service provider's problem but are instead a city wide problem, involving stakeholders in all areas of provision: education; social services; employment; counselling; support groups; etc

**Learning Point 6:** Publicity and education increases demand for services and can help servicemen overcome the stigma that they feel exists in revealing illness and weakness related to service. Promotional work should be sustained.

**Learning Point 7:** Military personnel should be encouraged (both in and after service) to address their problems quickly and there should be clear routes to support. The development of an information pack provided before discharge from the army is essential. This should also be made available through doctors' practices for all Veterans registering for general medical services after leaving the military.

**Learning Point 8:** The existence of the 'macho' culture, and its attendant expectations of service men and women, was a major obstacle to seeking help for psychological problems. Mental illness was viewed as something that would be perceived as weakness by others. Health professionals should have further training to improve investigation of presenting symptoms and behaviours that might be treated superficially but often mask more serious underlying conditions. It is essential that those service providers seek understanding of problems not only from the Veterans themselves but also from their spouses/dependents.

**Learning Point 9:** Psychological well-being was affected badly by a lack of forward planning and an absence of advice and guidance in respect of resettlement. Personnel leaving the service without qualifications or plans for employment were often defeated and developed feelings of guilt and inadequacy. Signposting towards possible/suitable career paths with associated, relevant further education would reduce the impact of losing a lifestyle, camaraderie and a steady income. Partnership working between health, education and other providers should be considered in order that a holistic safety net is developed.

**Learning Point 10:** Whilst there is a general acceptance amongst many Veterans that anger and aggression develop in service personnel, there is evidence, inherent in the interviews that where education and life opportunities are available this impact is managed more effectively after discharge from the military. For many individuals with low academic and/or skills attainment and associated limited life/career opportunities, a 'macho' life where training for combat and institutional management, replace education and social development is likely to reinforce or exacerbate tendencies for anger and aggression that already were part of their characters. It is therefore essential that education, training and career planning for post-service lives are an integral part of military service and linked to further development in civilian situations. From a mental health perspective there should be the potential for referral to career advice, guidance and training initiatives.

**Learning Point 11:** Associated with the general requirement for more information about services, easy access to support and the development of understanding by staff within primary care services was the frequently identified requirement to have ex-military providing care in civilian settings. It is desirable that staff recruited to health service and health education roles, to give care and guidance to ex-service personnel, are either recruited on the basis that they have military experience and personal insight or are trained extensively to improve their understanding of the issues that impact upon Veterans.

**Learning Point 12:** It was clear that, once accessed, there were generally good levels of satisfaction with services that existed. The main problems existed in the primary contact and referral to appropriate services, understanding of the problems faced by Veterans, the information available and the links to care following discharge from the armed forces. It is essential that health and social welfare information is provided more promptly and disseminated to service personnel and Veterans more effectively. Health and social service workers need improved training to give them added insight into the problems and needs of Veterans. Local networks with opportunities for virtual (internet based) and face to face discussions would be a valuable resource for Veterans suffering social and economic isolation.

## **Conclusions**

The research confirmed the widely held professional view that a wide range of health issues associated with health issues related to Veterans' service in the armed forces exist. Hull appears to have developed an excellent set of interventions, some of which were well acknowledged by Veterans in receipt of services. That being said, considerable tasks remain in order to address the needs of Veterans, who for a variety of reasons have unresolved problems and little support. In particular:

- i) The need to train health service personnel in all aspects of Veterans' health issues and in particular:
  - Immediate recognition of Veterans at discharge from service careers
  - Investigation and understanding of symptoms – both apparent and hidden
  - Treatments: physical; psychological; psychiatric
  - Implications for families
  - Need for referral
- ii) The need for enhanced information for Veterans and their families on symptoms, services, access routes and networking
- iii) The need for 'an all party' recognition and solutions to the needs of Veterans by the PCT stakeholder partners including the city council and the 3<sup>rd</sup> sector.

## **Veterans' Health and Lifestyle Survey**

### ***Aims***

To describe physical and mental health status of Veterans who had served in and left the Armed Services in 1970 or afterwards, and examine if they felt their service had influenced their health and if they felt health needs were being addressed. The intention was to obtain as many completed questionnaires as possible, and to conduct in-depth interviews with 15-20 Veterans.

### ***Methods***

A press release was issued in August 2009 and Veterans who had left the Armed Services after 1970 were asked to contact SMSR, the research company undertaking the survey on behalf of NHS Hull, if they wanted to take part in the survey. Other people were approached directly where postal contact details were available through the National Gulf Veterans and Families Association (NGVFA) whose Head Offices are in Hull and who supported the survey, through a clinical psychologist at Humber Mental Health Trust and through the Membership of NHS Hull<sup>1</sup>.

Some questionnaires were completed by Veterans who had served and left the Armed Services prior to 1970. As at mid-October 2009, a total of 105 questionnaires had been received. Fifty-three were from Veterans who had left the Armed Services after 1970 and 47 from Veterans who had left prior to 1970 (with the remaining five not answering that question).

A Health and Lifestyle Survey was conducted in Hull during 2007 using a similar questionnaire to the one used subsequently in the Veterans' Survey. This survey involved over 4,000 adults living in Hull, and was broadly representative of Hull's population in terms of age, gender and geography (as well as employment and area based measure of deprivation). The full survey report is available on [www.hullpublichealth.org](http://www.hullpublichealth.org). The general characteristics of the Veterans can be compared with the general characteristics of the general population, such as self-report general health status, smoking prevalence, alcohol consumption, etc. As these characteristics tended to differ with age in the general population, the comparisons are made in relation to the age of the survey responders and the age of the Veterans.

### ***Data considerations***

Due to the way in which Veterans were approached (mainly membership of an organisation or through a clinical psychologist), the Veterans who took part in the survey are more likely to have problems or health issues associated with their Service. The many Veterans who did not feel they had health issues or health issues which they felt were associated with their service would have been less likely to be

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<sup>1</sup> Residents within Hull can become Members of NHS Hull, and they receive discounts from local retailers as well as newsletters. Around 60 members are known to be Veterans (although when they served was unknown) and these were contacted to ask if they would participate in the survey.

interested in taking part in the survey. Therefore, any findings need to be treated with caution. It is very unlikely that the Veterans who have taken part in this survey are a representative group relative to the general population of Veterans. Nevertheless, the Veterans who did take part in the survey may have physical or mental health issues which they feel that their service has caused or influenced, and can provide valuable information on this, and their contact with the health service, and provide information on ways in which the health service can improve their care from their perspective.

Not all the Veterans answered all questions, but in most cases the numbers of Veterans who answered each question is stated if there were Veterans who did not answer that specific question.

## Results

### Age and time in services

Of the 53 who had left the Armed Services after 1970, 50 were men and three were women. Their ages ranged from 23 to 83 years with a mean age of 54 years. Six were aged under 40 years, 13 aged 40-49 years, 17 aged 50-59 years, 10 aged 60-69 years and seven were aged 70 years or older (**Figure 1**). They had left the Armed Services between 1971 and 2008 (**Figure 2**). They has served between one and 38 years before they left the Armed Services, and served on average 16.2 years. One half of these Veterans had served between nine and 26 years (so quite a large variation in the number of years in the Armed Services). Their ages when they had left the Armed Services ranged from 21 to 58 years, with the mean age being 37.9 years, with one half of Veterans being between 31 and 43 years when they left the Armed Services.

Figure 1

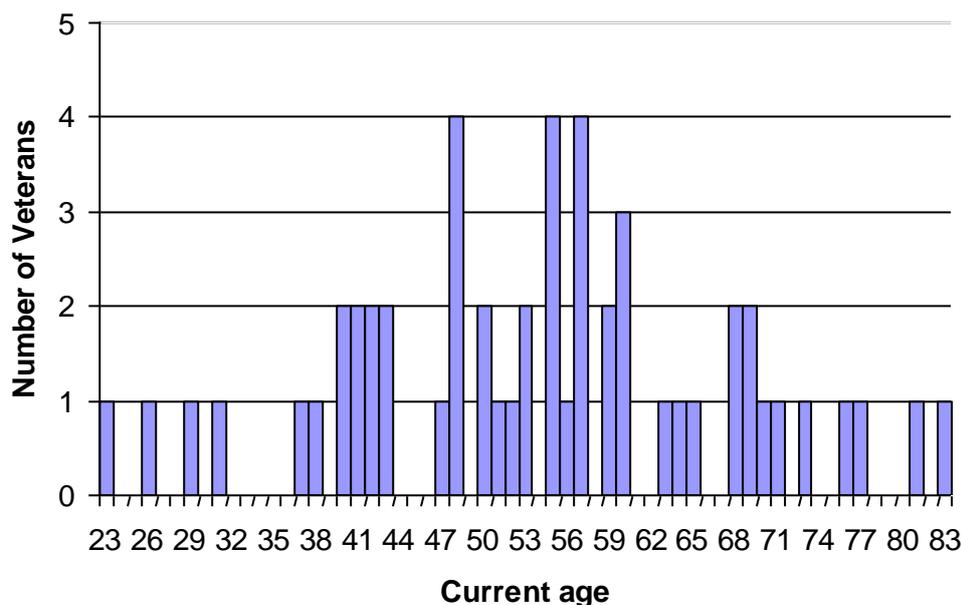
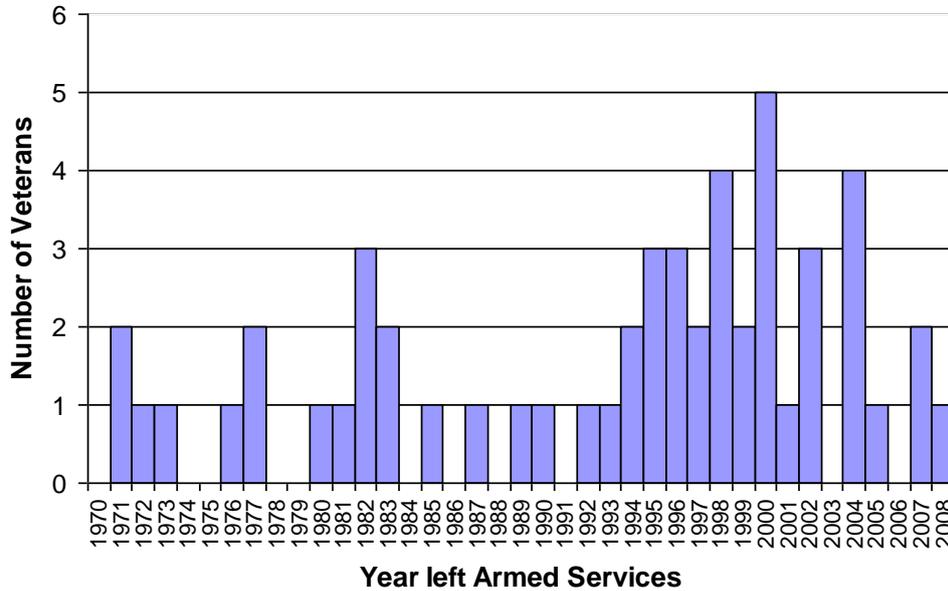


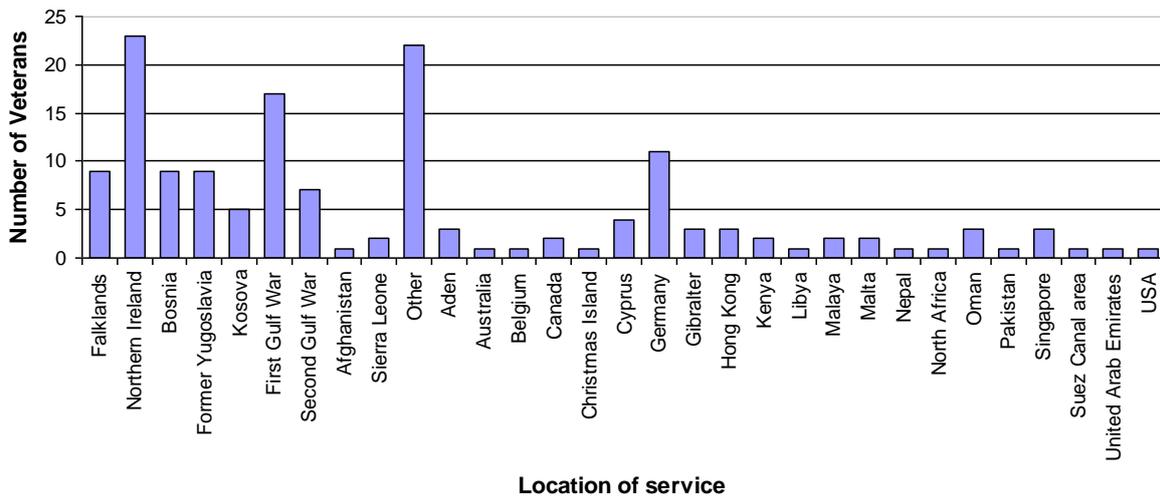
Figure 2



Where they served

Of the 51 Veterans answering the question, nine had served in the Falklands, 23 in Northern Ireland, nine in Bosnia, nine in Former Yugoslavia, five in Kosovo, 17 in the First Gulf War, seven in the Second Gulf War/Iraq, and three in Afghanistan or Sierra Leone, and 22 had serviced in ‘other’<sup>2</sup> places (**Figure 3**).

Figure 3



<sup>2</sup> It is likely that more Veterans could have served in the countries listed after the ‘other’ category than the actual numbers given in the figure. This is because these represent ‘free’ text where Veterans were asked to write all other places they had served in the box on the questionnaire, whereas the categories before the ‘other’ category were listed and would act as a reminder.

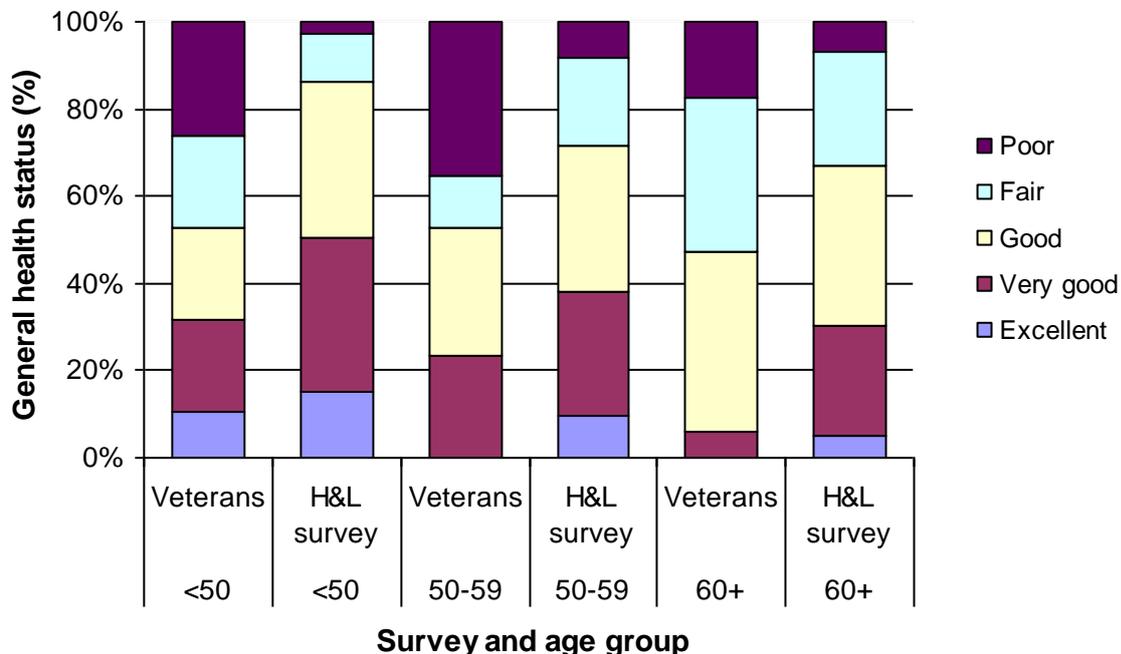
### General health

Two out of 53 (4%) described their health as “excellent”, nine (17%) as “very good”, 16 (30%) as “good”, 12 (23%) as “fair” and 14 (26%) as “poor”. Comparison with Hull’s local Health and Lifestyle (H&L) Survey reveals that the health of Veterans who participated in the survey is worse than that of the general population (**Table 1** and **Figure 4**). Over all age groups, three times as many people in the Health and Lifestyle Survey reported their health as “excellent”, and almost twice as many reported their health as “very good”, and more than five times as many Veterans reported their health as “poor” compared to the general population of Hull.

Table 1

Age	Survey	Number in survey	Self-reported health status (percentage)				
			Excellent	Very good	Good	Fair	Poor
<50	Veterans	19	10.5	21.1	21.1	21.1	26.3
	H&L	2,338	15.1	35.4	35.7	10.9	2.9
50-59	Veterans	17	0.0	23.5	29.4	11.8	35.3
	H&L	546	9.7	28.6	33.2	20.5	8.1
60+	Veterans	17	0.0	5.9	41.2	35.3	17.6
	H&L	1,094	5.2	25.2	36.4	26.4	6.8
All	Veterans	53	3.8	17.0	30.2	22.6	26.4
	H&L	3,978	11.6	31.6	35.5	16.5	4.7

Figure 4



Forty (75%) of the Veterans stated that they had an illness or disability which has lasted for longer than a month, with 30 of the 37 who answered the question stating that this illness or disability limited daily activities. Therefore, 30 out of 50 (60%) stated that they had an illness or disability which has lasted for longer than a month which limited daily activities. A higher percentage of the younger Veterans stated

they had an illness or disability which limited daily activities compared to the older Veterans (**Table 2**). As mentioned on **page 4**, Veterans who took part in the survey are more likely to have health issues and limiting long term illness or disability because they were or had been in contact with the NGVFA or had been seen by a clinical psychologist at Humber Mental Health Trust, and/or because they had a particular interest in Veterans' health perhaps because they themselves had a health problem.

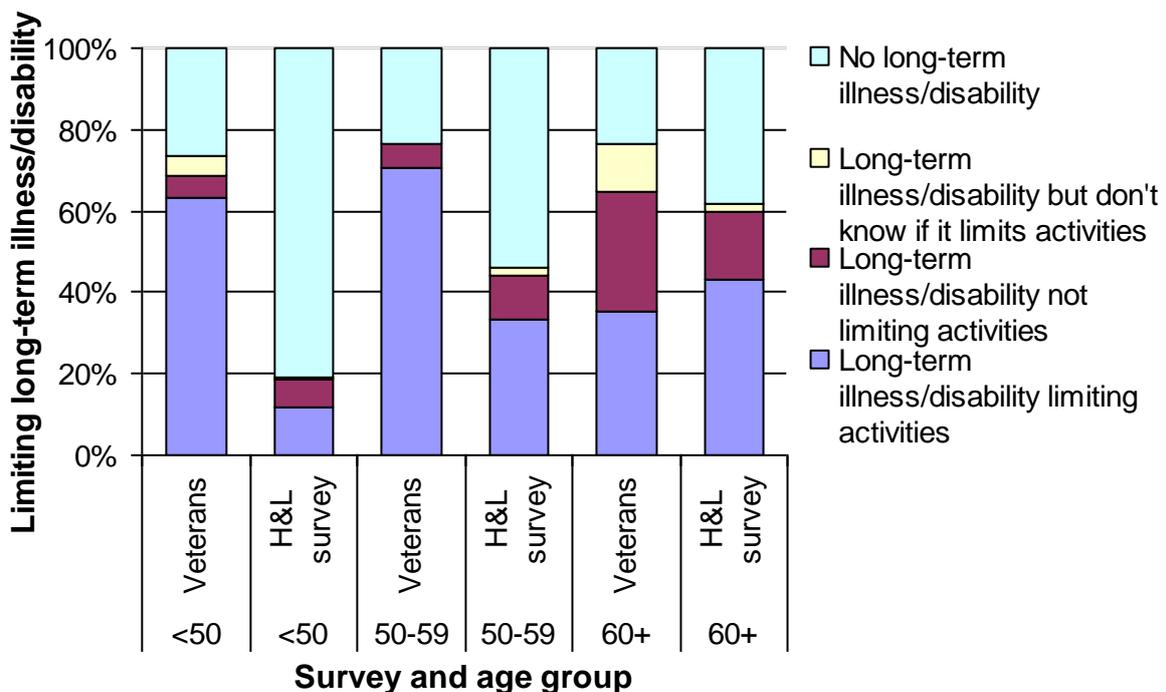
Table 2

Age group	Illness or disability lasting more than a month		This illness or disability limits daily activities*		Illness or disability lasting more than a month which also limits daily activities	
	Number ans. Q	Num. (%) stating 'yes'	Number ans. Q	Num. (%) stating 'yes'	Number ans. Q	Num. (%) stating 'yes'
<50	19	14 (74)	13	12 (92)	18	12 (67)
50-59	17	13 (76)	13	12 (92)	17	12 (71)
60+	17	13 (76)	11	6 (55)	15	6 (40)
All	53	40 (75)	37	30 (81)	50	30 (60)

\*Only those who stated that they had an illness or disability that had lasted more than a month were asked to answer this question.

Comparison with the local H&L survey reveals that Veterans, particularly those aged under 60 years have a much higher proportion with long-term illness or disability which limits daily activities (**Figure 5**).

Figure 5

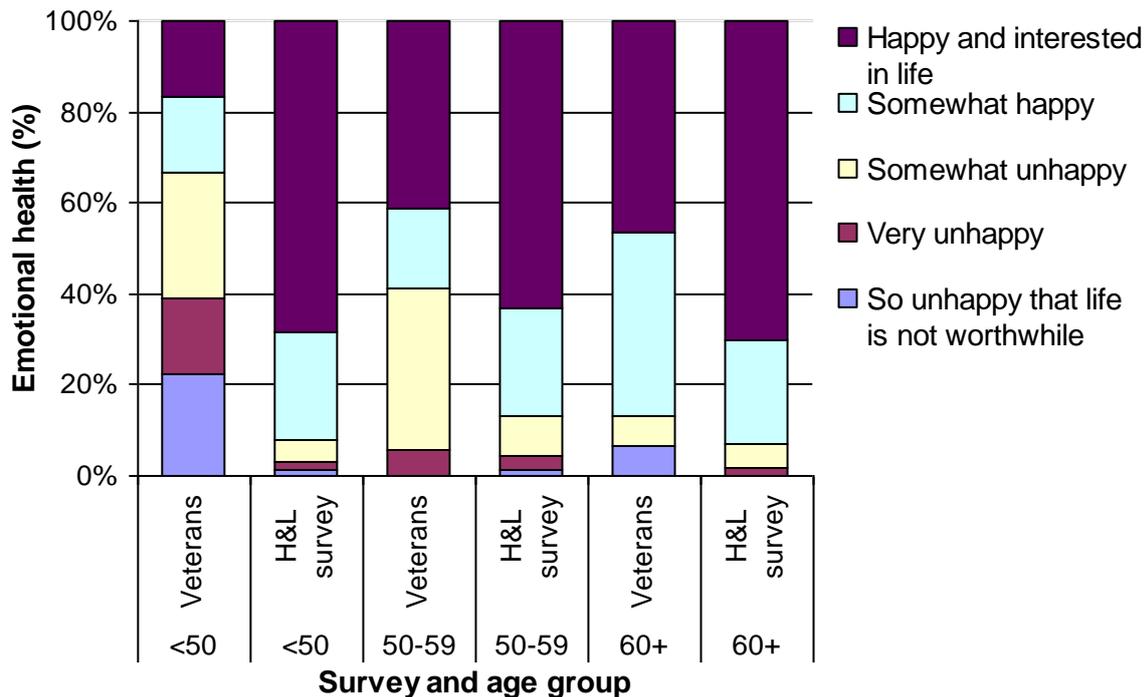


A total of 14 (28%) of 50 Veterans in the survey answering the question were registered as disabled (5 out of 18 (28%) for those aged under 50 years, 4 out of 15 (27%) for those aged 50-59 years and 5 out of 17 (29%) of those aged 60+ years). The 95% confidence interval (CI)<sup>3</sup> is 17.5% to 41.7% which is relatively wide. Despite the small number of Veterans participating in the survey, the percentage is significantly higher than that for the local H&L survey 2007 where 8.6% (95% CI 7.8% to 9.5%) were registered as disabled. Four percent of H&L survey responders aged under 50 years were registered as disabled, and 15% for those aged 50-59 and 60+ years.

*Mental health*

Veterans were asked how often they felt happy or unhappy. Of the 51 answering the question, 17 (33%) stated that they were “happy and interested in life”, 12 (24%) “somewhat happy”, 12 (24%) “somewhat unhappy”, 4 (8%) “very unhappy”, 5 (10%) “so unhappy that life is not worthwhile” and one did not know. The percentages “happy and interested in life” and “somewhat happy” were considerably higher in the local survey (**Figure 6**), and this was particularly the case when compared with the Veterans aged under 50 years.

Figure 6



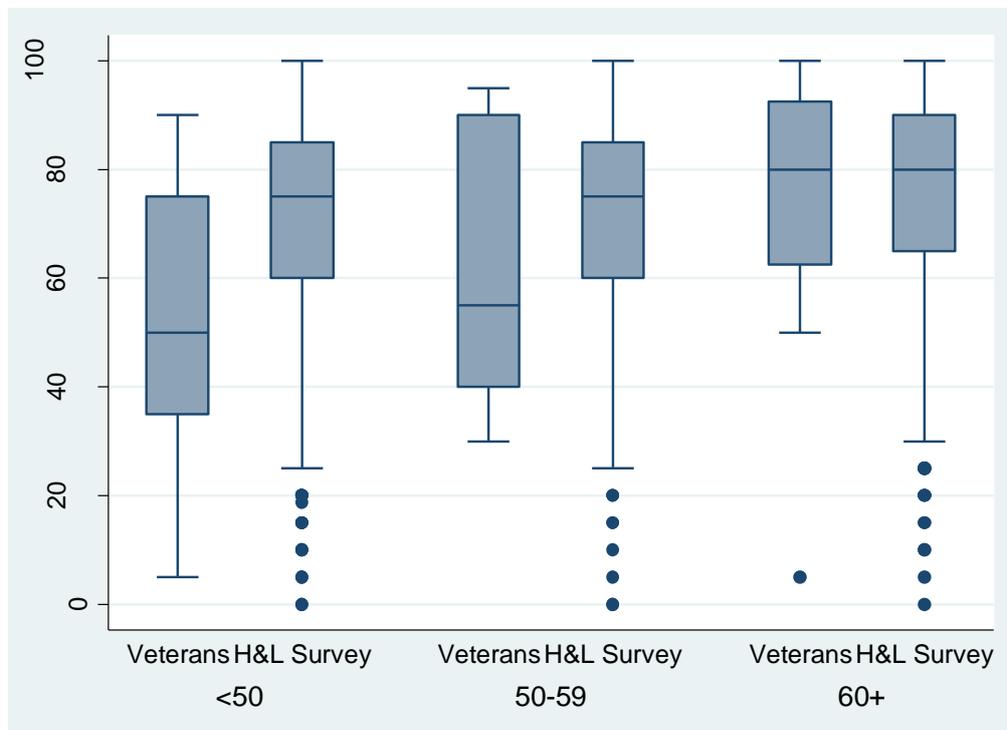
<sup>3</sup> The true underlying figure in the overall population is unknown, and we are attempting to estimate the figure with a survey. Another survey will give slightly different results due to slightly different Veterans being surveyed. To allow for this variability, confidence intervals give a range of values which should contain the true underlying percentage in the overall population 95% of the time (providing the survey responders are not a biased sample in relation to the overall population).

Veterans were also asked how often they felt fretful, angry, irritable, anxious or depressed. Of the 51 answering the question, 5 (10%) stated rarely, 21 (41%) occasionally, 15 (29%) often and 9 (18%) almost always (with one stating “don’t know”).

Of the 52 answering the question, 22 (42%) stated that they felt extremely fretful, angry, irritable, anxious or depressed to the point needing professional help, 25 (48%) stated that they did not, and 5 (10%) stated that they did not know.

Veterans were asked five questions from which the Mental Health Index could be calculated. The transformed Mental Health Index ranges from 0 to 100 with the highest score denoting the best mental health. The range of the scores for survey responders in the Veterans and H&L surveys are given in **Figure 7**. This boxplot illustrates the quartiles for the transformed Mental Health Index. The top and bottom of the boxes show the upper and lower quartiles respectively, where one-quarter (25%) of survey responders have a score higher or lower than the value shown. The line across the middle of the box illustrates the median where half of survey responders have a score less than this value and a half have a score more than this value<sup>4</sup>. The scores are lower denoting worse mental health for the Veterans for those aged under 50 years and 50-59 years, but the scores are comparable to the H&L survey responders for Veterans aged 60+ years. For example, around one-quarter of Veterans (denoted by upper quartile – top of box) aged under 50 years have a Mental Health Index score of around 75 or more, but for the H&L survey, half of survey responders aged under 50 have a score of 75 or more (denoted by the median – line across the box).

Figure 7



<sup>4</sup> The lines denote the range of values and the dots illustrate outliers (outside this range of values).

## Lifestyle

Forty-one (79%) and 14 (27%) of the 52 answering these questions stated that they had a healthy diet and ate five or more portions of fruit and vegetables per day respectively, which was similar to Hull's H&L survey (**Figure 8** and **Figure 9**).

Figure 8

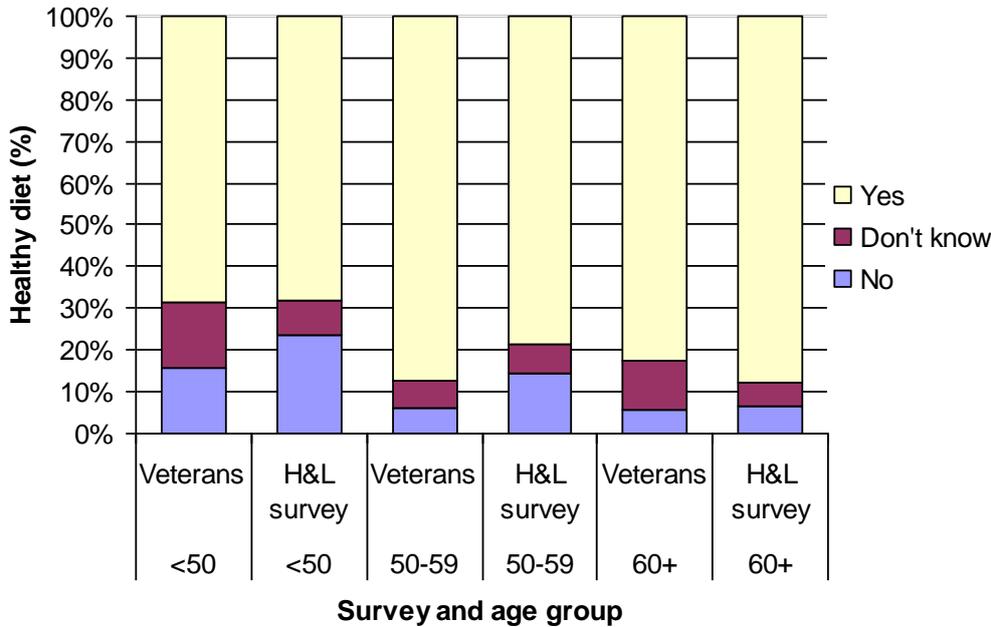
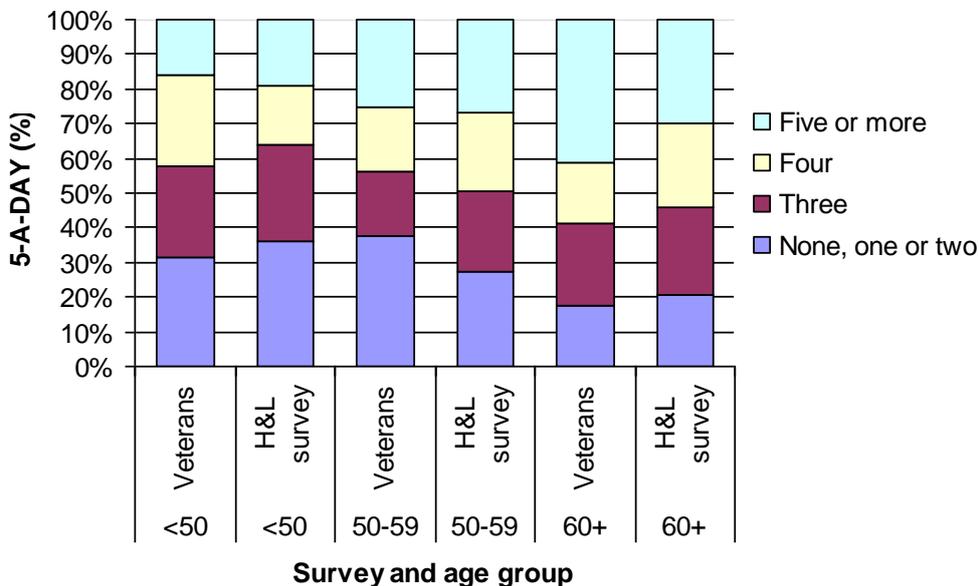


Figure 9



Six (12%) stated that they drank alcohol everyday, 4 (8%) drank alcohol 4-6 days a week, 13 (25%) drank alcohol 1-3 days a week, 12 (23%) 1-3 days a month, 12 (23%) less than once a month and 5 (10%) never drank alcohol. Veterans drank alcohol slightly more frequently than H&L survey responders, but the differences were small (**Figure 10**). A higher proportion of Veterans exceeded the weekly

alcohol units recommendation (**Figure 11**), but the proportion binge drinking was similar to the H&L survey. Of the 47 Veterans that did drink alcohol, 10 (21%) exceeded 8+ units (or 6+ units for women) in a single day at least once a week. Of the 47 who drank alcohol, 8 (17%) said that a relative or friend or a doctor or other health worker has been concerned about their drinking or suggested they cut down (seven during the last year and one stated this was the case but not in the last year).

Figure 10

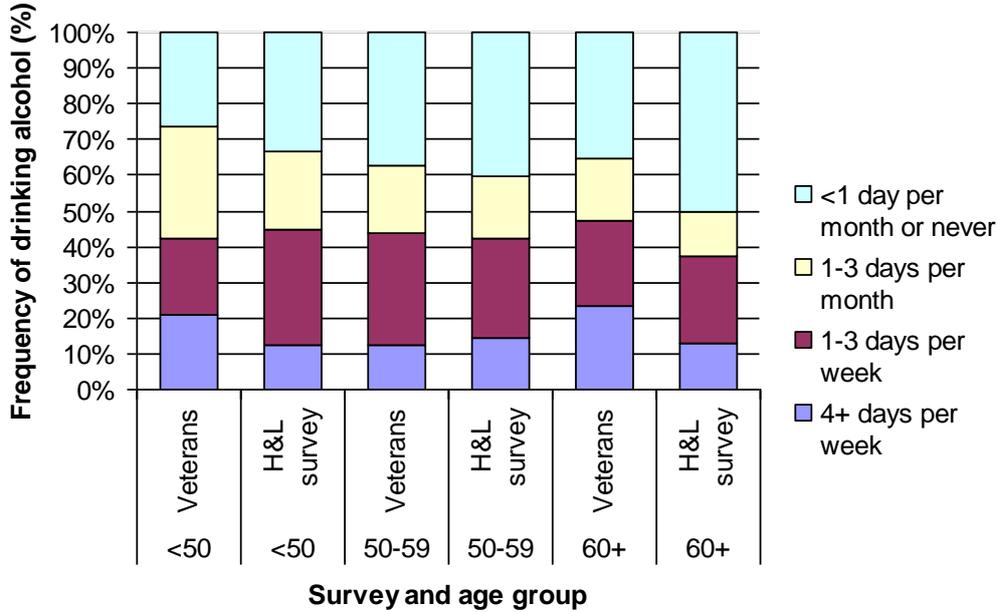
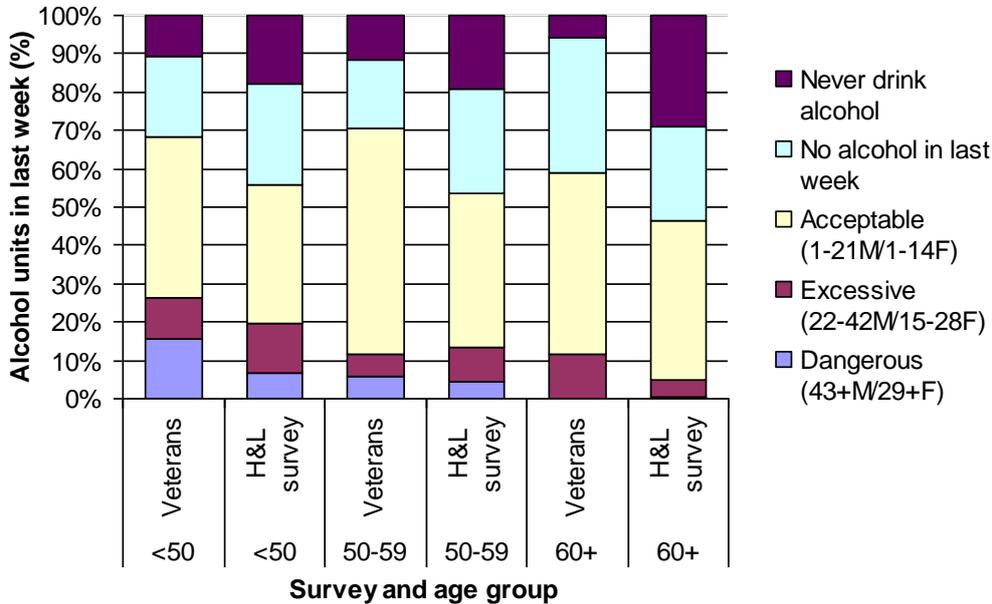


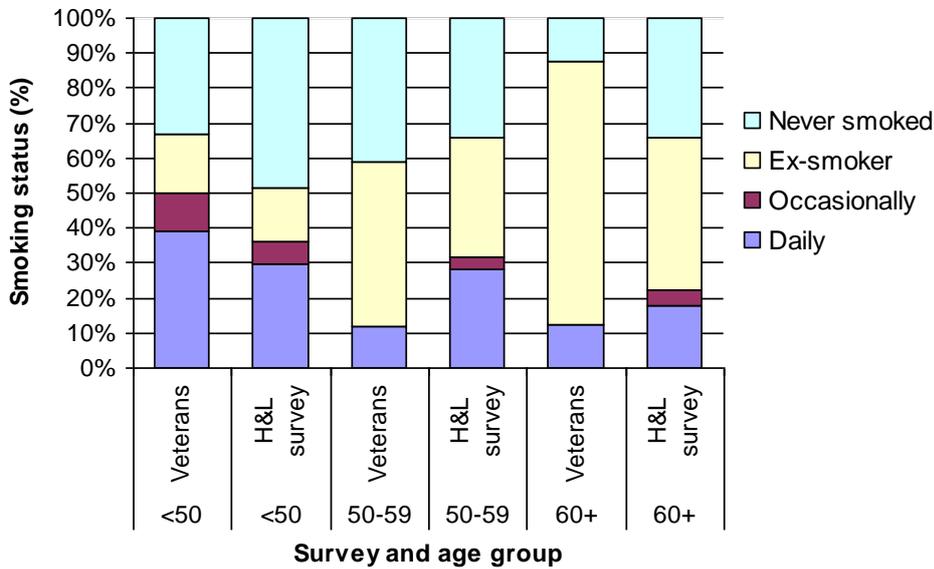
Figure 11



Twelve (23%) out of 52 answering the question had smoked in the previous week, which is the same or perhaps lower than in Hull H&L survey (31% in the survey but lower for the older groups). Eleven (22%) out of 51 smoked daily, 2 (4%) smoked but not every day, 23 (45%) used to smoke and 15 (29%) had never smoked. The prevalence of smoking is lower than in the H&L survey for Veterans 50+ years

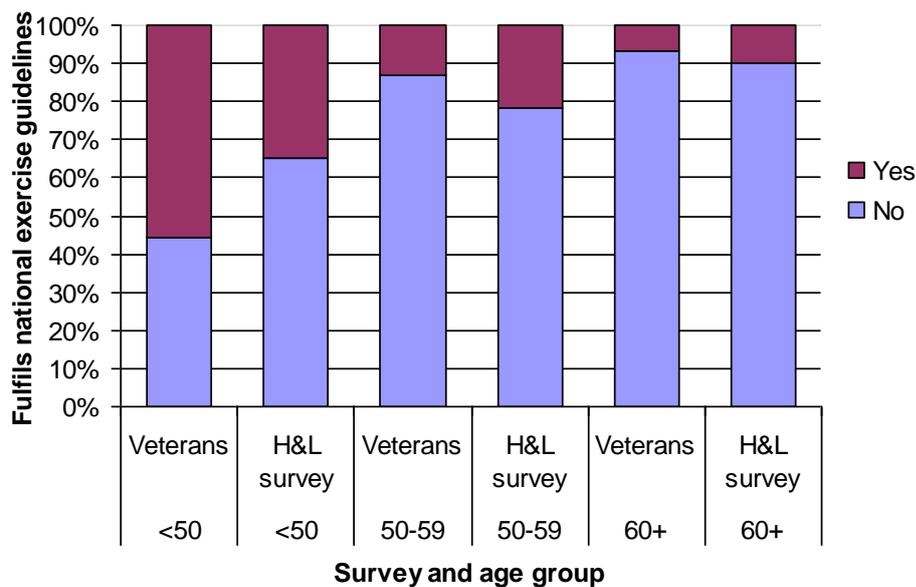
(**Figure 12**). However, half of Veterans aged under 50 years smoked daily or occasionally compared to 36% for survey responders in the H&L survey.

Figure 12



Thirteen of the 48 (27%) answering the question stated that they undertook 30 minutes of vigorous or moderate exercise on at least five occasions per week (national exercise guidelines) which was similar to the H&L survey, however, this overall figure masked large variations among the three age groups. Over half of Veterans aged under 50 years (56%) fulfilled the national exercise guidelines compared to 44% for the H&L survey, but in the Veterans aged 50-59 and 60+ years, 13% and 7% respectively fulfilled the national exercise guidelines compared to 22% and 10% for the H&L survey respectively (**Figure 13**).

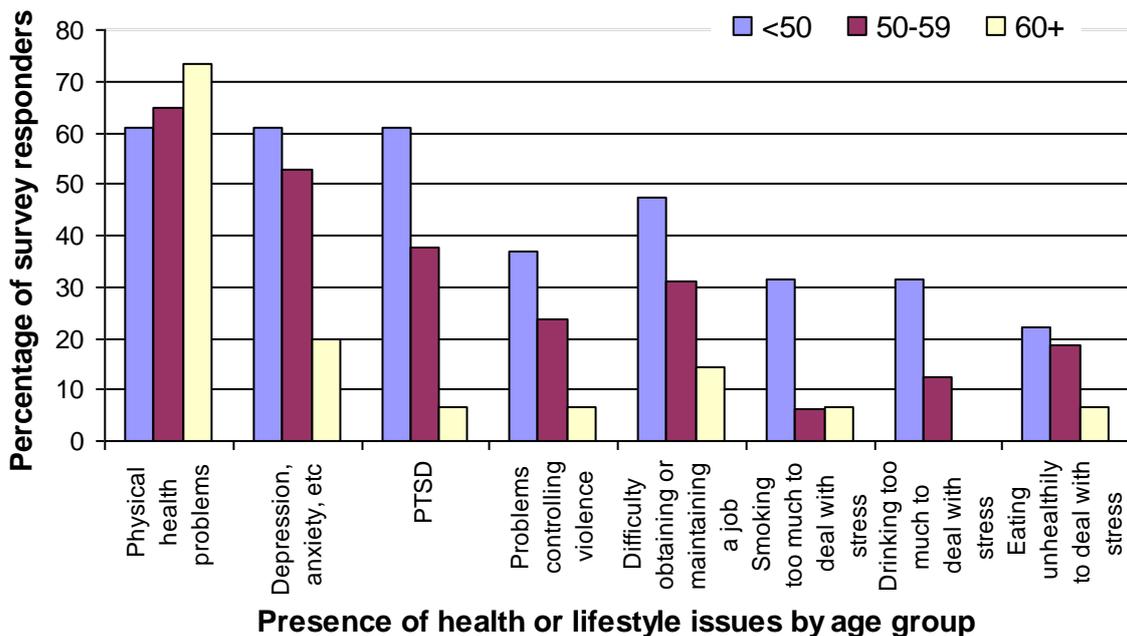
Figure 13



### Health issues

Veterans were asked if they felt they had various health or lifestyle issues. Around 50 answered each question but the exact number differed for different questions. Some Veterans will have answered yes to more than one different health or lifestyle issues. Thirty-three (66%) stated they had physical health problems, 23 (46%) that they had “depression, anxiety, etc”, 18 (37%) post traumatic stress disorder (PTSD), 12 (24%) problems controlling violence, 16 (33%) difficulty in obtaining or maintaining a job, 8 (16%) “smoked too much to help with stress etc”, 8 (16%) “drank too much to help with stress etc”, and 8 (16%) “ate unhealthily diet to help with stress etc”. Two of the 53 Veterans did not answer any of the question in this section, 10 out of the remaining 51 (20%) stated that they did not have any of these health or lifestyle issues, and a further 11 (22%) stated that they had “physical health problems” but none of the other health or lifestyle issues. Whilst older Veterans were more likely to have physical health problems, the younger Veterans were more likely to have depression or anxiety, PTSD, problems controlling violence, more problems obtaining employment (although some of the older Veterans will not be in or seeking employment), and also smoking and drinking alcohol too much to help cope with stress (**Figure 14**).

Figure 14



Those who stated that they had any of the above health and lifestyle issues were asked if they felt this impacted on their family. Forty people answered this question, so all except one person who had answered “yes” to any of these health and lifestyle issue and the this one person had “physical health problems” only so perhaps felt that this question did not apply to them. Twenty-eight (70%) stated that they felt there was a negative effect on their family (four of whom had physical health problems only), 6 (15%) stated that there was no negative effect on their family (five of whom had physical health problems only), three did not know and three gave the response “not applicable (don’t have family)” (one of whom had physical health

problems only). If those with physical health problems were excluded, then of the 30 Veterans stating that they had one or more of the other health or lifestyle issues listed, 24 (80%) stated that they felt the issue(s) had a negative effect on their family.

For those aged <50, 50-59 and 60+ years, **Figure 15**, **Figure 16** and **Figure 17** respectively illustrates the percentages having combinations of physical problems, emotional problems (depression/anxiety and/or PTSD), problems with controlling violence or problems with obtaining or maintaining a job, and problems with lifestyle relating to dealing with stress (smoking too much, drinking too much alcohol, taking drugs and/or eating unhealthily). The information is also classified depending on whether they felt this health and lifestyle issues had a negative impact on their family (blank = no/missing; \* = yes; \*\* not applicable (don't have family); and \*\*\* don't know).

Only two of the 19 Veterans aged <50 years had none of these health and lifestyle issues. The majority of the rest felt that their health and lifestyle issues did have a negative influence on their family. Five of the 19 had all four of these grouped health and lifestyle issues, and a further five had three of these health and lifestyle issues.

Four of the 17 Veterans aged 50-59 years had none of these health and lifestyle issues. As with those aged <50 years, the majority of the rest felt that their health and lifestyle issues had a negative impact on their family. One stated that they had all four, and a further six had three of the grouped health and lifestyle issues.

Four of the 15 Veterans aged 60+ years who answered the questions had none of these health and lifestyle issues, and a further seven had physical health problems only (with four stating that they did not have a negative influence on their family). Three had physical health problems and either emotional health issues or problems with controlling violence / problems with their employment, and one Veteran aged 60+ years had all four of the grouped health and lifestyle issues.

Therefore, the majority of the younger Veterans in the survey did have health and lifestyle issue that impacted negatively on their family, whereas the older Veterans with the exception of physical health (which might be due to aging anyway) had fewer health and lifestyle issues and generally felt that any issues that they did have did not have a negative impact on their family.

Figure 15

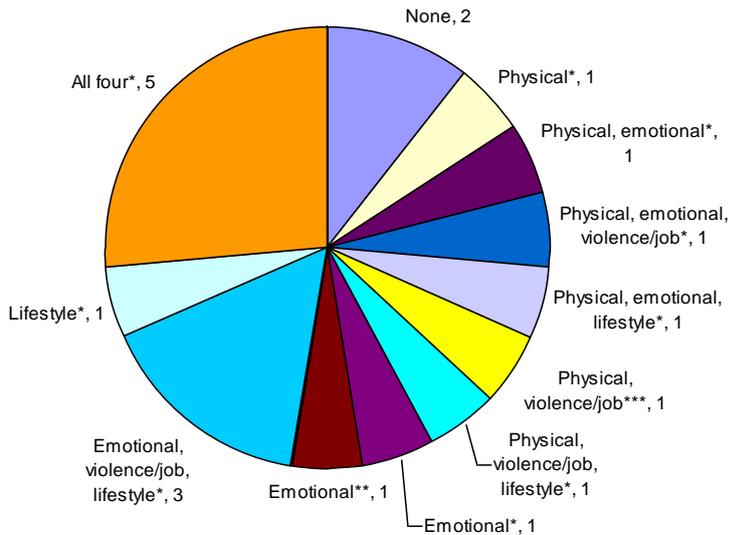


Figure 16

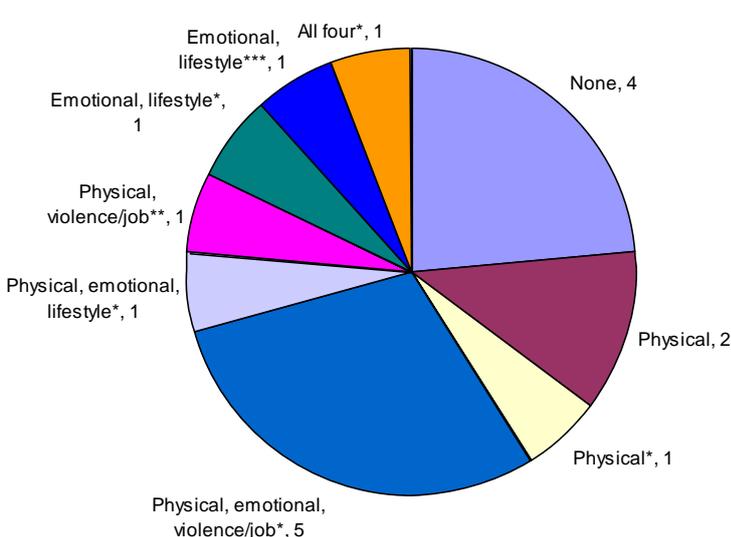
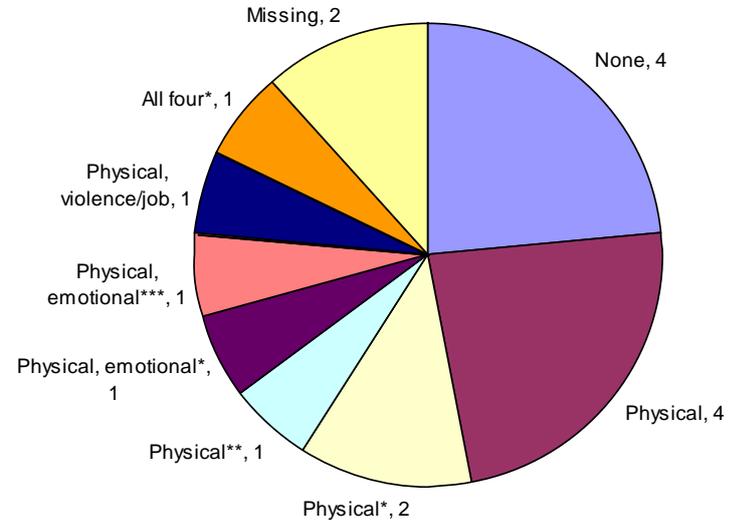


Figure 17

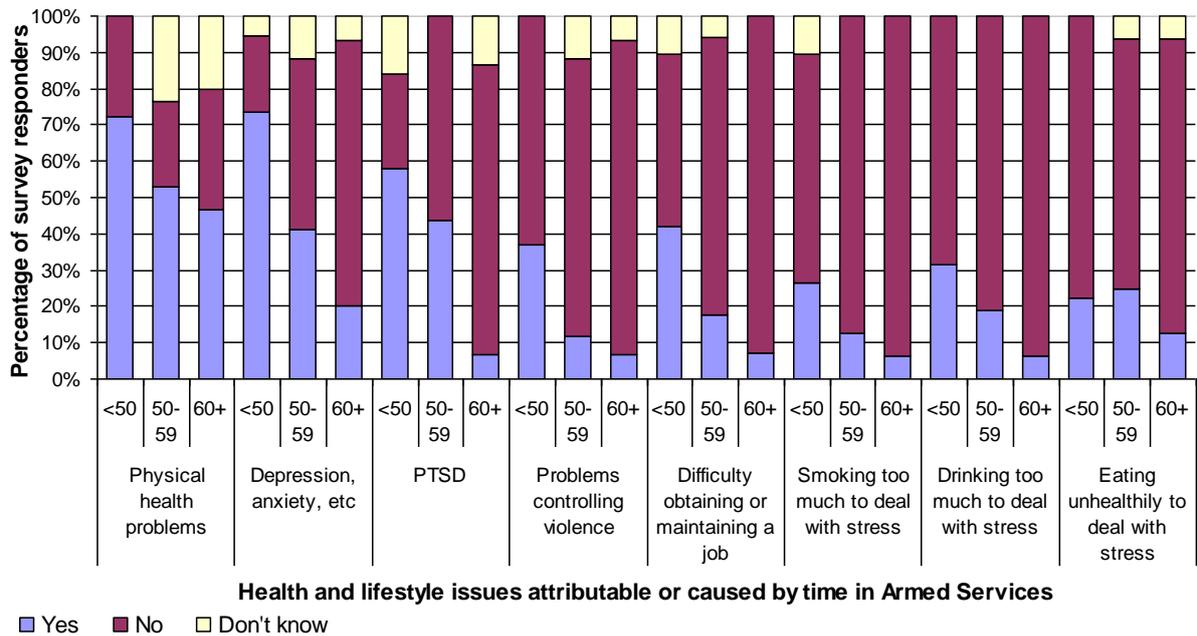


Veterans were also asked if they know of anyone else who used to be in the Armed Services who they thought had any of the health and lifestyle issues, and between 44 and 48 Veterans answered these questions (exact number differed for each question). The responses were very similar to themselves for physical health problems, depression/anxiety, PTSD, problems in controlling violence and difficulty in obtaining or maintaining a job. The only differences were for lifestyle issues with the percentage attributing smoking too much, drinking too much, using drugs and eating unhealthily to others to help with their stress being considerably higher (around 40% for smoking and drinking and around 30% for drugs and diet). Twenty-nine of the 34 who answered the question, thought these issues had a negative effect on their friends/colleagues family. Therefore, Veterans were more likely to attribute lifestyle issues to others than they were to themselves.

Veterans were asked if they felt any health or lifestyle issues were attributable or caused by their time in the Armed Services. Between 50 and 51 answered these questions with some answering that they did not know. Twenty-nine (58%) thought physical health problems were attributable to their time in the Armed Services, 14 (28%) stating that they were not and the remaining seven stating that they did not know. Twenty-four (47%) stated that depression/anxiety was related to the service, 23 (45%) did not and the remaining four did not know. Nineteen (38%) stated PTSD was related to the service, 26 (52%) stated no, and five did not know. Ten (20%) stated that problems with violence was related to their service, 38 (75%) stated not and three did not know. Twelve (24%) stated that they had problems maintaining a job due to their service, 35 (70%) stated not, and six did not know. Eight (16%) smoked too much, 10 (20%) drank too much alcohol, three (6%) took drugs and 10 (20%) ate unhealthily to help deal with stress etc.

The majority of Veterans aged under 60 years thought that their physical health problems were attributable or caused by their time in the Armed Services, and the majority of those aged under 50 years attributed their depression and anxiety and PTSD to their time in the Armed Services, and around 40% of those aged under 50 years attributed problems with controlling violence and difficulty in obtaining or maintaining a job. Around one-third of fewer of Veterans aged under 50 attributed lifestyle issues to their time in the Armed Services. Older Veterans were less likely to attribute health and lifestyle issues to their time in the Armed Services than those aged under 50 years, and this was particularly the case for Veterans aged 60+ years (**Figure 18**).

Figure 18



### Use of health services

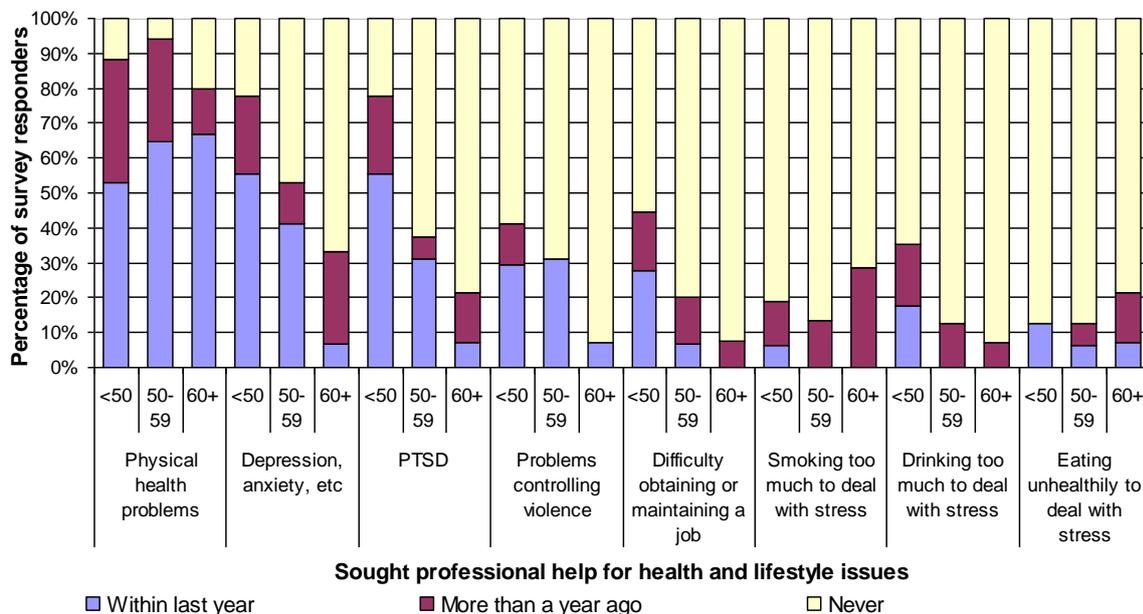
All 53 were registered with a GP. Between 47 and 49 stated whether they had used any health services within the last year (with slightly more answering the question about seeing the GP or practice nurse). The majority (48; 94%) had visited their GP in the last year, 31 (62%) had seen the practice nurse, 11 (23%) had seen a community psychiatric nurse, 12 (26%) had attended a physiotherapy appointment, 18 (38%) had attended a counselling appointment, 15 (31%) had attended a psychologist appointment, 35 (71%) had attended a dental appointment, 9 (19%) had attended A&E, 26 (53%) had attended an outpatient appointment, 19 (39%) had attended a daycase appointment and 9 (19%) had been admitted as an inpatient within the last year.

Veterans were asked if they had received professional help or advice for any of the health and lifestyle issues. Between 45 and 50 answered the questions depending on the question. Thirty (61%) had sought professional help or advice within the last year about physical health problems, 13 (27%) more than a year ago and 6 (12%) never. Eighteen (36%) had sought help in the last year for depression/anxiety, 10 (20%) more than a year ago and 22 (44%) never. Sixteen (33%) had sought help within the last year for PTSD, 7 (15%) more than a year ago and 25 (52%) never. Eleven (23%) had sought help within the last year for problems with controlling violence, 2 (4%) more than a year ago and 34 (72%) never. Six (13%) had sought help in the last year with problems in obtaining or maintaining a job, 6 (13%) more than a year ago and 34 (76%) never. Three (6%) had sought help within the last year for drinking too much alcohol, 6 (13%) more than a year ago and 38 (81%) never. Very small numbers had sought advice or help in the last year for smoking too much or with taking drugs, but nine in total (20%) had sought advice at some point in time for smoking too much, and 5 (10%) had sought advice at some point in

time for taking drugs. Four (9%) had sought advice within the last year about eating unhealthily, 3 (7%) more than a year ago and 38 (85%) never. Eleven (23%) had sought advice within the last year about problems with family relationships, 3 (6%) more than a year ago and 33 (70%) had never sought advice for problems with family relationships.

Over half of Veterans aged under 50 years had sought professional help within the last year for depression or anxiety and for PTSD, and around 30% for problems with controlling violence, and slightly less for difficulty in obtaining and maintaining a job. Around 10% or fewer of Veterans aged under 50 years had sought help for their smoking or diet, but just under 20% had sought professional help for the drinking. With the exception of physical health and for problems controlling violence for those aged 50-59 years, fewer Veterans aged 50-59 and 60+ years had sought professional help for these health and lifestyle issues within the last year (**Figure 19**).

Figure 19



### Working status

Twenty of the 50 answering the question (40%) were working (although three additionally stated in the not working section that they were in full-time education, retired and had an 'other' employment situation). Of the remaining 30, 13 (43%) were retired, 15 (50%) unable to work because of long-term sickness or disability with the remaining Veterans stating they were unemployed or in full-time education.

### Interactions with others

Thirty-six of the 52 answering the question (69%) were married or co-habiting with a partner. All Veterans answered the three questions asking about frequency of speaking to non-household family, friends and neighbours. Thirteen (25%) spoke to family every couple of months or less including four who spoke to family once or twice a year or less. Eleven (21%) spoke to friends every couple of months or less

including four who spoke to friends once or twice a year or less. Thirteen (25%) spoke to neighbours every couple of months or less including five who spoke to neighbours once or twice a year or less. However, combining responses, the majority (47; 91%) spoke to family, friends and/or neighbours at least weekly. Of the five that did not, all spoke to family, friends and/or neighbours once or twice a month, and all but one was married or living with a partner.

Sixteen (30%) had no friends or family that they felt close to living within a 15-20 minute walk or 5-10 minute drive not including the people who lived with them, and 11 of these Veterans were married or living with a partner.

#### *Access to health care*

Twenty-five (48%) stated that they did know the 'fast-track' service existed and 27 (52%) did not. Twenty (39%) stated that they did have all the services necessary to treat the medical conditions that they felt were related to their time in the Armed Services, whereas 22 (43%) did not with 9 (18%) stating that it was not applicable as they had no medical conditions related to their time in the services. Seven (14%) stated that there were reasons why they might not want to engage with local health services in order to treat the conditions they felt were related to their time in the Armed Services, 34 (67%) stated there were no reasons why they would not want to engage with local health services, and 10 (20%) stated that it was not applicable as they had no medical conditions related to their time in the services. There were mixed responses to the open questions, but a general theme that civilians did not understand their issues or the things that had happened to them, and some had experienced long delays for treatment.

## **Veterans' Health and Lifestyle Interviews**

The following extract comes directly from the report produced by Ian Mills at SMSR, the company who undertook the survey and the interviewers on behalf of NHS Hull.

Following the postal survey, which examined the health requirements of Veterans in the area, face-to-face interviews were conducted to add depth to the survey findings.

The interviews were structured to provide the interviewee with some insight into the survey findings and an opportunity to add their own experience to the statistical findings.

Interviews were carried out by a team of experienced interviewers and all participants were asked to provide a summary of their military service and to say whether they had acquired any health problems during their service or as a consequence of their service after they returned to civilian life.

Sixteen Veterans and three professionals associated with Veterans were interviewed during early 2010.

### ***Physical health and lifestyle***

Veterans taking part in interviews were asked a series of questions related to their own physical health since leaving military service and their perceptions of the impact of physical problems on their own lives and other Veterans of their acquaintance.

### ***Personal health***

#### ***General health***

Most of those interviewed had reasonably good health themselves but where physical health problems were identified it was clear that they had a deleterious impact on the lifestyle of the individuals concerned.

Veterans who said that they were healthy appeared to be those who had managed to maintain an exercise and fitness regime that was learned in service. Some said that they had benefitted in this respect and were pleased that their service experience had a long term, positive impact on their health.

There was a view expressed that any actual differences in the health and fitness of Veterans (when compared unfavourably with civilians) was probably related to the unsettled lives and high stress levels of those in active service. It was also suggested that judgements about one's own health and fitness were likely to be subjective and that many Veterans who felt that they were unhealthy might have had unrealistic expectations of maintaining fitness into old age.

### *Smoking and drinking*

Common health and lifestyle problems in Veterans were thought to be associated with a smoking/drinking culture that existed both in and out of service.<sup>5</sup> Veterans suggested that personnel were not prepared mentally for situations like Iraq and Afghanistan and because the potential difficulties were never discussed, individuals bottled up their anxieties. Whilst alcohol and smoking helped in service situations, underlying health and behavioural problems emerged on discharge<sup>6</sup>.

### *Diet*

Though half of the Veterans claimed that they ate healthily there was a great deal of evidence that some did not fully understand the constituents of a balanced diet. Some commented that soldiers developed bad habits whilst in service as they were not encouraged to eat properly and were not provided with a healthy diet whilst in service. They referred to the common provision of steaks, big breakfasts and fat which were regular features of the service diet.

### *Alcohol*

Alcohol consumption was referred to throughout the interviews as a cultural norm. It was considered to be an integral part of service life where people worked and played hard; fitting into that macho (largely male) culture was necessary. Of those interviewed however most drank moderately and several reported that consumption was reserved for weekend drinking bouts. Some however consumed alcohol on a daily basis and in quite large quantities.

It was widely believed that a heightened level of alcohol consumption among Veterans was due to a necessity to block out problems and alleviate stress. More than one individual pointed out that on the whole service personnel returned to a culture where everything was an excuse for excessive alcohol consumption: births, weddings, christenings, birthdays, deaths were all occasions when the general public tended to over imbibe.

The issue of unsafe levels of consumption was low on the list of concerns of most ex-servicemen but consumption was positively influenced by successful re-settlement into responsible work roles.

Most of those interviewed had either never smoked or had given up smoking because of health considerations. There was agreement that many servicemen did smoke heavily and one serviceman said that he had smoked incessantly in Iraq because they were cheap and helped cope with stressful situations.

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<sup>5</sup> It was suggested that the existence of a macho hard-drinking lifestyle was often denied by the MOD.

<sup>6</sup> Healthcare was described as 'better' in the RAF than in the army. Veteran said that the RAF believed in keeping whole families happy.

### *Service impact*

Veterans interviewed attributed a variety of their own health issues and behaviours to their service experience. These included aggression and violence; drinking unwisely; integration into family and social situations.

### ***Broader perceptions of Veterans' health (self & others)***

#### *Overall*

As might have been predicted, the views of Veterans on the wider impacts of military service on ongoing physical health of Veterans were somewhat mixed. Though some were either unsure or reluctant to accept that over half of Veterans with health problems attributed them to military service, others agreed that it was probably true.

#### *Physical*

The majority of interviewees had not suffered personally with service related physical problems and some held the view that the incidence of illnesses suffered by ex-military was similar to and had the same frequency as physical conditions affecting civilians.

Veterans said that generally the health impacts of a physical nature were largely dependent upon individual service situations. In some campaigns<sup>7</sup> for instance, the body was subjected to huge stresses and strains which were not an element of everyone's experience.

Some described their own problems and outlined specific physical problems suffered by others. The nature of problems identified ranged from hearing impairment suffered by personnel in conflict or artillery exercise situations, to chronic conditions such as osteoporosis affecting backs and knees of soldiers who had seen active service. Though some Veterans said they had no service related health and lifestyle problems there were many who knew of others who had.

#### *Other issues*

Some had acquaintances with problems linked to a variety of issues which included the effects of institutionalisation, PTSD, Gulf War Syndrome and unemployment. Others knew other Veterans, or had worked with personnel, who had suffered physical trauma including loss of limbs and other injuries or illness that meant they were dependent on wheelchairs for mobility.

Those interviewed expressed common views about the existence of behavioural patterns and a tendency for ex-servicemen to behave similarly when faced with problems of resettlement. Some knew people from the services who had

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<sup>7</sup> Iraq and Afghanistan were identified as conflict situations which had negative impacts on physical health

experienced problems in relation to civilian life and had drifted into alcohol and substance misuse.

Others had friends who experienced real financial hardship related to health problems acquired whilst in service and these had resulted in depression and relationship breakdowns.

### ***Reasons for reports of poor physical health in Veterans***

When questioned about the reasons for reports/incidence of poorer health in Veterans, individuals gave a range of reasons, some of which were associated with the lifestyle that was adopted by service personnel. It was again pointed out that the consumption of alcohol had played a major part in the lives of many Veterans.

Interestingly, though some individuals reported on-going health benefits related to physical fitness gained through military training, others considered that factors like exposure, hard physical training and carrying heavy loads had created strain and damaged parts of the body.

It was believed that the army, in general, treated all service personnel as though they had the same physical abilities and strength and expected that all bodies would respond in the same way to training.

#### *Diet*

Additionally, the poor (army) diet was considered to be a contributory factor to ill-health amongst Veterans and was referred to by one participant as 'laden with fat.'

#### *Climate*

Other physical health issues were thought to be associated with life in different climates like the acquisition of long term illnesses like malaria.

### ***Impact of health and lifestyle problems on families***

Veterans were invited to speculate on the general negative effects on families of Veterans' health and lifestyle problems and explained that the negative impacts of military service on families were linked to a variety of factors.

#### *Expectations*

It was said that ex-service personnel often left service life with unrealistic expectations of the future, themselves and others and had forgotten how to behave in both family and social situations.

### *Relationships*

Relationships, already compromised by long periods of separation during service were difficult to re-establish and in many cases feelings of disappointment and disillusionment were compounded by the psychological impacts of previous experience.

### *Unemployment/skills/qualifications*

Though some had managed resettlement with minor difficulties, the disappearance of the secure structures of service and the difficulties for many of finding well-paid, rewarding employment resulted in feelings of insecurity and guilt for others.

Some Veterans had worked in responsible situations for two decades or more but found that their skills were not useful beyond military service and, without qualifications a successful entry into civilian employment was extremely problematic.

### *Institutionalisation*

Individuals said that they had grown to rely on an institutional regime where timetables, shelter, food and clothing were provided. The removal of this rigidity meant that individuals became alarmed and angry resulting in conflict situations within the family caused by unrealistic demands for strict time-keeping, standards of dress and adherence to rules etc.

### *Family impacts*

Many Veterans found themselves unable to provide for their families once their period of service was over and some suggested that they felt that they had been devalued by partners and children who had learned to cope without them. Personal experiences included an abandonment of family for lengthy periods, separation and divorce and a recognised tendency of some Veterans to drift towards reliance on drugs and alcohol.

Family disruption, even where physical illness had not become an additional burden, was caused by nightmares, sleeplessness, anger and aggression. Depression and reliance on pain-killers had become a problem for ex-service personnel and daily drinking was recognised as having a huge impact on family life.

### *Wives/partners*

They were recognised as having a major role in helping the resettlement process and together with other family members, they took responsibility for much of the physical care of ill and disabled Veterans. They were also the driving force in seeking help and assistance when psychological and behavioural problems became insurmountable.

### *Social isolation*

Veterans felt that those who were isolated upon leaving service would find that problems, sometimes alleviated by interventions from family and friends, were likely to be exacerbated without an established social network.

### ***Increased demands for medical health***

#### *Publicity*

Some Veterans considered that requests for medical treatment might have increased recently because of publicity given to the types of support that was available.

#### *Reporting*

Others suggested that Veterans had failed to report physical problems whilst in service and (consequently) had reported illness when they came out. It was considered that some, close to leaving military life, were less likely to report illness in its early stages as they were anxious to avoid providing evidence of conditions that might jeopardise future applications for employment.

Minor conditions sometimes went unreported because personnel were constantly on the move and so services were used more heavily after discharge.

Others suggested that service-men did not want to appear weak and that they avoided reporting ill health in medical examinations within the service because they were afraid of undesired repercussions. One soldier reported that colleagues had been threatened with dismissal when they had reported hearing problems associated with artillery fire.

#### *Assessment of service medical care*

The opinions of Veterans varied widely in respect of their experience with medical care in the services. Whilst some believed that care was good or that they had learned lessons on how to care for themselves others believed that support was poor.

Some of the Veterans had sought no medical health assistance following their return to civilian life but others had sought assistance from GPs or received treatment from drug and alcohol counsellors.

### ***Signposting and provision of support***

#### *Availability of information*

On the whole, Veterans felt that there was insufficient information and guidance about assistance that was available outside of the service.

### *Resettlement management*

There was a strong inference that soldiers (particularly) were not encouraged to discuss problems and that some would have sought assistance if there had been better management of the resettlement process.

Standard provision of guidance and information was required so that referral or routes to doctors, dentists and counsellors was available to all personnel leaving military service.

It was considered widely that improved education in respect of the aftermath of service (physical and psychological impacts) would, over time, result in easier and more timely discussion both within families and with health (and other) professionals. A development of wider understanding and further personal insight into the long term impacts for Veterans themselves would help persuade Veterans that their reactions were predictable and that their need for care and support were normal and not a sign of weakness. The removal of the stigma of illness would encourage individuals to access the services they needed more promptly.

### ***Mental health and lifestyle***

Veterans were asked a series of questions about their own mental health and their perceptions of the impacts of service on the general mental health of others.

#### *Stress, anxiety, depression and aggression*

Stress levels related to employment and an occasional bout of low spirits were regarded as normal but several reported stress and anxiety that they associated with the impact of service life. In some circumstances these were related to service experience that had occurred up to three decades ago<sup>8</sup> and others linked it to the removal of structure and routine and to difficulties with colleagues and pressures in work situations. Additionally some reported a lack of trust and confidence in those around them.

#### *Recognition of mental health problems*

Many of those interviewed agreed that stress and anxiety suffered by Veterans was probably service related and some thought that the level revealed in research was probably under-represented. The idea that service personnel hid symptoms of mental illness because of the 'macho' expectations of both colleagues and officers was re-stated. Problems that might be resolved by contact with counsellors or medical officers were ignored 'to save face,' and the army had no interest in its personnel once they had returned to civilian life. Post army counselling was considered to be a necessity by some Veterans.

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<sup>8</sup> One Veteran referred to experience in the Falklands that had left him more reserved and guarded with others.

### *Psychological impacts of physical problems*

Physical injury and lifestyle changes were said to have long-lasting psychological impacts and the presentation of evidence of PTSD was unpredictable. One Veteran pointed out that even those in support, (rather than close conflict roles), often dealt with the aftermath and saw many things that were shocking and difficult to deal with.

Serious unhappiness and mental breakdown were attributed by some to serious physical health problems and related social isolation and a forced dependence on family members. Again interviewees reiterated the need for preparation and training for return to civilian life and the requirement for recognisable qualifications.

### *Direct or indirect effect of service*

It was considered by some that post-service mental illness was not attributable to things that happened in the military but to things that went badly wrong after discharge from the army. Mental illness, anxiety states and ongoing psychological problems developed when Veterans had no support network, lost touch with their friends [who had begun families] and found themselves in a lonely and unproductive situations. It was suggested that drug and alcohol dependency were symptoms of an illness rather than a cause.

Veterans spoke of feeling 'let down' when they were returned to civilian life and all those who reported good levels of mental health were largely individuals who had stable family lives, good health and employment.

Some however considered that the case was over-stated. In this respect one Veteran believed that many service men and women escaped from service by 'bluffing' the symptoms of stress and depression and another expressed the view that often military personnel spent decades in the forces without ever facing and stressful situation or having any traumatic experience.

### ***Attitude to incidence of mental health symptoms***

The statistics that revealed that the majority of Veterans suffered with anger, irritability, anxiety and depression came as no surprise to interviewees. Personal experiences of these temperamental symptoms varied; some admitted to be periods of time when they had suffered and made people around them suffer and said that they had, eventually dealt with the difficulties.

### *Support*

Some had sought medical intervention that had been successful but others had sought help but been disappointed in the results. The possibility of using colleagues in a close-knit group as sounding boards was removed when military personnel left the service. The opportunity to release tension disappeared once colleagues were replaced with civilians who were unable to understand the feelings that accompanied each experience. Ongoing feelings of distress and anger were related to traumatic

experiences, people being wounded and maimed and these continued but were difficult to relate to people without the insight of other soldiers.

### *Anger*

Lack of control in respect of anger was discussed and Veterans largely agreed that a large proportion of Veterans probably had difficulty in controlling violence and aggression. They agreed that some had severe problems, resulting in violent and unpredictable behaviour that occurred on a frequent basis.

One interviewee said that this was a problem that was linked more strongly to the army than to the other armed forces and that the development of this tendency was difficult to avoid.

One interviewee explained that aggression and violence were 'desirable' in situations where servicemen were being asked to kill or be killed. Servicemen lived on a day to day basis in an environment of 'high alert' and reliance on those around them. The feeling instilled by military training and conflict encounters did not disappear on discharge.

There were suggestions that some of the violence might be caused by the way servicemen were trained and the conflict situations they faced so the circumstances faced outside could contribute to the frustration and anger that Veterans felt.

## ***Increased demand for assistance and PTSD & anxiety***

### *Impact of promotion and education*

There was a belief held by some interviewees that increased promotion of services together with a wider understanding of the problems had increased the demand and uptake for services. It was considered that more people were willing to come forward once there was a broader understanding of the problem.

### *Partners*

Wives and girlfriends had also been instrumental in encouraging partners to seek help and some interviewees believed that it was usually 'pressure' from third parties that drove Veterans to seek medical help. Family and friends often identified problems before individuals recognised (or accepted) that they were suffering in any way.

## ***Awareness of service***

### *Low Primary Care Trust / service awareness*

Though most Veterans had some contact with primary care services after leaving military life there was low recognition of the wider services available. In general, when asked about support service Veterans talked about their military associations

rather than medical and counselling services. One pointed out that these organisations provided signposting to many other support organisations and services.

Some expressed the view that the services that existed were 'sufficient' but not 'sufficiently promoted,' others however thought the present provision was inadequate and that there were real problems of 'finding out where the help could be accessed.' It was suggested that people leaving military service in general had limited understanding about what was possible in terms of support

#### *Role of GP*

Most of those who had received counselling and treatment had been referred through their own GP and had found the support good but difficult to access at the outset.

#### *Providers lack of military understanding*

It was also stated that general providers of health and psychological care had little insight into what ex-serviceman might suffer or need in the future. One suggested that mental health services should seek to engage ex-military personnel to provide services that could then be based on real insight into the problems

### **Access to health care**

#### *Fast track service*

Most had not heard of the Fast Track Service although those that had held mixed views about its value. One Veteran felt that the Fast Track Service had been introduced as a public relations exercise and another considered that better referral processes and understanding within general health provision would negate any need for this additional provision.

### **Barriers to accessing general health services**

#### *'Macho culture'*

There were various attitudes expressed in respect of the reluctance of Veterans to access mainstream health services for illnesses and conditions acquired whilst in the services. Though a few were not able to understand why this was the case most related this reluctance strongly to the "soldier's" need to appear strong and resilient so they do not want others to develop the view that they are 'wimps' and so continue to suppress problems until they have become serious.

#### *Professional's lack of understanding/awareness*

Others considered that it was because of the poor levels of understanding that existed in general health providers so that a soldier reporting symptoms of panic was regarded in the same light as someone who had a fear of heights or spiders. One

said that once referred to a specialist, the cause of panic, anxiety and related symptoms was investigated but it was not easy to go through the process with GPs who were largely unaware of the problems. Though doctors were provided with service records they were rarely 'put in the picture' and therefore were unable to help.

Another serviceman suffered with erectile dysfunction, which he related to PTSD but he was unable to engage in discussion with his Asian GP because of existing, language related, problems of communication between them.

### ***Satisfaction with local provision***

#### *General*

In terms of general healthcare, the Veterans interviewed largely regarded the local provision and scored Hull provision with marks of 7 or above. Veterans who had left the military some years ago said that services had improved tremendously over recent years.

#### *Specific*

Provision for care related to illnesses and conditions acquired in service situations was largely related as poor with scores of 5 and below. These low scores were given because the Veterans were often of the opinion that the city provided little in health and expertise in dealing with the psychological impacts combat.

### ***Improving the service***

#### *How to improve*

Veterans were unified in the view that in order to improve provision there was a need for:

- i) better information,
- ii) easier access to appointments
- iii) a general 'raising of awareness' among health care providers of issues affecting Veterans.

The latter was regarded as something that would require extra training focused on developing insight into conditions and problems and into interviewing patients. One Veteran said it was "essential that health workers did not take things at face value but were able to probe and coax information from patients from service backgrounds."

#### *Dedicated clinic*

It was suggested that a local clinic should be established, where staff with experience of military life can deal empathetically with physical and mental issues related to service.

### *Information*

Information was considered to be the key to improving services and there were various factors to consider in this respect:

- The healthcare providers would need a **database** so that they were made aware of personnel coming into the area after service.
- It was recommended that all military personnel leaving service and coming to Hull should be provided with a **comprehensive booklet** that gave information about problems that might be encountered, how to address the problems and where to go for assistance. It should provide details of GP services (including how to register), counselling services, alcohol support and family support.
- There was a view expressed that there was a need for a dedicated **help-line** so that ex-servicemen and women had someone to call and discuss their problems. Personnel manning the line should have appropriate knowledge and military experience.
- There was a need for the establishment of a **local network** for 'ex-forces members in the same boat' so that they could engage easily with one another and have focus group discussions on a regular basis.
- It was also suggested that links to services could be established early, whilst soldiers were on leave. It might be useful for serving soldiers to be provided with a **list of services** and where to find them locally (around the base) and in the vicinity in which their family lived. One said that information should be given within the framework of an interview, similar to the one carried out during the research in which he was involved.