Cambridgeshire Joint Strategic Needs Assessment (JSNA)

Armed Forces 2012-13

FINAL REPORT
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CONTENTS

1. Executive Summary

1.1 Demographics

The Armed Forces JSNA focuses on **military personnel, veterans, reservists and their dependents.** For the purpose of the JSNA 'veterans' were classed as ex-service personnel who served at any time and irrespective of length of service.

There are four Armed Forces bases in Cambridgeshire - Bassingbourn (RAF/Army), Waterbeach (Army), Brampton/Wyton (RAF) and Alconbury (USAF). As at 1 January 2013 there were 1,240 Armed Forces personnel located in Cambridgeshire; 70% Army, 28% Royal Air Service and 2% Naval Service. Two thirds of personnel live in South Cambridgeshire, with a further 31% living in Huntingdonshire and 2% in Cambridge City.

In general, there are poor data to quantify the number and demographics of veterans in Cambridgeshire, a picture also seen nationally. There is a variety of reasons for this, such as no central data collection, a perceived stigma by veterans leading to poor access of services and ex-service personnel not considering themselves to be a veteran, especially in younger personnel. However, national prevalence estimates suggest that there are between 54,000 and 58,000 veterans living in Cambridgeshire, including 9,000 reservists. 60% of veterans are aged over 65, due to compulsory national service for men which continued until 1960. There will be a Census 2011 Armed Forces release in the spring of 2013, which will provide a wealth of data on existing service personnel, but not veterans.

1.2 Data and Inequalities

Generally, service in the Armed Forces is associated with good physical and mental health, due to good diet, exercise and access to medical services. However, there is a variety of health and lifestyle issues that ex-service personnel face on leaving the Armed Forces, with Early Service Leavers being the most vulnerable.

The key inequalities that ex-service personnel face are:

Health – the majority of veterans are older people who face the same health issues as the general population. However, veterans may have a higher prevalence of musculoskeletal conditions, cardiovascular disease, respiratory problems, sight problems and mental health problems. Stigma and reluctance to access services are the main barriers to care.

Mental health – the prevalence of mental disorders in younger veterans is three times higher than the UK population of the same age. Exposure to violent or traumatic experiences, instability in domestic life, difficulties in making the transition from service to civilian life and the consequences of the excessive drinking culture increase mental health risks for veterans.

Oral health – dental emergencies are up to five times higher in a dentally ill-prepared Force, compared to a well-prepared force. Dental morbidity is one of the most significant causes of Disease and Non Battle Injury (DNBI) and subsequent lost time from operation is considerable.

Lifestyles – alcohol misuse in the serving population is substantially higher than the general population, at over double the rate.

Wider determinants of health – the Armed Forces, especially the Army, recruit from more deprived communities. Unemployment rates in people of working age are similar to the national average, but double the national average for people aged 18-49 years. There is an increased risk of violence by veterans due to experiences of combat and trauma, mental health problems and alcohol misuse. It is estimated that 3.5% of the prison population are veterans, with a higher prevalence of sexual offences compared to the general prison population. Access to housing is an issue for personnel leaving the service. All districts in Cambridgeshire include Armed Forces personnel in their eligibility criteria for social housing. It is estimated that between 6% and 12% of rough sleepers are ex-armed forces personnel.

Dependents and families – Service children who face regular moves from home and school can suffer high levels of anxiety and stress. Access to services, such as NHS dentistry, immunisations and planned hospital care, is a particular issue for families that frequently move, as is their opportunities for employment, education and training.

1.3 Priority Needs

Whilst the Armed Forces have specific needs many of these are also seen within the general population. For example, mental health disorders are relatively high within the veteran population but are also an issue for the general population, with the required services and treatments likely to be similar for both groups. However, specific needs for veterans need to be taken into consideration, such as their vulnerability to access services.

Cambridgeshire has an Armed Forces Covenant Board that aims to improve the outcomes and life choices of military personnel, reservists, their families and veterans living in Cambridgeshire and Peterborough. The Covenant Board also aims to enhance the relationship between the civilian and military communities.

In Cambridgeshire there are other Joint Strategic Needs Assessments that cover many of the key inequalities experienced by veterans, such as risk of homelessness and mental health. Table 7 Matrix of Military personnel, reservists, veterans and dependents (AF) against Covenant Board Action Plan and Current JSNAs shows the relationship between the key inequalities, the current JSNA's and the Covenant Board's action plan. This triangulation provides an action plan for the priority needs of military personnel, reservists, veterans and dependents in Cambridgeshire.

2. Introduction

The following report examines the health and wellbeing of **military personnel, veterans, reservists and their dependents.** This definition of the Armed Forces aligns with the Cambridgeshire and Peterborough Community Covenant Board**.** The term 'veteran' can lead to much confusion, even within the service population itself. It is believed that a large proportion of so-called veterans would not describe themselves as such, as younger members perceive the word relates to World War Two veterans. These people are more likely to class themselves as 'ex-service'. For the purpose of this report veterans are ex-service personnel who served at any time, irrespective of length of service.

Fortunately there is a wealth of research available on veterans, mainly from other area's Joint Strategic Needs Assessments, charities such as the Royal British Legion, and the King's Centre for Medical Health Research unit, but unfortunately the majority are generally quite out of date. However, there is nothing to suggest that the findings are not reflective of today's current and ex-armed forces populations, as well as their dependents.

It is important to note that this JSNA does not cover all the national and local services and policies that are available for the Armed Forces population, but is a reflection of the health and wellbeing needs of this group of people.

3. What do we know?

There are currently four Armed Forces bases in Cambridgeshire, as shown in Map 1 below:

- Bassingbourn (RAF/Army)
- Waterbeach (Army)
- Brampton/Wyton (RAF)
- Alconbury (USAF)

Map 1: Armed Forces bases in Cambridgeshire (as at March 2013)

As at 1 January 2013 there were **1,240 Armed Forces personnel** located in Cambridgeshire. The table and chart below show that the majority were in South Cambridgeshire, with the numbers varying by service and district.

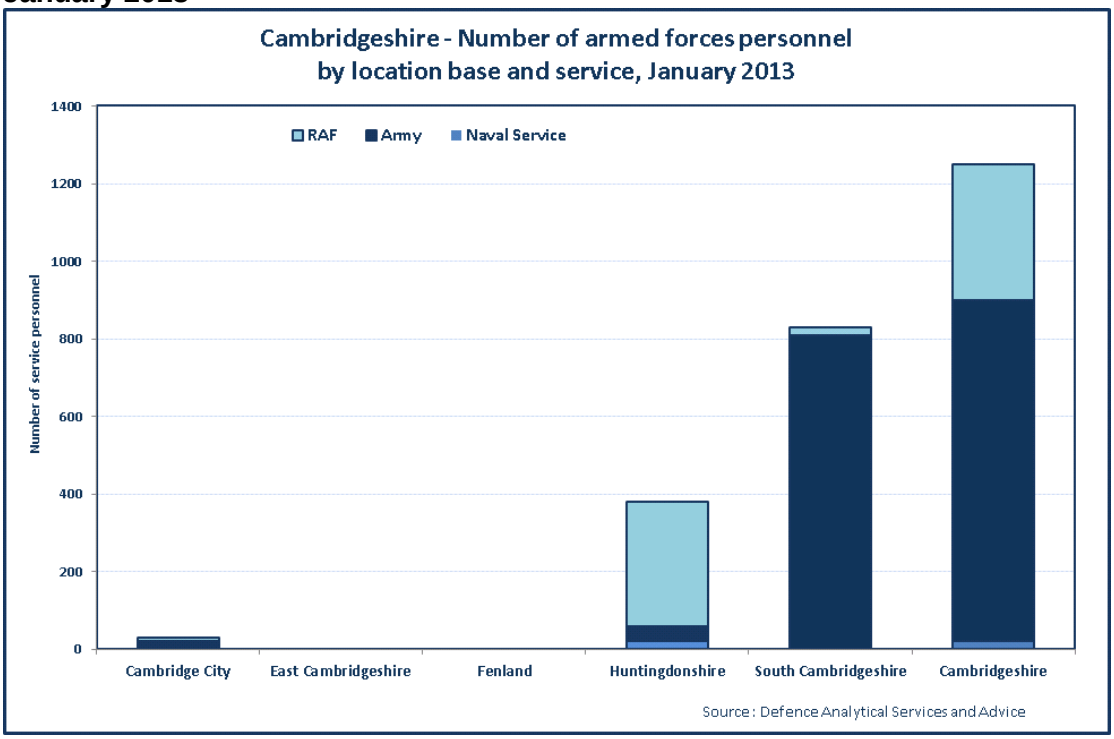
Table 1: Armed Forces personnel by Location Base, as at 1 January 2013

District	Naval Service			Army			Royal Air Forces			All Services		
	Officers	Other ranks	Total	Officers	Other ranks	Total	Officers	Other ranks	Total	Officers	Other ranks	Total
Cambridge City	-	~	~	10	20	20	~	-	10	10	20	30
East Cambridgeshire	-	-	-	-	-	-	-	-	-	-	-	-
Fenland	-	-	-	-	-	-	-	-	-	-	-	-
Huntingdonshire	10	10	20	10	30	40	80	240	20	100	280	380
South Cambridgeshire	-	-	-	60	750	810	10	10	20	80	760	830
Cambridgeshire	10	10	20	80	790	880	100	250	350	190	1,060	1,240

~ denotes fewer than 5 - denotes zero or rounded to zero Totals do not agree due to rounding

Source : Defence Analytical Services and Advice (DASA) (FOI request)

Chart 1: Number of Armed Forces Personnel by location and service, January 2013



In 2011/12 there were 330 Regulars recruited within the Cambridge and Peterborough Armed Forces Careers Offices (AFCO). Of these, 270 were recruited into the Ranks and 60 were recruited as Officers. The table below shows this broken down by single service and shows the trend.

Table 2: Estimated Veteran and Reservist population

Regulars							
Financial Year	Officers			Ranks			Total
	Navy	Army [1]	RAF	Navy	Army	RAF	
2007/08	40	n/a	20	50	110	130	350
2008/09	30	n/a	60	50	220	130	480
2009/10	50	n/a	20	70	230	90	450
2010/11	50	n/a	10	50	120	50	290
2011/12	50	n/a	10	40	160	70	330

[1] Recruiting Group (RG) cannot allocate officer data to specific offices as candidates may go to school in one area, have a home address in another and attend university in a third. Therefore, RG treat officer recruiting nationally and not regionally.

Totals do not agree due to rounding

Source: Defence Analytical Services and Advice (DASA) (FOI request)

Between January 2012 and December 2012, 100 trained UK Regular Forces personnel left the armed forces through voluntary outflow when they were stationed in Cambridgeshire. Voluntary outflow is defined as all exits from trained UK Regular Forces which are voluntarily generated by the individual before the end of their agreed engagement or commission period. This does not include Gurkhas, full time Reserve Service personnel and mobilised reservists. (Source : DASA – FOI request)

Generally there are poor data to quantify the number and demographics of veterans in Cambridgeshire, a picture also seen nationally. There are a variety of reasons for this, such as no central data collection, a perceived stigma by veterans leading to poor access of services and ex-service personnel not considering themselves to be a veteran. There is a wealth of data collected on existing service personnel, including the 2011 Census, which is due for release in the Spring of 2013. The Census collects information on those currently serving in the Armed Forces, but does not collect data on Veterans.

There are national estimates of veterans, such as the Royal British Legion (RBL) estimate of 8% of the UK population being veterans. The table below shows that by using the RBL and Office for National Statistics (ONS) estimates it can be approximated that there are between **54,000** and **58,000 veterans** living in Cambridgeshire. This does not take into account, however, bias towards areas that already have armed forces bases, or for personnel who, on leaving the forces, may settle in the surrounding area.

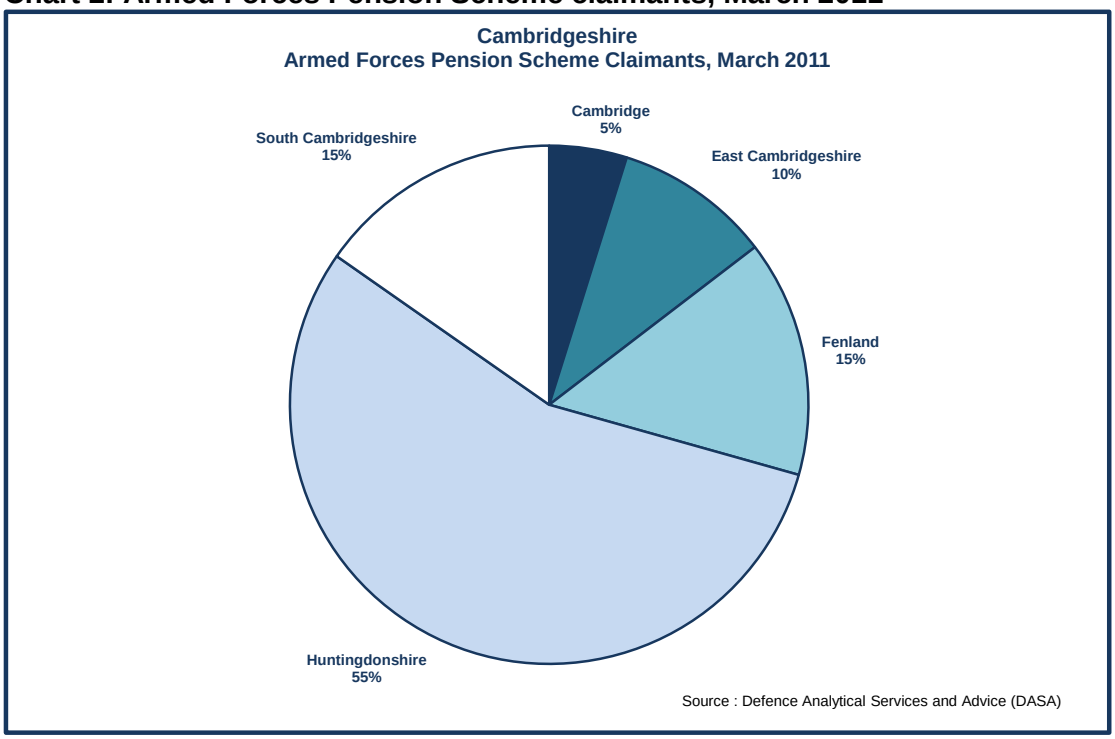
Table 3: Estimated Veteran population, mid 2011

Age group	Mid 2011 population estimates	Royal British Legion		ONS	
		Estimated prevalence	Estimated number	Estimated prevalence	Estimated number
16-24	75,907	1%	759	2.5%	1,898
25-34	83,751	5%	4,188	5.5%	4,606
35-44	88,779	8%	7,102	10.5%	9,322
45-54	85,925	9%	7,733	10.2%	8,764
55-64	73,779	13%	9,591	11.0%	8,116
65-74	53,802	30%	16,141	25.6%	13,773
75-84 (75+ ONS)	33,489	26%	8,707	34.5%	11,554
85+	14,060	4%	562	-	-
Total			54,784		58,033

Source: prevalence estimates taken from Southampton Veteran's Needs Assessment and Mid 2011 population estimates, ONS

As at March 2011 there were 5,790 people, in Cambridgeshire, claiming pensions on the Armed Forces Pensions Scheme. There were 1,365 claimants under the War Pension Schemes and a further 115 to 123 people claiming from the Armed Forces Compensation Scheme (AFCS). Huntingdonshire has the highest numbers claiming from the Pension Scheme.[1]

Chart 2: Armed Forces Pension Scheme claimants, March 2011



[1] Armed Forces Compensation Scheme (AFCS) lump sum payments awarded as at 31 March 2011, Defence Analytical Services and Advice (DASA), www.dasa.mod.uk/applications/newWeb/www/index.php?page=48&pubType=3&thiscontent=3950&PublshTime=09:30:00&date=2011-11-15&disText=Single%20Report&from=listing&topDate=2011-11-15

The Royal British Legion estimate that **reserve** forces account for approximately 16% of the veteran population, which could equate to around **9,000** veterans in Cambridgeshire.

The profile of veterans is forecast to change in the medium term, as there will be many more very elderly (85+ years) veterans, an increase in the proportion of younger veterans and a large reduction in veterans aged 65-74 years. [9]

There are also neighbouring Armed Forces, such as US bases, that may have an impact on Cambridgeshire's primary and secondary care services, such as Cambridge University Hospital Foundation Trust.

4. Key Issues/Findings

Several areas, such as Kent and Medway, Sussex and Southampton, have already completed JSNAs on Armed Forces and mainly focus on veterans. It was decided, due to time constraints and the availability of good quality needs assessments, to review these documents for issues that are pertinent to the Armed Forces population rather than to start a new literature review. The following section examines the outcome of this review, and includes further research.

4.1 Recruitment

- Armed forces recruit heavily from deprived communities and veterans are known to have lower than average household incomes.[2]
- A typical UK recruit is a relatively poor, white teenager with limited education and work prospects, recruited from a difficult home environment into the Army infantry. [2]
- An estimated 86% of UK veterans are male, 94% are white and only 9% of recruits have a GCSE grade A*-C.[2]
- Military service can be a very positive intervention. Service in the Forces is generally associated with good physical and mental health but the challenge is to maintain any post-service benefits. [2]
- Infantrymen have an average service career of 3.7 years, with these early service leavers receiving limited support with their transition back to civilian life. There is a risk that these veterans do not register with a GP, lose the benefits of a structured life and camaraderie, and in a sense are 'dropped back' into the community from where they were recruited.[2]

4.2 Welfare Needs

In 2006, the Royal British Legion looked at the welfare needs of the ex-service community[3] and concluded that the greatest needs of 16-44 year olds were financial difficulties (both lack of money and debt), unemployment or lack of skills/training and depression/mental health problems. The greatest needs of 45-64 year olds, were related to poor health and mobility, followed by caring responsibilities, bereavement, depression and financial difficulty. The greatest needs of over 65 year olds, were house and garden maintenance, mobility and low income; followed by exhaustion or pain, loneliness and depression. People aged 65-74 years old additionally had caring responsibilities; whilst over 75 year olds, had more severe mobility problems, encompassing difficulty navigating around their own home and the community.

The following sections look into some of these issues more closely.

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[2] Veterans' (ex-military') Health Needs Assessment, Kent and Medway, October 2011, www.kmpho.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=198784

[3] Greatest welfare need of the Ex Service Community, Royal British Legion, www.britishlegion.org.uk/media/33538/greatestneedfinal.pdf

4.3 Health

Service in the Forces is generally associated with good physical and mental health due to good diets, exercise and access to medical services. The Armed Forces Covenant Interim Report 2011[4] stated that satisfaction with in-service medical and dental treatment remains high, and is cited as retention factors by personnel.

In general most veterans are older people who have the same health needs as older people in the general population. However, veterans may have higher prevalence of musculoskeletal conditions, cardiovascular disease, respiratory problems, sight problems and mental health problems compared to the general population. [9]

All veterans are entitled to priority access to NHS hospital care for any condition if it is related to their service, whether or not they receive a war pension. All people leaving the armed forces are given a summary of their medical records and are advised to give them to their new GP on registration. Veterans are encouraged to tell their GP about their veteran status in order to benefit from priority treatment.[5]

It has been found that stigma has an adverse role in veterans' access of healthcare services, together with perception of levels of understanding of Forces' cultures amongst civilian healthcare staff.[6] Stigma and reluctance to access services are the main barriers to care.[7]

There are certain health issues that arise from frequent moves, especially for dependents' to gain access to NHS dentistry, immunisation programmes and health promotion activities. Patients who are on waiting lists, and whose care transfers between organisations, can experience extended pathways.[8]

The Defence Medical Services (DMS) are responsible for primary care for Armed Forces personnel. The NHS is responsible for their dependents and veterans, and for the secondary care of Armed Forces personnel, as shown in the commissioning responsibilities diagram below.[10]

4 Armed Forces Covenant Interim Report (2011), Ministry of Defence, www.veterans-uk.info/interim_covenant/20111220-Armed_Forces_Covenant_Interim_Report_2011-U.pdf

5 NHS Choices - www.nhs.uk/NHSEngland/Militaryhealthcare/Veteranshealthcare/Pages/veterans.aspx

6 Veterans' Health Needs Assessments, Southampton, 2012 www.southamptonhealth.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=131366

7 King's Centre for Military Health Research: A fifteen year report September 2010 What has been achieved by fifteen years of research into the health of the UK Armed Forces?, September 2010 www.kcl.ac.uk/kcmhr/publications/15YearReportfinal.pdf

8 Health Services for the Armed Forces, their families and veterans – Guidance for SHAs, Department of Health, www.pcc-cic.org.uk/sites/default/files/articles/attachments/letter_to_sha_ces_-_gateway_10070.pdf

Table 4: Armed Forces Commissioning responsibilities, NHS and DMS post April 2013

	Serving Armed Forces in England	Serving Armed Forces overseas	Armed Forces Families registered with DMS med centres in England	Armed Forces Families registered with DMS med centres overseas	Armed Forces Families registered with NHS GP Practices	Reservists while mobilised [i]	Veterans (inc. reservists when not mobilised)
Primary Care	DMS [ii]	DMS	DMS	DMS	NHS CB	DMS & NHS CB [iv]	NHS CB
Community Mental Health	DMS	DMS	NHS CB	DMS	CCGs	DMS	CCGs
Secondary acute & community care	NHS CB	DMS & NHS CB [iv]	NHS CB	DMS & NHS CB [iv]	CCGs	DMS & NHS CB [iv]	CCGs [iii]
MOD Enhanced pathways	DMS	DMS	N/A	N/A	N/A	DMS	N/A
	i - Reservists have access to DMS care whilst mobilised ii - Serving personnel can access local GPs on an emergency basis if needing to access care whilst away from the military address iii - The NHS CB will commission specialised services for veterans, e.g. limb prostheses iv - While overseas, serving personnel and families can access DMS-commissioned healthcare where such provision exists, or may be provided with non-DMS healthcare by local Host Nation or other contracted arrangements, or have right of return for NHS CB-commissioned NHS care in England						

Source: Securing excellence in commissioning for the Armed Forces and their families, March 2013, NHS Commissioning Board 9

Military hospitals were phased out from the mid-1990s as there were too few cases for military medical staff to maintain their skills. In their place, five Ministry of Defence Hospital Units (MDHUs) were set up within NHS hospitals, where military medics work alongside NHS staff, providing medical, nursing and other clinical treatments to both NHS and military patients. Peterborough City Hospital is one of these hospitals. Since 2001, the Royal Centre for Defence Medicine (RCDM) at the University Hospitals Birmingham, has been the main treatment centre for military patients injured overseas.[5]

Between October 2001 and February 2013 there had been **37 casualties** that had occurred on operations in Iraq and Afghanistan for UK Regular Forces personnel located in Cambridgeshire. These casualties are a Battle Injury, a Non Battle Injury or Natural Causes, such as illness, disease or pregnancy.
(Source: DASA – FOI request)

9 Securing excellence in commissioning for the Armed Forces and their families, March 2013, NHS Commissioning Board, www.commissioningboard.nhs.uk/files/2013/03/armed-forces-commissioning.pdf

4.4 Mental Health

4.4.1 Mental Health Disorders and self-harm

There are risks to the mental health of veterans and current service personnel as a result of exposure to violent or traumatic experiences, instability in domestic life, difficulties in making the transition from service to civilian life and the consequences of the excessive drinking culture.[9]

A Royal British Legion survey found that the prevalence of mental health disorders among younger veterans (aged 16-44 years) was three times higher than that of the UK population of the same age.[9] Ex-service personnel may be at an increased risk of self-harm and young male veterans, particularly those with shorter lengths of service, are at an increased risk of suicide.[9]

Self-harm has been under-reported by the military for many years, in part because, until relatively recently, it was deemed a disciplinary offence. The Ministry of Defence (MOD) has strategies to support mental health, such as mentoring service for Early Service Leavers to help with transition, third location decompression (TLD) and Trauma Risk Management (TRiM), a peer-delivered psychological first aid process.[9]

Some veterans, when leaving the Armed Forces, do not register with a GP practice and so are limiting their access to healthcare and are not receiving necessary healthcare services eg NHS psychological therapy services.[9]

4.4.2 Post-Traumatic Stress Disorder (PTSD)

A cohort study[12] of 10,000 people who had been deployed to Iraq and Afghanistan found that the level of Post-Traumatic Stress Disorder (PTSD) was lower than expected, with 4% of personnel suffering from PTSD. Around a fifth of personnel reported other common mental health disorders. This study found that reservists were more likely to report probable PTSD than those not deployed and that regular personnel in combat roles were more likely than those in support roles to report probable PTSD. No link was found between the experience of mental health problems with the number of deployments.[7]

Within service, it has been revealed that single-session, psychological debriefing does not reduce psychological problems after trauma. Only a minority of those with mental health problems in service have sought medical help. Non-medical sources of support, such as padres, were found to be more popular than medical personnel.[7]

Mental health screening before deployment does not reduce post deployment ill health, and has adverse consequences for some individuals as well as the Armed Forces. Mental health screening after deployment is practiced in other countries, but is not yet supported by evidence of benefit. Peacekeeping creates as many psychological problems as war fighting, due to high threat ambiguity and helplessness.[7]

Combat Stress (CS) is a national mental welfare society that provides psychological support to veterans experiencing mental health problems, predominantly Post Traumatic Stress Disorder (PTSD). In 2010 they produced a ‘typical’ new referral to their service.

They were: [9]

- Average age of 44 years old
- Ex-Army
- Childhood trauma, neglect, poor care giving
- Multiple, traumatic exposures
- Family ultimatum
- History of multiple house moves, employers, long spells of unemployment or homelessness
- Many children, mostly not in touch
- History of domestic violence
- Significant physical illness
- Classically diagnosed with PTSD, depression, alcohol abuse
- No prior intervention
- NHS had not helped (for a variety of reasons)

4.5 Oral Health

A literature review of dental casualty rates found that the annual incidence of dental emergencies for a dentally well-prepared force is 150 to 200 per 1,000 personnel, but can be up to five times higher in an ill-prepared force.[10] Operational health surveillance reporting has established dental morbidity to be one of the most significant causes of Disease and Non Battle Injury (DNBI) for all medical reasons. Subsequent time lost from operations is considerable as is the time spent travelling to access dental care.[11]

Until now, like almost all dental care delivery organisations, the Defence Dental Services (DDS) has predominantly followed a treatment focused model of treatment delivery with modest resource allocation to preventive care. Adopting a more preventive approach to care may lead to a reduction of dental problems both on deployment and at home.[11]

Dental caries, like many other diseases, is increasingly associated with social deprivation. Recruits from deprived backgrounds are more likely to carry a heavier burden of disease requiring more intervention, more maintenance and have a higher associated risk of dental emergencies.[11]

At present, not much is known about the oral health of families of military personnel. While the DDS provides comprehensive dental care for military personnel, this provision does not include family members or veterans.[11]

Smoking has a strong association with poor periodontal health, gum disease and oral cancer, and both smoking and alcohol consumption have a strong association with oral cancer. Smoking combined with excessive alcohol consumption leads to a much greater risk of cancer than either in isolation. [11]

10 A literature review of dental casualty rates, Mahoney GD, Coombs M. University of Sydney, Dental School, New South Wales, Australia, www.ncbi.nlm.nih.gov/pubmed/11050872

11 Military Health 2013, Oral Health, Amanda Crosse, Consultant in Dental Public Health, NHS Cambridgeshire

Military personnel stationed in Cambridgeshire are able to access dental care through their own health services. Access to NHS dental services in Cambridgeshire and Peterborough is generally good. NHS dental services are available in the Cambridge and Huntingdon areas and are accessible to the four Armed Forces bases in Bassingbourn, Waterbeach, Brampton and Alconbury.[11]

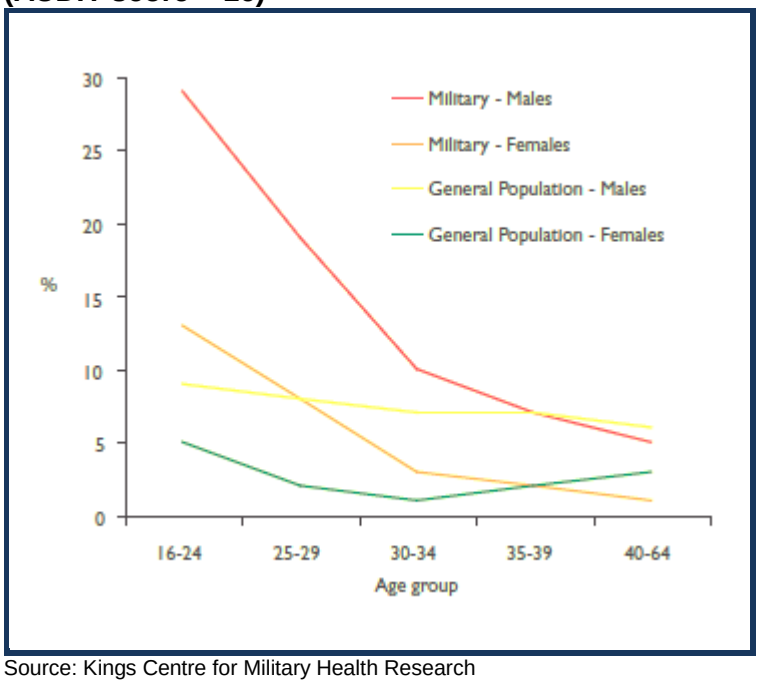
4.6 Lifestyles

4.6.1 Alcohol misuse

A study[12] of 10,000 serving personnel in 2010 (83% regulars, 27% reservists) found that alcohol misuse was substantially higher than the general population, 13% compared to 6% in the UK. It also found that regulars deployed to Iraq or Afghanistan were significantly more likely to report alcohol misuse than those not deployed.

At the end of 2010, the King's Centre for Military Health Research (KCMHR) produced a report looking at 15 years of research into military health, including risk taking behaviour. They found that within the Armed Forces, people were more likely to excessively drink if they were male, in the Navy or Army, single, of junior rank, and had a parent with a drink or drug problem. High risk drinking in the Armed Forces decreases with age and is similar to the general population by the age of 35 years, as can be seen in the chart below. [7]

Chart 3: Prevalence of high risk drinking in the military (AUDIT score > 16)



Source: Kings Centre for Military Health Research

12 Fear NT, Jones M, Murphy D et al (2010). What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. The Lancet (2010) 375 (9728): 1783–1797.

4.6.2 Smoking

Prevalence of smoking has fallen in the UK Armed Forces. Between 2003 and 2007 smoking fell by 5%, from 30% to 25%.[7]

At the same time, the General Household Survey reported smoking prevalence in males aged 16 to 19 years to be 18%, 20 to 24 years to be 29%, 25 to 34 years 30% and 35-49 years to be 24%.

4.7 Wider Determinants of Health

4.7.1 Deprivation

Socio-economic status varies between Armed Forces. Just over 60% of Army recruits are from the two most deprived quintiles (based on the Index of Multiple Deprivation) in England, compared to 43% for Royal Navy recruits and 37% RAF recruits. However, it is important to note that these data were based on relatively small numbers.[9]

4.7.2 Unemployment

In 2006, a Royal British Legion study on the welfare needs of ex-service personnel found that unemployment rates in people of working age were similar to the national average, but was double the national average for people aged 18-49 years.[9]

The Kings Centre Research unit followed 4,000 people who had left the Armed Forces at some point between 1991 and 2001 and found that 90% were in employment.[7]

A Strategic Needs Assessment of one of the Army Divisions reported that the relative rurality of bases can lead to increased transport expenditure, household incomes being lower and healthcare being less accessible for dependents. This, as well as the generally transient nature of the Armed Forces, reduces the opportunities for local employment for dependents. A number of special provisions have been, in terms of benefits and tax, due to the mobility obligations, the location of deployments and the ownership of more than one house.[4]

The Career Transition Partnership (CTP) provides a no-cost resettlement service for people leaving the Armed Forces and helps with job finding and other employment support services for up to two years after discharge.[13]

4.7.3 Crime and prisons

Combat and trauma experiences during deployment are significantly associated with violent behaviour following homecoming in UK military personnel. Post-deployment mental health problems and alcohol misuse are also associated with increased violence. A study found that 12.6% of

[13] Veterans: how can the Armed Forces Covenant help me?, Ministry of Defence, www.gov.uk/government/uploads/system/uploads/attachment_data/file/28285/afc_veterans.pdf

respondents surveyed had been physically violent to either a member of their family or non-family members in the weeks following their home coming.[14]

Violence after deployment was strongly association with pre-enlistment antisocial behaviour. It was also associated with younger age, single men with a lower educational attainment. Military characteristics associated with post-deployment violence included being in the Army, holding a non-officer rank, and having left service. Increased length of deployment within the last three years was also significantly associated with post-deployment violence. Military personnel's experiences of combat and traumatic events and the perception of being at risk of death while on deployment increase their risk of violent behaviour post deployment.[14]

There are conflicting statistics about veterans in prison, with some studies suggesting that there are fewer veterans than expected and others saying that they are overrepresented in prisons in comparison to the general population. The Royal British Legion conducted a literature review on UK veterans and the criminal justice system[15] and concluded that the most reliable evidence (from DASA) suggests that 3.5% of the total prison population are veterans.

In 2010, the Defence Analytical Services and Advice (DASA) conducted a study of matching adult prisoner details to their Service Leavers' database in order to estimate the proportion of prisoners who were ex-Armed Forces. The outcome suggested that there were 80 veterans subject to a supervision record in Cambridgeshire, which is likely to be an underestimate due to lack of data completeness. The majority were male and over three-quarters were aged 18 to 44 years.[16]

The report concluded that the most common offence type amongst veterans in prison is violence against the person at 33%, followed by sexual offences at 25%, and drug offences at 11%. Male veterans in England and Wales are imprisoned for drugs offences, proportionally, at less than half the rate of the general population. All other offences, with the exception of sexual offences, were found to be lower within the veteran prison population than the general prison population.[17]

14 Violent behaviour in UK military personnel returning home after deployment, Psychological Medicine (2012), 42, 1663–1673. © Cambridge University Press 2011, www.kcl.ac.uk/kcmhr/publications/assetfiles/interventions/macmanus2012violentbehaviour.pdf

15 Literature review : UK veterans and the criminal justice system, The Royal British Legion, /www.britishlegion.org.uk/media/31583/LitRev_UKVetsCrimJustice.pdf

16 Estimating the proportion of offenders supervised by Probation Trusts in England and Wales who are ex-Armed Forces, DASA, www.dasa.mod.uk/applications/newWeb/www/index.php?page=48&pubType=3&thiscontent=570&PublishTime=12:30:00&date=2011-03-16&disText=Single%20Report&from=listing&topDate=2011-03-16

17 Estimating the proportion of prisoners in England and Wales who are ex-Armed Forces - further analysis, Defence Analytical Services and Advice (DASA), www.gov.uk/government/uploads/system/uploads/attachment_data/file/28110/20100916_Veterans_in_prison.pdf

Table 5: Offence types for prisoners, males aged 18 to 54 years, November 2009

	Rate per 100,000 prisoners	
	General population (n=14,620,000)	Veteran population (N = 651,235)
Overall	496.3	298.4
Burglary	53.4	13.2
Fraud and Forgery	11.6	3.8
Theft and handling	19.9	7.2
Motoring	5.9	2.3
Drug Offences	71.7	32.7
Robbery	62.2	23.8
Violence against the person	134.6	100.6
Sexual Offences	51.5	63.1

Source: Defence Analytical Services and Advice, Ministry of Defence 17

An inquiry into Penal Reform into former Armed Service personnel in prison found that: [9]

- Social isolation and exclusion, alcohol and financial problems are drivers for offending in the veteran population, as they are for the general population.
- It is estimated that there is a delay of around 10 years between leaving the Armed Forces and starting a custodial sentence.
- Making the transition to civilian life without the discipline and structure of relationships and the security of accommodation can be a challenge. Resettlement services are available but often ex-servicemen neither recognise the need for help, nor feel able to ask for help.
- The proliferation of voluntary sector agencies and charities supporting ex-servicemen causes confusion for those seeking help.
- Compared to the general prison population, the veteran prison population are more likely to be imprisoned for sexual offences.
- No evidence was found to support any hypotheses about links between PTSD and serving in Iraq or Afghanistan.

4.7.4 Housing

Serving armed forces personnel regularly move location and are therefore reliant on MOD accommodation and are limited to the choice of housing available to them. As a result of being a transient population, it is often difficult for personnel to access mortgages. The latest Armed Forces Continuous Attitude Survey (AFCAS) reported that the majority of personnel live in MOD accommodation during the week and that they are generally satisfied with the standard (57%) and value for money (65%), but scores were lower for maintenance and repair and fairness of allocation. Almost a third of personnel reported owning their home, but less than a quarter of these were satisfied with the opportunities to live in their own home. Affordability was cited as the main reason personnel did not own their own house, although almost a quarter were making financial preparations to buy. A shared equity scheme was launched in April 2010. [4]

Some ex-service personnel and their families require a social home when they leave the Armed Forces and demand may increase following the latest redundancies. All of the districts in Cambridgeshire include a priority need in the eligibility criteria for social housing for people with Armed Forces service.

4.7.5 Homelessness

It is estimated that between 6% and 12% of rough sleepers are ex-armed forces personnel.[9] The characteristics of homeless veterans are similar to that of the wider homeless population. However, research has shown that homeless veterans tend to be older, have slept rough for longer, be less likely to use drugs and more likely to have alcohol related problems. Routes to and causes of homelessness are multi-factorial and, while often influenced by a career in the military, is rarely a direct result of it.[18]

One study reviewed by the RBL found that social isolation, chemical addiction and institutionalisation were the main reasons why veterans became homeless. Another study reported that just under a quarter of homeless veterans surveyed reported having spent time in a psychiatric unit.[18]

4.8 Early Service Leavers

Research suggests that there are particular groups of 'Early Service Leavers' that are more likely to be vulnerable to social exclusion. These risk factors include: [19]

- Males under 21 years of age who have served less than four months.
- Under 18 years old, who may be discharged from Phase 1 training.
- Males aged 35-50 years undergoing relationship difficulties
- Those with fragile post service living arrangements (eg those single personnel returning to a parental home)
- Those intending to find work in London
- Those subject to a Care Assessment Plan (CAP) under AGAI 110
- Non-British citizens who may be subject to immigration control
- Non-British citizens with identified complex medical and/or social welfare needs who are returning to their country of origin, on discharge
- Those being discharged for substance misuse
- Those being discharged from training (particularly from Army Regiments)
- Those who are Care Leavers
- Single Parents
- Those being discharged from the Services after a period at a Military Corrective Training Centre or HM Prison Service

Other indicators that have been shown to be risks for social exclusion are:

- Individual lifestyles (eg heavy drinkers)
- Those who have had frequent periods of detention
- Those unable to cope with daily living

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[18] Literature Review: UK Veterans and homelessness, Royal British Legion, www.britishlegion.org.uk/media/31582/LitRev_UKVetsHomelessness.pdf

[19] Early Service Leavers - Guidance Notes for Resettlement Staff, Career Transition Partnership www.ctp.org.uk/assets/x/51978

- Individuals who become either voluntarily or involuntarily socially excluded from their peer group
- Depression/anxiety
- Financial difficulties
- Relationships difficulties

4.9 Families

In 2011, the Office for Standards in Education, Children's Services and Skills (Ofsted) published the report 'Children in Service families. The quality and impact of partnership provision for children in Service families' [20] concluded that Service children who face regular moves from home and school suffer high levels of anxiety and stress, especially when their parents deploy to armed conflicts overseas. It stated that athough many Service children, with support, do catch up or exceed the achievement of their civilian peers, some did not achieve the grades they might have achieved if they had not moved around so much. Ofsted recommended that a single database of Service children is needed to track their movements.

Informal networks of social support ('military family') remain strong and there appears to be no overall impact of deployment on marital breakdown.[7]

In 2010, the King's Centre for Research started an epidemiological study to examine mental health outcomes for children across the ages ranges, three to 16 years. Data will be collected from fathers, mothers, children themselves (11+), their teachers and care-givers. The study will compare outcomes for children of fathers with PTSD with those of fathers who return without a combat related psychiatric injury. The study will run over three years and involve more than 600 military fathers, their spouses/partners and children. [7]

[20] Children in Service families. The quality and impact of partnership provision for children in Service families',Ofsted, www.ofsted.gov.uk/resources/children-service-families

5. What is this telling us?

5.1 What are the key inequalities?

Research has highlighted some inequalities which affect the health and wellbeing of military personnel, reservists, their families and veterans, as shown below. However, it is important to note that the majority of these are also faced by the general population, and that although perhaps more prevalent in the Armed Forces there are structures and services already in place to help military personnel, for example, mental health services. The main problem appears to be access to these services.

Key inequalities include:

- Alcohol misuse
- Risk to mental health
- Crime, especially sexual offences
- Long term conditions such as musculoskeletal conditions, cardiovascular diseases, respiratory problems and sight problems.
- Housing
- Risk of homelessness
- Early service leavers
- Transition to civilian life
- Transient lifestyle affecting education and employment for dependents
- Barriers to care, including stigma
- Access to services for dependents

6. What are the key trends?

In October 2010, the Strategic Defence and Security Review announced cuts in Armed Forces personnel of almost 10% (7% Army, 13% RAF and 14% Navy). This will obviously have an impact on the number of veterans moving into the population, and in turn will lead to an increase in their needs, such as housing availability, employment, education and health services. In 2006 the Royal British Legion forecast the future needs of the ex-service community[21], which included veterans and their dependents combined. It is important to note that this review was written before the latest Strategic Defence and Security Review.

The RBL report states that there will be an overall decrease in the number of veterans by 2020. However, it is predicted that there will be an increase in those aged 16-24 years, as well as a large increase in the veteran population aged 85+ years, due to the final National Service generation reaching old age.

The number of dependants under 16 years of age is forecast to remain constant, but in terms of the total ex-service community they will represent a greater share. Men will continue to predominate veterans while women predominate dependants.

Most welfare needs are set to decline by 2020, due to the decreasing size of the adult ex-service community. There will be a slower reduction in the welfare needs of younger adults and the most elderly. Financial difficulties, employment and training needs, difficulty dealing with authorities and psychological problems will continue to affect a larger number of ex-service adults, aged 16-64 years, compared to those aged 65 years and over.

Reported poor health and long-term illness, disability or infirmity are set to remain the most common source of welfare needs among the adult ex-service community. After this the greatest welfare needs for the ex-service community of retirement age in 2020 are forecast to be mobility problems, self care and housing.

Lack of training, qualifications or skills is set to become more common between 2006 and 2020, which is in line with the growth in the number of veterans aged under 45 years.

[21] Future profile and Welfare Needs of the Ex-Service Community, November 2006, www.britishlegion.org.uk/media/33544/orangereport.pdf

7. What are the gaps in knowledge/services?

Some of the key inequalities experienced by the Armed Forces population are already under consideration with the Cambridgeshire and Peterborough Covenant Board. The following section outlines the membership and remit of the Board and their current action plan. These are then triangulated against the needs identified in this assessment with other current Cambridgeshire JSNAs that are in place to be able to support the Armed Forces agenda. It is felt that, whilst the Armed Forces have specific needs, many of these are also seen within the general population. For example, whilst mental health disorders are relatively high within the veteran population they are also an issue for the general population. The services and treatments are also likely to be similar for both groups of people, although specific needs for Armed Forces personnel will need to be taken into consideration, such as vulnerability to access to services.

It is hoped that by informing the relevant JSNAs and the Covenant Board of the key inequalities presented in this report, they can include the needs of the Armed Forces within their own programs of work. Any gaps identified will need to be taken forward and included in the work of the Covenant Board and/or considered for further needs assessments.

7.1 Cambridgeshire and Peterborough Community Covenant Board

In May 2011, the government published the Armed Forces Covenant which focuses on equality and has four key principles:

1. No disadvantage in the provision and continuity of public services
2. Minimises the social and economic impact of military life
3. Uses positive measures to enable equality of outcome
4. Special treatment for the injured & bereaved as a proper return for sacrifice

The Armed Forces Community Covenant Scheme was launched in June 2011, with a pledge for mutual support between civilian communities and its local armed forces community. As a response to this a Community Covenant Board was set up to cover Cambridgeshire and Peterborough with membership from Cambridgeshire County Council, Peterborough City Council, District Councils, NHS Cambridgeshire and Peterborough, Cambridge University Officers' Training Corps, Royal Navy, RAF Wyton, RAF Wittering, Cambridgeshire Ecumenical Council, Royal British Legion RAF Benevolent Fund, Operation Warrior Return, SSAFA Cambridge City / South Cambs, Cambridge Housing Society, Luminus Housing and Roddons Housing.

The Covenant Board covers military personnel, reservists, their families and veterans living in Cambridgeshire and Peterborough and has the following remit:

- To improve the outcomes and life choices for military personnel, reservists, their families and veterans living in Peterborough and Cambridgeshire.
- To enhance the relationship between the civilian and military communities in Peterborough and Cambridgeshire.
- To support and advise the Cambridgeshire Public Service Board, Peterborough City Council, Cambridgeshire County Council and District Councils' Cabinet meetings and the Ministry of Defence by working in

partnership to develop, evaluate and ensure the delivery of an Action Plan for Cambridgeshire across the key public agencies responsible for working with the military community.

- To liaise with other agencies on broader issues to ensure that their strategies, policies and plans relate to Peterborough and Cambridgeshire's military personnel, their families and veterans.

The aims and objectives of the local Community Covenant Board are:

- To develop local policy and contribute to national policy on delivery of the Community Covenant.
- To establish links with other Community Covenant Boards across the country.
- To produce an Annual Report and Action Plan, for endorsement by Cambridgeshire Public Service Board, Peterborough City Council, Cambridgeshire County Council and District Councils' Cabinet meetings and the Ministry of Defence.
- To monitor the implementation of the Action Plan.
- To consider proposals for cross-organisational activities that support the delivery of the Action Plan, including potential funding issues identified by the relevant groups.
- To support and steer the Community Covenant Board and relevant partner agencies towards shared priorities and targets.
- To respond to national and local consultations as and when necessary.
- To administer the local requirement relating to the implementation of the Community Covenant Grant Scheme, including receiving bids for grant funding and considering their value.

Following this the Covenant Board have produced the below action plan.

Table 6: Peterborough and Cambridgeshire Community Covenant Board Action Plan

Objectives	Lead
Strategic Objective 1: Housing for serving personnel	
1. Access to housing on moving to Cambridgeshire 2. Housing support and advice	South Cambridgeshire District Council
Strategic Objective 2: Supporting veterans	
1. Access to services to veterans 2. Outreach services to veterans on the street 3. Health and wellbeing of veterans	All Cambridge City Council NHS Cambridgeshire and Peterborough
Strategic Objective 3: Education for children of serving personnel	
1. Swift entry into local schools on arrival in Cambridgeshire 2. Activity to enhance the educational outcomes for children of serving personnel	Learning Directorate, Children and Young People's service
Strategic Objective 4: Community use of service amenities	
1. To identify the local service offer 2. Local bases to work to integrate military and civilian families	All All
Strategic Objective 5: Preparation for civilian life	
1. To identify appropriate education opportunities 2. To establish local employer network	Local Enterprise Partnership
Strategic Objective 6: To enhance relationship between civilian and military communities	
1. To share information between the military and civilian authorities 2. To create cultural exchange opportunities 3. Development of Cadets Association in the secondary school sector 4. Development of veteran's offer to work with PRU students on team building 5. Introduction of veteran's ID card	All All Secondary Heads Voluntary, Military and Cambs PRU All
Strategic Objective 7: Communications Strategy	
1. To develop a Communications Strategy	Cambridgeshire County Council

The matrix below matches the reported needs of the Armed Forces against the Covenant Board's action plan and other Cambridgeshire JSNAs to help identify areas of cross working and also to identify any gaps.

Table 7: Matrix of Military personnel, reservists, veterans and dependents (AF) against Covenant Board Action Plan and Current JSNAs

Needs		Current relevant area		Comment	Suggested Action
		Covenant Board (CB)	JSNA's		
Health	Mental Health including PTSD, self harm and depression	×	✓ • Mental Health in adults of working age JSNA • Child and Adolescent Mental Health JSNA currently underway	The JSNA does not include Armed Forces (AF)	✓ • Make contact with relevant JSNA leads • Suggest the CB Health and Wellbeing Objective be widened to include a specific measure around AF mental health, e.g. access to care
	Physical Health (including long term conditions for veterans)	✓ Objective 2 - Health and wellbeing of veterans	✓ Adults with a Physical or Sensory Impairment and or Long Term condition	The JSNA does not include AF	✓ • Make contact with relevant JSNA leads • Suggest the CB Health and Wellbeing Objective be widened to include a specific measure for veteran physical health including long term conditions • Suggest Objective 2 be widened to include all AF, not just Veterans
	Barriers to care (including stigma, rurarlity, dependents access)	✓ Objective 6 - To enhance relationship between civilian and military communities	×		✓ This is covered under the CB Objective - but may need to add targets to minimise barriers to access/care - such as increasing GP registrations, reducing stigma
	Dependents access to NHS services	×	×		✓ • Suggest the CB Health and Wellbeing Objective be widened to include all AF and specific measures for immunisations, access to NHS dentistry and screening
Lifestyles	Alcohol Misuse	×	× Not specific but reference in Prevention of Ill Health in Adults of Working Age	There is currently an Alcohol Needs Assessment underway	✓ • Link has already been made with the relevant leads to ensure AF needs are considered in Alcohol Needs Assessment • Suggest the CB Health and Wellbeing Objective be widened to include alcohol misuse
Wider determinants of health	Homelessness	✓ Objective 1 - Housing for service personnel	✓ People who are homeless or at risk of homelessness JSNA	The JSNA does not include AF	✓ • Make contact with relevant JSNA leads
	Education and training - for dependents	✓ Objective 3 - Education for children of service personnel	×		× This is covered under the CB Objective
	Housing	✓ Objective 1 - Housing for service personnel	✓ Housing JSNA currently underway		✓ • Make contact with relevant JSNA leads
	Crime (including sexual offences, prisons and violence on discharge)	×	×		✓ • This is an area that needs further investigation with Cambridgeshire County Council Crime analysts • Suggest the CB have an objective relating to this and to also include the Police on the CB membership
	Employment - for veterans and dependents	✓ Objective 5 - Preparation for civilian life	×		× This is covered under the CB Objective
	Social Care and Welfare needs not covered elsewhere e.g. finances	✓ Objective 2 - Supporting veterans	×		✓ • Suggest further this objective is widened to ensure veterans have access to financial advise etc
Other	Transition to civilian life, with a focus on Early Service Leavers	✓ Objective 5 - Preparation for civilian life	×	The Objective does not specifify Early Service Leavers	✓ • Suggest the CB Preparation for civilian life Objective be widened to include a focus on Early Service Leavers

8. What do we need to do?

The main outcome of this JSNA is to inform the Covenant Board and the current JSNA leaders about the issues and inequalities that the military, reservists, veterans and their families face, for review and action. It also highlights key areas of further work that are currently not within the remit of either of these arenas, eg crime and alcohol misuse. These will either need to be included in the remit of the Covenant Board or taken further through discussions at the Health and Wellbeing Board.

Appendix 1 – Veteran Needs Map from Veterans UK - http://www.veterans-uk.info/pdfs/publications/misc/needs_map.pdf