NIVHWS

Northern Ireland Veterans
Health and Wellbeing Study

Current and Future Needs of Veterans in Northern Ireland

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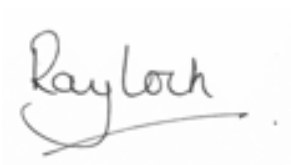## Figures

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Foreword

The Northern Ireland Veterans Health and Well-being Study will result in a series of inter-related yet distinct reports. In the first of these reports I suggested that it marked the beginning rather than the destination itself. It's not a surprise, then, that the publication of this latest report, on current and future needs of veterans in Northern Ireland, marks a milestone and offers a signpost along that journey which will culminate we hope in veterans being supported in a way that reflects how our society wishes them to be treated.

Outside the confines of this project though, some of the sands have been shifting. The instigation of the Veterans Gateway Service aims to provide a safety net – a single point of contact for any veteran who cannot easily connect to the multiplicity of statutory and voluntary services available. By contributing to the Gateway, our research team at Ulster University has delivered, albeit in a different manner to that originally conceived, some of the functionality our project originally envisaged.

Politics too has played a part, and the involvement of the DUP in the post-2017 general election government of the United Kingdom has highlighted delivery of the UK Armed Forces Covenant in Northern Ireland, an area this report makes clear is seen as at best patchy, and at worst non-existent. Some of this might be perception, and whilst comparison with the mainland could yield further evidence, it might also be hard, and possibly valueless, to compare Cornwall with Croydon with the Cairngorms with Coleraine.

What this report does make clear, supported by a body of evidence more credible and comprehensive than any other yet delivered, is that veterans in Northern Ireland have both morally and legally legitimate and unsupported needs. This report in its concluding chapter also recommends a series of actions that I commend to policy makers and service providers.

The report is long, because the issues are complex. The recommendations are extensive, because there is considerable potential and opportunity to change. The rewards though are that veterans in Northern Ireland receive the support they deserve. And that is surely worth the time taken to read carefully through this entire report.

Air Vice-Marshal Ray Lock CBE

Chief Executive, Forces in Mind Trust

Forces in Mind Trust

The Forces in Mind Trust was founded in 2012, through an endowment of £35 million from the Big Lottery Fund, to promote the successful transition of Armed Forces personnel, and their families, into civilian life.

Our Vision is that all ex-Service personnel and their families lead successful and fulfilled civilian lives. Our Mission is to enable them to make a successful and sustainable transition.

Our Strategy is to use our spend-out endowment to fund targeted, conceptually sound, evidence generation and influence activities that will cause policy makers and service delivers to support our Mission.

Full details of what we have funded, our published research, and our application process can be found on our web site www.fim-trust.org

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Acronyms

AFC	Armed Forces Covenant
CTP	Career Transition Partnership
ESLs	Early Service Leavers
FiMT	Forces in Mind Trust
MOD	Ministry of Defence
NI	Northern Ireland
NISRA	Northern Ireland Statistics and Research Agency
NIVHWS	NI Veterans' Health and Wellbeing Study
NIVSC	NI Veteran Support Committee
PTSD	Posttraumatic Stress Disorder
UDR & R IRISH (HS)	Ulster Defence Regiment & Royal Irish Regiment (Home Service)
VCS	Voluntary and Community Sector
VSS	Victims and Survivors Service

Executive Summary

Overview

The *Current and Future Needs of Northern Ireland Veterans* is the second of a series of reports from the NIVHWS. The aim of this research is to gain insight into the experience of veterans in Northern Ireland in accessing services, and to use these perspectives to outline the key needs of the cohort presently and as they are anticipated to develop in the longer term. This was completed by conducting a series of focus groups and interviews with veterans and service providers in the region. Building on the understanding of the sector gained in *Supporting and Serving Military Veterans in Northern Ireland* (the first report from the NIVHWS), alongside a review of existing literature on the needs of veterans in the UK, interview and focus group topic guides were developed to yield a user-led evidence base. Interviews were conducted with service providers working with veterans across the three core sectors, (statutory, voluntary and community, and MOD funded) which represented those providing direct support, those providing specialist provision to this population, such as those in public sector agencies who provide support to veterans as citizens of NI. Focus groups were comprised of a range of participants who met the criteria for veteran status according to the MOD definition[1]. The team has endeavoured to recruit participants from across the veteran population in the region to represent various age ranges, ranks and branches of the armed forces. The aim was to include veterans with a variety of specialist needs, including those who were medically discharged ones, as well as those who are largely disengaged from service providers. The key themes emerging from these findings include:

- The complex and overlapping nature of the needs of this population;
- A series of personal, social and institutional barriers to seeking support;
- The present and future difficulties posed by an ageing population;
- The importance of families, social networks and peer support;
- The legacy of the Troubles and its impact on various aspects of veterans' lives; and
- The need for improved resources and communications across public and voluntary services.

While *Supporting and Serving Veterans in Northern Ireland* outlined the available services and networks for this population, the experiences relayed by veterans and service providers help better understand how these networks operate in practice, their accessibility and appropriateness in the views of those delivering and utilising services.

The Context of Northern Ireland

Northern Ireland is one of four devolved nations within the United Kingdom. It is a relatively small and sparsely populated region, which is recovering economically and socially from several decades of ethno-religious conflict. Health and social care services in the region are largely delivered or commissioned by the state, and are governed by the local Assembly legislature. The post-conflict governance model of power-sharing between parties which are opposed to each other along fiscal and ethno-religious lines has led to difficulty in policy-making in the region and at the time of writing, the region has been temporarily returned to direct rule by Westminster. NI does benefit from advanced equality legislation,

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[1] Anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve).

through Section 75 of the Northern Ireland Act, which promises protection from discrimination for named groups. However, the conflict, in which the British military had an active role for more than 30 years, has led to military service and relationships to the armed forces being contentious issues. As such, the Armed Forces Covenant (AFC), which provides a guarantee that veterans will not be disadvantaged because of their time in the military, is not directly enacted in NI.

Like other regions of the UK, particularly Scotland,NI has an ageing population. Between 1975 and 2015 those aged 65-years and older (the 1940-60s baby boomer generation) increased from 14.1% to 17.8% (Northern Ireland Statistics Research Agency, 2012). This cohort is projected to continue to grow to nearly a quarter of the population by 2045 (Northern Ireland Assembly, 2016). Population growth and changing demographics affect public expenditure. The two most likely to be impacted are health and pensions, since older people consume more health services per capita and longer life expectancies mean pension payments continue for longer. NI also faced slow economic growth and stagnation. The professional services firm PricewaterhouseCoopers (PWC; 2017) forecasts NI to have the lowest economic growth of the UK regions in 2017 and 2018 and to be the poorest-performing UK region in 2018. PWC points out that consumer spending growth will slow down to around 2% in 2017 and 1.7% in 2018, and spending on housing and utilities could rise from 25% in 2016 to 30% by 2030. This is combined with NI workers' real wages down by around £930 per annum compared to 2009. Declines in real wage levels can have an effect on the level of poverty which was 15% and 17% for absolute or relative income poverty[2] in 2015/2016 respectively (Department for Communities, 2017a). According to the Institute for Fiscal Studies (IFS) (Browne, Hood & Joyce, 2014) the projection for working age poverty in NI could increase by more than 7.5% for both measures by 2020. All of these concerns have the potential to be compounded by upcoming policy changes already faced in the UK and only now being implemented in NI. According to Beatty and Fothergill (2013) welfare reforms already in place across GB will have a greater impact on NI than other parts of the UK. The largest financial losses will be £230 million in incapacity benefits; £135 million per year in tax credits; £105 million in disability living allowances and; £20 million in housing benefits. Indeed, welfare reforms will take £750 million per annum out of the NI economy; equivalent to £650 a year for every adult of working age. Three of the reforms most likely to impact on people are: 1) the delay from initial claim for Universal Credit and other benefits such as Employment and Support Allowance to first payment (up to six weeks); 2) the Spare Room Subsidy (reduced benefit for each 'spare' bedroom) and; 3) the Work Capability Assessment (Kennedy, Murphy & Wilson, 2016).

Governance of the majority of local services was devolved to NI in 1997 as part of both a wider UK programme of devolving powers to regional legislatures and the development of the peace process. As part of the devolution legislation, the UK Government retains control over Reserved and Excepted matters such as foreign affairs, defence, social security, macro-economic management and trade. It also retains power over finance; that is, how much money each devolved region receives from the Chancellor. The Northern Ireland Executive and Assembly control a range of devolved matters such as legislation and scrutiny of the NI Civil Service. Local government has a range of limited powers covering waste and recycling, leisure and community services, building control and local economic and cultural development (Gormley-Heenan and Birrell, 2016). This governance structure has several important implications for Armed Forces veterans in NI. The NI Assembly is currently suspended because the two largest parties in the power-sharing Executive, the Democratic Unionist Party and Sinn Féin, have failed to reach an agreement on the reform of government institutions.

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[2] Absolute poverty – proportion of individuals with incomes below 60% of the UK (inflation adjusted) median income in 2010/11; Relative poverty – proportion of individuals with incomes below 60% of the UK median;

Public services in NI are stretched, and health and social care is characterised by long wait lists and a lower likelihood of help-seeking for common mental disorders. Wait lists for mental health treatment in NI have been increasing steadily in the past five years, with none of the five health and social care trusts meeting their wait list targets (Belfast Telegraph, November 2016). Data from the Northern Ireland Study of Health and Stress showed that in NI, the annual total direct and indirect cost of mental health difficulties such as PTSD, was more than £172 million in 2008 (Ferry et al., 2015).

NI Veterans' Needs

For the purposes of this study, a veteran is defined in line with the MOD definition: someone who has served in the Armed Forces for at least a day and is no longer serving in regular forces (Murphy, 2016). Annually more than 20,000 Service personnel leave the Armed Forces and there are around 4 million Armed Forces veterans living in the UK (MOD, 2017a). According to the Ministry of Defence (2004) around 300,000 veterans served on Operation Banner during the Troubles in NI. More than 40,000 of those personnel served in the Ulster Defence Regiment (UDR) and Royal Irish Regiment (R IRISH) – replaced in 2009 by the 38 (Irish) Brigade. These 'home service' regiments were recruited locally, and often included individuals who served in a part-time capacity alongside their civilian jobs. While there is to date no reliable estimate of the veteran population living in NI, an extrapolation of data from The Royal British Legion report estimated the population to be roughly 115,000. Military personnel leaving the Armed Forces may seek help with a number of issues such as accessing services, education and training, employment, housing, reintegrating into family life, and specialist support for difficulties such as mental health.

Some veterans express worries about social stigma associated with mental health difficulties, and have concerns that seeking help for mental health difficulties is a sign of weakness or being 'different'. Military culture may also mean that veterans self-stigmatise and so do not seek or accept help (Greenberg, Langston & Gould, 2007). Issues of barriers between military and civilian populations, and a mismatch of expectations on public health services following military service are also perceived to be an issue for veterans in seeking support. Some veterans reported civilian healthcare professionals as not understanding military-related injuries or ways of doing things (Greenberg, Langston & Gould, 2007). The Call to mind: A Framework for Action report (2015) stated some veterans have unrealistic expectations about waiting times and service responses. Veterans report difficulties with scheduling appointments (Greenberg, Langston & Gould, 2007), and some may lack awareness and understanding about the options available to them and who provides those (Forces in Mind Trust, 2015). Negative attitudes and poor perceptions of the effectiveness of mental health interventions lead to reluctance to engage in treatment such as psychotherapy and cognitive behavioural theory. For veterans in NI, these issues are exacerbated by security concerns. Veterans here express concerns for their safety and that of their family if they reveal their facing discrimination if they reveal their Service history to healthcare professionals (Armour et al., 2017). Given only around 20% of veterans with a mental health difficulty will seek help (Iversen et al., 2011), there is a clear need to understand more about veterans' perceptions, attitudes, and experiences of healthcare and other services in NI in order to improve engagement rates with this population.

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Methods

A total of 13 veteran-led focus groups were conducted between April 2017 and October 2017. Focus groups ranged from 3 to 8. The majority of the participants were male (96%). The mean age of participants was 56 years. Separate focus groups were conducted based on pre-designed age bands: 18-24; 25-44; 45-64; 65-84; and 85+. To complement focus groups, a total of 20 interviews were carried out between October 2016 and February 2017 with representatives from voluntary and statutory agencies providing support to veterans in Northern Ireland.

PHASE ONE	PHASE TWO
Service Provider Interviews	Veteran-led Focus Groups

ANALYSIS OF DATA FROM PHASE ONE	ANALYSIS OF DATA FROM PHASE TWO

INTEGRATION OF PHASE ONE AND TWO DATA

Overall aim of the study: To provide a detailed insight into the current and future needs facing the veteran community in Northern Ireland.
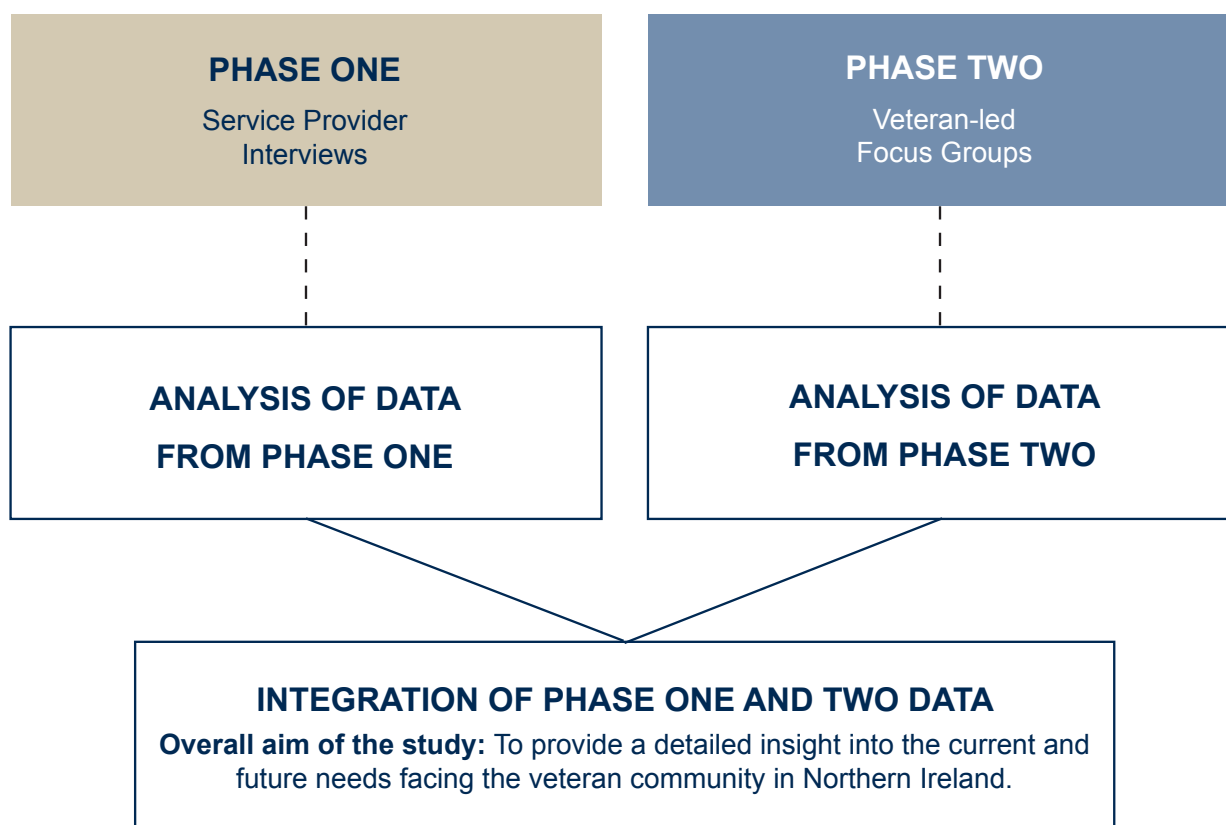
Interviews and focus groups were coded and analysed using NVivo data analysis software based on a series of key themes identified through a review of the existing literature on veteran health and wellbeing and recommendations sought through stakeholder engagement.

Veterans' Current Needs

Previous research (e.g., Hoge, Auchterlonie & Milliken, 2006; Holdeman, 2009; Iversen et al., 2005) has highlighted the complexity of veterans' needs, especially in relation to mental health problems. Discussions with service providers and veterans about the current needs of veterans living in NI produced a varied list of issues, ranging from desire for improved information and guidance to specialist mental health treatment. Most service providers described these issues as multiple in nature, and that seeking help for one problem often led to identification of a number of other adversities through the case-work process. Veterans identified many of the same problems raised by service providers. However, veterans tended to be more specific about their needs, and emphasised the importance of social support networks and family components.

The current needs of veterans according to respondents often ran parallel to those issues facing the wider population in NI, though specific needs or complexities regularly emerged associated with military service. Some service providers discussed how 'trigger' events (e.g., security threats reported in the news) could precipitate the onset of need within veterans, especially among the ex-UDR R IRISH populations. From service providers, charities (both large and small) who deal directly with veterans on a daily basis appeared more cognizant of veterans' needs on the ground. Some statutory organisations that have no 'direct' link with veterans, but who provide services to them as part of their remit, spoke about veteran need from a general, hypothetical stance in relation to their Departmental aims. Table 1 presents an overview of the main current needs in the veteran community from the perspective of veterans and their service providers[34].

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[3] This list is not exhaustive.
[4] With reference to mental health needs, some of these were reported by non-specialist service providers and so may not carry a confirmed clinical diagnosis.

Table 1 - Veterans' Current Needs

Themes	Sub-Themes
Complex and Overlapping Needs	Employment; health; social; domestic; emotional
Health Needs	Mental health; PTSD; anxiety; guilt; physical health; prosthetics; ageing
Issues Associated with Ageing	Isolation; healthcare; care; mobility; care
Finance	Funeral costs; domestic bills: food, rent, home-heating oil, unemployment, training courses, benefits
Welfare, Benefits and Pensions	Financial assistance; scheme entitlement; money management; entitlement; applying; remote vs Troubles
Social Support and Comradeship	Shared culture; membership organisations; comrade organisations; like-minded people; feeling like part of a family and part of a network; feeling comfortable; mutual understand; not being judged
The Shock of Transition	Career Transition Partnership; vocational skills training; identity management; entitlement; cultural adjustment
Safe Space	Trust; non-judgemental; like-minded people; drop-in centre

Although they are not an amorphous group with homogenous needs, those veterans who are in contact with support agencies are relatively consistent about the needs with which they present; and these needs are normally multiple, interrelated, and sometimes at odds with each other. Mental health continues to be an issue, but not one with which the majority of veterans are forthcoming. Many of the issues, such as financial difficulties and those complexities facing an ageing population, are consistent with the issues facing the general population. This is a population for which comradeship and belonging play a major part in mental and emotional wellbeing, and moving forward, support providers would do well to incorporate social elements in responsive service provision.

Barriers to Support

Problems around accessing services and barriers to access were mostly raised by participants working in the voluntary sector and veterans themselves. Service providers described several multifaceted barriers inhibiting veterans in seeking support services, and frequently pointed out the personal/psychological barriers of veterans themselves. Across responses from service providers and veterans, the main barriers

can be classified as either structural or psychosocial. Key structural barriers related to the practical accessibility of services; this encompassed disconnect around the roles and responsibilities for 'who does what' in managing veterans' support needs. Other practical barriers included fragmentation of services due to geographical location and a lack of information about what services and support exists for veterans. Of the psychosocial barriers, stigma and lack of trust (associated with fears for personal safety) were noted as the major inhibitors to seeking treatment.

Table 2 - Barriers to Support

Themes	Sub-Themes
Armed Forces Covenant	Recognition of Service; Recognition of special needs
Accessibility	Geographical location; Client engagement and awareness; acceptability of modes of service
Stigma	General stigma associated with mental health; Stigma related to military culture
Military Culture	Cultural understanding; mental health stigma; labelling; Service identity; recognition of Service
Trust	Expectations of service provider and service user; Hypervigilance and the legacy of the Troubles

Based on the description of the barriers to accessing care given by service providers, veterans - particularly those with mental health problems - may require more targeted outreach in order to reduce unmet need(s) across NI. Service providers should work to break down those barriers that interfere with getting access to care and interfere with service utilization among veterans. Although each veteran will be an individual with different military experiences, they may face similar barriers to care. Service providers clearly have an awareness of the barriers potentially preventing veterans from accessing their services; therefore, it is not enough for service providers to just 'exist' – practical improvements are needed to foster the trust and confidence of those who are in need, and to engage those harder to reach populations. Furthermore, expectations serve as a major determinant in a client's service quality evaluation, satisfaction, and willingness to engage in future. If misunderstandings in the roles and responsibilities between service users and service providers continue to exist, this may lead to veterans having unrealistic and unmet expectations, which in turn may lead to poorer engagement with services, highlighting the need for veterans to be better informed (at the point of discharge) about what the roles and expectations are when accessing support services.

Veterans' Future Needs

Many respondents struggled with the idea of predicting future need, but they were able to discuss it at length indirectly. Most service providers anticipated issues with an ageing population and recognised the

time-lag in the discharge from the military and help-seeking for mental health, while veterans themselves tended to focus on their families and alternatives to the 'norms' of support. Respondents were aware of the urgency in thinking about how the needs of veterans will change and the impact this will have on how support organisations operate, and policy is made.

Perspectives on future needs of veterans varied between respondents. For veterans, age and life stage impacted on responses, whereas for service providers, issues varied between sectors. For example, younger veterans were more interested in issues related to future careers (e.g. training, employment), whereas older veterans were more focused on pensions and retirement. However, younger veterans did claim that older veterans, (those of Operation Banner), seemed to get more financial benefits than those who had served overseas. From a statutory perspective, there needs to be continued investment in mental health services, which is consistent with the needs of the population as a whole. From the veteran-specific service perspective, mental health is also of paramount concern. Given the lack of UK involvement in any major global conflicts, participants believe that investment needs to be made in tackling the stigma of coming forward with mental health problems (see *Heads Together*, a mental health initiative led by The Duke and Duchess of Cambridge and Prince Henry of Wales). Encouraging self-referral and breaking down barriers associated with such is deemed to be a priority in moving forward. Across the sectors, an ageing population is deemed to be a key problem facing those serving veterans in NI, and services need to be responsive to this significant demographic change and all that comes with it. In some cases, ageing and mental health overlap, and the intersection of the two issues will also be addressed in this report. Veterans were more likely to focus on personal issues and family support, and showed a desire for more adaptable, holistic and non-traditional services. This was one of the biggest areas of divergence between veteran and service provider responses, with only mental health as a shared theme.

Table 3 - Veterans' Future Needs

Themes	Sub-Themes
Mental Health	The dynamic nature of mental health needs; increasing wider awareness; long-term investment in mental health services
Ageing	Physical health; mobility; infrastructure
Family Services	Welfare; pastoral; health; emotional; child-support
Alternative Support Services	Dogs for veterans; outreach programmes

In looking to the future, the needs of the veterans in NI will remain a complex, evolving network of issues and service providers will need to adapt to these changes if they are to meet needs, especially in relation to ageing and mental health problems. Based on the descriptions given by veterans about their current and future needs, better support for the veteran's family unit should be more readily available. Other alternative forms of support described included the use of dogs for emotional support. Although there was acknowledgement from service providers that some positive steps have been taken (e.g. breaking

down barriers to stigma, long-term statutory health and social care plans), more needs to be done to ensure that veterans and their families are able to access support which is appropriate to their need.

The Legacy of the Troubles in Northern Ireland

In addressing the needs of veterans in NI, service providers, especially those funded by the VSS within the voluntary sector, delineated additional layers of complexity for veterans who served in NI during the Troubles compared with veterans who served in remote operational theatres (e.g., Iraq and Afghanistan). Many respondents differentiated between veterans who served during Operation Banner and those who didn't, and ultimately implied that the former experienced more significant barriers. Many veterans of Operation Banner feel they have been 'demonized' and 'criticized' and believe they do not receive adequate recognition for their service. This is compounded by perceived security concerns for themselves and their families – which often leads to a reluctance to seek help.

While equality legislation prevents agencies from discriminating against this population, there are some elements of service which can lead to disadvantage in terms of accessing education for children of service personnel or losing places on housing lists. In GB, the AFC seeks to address these potential disadvantages. However, in NI, lack of implementation of the AFC may mean these issues are not being address. Additionally, the legacy of the Troubles in Northern Ireland and the ongoing security threats against security personnel in the region mean that public perception and personal concerns act as barriers for those who served in this conflict. While it is important to avoid the development of a two-tiered system of support, or differentiating too much between groups of veterans based on where they served, the impact of the Conflict in NI cannot be ignored when attempting to mitigate against barriers to improving the wellbeing of veterans in the region.

Organisational, Systemic and Institutional Barriers

A fundamental organisational challenge when striving to improve, is not simply to maintain static, but to engage in a continuous need to balance and coordinate change throughout the organisation (Lam, 2004). All service providers discussed key factors that can and do affect service delivery. The main challenges included working with limited resources (e.g. funding and staffing); and communication and information sharing. The nature of these organisational challenges requires constant adaptation, with funding/budgetary constraints being the largest and most significant factors faced across all sectors.

Table 6: Organisational Challenges

Themes	Sub-Themes
Resources	Funding; staffing; organisation/funder relationship
Health Services	Mental health support and delivery; family; information sharing; service-user-health professional interaction
Communications	Collaboration; competition

Service providers and veterans put forward several complex factors that pose a challenge to implementing service delivery. Funding, across all organisations and sectors, was stated as the most common challenge in service delivery. The centralisation of services within the while designed to be more cost-effective and efficient, may not be the most effective way to reach out to veterans in need. This is particularly true, according to many respondents, of the move towards more self-help and remote interventions. Moreover, voluntary organisations that rely on volunteers or a small staff pool are in a precarious position when it comes to being able to meet demand. Communication within and between organisations, and externally towards veterans, was highlighted as needing improvement. Large umbrella organisations, such as Cobseo, should do more to ensure that smaller organisations are given opportunity to join up, which would improve information sharing within the sector across NI. Service providers also need to better disseminate their information to veterans to reassure the veteran community that their cases will be fully understood and kept confidential. Greater communication and engaging with internal and external partners to build working relationships would help with developing signposting routes for veterans and enhance an organisation's capacity to deliver constructive support. These are consistent with many of the conclusions and recommendations from the *Supporting and Serving Veterans in Northern Ireland* report.

Conclusions and Recommendations

Key actions moving forward should include, finding ways to recognise veterans' service, improvement in communication between different organisations that work with veterans and between their employees and the veterans, resourcing to improve the services that can be delivered, and exploring alternative forms of reaching out to and engaging with veterans.

Reflecting on the key findings of this report, and following on from the previous work carried out in *Supporting and Serving Veterans in Northern Ireland*, we have developed a number of practical recommendations based on the experiences relayed to us throughout this research to date. These recommendations are for the consideration of policy-makers in MOD, Northern Ireland Office (NIO) and the NI Executive. There are also recommendations for service providers and care commissioners across the statutory and voluntary sectors.

Key Area	Recommendation	Implications
The Armed Forces Covenant	Key officials should undertake a public engagement exercise with veterans in NI to establish potential solutions to the lack of implementation of the Armed Forces Covenant in the region.	While the political sensitivities around the Armed Forces Covenant are such that implementation of the Covenant is a complex, issue a public engagement exercise may help identify innovative solutions, and provide an opportunity for veterans to express their wishes/concerns surrounding these issues.
Community Integration	Local Authorities should work with Armed Forces Charities to identify ways in which community integration activities could be undertaken and where service might be recognised in a safe space for veterans. For example, Armed Forces Day can be used as an example for how the public may be able to engage with veterans in a meaningful way.	Help develop veteran and community cohesion, trust, and understanding in order to help strengthen and normalise relationships.
Communication	A centralised resource (whether the NIVSC, Veteran Support Office (VSO) or related agency) should support the facilitation of increased communication and information sharing between military charities, statutory services and the wider VCS. To support this, we recommend the adoption of the model proposed in *Supporting and Serving Veterans in NI* (Armour et al, 2017)	Improved information sharing can support better access and appropriateness of services as veterans are more easily referred to the appropriate provider, and resources can be pooled and shared to serve the population.
Resourcing	Recommendations around improving resources to local organisations outlined in *Supporting and Serving Veterans in NI* should be adopted.	Improving resources to grassroots organisations has the potential to improve overall service provision to veterans in NI.

Key Area	Recommendation	Implications
Awareness Training	A programme of training should be made available to public sector service providers, with particular emphasis on mental health professionals. This awareness raising could be done through one-off workshops or online provision, and could provide insight into the differences between military/civilian culture.	Training has the potential to improve understanding of veteran related issues in public sector service providers, and in turn improve the quality and efficacy of the services.
	Cobseo should support the development of a standardised volunteer induction programme, of which smaller charities could avail. This should be accessible to all veteran-related charitable services in this region.	Standardised volunteer training supports a high standard of volunteer capacity, with minimal resource investment.
	Work should be done around developing clinical interventions to treat PTSD where hyper-vigilance is a normalised part of the patient's culture, as has been the case in NI.	PTSD treatment for those in NI could be improved to suit the local setting
Age-Related Support	Ex-service charities should begin to develop pro-active strategies to prepare for changing demographics. This should include liaison with statutory community care providers in order to support the delivery of veteran appropriate services where required.	Service providers may be able to be more responsive to changing demographics if they are able to plan ahead.
	Further research on potential relationships between veteran-related issues and dementia should be explored. dementia could support the	A greater understanding of relationships between PTSD and dementia or Traumatic Brain Injury (TBI) and development of improved services to this population.

Key Area	Recommendation	Implications
Alternative Support	Services which centre the importance of social and peer support should be funded and promoted. Some potential options include: - Providing training to veterans to deliver peer support to those dealing with mental ill health - Identification of less clinical approaches to mental health support and supporting their implementation (i.e., Men's Shed for veterans, veteran specific running clubs or training groups)	Providing alternative forms of support allows veterans to access the support they need in spite of the stigma and social barriers they face in seeking help. Providing opportunities for social support helps reduce isolation and facilitate the comradeship so many veterans expressed missing in civilian life.
Access to support	Organisations should acknowledge the importance of more pro-active outreach to identify and engage hidden or hard to reach veterans.	Allow less able and or reluctant veterans to get the help and support that they need.
Increased support for Transition in NI	More work should be done to support the long-term employment needs of veterans in NI. While the CTP programme is available to veterans in NI, it is not clear that there is sufficient resource to deal with the complex issues facing some veterans entering the civilian workforce in NI. A piece of work should be undertaken around the transition process as it relates to NI, recognising the specific issues facing veterans in this region. This work should also include the experiences of families during transition, given the prominence given to family support in focus groups.	Improved resources for CTP and associated programmes in NI could allow for more regionally specific adaptation and could reduce both underemployment and unemployment in this population. Research on the transition process in NI would provide insight into the needs of NI veterans during this time, and support the improvement of transition support for this population.

Further Research

The relative absence of research specifically on NI veterans and their specific needs is a key finding of this report. In the context of limited information, there are a number of potential avenues for further research:

- *Explore public and health service professionals' perceptions of NI veterans:* NI veterans talked about security issues with divulging their former military identity to those in public and health services. Interviewing public service and health professionals to identify their attitudes, perceptions and experiences of NI veterans might help to identify possible interventions that would help develop trust in the services they provide;

- *Explore alternative ways to support and engage NI veterans:* Given Iversen et al. (2011) suggested that only around 20% of veterans with a mental health difficulty will seek help, feasibility studies could explore the development of veteran drop-in centres and the employment of community liaison officers. A systematic literature review might also shed light on alternative means of outreach to veteran populations;

- *Support needs of military veterans' families:* The importance of family support networks, and the specific needs of families in NI was raised throughout the study. Research exploring how the different sectors can best provide support relevant to families of NI veterans would provide further insight.

- *Veterans' help-seeking behaviours:* Patterns of veterans' help-seeking is an emerging area of research (see Rafferty et al, 2017), but is still lacking a substantial evidence base (Murphy et al., 2015). We would recommend an exploratory study like this one that invites those veterans who have sought help to discuss their personal experiences. This would be a more specific and detailed exploration of some of the points raised during the focus groups in this study;

- *Online mental health support:* Bristol University INTERACT study (http://www.bristol.ac.uk/psychiatry/research/interact-delphi/) has shown that the online administration of Cognitive behavioural therapy (CBT) can be a low cost effective way to treat depression. Additionally, there is an ongoing study by Combat Stress on the acceptability of teletherapy for remote veterans suffering mild to moderate PTSD which is due to report in February of 2018. Therefore, it would be useful to explore whether this form of treatment would benefit those veterans who either have access issues or are reluctant to seek face-to-face support.

Concluding Remarks

This study seeks to provide insight into needs of veterans living in NI based on their experiences, and the perceptions of those who come into direct contact with this group. Given the personal nature of this research, it is important that the detailed information provided by participants will be used to contribute to the continuation of present and development of new health and social support for NI veterans and their families. NI veterans' express needs similar to many of the rest of the veteran population in the UK, but also identify a unique set of issues related to living where they were formerly deployed. Issues related to trust, social stigma, and a desire for public recognition of military service are significant for NI veterans and as such, different methods of engagement and interventions may be required. The findings of this report validate many of the inferences made in Supporting and Serving Veterans in NI (Armour et al, 2017), and the recommendations are designed to complement and build upon those made in the previous report. Future work packages from the NIVHWS will develop these issues

further; exploring the idea of a veterans' centre, providing the best possible estimate of the number and location of veterans in NI, and finally exploring the mental health and wellbeing of the population through a large-scale survey. Taken as a full study, this compliment of research will provide a substantial evidence base upon which policy-makers and service providers can draw to develop flexible and responsive health and social support for this population.

1.0 Introduction

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Overview:

- Northern Ireland Veterans' Health and Wellbeing Study (NIVHWS)

- Current and Future Needs: aims and objectives

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This report is the second in a series of reports providing the first ever comprehensive evidence base on veterans living in Northern Ireland (NI). It focuses specifically on the current and future needs of veterans, by using the experiences of veterans residing in the region.

1.1   The Northern Ireland Veterans' Health and Wellbeing Study

In 2015, Forces in Mind Trust (FiMT) commissioned Dr Cherie Armour and Ulster University (UU) to conduct two studies into the health and wellbeing of Northern Irish veterans. The studies were a direct response to a significant gap in information about the support needs of the veteran population living in NI.

Recognising the overlap between the different components of the two studies, as well as seeing the value in combining resources and approaches to create a more streamlined and holistic study, the two projects were merged into one, large-scale project to be conducted over four years in total. The two studies were merged to produce *The Northern Ireland Veterans' Health and Wellbeing Study* (NIVHWS), consisting of four work packages:

1. Scoping Services to Veterans in NI (completed June 2017):

- The production of a report scoping the services available to veterans living in NI across the statutory, voluntary and community sectors (VCS).
- The development of practical recommendations for adoption at the strategic and operational levels, designed in conjunction with key stakeholders.

2a. Current and Future Needs of Veterans in NI – Experience Based (completed December 2017):

- Focus groups with veterans living in NI and interviews with service providers working with veterans in NI to identify the current and future service and support needs of the population.

2b. Current and Future Needs of Veterans in NI – Self-report Survey Based (anticipated Spring 2019)

- A large-scale mental health survey for veterans in NI, where they will report on their physical and mental wellbeing, lifestyle, social networks, transition from military life, the development of a veteran centre, and more.

3. *Quantification of the Veteran Population (anticipated in the final quarter of 2018)*

- The development of a self-identification survey for veterans in NI.
- The use of statistical methods to use existing data combined with the self-report findings to produce an informed estimate of the size and location of the veteran population in NI.

4. *Communication and Awareness Raising (ongoing)*

- Consultation with key stakeholders throughout the research process.
- Development and maintenance of a project website, social media pages, and physical presence at key events (e.g. Armed Forces Day).
- The production of a series of reports detailing the findings of each work package.
- Launches, executive summaries and lay summaries of each of the reports to disseminate the materials across a range of stakeholders.

Figure 1: Project Work Packages

Scoping of Available Services

Quantification

NI Veterans' Health and Wellbeing Study

Current and Future Needs

Communications and Dissemination

At the time of writing, the first work package of the NIVHWS has been completed, and two additional ones are ongoing. These work packages are outlined briefly below.

Scoping Current Supports and Services

The first report Supporting & Serving Military Veterans in Northern Ireland (Armour, Waterhouse-Bradley, Walker, & Ross, 2017) used a scoping methodology to map out the service provision landscape for veterans in NI. It examined:

- The existing mental health services, support arrangements, and channels of communication between the Ministry of Defence (MOD), local authorities and not-for-profit organisations;
- The existing service provision, barriers to access, gaps in provision, and duplication;
- How existing mechanisms that underpin support might be improved, including relationships with statutory bodies, and suggested new mechanisms to be developed.

A systematic approach was deployed to gather information from publicly available documents, online resources, and communication with service providers. The data was collated and written into a report distributed to key stakeholders in statutory, MOD and voluntary and community sectors. The scope of the report sought only to identify the availability of services to this particular population, and did not evaluate or examine accessibility, acceptability or efficacy of these services and service providers.

While there was evidence that there were a wide range of support services available to veterans in NI, potential barriers to accessing these services did emerge. There are clear differences in the region in the way veterans access services, the nature and number of statutory and voluntary services available to them, and their levels of direct representation in local and regional government. These differences, and the potential for the wider policy and implementation structures to be misunderstood by national legislators or GB-based voluntary organisations, increase the importance of having services informed by those with significant local knowledge and understanding, and effective communication across sectors and governments. It was not clear from the evidence that these things were in place, and recommendations were made to enhance these engagement networks and make them more locally relevant and appropriate. The issues around understanding, and structures are compounded by real and perceived concerns about personal security and the related reluctance to disclose Service history when accessing services. This leads to problems with the visibility of voluntary and community organisations serving this community. The report did not assess the quality of the services available to veterans in NI, but it did outline the availability and accessibility of what veterans have at their disposal in the region. Through placing this in the wider social and political context of the region, some early conclusions were drawn (Armour et al., 2017).

Quantification of the Veteran Population

To address the lack of information on the location and general demographics of the veteran population in NI, and the absence of data collection in this area at present, this work package is employing advanced statistical methods to make an informed estimate of the numbers and general geographical spread of this cohort. It will do this by generating a new dataset by administering a self-identification survey for veterans in NI, and through accessing existing data sets of service users from key organisations providing support to veterans in NI. By using encryption software to ensure anonymity, these data sets will be merged and duplicates used to estimate the size of the veteran population to date. At the time of writing, more

than 1,000 veterans had completed the self-report survey, and agreement has been obtained to share anonymous data sets. This work is expected to complete in the final quarter of 2018.

The Veteran Health and Wellbeing Survey

The research team have designed and developed a large scale self-report survey that will be promoted within the Northern Irish veteran population. This survey will allow for the collection of data that will provide and understanding of veterans' health and wellbeing by assessing a number of key areas, such as help-seeking, coping skills, social support networks and whether or not people have, or are experiencing, any psychological difficulties. In designing the survey, the research team reviewed a large number of pre-existing surveys that had been administered in military and veteran populations across the world. The purpose of this was to identify the most frequently used measures across a number of constructs to allow for future comparisons between our data and existing datasets. The research team developed a list of modules and related measures for inclusion in the survey. The use of existing measures allows us to collect the data using reliable and pre-tested tools, while the development of NI specific measures will provide us with information specific to this cohort. The survey has been piloted using the 'thinking aloud' method, where a small group of veterans were invited to take the survey alongside a researcher, reporting on their understanding of the full survey and the measures included within it. The team anticipates launching the survey before the end of the year (2017).

Communication and Awareness Raising

This work package endeavours to increase awareness of support and services available to veterans in NI. This originally included the development of a responsive website, which was designed to improve accessibility to supports and services using the information collected during the scoping review. A part this work package was the collection of information about how and where the website was being used and by whom. During the first year of the report, however, it came to our attention that the Veterans' Gateway project had similar goals. While the Gateway project is in development, the team has deferred progression of this work package while retaining a watching brief on the role of the Veterans' Gateway for veterans based in NI. This ensures that there is no confusion or duplication to the user group. By channelling information gleaned from the NIVHWS into the Veterans' Gateway, there is a greater chance of sustainability of the site beyond the life of the current project. No final decisions have been taken on the future plans for the website, but any changes will be done in collaboration with FiMT and other relevant stakeholders.

1.2   The Current and Future Needs: Aims and Objectives

The *Current and Future Needs of Northern Ireland Veterans* is the second of a series of reports from the NIVHWS. The aim of this research was to gain insight into the experience of veterans in NI in accessing services, and to use these perspectives to outline the key needs of the cohort presently and as they are anticipated to develop in the longer term. This was completed by conducting a series of focus groups with veterans living in NI, in addition to conducting a number of interviews with service providers working with veterans in the region. Building on the understanding of the sector gained in *Supporting and Serving Military Veterans in Northern Ireland* report, as well as a review of the existing literature on the needs of veterans in the UK as a whole, interview and focus group topic guides were developed to yield an evidence base which is user-led. Interviews were conducted with service providers working with veterans across the three core sectors, which represented those providing direct support, those providing specialist provision

to this population, as those in public sector agencies who provide support to veterans as citizens of NI. Focus groups were comprised of a range of participants who met the criteria for veteran status according to the MOD definition[5]. The team has endeavoured to recruit participants from across the veteran population in the region to represent various age ranges, ranks and branches of the Armed Forces. The aim was to include veterans with a variety of specialist needs, including the medically discharged ones, as well as those who are largely disengaged from service providers. The key themes emerging from these findings comprise the majority of this report.

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[5] Someone who has served for at least one day with the Regular Armed Forces (this may include current Reservists) or someone who has served with the Reserves and no longer serves.

2 The Northern Ireland Context

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Overview:

- Introduction

- Demographics and Population Change

- The Political Context

- UK Government

- Northern Ireland Assembly and Executive

- European Union

- The Economic Context

- The Wellbeing of the Population

- Mental Health and Service Use

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Northern Ireland is one of four devolved nations within the United Kingdom. It is a relatively small and sparsely populated region, which is recovering economically and socially from several decades of ethno-religious conflict. Health and social care services in the region are largely delivered or commissioned by the state, and are governed by the local Assembly legislature. The post-conflict governance model of power-sharing between parties which are opposed to each other along fiscal and ethno-religious lines has led to difficulty in policy-making in the region and at the time of writing, the region is at risk of being returned to direct rule by Westminster. The region does benefit from advanced equality legislation, through Section 75 of the Northern Ireland Act, which promises protection from discrimination for named groups. However, the conflict, in which the British military had an active role for more than 30 years, has led to military service and relationships to the armed forces being contentious issues. As such, the Armed Forces Covenant (AFC), which provides a guarantee that veterans will not be disadvantaged because of their time in the military, is not directly enacted in NI. This chapter will provide insights into NI as a social, cultural, economic and jurisdictional context for the current and future needs of veterans living in the region.

2.1 Demographics and Population Change

According to the most recent estimate (at 30 June 2016), NI has a population of 1.86 million people (Northern Ireland Statistics and Research Agency (NISRA), 2017a). Population growth has remained steady in the region due to a relatively high birth rate and recent immigration increases. The population is predicted to grow to 1.94 million by mid-2026 (NISRA, 2017a) (Like other regions of the UK, NI has an ageing population. In the year ending mid-2016, the number of people aged 65-years or older increased by 2%, reaching a total of 16% of the NI population. It is estimated that this age group will increase by 25% by mid-2026 (NISRA, 2017a). An ageing population has also coincided with longer life expectancies. Males born between 2011 and 2013 are expected to live up to 78.1 years of age and females born in this period

are expected to live up to 82.4 years of age (NISRA, 2015). Population growth and changing demographics affect public expenditure. The two most likely to be impacted are health and pensions, since older people consume more health services per capita and longer life expectancies mean pension payments continue for longer. Recent political decisions mean that the State Pension age, which is currently 65 for men and 63 for women, is set to increase to 66 for both men and women by 2020 and then 67 by 2028 (Northern Ireland Assembly, 2016).

2.2 The Political Context

Governance of the majority of local services was devolved to NI in 1997 as part of both a wider UK programme of devolving powers to regional legislatures and the development of the peace process. Northern Ireland has a devolved government. As part of the devolution legislation, the UK Government retains control over Reserved and Excepted matters such as foreign affairs, defence, social security, macro-economic management and trade. It also retains power over finance; that is, how much money each devolved region receives from the Chancellor. The Northern Ireland Executive and Assembly control a range of devolved matters such as legislation and scrutiny of the NI Civil Service. Local government has a range of limited powers covering waste and recycling, leisure and community services, building control and local economic and cultural development (Birrell & Gormley-Heenan, 2015). This governance structure has several important implications for Armed Forces veterans in NI.

2.3 UK Government

First, and most obviously, the level of funding from the UK Government will determine how much the Northern Ireland Executive and Assembly have to allocate to public services that veterans are likely to require, such as healthcare, welfare benefits, housing and so on. Of the 88% of government spending (after defence spending etc.), NI gets 21% more than the UK as a whole (Scotland 16%, Wales 10%). But, although funding levels are set to increase, in real terms they will decline as spending cuts need to be made to manage the UK public deficit (Northern Ireland Assembly, 2016). As noted above, two of the public services most likely to be affected, and in turn potentially impact on veterans, are health services and the state pension. Other areas such as public-sector housing and welfare reform are also likely to be affected. In addition, the UK Government is responsible for the Brexit[6] negotiations and what happens to trade, freedom of movement, the NI / Republic of Ireland border and other important issues between NI and the Republic of Ireland which have the potential to impact on peace and security.

2.4 Northern Ireland Assembly and Executive

The NI Assembly is currently suspended because the two largest parties in the power-sharing Executive, the Democratic Unionist Party and Sinn Féin, have failed to reach an agreement on the reform of government institutions. A suspended Executive and Assembly puts increasing pressure on public services, as operational and budgetary decisions cannot be made without Ministerial assent.

Decisions by the Northern Ireland Executive and Assembly also impinge the implementation AFC. The AFC is a promise made on behalf of the UK Government and society that those who serve and have served in the Armed Forces will not experience disadvantage. There has been success in adopting the AFC in

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[6] A popular term for the withdrawal of the United Kingdom from the European Union.

England, Scotland and Wales. The AFC is underpinned by considerable financial investment (£10m per annum; MOD, 2017). The NI Assembly has not formally adopted the AFC. Section 75 of the Northern Ireland Act 1998 requires NI public authorities to carry out their functions and duties equally irrespective of gender, ethnicity, political opinion, religious belief, disability, age, sexual orientation, dependant and marital status. It has been argued (House of Commons Northern Ireland Affairs Committee, 2013) that the implementation of the AFC in NI could provide preferential access to cross-government services for military personnel and thus counter to equalities legislation (Section 75). Although the NI Legislative Assembly has not formally adopted the AFC, some local councils in NI have adopted the principles of the AFC at a community level.

2.5   European Union

Lastly, some NI veterans may have access to support provided by the various projects funded by the *Peace IV Programme, a European Union Programme for Peace and Reconciliation*. The series of EU programmes for peace and reconciliation are aimed at improving cross-community relations and integrating divided communities through funding projects which benefit a wide range of sectors, areas, groups and communities which have been particularly affected by the civil conflict, colloquially known as Troubles. The Peace IV Programme runs from 2014-2020. It is not yet known whether Brexit will affect this. The EU funds 85% of the Programme (Peace IV) or €229m. The remaining 15% or €41m is match-funded by the Irish Government and the NI Executive. Projects that have benefited include the Victims and Survivors Service (VSS) (2017) that has been awarded more than £11.3m to assist all victims and survivors of the Troubles. This includes those physically or psychologically injured; those who care for people who are injured; and those who have been bereaved.

2.6   The Economic Context

The economic situation of the region is likely to have significant impact on the population through availability of resources, employment, and funding of support and services. Developing a strong and sustainable economy has been determined to be a primary focus of the Programme for Government of the NI Executive (Northern Ireland Assembly, 2016). Traditionally, Gross Domestic Product has been used as a measure of the health of the economy, presuming that if production is healthy then other areas of the economy are likely to be too. According to the Northern Ireland Executive (2016), the economy continues to grow with forecasts for 2017-2018 to be between 1.7-1.9%, depending on the forecast source (Northern Ireland Executive 2016; Danske Bank, 2017). However, such measures can be misleading, because they do not necessarily measure the wellbeing of a society. Thus, in 2008 the Commission on the Measurement of Economic Performance and Social Progress was set up to examine how the wealth and social progress could be measured without relying on the Gross Domestic Product. Their report (Stiglitz, Sen, & Fitoussi, 2009) resulted in a number of countries and organisations revising their measures of wealth and social wellbeing. The Measuring National Wellbeing programme established by the UK Office for National Statistics was launched in 2010 and sets out a range of measures, organised under 10 key domains: personal wellbeing; personal relationships; health; people's activities; location; personal finance; the economy; education and skills; governance; and the natural environment.

The professional services firm PricewaterhouseCoopers forecasts NI to have the lowest economic growth of the UK regions in 2017 and 2018 and to be the poorest-performing UK region in 2018 (PricewaterhouseCoopers, 2017). PricewaterhouseCoopers points out that consumer spending growth

will slow down to around 2% in 2017 and 1.7% in 2018, and spending on housing and utilities could rise from 25% in 2016 to 30% by 2030. This is combined with NI workers' real wages down by around £930 per annum compared to 2009. Declines in real wage levels can have an effect on the level of poverty which was 15% and 17% for absolute or relative income poverty[7] in 2014/2015 respectively (Northern Ireland Executive, 2016). According to the Institute for Fiscal Studies, the projection for working age poverty in NI could increase by more than 7.5% for both measures by 2020 (Browne, Hood, & Joyce, 2014).

Forecast declines in economic growth and performance (PricewaterhouseCoopers, 2017) may also impact on the level of social housing. Although there have been increases in the number of dwellings in NI (Department for Communities, 2017b) the Royal Institution of Chartered Surveyors (2017) points out that the stock of housing in NI remains at a record low, whilst at the same time there has been a steady demand in the number of applicants for social housing (Department for Communities, 2017b). The disparity between the need for accommodation and its availability inevitably means that some will face homelessness. According to the Northern Ireland Audit Office (2016), there has been a steady increase homelessness in recent years.

Although employment is near its pre-2008 financial crisis levels and the number of unemployment claims have been steadily declining, PricewaterhouseCoopers (2017) points out that there remains a significant amount of uncertainty over Brexit. NI will be the region of the UK most affected by Brexit (Tonge, 2017). The main concern will be the introduction of a 'hard border' with the Republic of Ireland. Customs controls and immigration checks are likely to have an adverse economic impact on cross-border trade and investment, and may also hinder the freedom of movement of people between NI and the Republic of Ireland (Tonge, 2017).

2.7   The Wellbeing of the Population

To best understand the health and wellbeing of the veteran population in NI, it is important to frame this cohort within the wider population. This section will provide an overview of some of the key issues affecting the health and wellbeing of people living in NI.

Overall, there is reason to be positive about life in NI. More people in NI report very high levels of life satisfaction, feelings of worthiness and happiness and low levels of anxiety, compared to the UK average (NISRA, 2017b). Only a small proportion (6.6%) report being fairly or extremely unhappy in their personal relationships, compared to 8.4% in the wider UK. Slightly more people in NI report being satisfied with the amount of leisure time they have (47%) compared to the UK as a whole (43.7%) and more people in the region feel that they belong to their neighbourhood (78.7%) than the national average (68.8%; NISRA, 2017b).

However, there are also some causes for concern. For example, compared to the wider UK, people in NI expect to have fewer years of good health and there are more people in NI aged 16-64 who have no formal qualifications (15.8%) compared to the wider UK (8.1%; NISRA, 2017b). According to the most recent figures from the Office of National Statistics, in 2015, NI also had the lowest gross disposable household income of all the regions; £15,913 compared to the UK average of £19,106 (Office for National Statistics, 2017).

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[7] Relative poverty – proportion of individuals with incomes below 60% of the UK median; Absolute poverty – proportion of individuals with incomes below 60% of the UK (inflation adjusted) median income in 2010/11

The life expectancy is increasing in the region, but health inequalities remain substantial. A man living in the most deprived region of NI can expect to live nearly five years less than his counterpart does in the wealthiest part (Gray, Horgan, & Leighton, 2015).

All of these concerns have the potential to be compounded by upcoming policy changes already faced in the UK and only now being implemented in NI. According to Beatty and Fothergill (2013), welfare reforms already in place across GB will have a greater impact on NI than other parts of the UK. The largest financial losses will be £230 million in incapacity benefits; £135 million per year in tax credits; £105 million in disability living allowances and; £20 million in housing benefits. Indeed, welfare reforms will take £750 million per annum out of the NI economy; equivalent to £650 a year for every adult of working age. Three of the reforms most likely to impact on people are: 1) the delay from initial claim for Universal Credit and other benefits such as Employment and Support Allowance to first payment (up to six weeks); 2) the Spare Room Subsidy (reduced benefit for each 'spare' bedroom) and; 3) the Work Capability Assessment (Kennedy, Murphy & Wilson, 2016).

Harrington (2012) carried out an independent review of the application of the Work Capability Assessment in NI and was critical of the suitability of the descriptors used in the assessment, particularly for claimants suffering from mental health conditions. This is of particular pertinence in NI, given the prevalence of mental health difficulties in the region – rates of up to 25% higher than in England (Department of Health, 2014a).

2.8   Mental Health and Service Use

Ferry et al. (2008) reported that the reason for high rates of mental health difficulties in NI could be the exposure to more potentially traumatic events in the region, related to the Troubles. A study conducted by Bunting et al. (2011) for the Commission for Victims and Survivors found an estimated 61% of the NI population have experienced some kind of a traumatic event at some point in their lifetime, and 39% of the total NI population have experienced a Troubles-related traumatic event. In relation to help-seeking, the study revealed great variability, depending on disorder type. For example, 79.1% of individuals who have experienced a Troubles-related traumatic event and had major depressive disorder sought help, 66.5% of individuals with PTSD sought help, but only 14.6% of individuals with separation anxiety disorder or adult separation anxiety sought help. There was also variability in terms of the perceived effectiveness of the received treatment. For example, 68.9% of those who sought help for major depressive disorder, found the treatment effective, compared to 44.1% of those who sought help for alcohol/drug use. Overall, 18.3% of individuals who experienced a conflict-related traumatic event used prescription medication for problems with their emotions, nerves or mental health in the 12 months prior to the study being conducted (Bunting et al., 2011). Delays in seeking treatment (from first onset of the disorder to first treatment contact) also vary with respect to disorder type. For example, Bunting et al. (2011) reported the average delay in seeking treatment for mood disorders was two years, for substance use disorders it was 15 years, and for anxiety disorders it was 22 years. There are 25% more people living with mental health problems in NI than in England (Department of Health, 2014a), yet the shortfall on mental health services in the region is so significant, it is estimated that an additional £17 million in spending across child and adolescent and adult mental health and primary care providers would be required to meet current demand (Belfast Telegraph, 2016).

Help-seeking for mental health in NI is complicated by long wait-lists and a lower likelihood of help-seeking

for those with more common mental disorders. Wait lists for mental health treatment in NI have been increasing steadily in the past five years, with none of the five Health and Social Care Trusts meeting their wait list targets (Belfast Telegraph, 2016). Funding is regularly cited as a key challenge in providing adequate support (Wilson et al., 2015).In their evaluation of mental health service provision in NI, Wilson et al. (2015) conducted interviews and focus groups with a wide range of mental health service users and service providers and reported the following major issues impacting upon effective service provision and delivery:

- Under-financing of mental health services
- A lack of clarity between what the mental health needs in NI are and what expenditure is needed to meet that need
- Fragmentation of mental health services due to restrictive eligibility criteria and poor communication with service users and carers resulting in discontinuity/inadequacy in service provision
- Poor communication between carers and healthcare professionals and the contribution of carers not being valued
- The medical model dominating mental health care provision in certain regions of NI
- Inadequate involvement of service users and carers in service development and delivery
- The care being provided not being person-centred
- Mental health stigma
- Service providers' difficulties in addressing Troubles-related and transgenerational trauma-related mental health needs
- Inadequate collaboration between service providers in different sectors.

Data from the *Northern Ireland Study of Health and Stress* shows the annual cost to the NI economy from the total direct and indirect cost of PTSD to be more than £172 million in 2008 (Ferry et al., 2015). To tackle issues with the provision of mental health services in NI, the Department of Health, formerly the Department of Health, Social Services and Public Safety has produced several action plans (Department of Health, 2014b) to better implement the recommendations set out in the *Bamford Review of Mental Health and Learning Disability* (Department of Health, 2006). The NI Minister of Health, Michelle O'Neill, recently pointed out in a speech to the Northern Ireland Assembly that despite the efforts already undertaken to improve services, there remained a need for additional support. In order to address the "unfolding crisis in mental health waiting times in every health and social care trust across Northern Ireland", she has been working on the following (TheyWorkForYou, 2016):

- A commitment to ensure that mental health receives the time, effort and resources required to meet local needs;
- A £2 million investment in the development of primary-care talking therapy hubs, with an acknowledgement that an additional £3 million is needed;
- An establishment of recovery colleges in each trust area;
- An allocation of a further £180,000 to complete the programme of developing a comprehensive mental trauma service, which is based on the psychological therapies stepped care mode; and
- Proposals for a managed care network to better utilise existing expertise and promote uniformity and continuity of care;

Given current budgetary restraints, and the constraints of a suspended Assembly, these developments are already experiencing delays. However, as O'Neill outlined (TheyWorkForYou, 2016), reshaping of the

Key Points:

- Population growth and an ageing population are likely to impact on the demand for public services;
- Self-reported wellbeing is higher in NI than in the rest of the UK, but the evidence economic and public health legacy of the conflict is apparent, and rates of mental health difficulties remain 25% higher than the rest of the UK;
- Welfare reforms are likely to place additional pressures on the most vulnerable;
- UK Government budgetary cuts are likely to impact on the provision of public services;
- Any suspension of the NI Assembly will make public service provision more challenging.

health and social care service is required to "...enable money to be released across the system so that it can be targeted at those areas that need it most".

3   Literature Review: NI Veterans' Needs

Overview:

- Introduction

- The Transition Process

- Support for NI veterans

- Veterans' Mental Health

- Barriers to Help-Seeking

Recent years have seen an increasing interest and investment in the health and wellbeing of veterans during and after the transition from service in the British Armed Forces. Indeed, issues around housing, employment, health, and wellbeing have been of particular interest. Through this process, there is a stronger evidence base developing on the needs of veterans at varying stages of life post-service. This evidence base can help inform future policy and service development to improve outcomes for this population. This chapter will review the existing literature around the understanding of the health and social wellbeing needs of veterans across the UK.

3.1   Overview

For the purposes of this study, a veteran is defined in line with the MOD definition: someone who has served for at least one day with the Regular Armed Forces (this may include current Reservists) or someone who has served with the Reserves and no longer serves. Annually about 20,000 Service personnel leave the Armed Forces (Regular and Reserve) and based on the ONS Annual Population Survey, the MOD estimated 2.56 million veterans living in the UK (MOD, 2017). According to the MOD (2004) around 300,000 veterans served on Operation Banner during the Troubles in NI. More than 40,000 of those personnel served in the Ulster Defence Regiment and the Royal Irish Regiment Home Service (UDR & R IRISH (HS)) – replaced in 2009 by the 38 (Irish) Brigade. These 'home service' regiments were recruited locally and often included individuals who served in a part-time capacity alongside their civilian jobs. While there is, to date, no reliable estimate of the veteran population living in NI, an extrapolation of data from The Royal British Legion UK household survey of the ex-Service community (Royal British Legion, 2014) estimated the population to be roughly 115,000. Military personnel leaving the Armed Forces may seek help for a number of issues related to, for example, accessing public and not-for-profit services, education and training, employment, housing, reintegrating into family life, and specialist support for difficulties such as mental health.

3.2   The Transition Process

The process of transitioning from the Armed Forces to civilian life has been recognised by the MOD and other support organisations as an area where more support is required. This recognition has resulted in targeted support for certain elements of the process, and investment in the development of new services

for those going through the process. To date, these processes have largely focused on the individual leaving service, as opposed to the family, and tended to prioritise support on post-service employment and training.

Every year, thousands of people leave the UK Armed Forces and face re-integration into civilian life. Between October 2016 and September 2017, this number was 15,010 for the UK Regular Forces (MOD, 2017). Most individuals will manage to make a successful transition, but a significant minority will experience difficulties in one or more domains of their life. The 2012/13 Career Transition Partnership (CTP) survey revealed that 12 months after leaving the Armed Forces, 40% of individuals who were engaged with the CTP reported that adjusting to civilian life was easier than they had expected, but 24% found it harder than expected (MOD, 2014). *The Transition Mapping Study*, published in 2013, was the first research study to estimate the cost of poor or unsuccessful transition (FiMT, 2013). In the year 2012, the estimated cost of poor transition was £113.8 million, with alcohol use problems, mental health issues (PTSD and neurotic disorders), unemployment, family breakdown, homelessness and imprisonment being the primary contributors to this figure. The study concluded that the "*differences between military and civilian life are under-estimated*" (p.5). Based on interviews with stakeholders and veterans, the *Transition Mapping Study* identified five major areas of transitional difficulties:

1) *Financial challenges:* Veterans seem to have particular problems with managing their finances. Whilst in Service, the expenses associated with meals and accommodation are deducted from one's pay, so all that the in-Service personnel are left with is essentially disposable income. Based on qualitative interviews, the *Transition Mapping Study* revealed low levels of awareness regarding what is needed to rent or to buy a house and it highlighted the need for more emphasis on teaching the life-skills needed to deal with the financial practicalities of the everyday civilian life.

2) *Cultural challenges:* For some veterans, adapting to the new civilian culture, particularly the new working environment can be a big challenge. The biggest change seems to be the loss of camaraderie and problems adjusting to the different codes of behaviour enforced in the different working environment.

3) *The role of the family:* The military families who used to live on base and essentially lived the military life, will experience a transition process themselves, and face similar challenges to their military spouse. Families who did not live on base will still be affected by their spouse's transition, often being the first ones to notice transition-related problems in their loved one and having to deal with these. *The Transition Mapping Study* acknowledged that unsuccessful transitions can impose a lot of burden on the family and this has been further corroborated in another FiMT-funded report: Better Understanding the Support Needs of Service Leaver Families (Brian Parry Associates, 2015).

4) *Sources of support:* For veterans who are not entitled to the full support of the CTP and/or those who decide to seek help for work-related, emotional or other problems outside of the MOD and statutory sector, there is a large number of charities offering a range of services. *The Transition Mapping Study* revealed that the problem is not in the number of the Armed Forces charities, but rather in the limited help and support that is available to veterans when it comes to navigating through these. In recent years, there has been a pervading myth that there are too many armed forces charities out there. However, the Directory of Social Change's Sector Insight report has

revealed that these claims are actually driven by a lack of understanding of the diversity of the armed forces charities available in the sector (Pozo & Walker, 2014). For veterans, it is not immediately clear which charities provide support for what veteran groups and which needs they are able to cater for. The recently established Veterans' Gateway project is expected to ameliorate this problem to some extent as it is intended to be a single-point of contact for all veterans looking for help or information.

5) *Identity and emotional welfare:* According to the Transition Mapping Study, the development of a 'civilian identity' is one of the most important indicators of a successful transition. The civilian identity is closely linked with finding a new, and ideally satisfying, civilian career path, as well as good emotional health and wellbeing. Leaving behind the rigidity of the military life, developing a new identity based on one's present circumstances and planning for future can be a challenge for some.

The existence of the above transitional difficulties was largely corroborated by Lord Ashcroft's 2014 *Veterans' Transition Review.*

Armed Forces personnel leaving the Services can seek employment support from CTP; a partnership agreement between the MOD and Right Management - a global career development and outplacement specialist. Personnel can get support on preparing for civilian employment, successful transitioning to employment, or how to achieve wider vocational outcomes such as full-time education, or how to prepare for retirement (MOD, 2012). Personnel contact the CTP prior to discharge or soon after. Support is available for up to two years post-Service. Whilst all Service personnel leaving the Armed Forces can benefit from CTP support, it is only those discharged on medical grounds and those serving more than six years who are eligible for the full support resettlement programme. According to the MOD (2014) around 40% of those who engage with CTP find that the help it provides is useful. However, the FiMT's (2013) *Transition Mapping Study* found that those who did not experience a successful transition experienced a variety of damaging outcomes such as alcohol and other substance misuse, mental health difficulties, unemployment, relationship difficulties, homelessness, or imprisonment which was estimated to incur an annual cost of more than £113 million. According to Godier, Caddick, Kiernan and Fossey (2017), those most at risk of an unsuccessful transition are Early Service leavers (ESLs; i.e., those who choose to leave the Armed Forces within four years of joining, or who are compulsorily discharged). This group will be addressed later in this chapter.

3.3 Veterans' Mental Health

Those supporting veterans often point out that problems with mental health are not generally greater amongst the veteran population than the population as a whole. However, there are some cohorts of the veteran population who have high rates of common mental disorders and PTSD, and some studies have found that barriers to seeking support for mental health problems exist amongst veterans, which may be specific to this population. In Call to Mind, a series of reports commissioned by FiMT between 2015-2017, a range of common issues and areas for improvement relating to mental health and support for veterans were identified across England, Scotland, Wales and NI. These included:

- Issues with the transition process;
- Access to relevant and appropriate information;

- Confusion around the services offered by the veterans' VCS;
- Reluctance to approach primary care providers for mental health support; and
- Internal and external barriers to specialist support within the NHS.

The report also pointed out issues with co-morbidity (i.e., the existence of more than one mental or physical health problem and how they interact with one another), self-harm and suicide, alcohol and substance misuse, and stigma associated with mental health and its impact on help-seeking. Finally, the need to better support families of veterans experiencing difficulties around mental health was cited as a key area for development, with targeted resources in this area recommended by the report (Hasan, Bashford, & Patel, 2017).

The most prevalent mental health conditions for those leaving the armed forces include anxiety, stress, panic, adjustment disorder, mood disorders (e.g., depression), alcohol and substance use disorders and posttraumatic stress disorder (PTSD) (Houses of Parliament, 2016). Veterans who develop mental health problems are at a higher risk of not seeking specialist help post-diagnosis (Iversen, Dyson et al., 2005), poorer work functioning (Vogt, Smith, Fox, Amoroso, Taverena & Schnurr, 2017), becoming homeless (Perl, 2015), and having eating disorders (Hoerster et al., 2015). They are also more likely to have greater difficulties with family and relationships (Ramchand, Rudavsky, Grant, Tanielian, & Jaycox, 2015). As noted earlier the ESLs are the group at highest risk of mental health difficulties.

In a study of referral patterns to Combat Stress over a 20-year period, Murphy, Weijers, Palmer and Busuttil (2015) found:

- Over the last 20 years there has been nearly a fourfold increase in the numbers of veterans seeking help;
- Those deployed in NI are the largest population of veterans seeking help[8];
- The average age of those seeking help appears to have declined from 53.8 years in 1994 to 42.2 years in 2014;
- Only a fifth of UK veterans with mental health difficulties engage in help-seeking behaviour;
- Veterans appear to be accessing services more quickly now than in the past;

Iversen et al. (2011) suggested that only around 20% of veterans with a mental health difficulty will seek help. Black and Collier (2014) argued that this disparity may, in part, be due to a lack of understanding of military culture by healthcare practitioners. For example, group therapy and exposure to trauma, which have been recommended for veterans with PTSD, may not be available or be delivered by adequately trained staff. This results, they argued, in high dropout rates from treatment due to mental health stigma and veterans reporting a lack of understanding from healthcare professionals. Indeed, they reported that veterans are sometimes not being treated if they are experiencing a comorbid mental health problem or addiction.

3.4   Early Service Leavers (ESLs)

There exists, a specific sub-group of the veteran population who seem to be at an increased risk of poor overall outcomes. These are the so-called ESLs who have left the service before completing four years

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[8] Murphy et al. (2015) suggested that this is due to Operation Banner in Northern Ireland being the largest and longest commitment of UK military personnel. Although precise data is not available on the numbers deployed to Northern Ireland they estimated that 21,000 soldiers were deployed annually during the 1970s, and 10,000 annually during the 1980s and 90s. This contrasts to around 53,000 in total for the 1991 Gulf war, 150,000 for the 2003 Iraq conflict and 139,000 for the Afghanistan conflict.

Academic research has revealed that when compared to the veterans who have served for longer, the ESLs are at increased risk for developing PTSD and common mental health disorders, such as depression and anxiety. They are also more likely to report fatigue and physical symptoms and more likely to have had suicidal thoughts and/or self-harmed in the past (Buckman et al., 2013; Woodhead et al., 2011). There is also some evidence suggesting that ESLs with mental health or neurotic disorders are less likely to seek help for their problems (Woodhead et al., 2011). Both studies also found that ESLs tend to be of younger age. An interesting study on suicide rates in military veterans was conducted by Kapur, While, Blatchley, Bray and Harrison (2009); the authors compared the rates of completed suicides in the UK Armed Forces veterans and the general population and found that the overall suicide rates did not differ across the two groups. However, veterans aged 24 or younger were 2-3 times more likely to have committed a suicide when compared to the general population or in-Service personnel. This increased risk was associated with shorter length of service. ESLs are also more likely to be unemployed after discharge compared to those who have served for longer (MOD, 2017). Yet, even though this group may need the most help, they are only entitled to the basic support through the MOD's CTP.

One of the reasons proposed in the academic literature to explain the increased risk of unsuccessful transition in ESLs is their history of adverse experiences in childhood, such as abuse, emotional neglect, difficult relationships and others. Buckman et al. (2013) reported that ESLs had experienced more childhood adversity than their longer-serving counterparts had. The authors concluded that "Service is not a factor causing personnel to become an ESL" (p.410). Similar results were reported in the RBL (2014) Household Survey: 36% of all veterans reported six or more different types of adverse childhood experiences (out of 16), but as many as three out of four veterans aged 16-24 fell into this category. Such results again suggest that early adverse experiences may be associated with individuals leaving the service early and subsequently experiencing difficulties during transition.

3.5   Veterans in Northern Ireland

Due to Section 75 of the Northern Ireland Act 1998, there are no veteran-specific public services in NI. For example, the Department for the Economy, which has responsibility for both further education and higher education, and the Department for Communities, which has a remit for apprenticeships, training and employment have no specific policies on additional information or support for veterans. The MOD, however, provides an Enhanced Learning Credits Scheme for veterans up to five years after discharge to encourage and support life-long learning and continued professional development. Veterans may apply for funds to subsidise engaging in educational courses at level 3 National Qualifications Framework or above. There is also a Publicly Funded Further Education/Higher Education Scheme offered in tandem with the Enhanced Learning Credits Scheme, which allows those who have served six or more years and reside in the UK to secure funds negating the tuition fees for a first level 3 qualification, foundation degree or first undergraduate degree. This is, in principle, available to veterans in NI, but there is no information on any NI-based websites to this effect (Armour et al., 2017).

Although the Department for Communities has responsibility for jobseekers in NI it does not have any statutory services providing specific support to veteran jobseekers. There are, however, some nominated Forces Liaison Officers in some NI jobcentres who can provide advice on the various support available to Service personnel, veterans, and their families. Veterans can seek support, advice or information from all such sources as those, which are available for anyone from the general public seeking help or support:

Access to Work (NI); Workable (NI); Bridge to Employment; Youth Employment Scheme; Into Work Training Support; Training for Success; and Steps2success. There are also no key policies specifically referring to veterans' transition to employment or additional help and support for veterans to access benefits and pensions to which they are entitled (Armour et al., 2017).

The NI Housing Executive, an arms-length body under the Department for Communities, is responsible for social housing and housing support but does not provide any specific or additional support for veterans or their families. The health and social care services in NI are commissioned through the Health and Social Care Board, an agency with direct accountability to the Department of Health. The Health and Social Care Board commissions services through five Health and Social Care Trusts across the region. The Department of Health recognises the needs of the veteran population in NI, but this tends to be at a strategic and operational level rather than at a grassroots level (Armour et al., 2017).

Medical care of NI veterans is met by health and social care in NI and charities and not-for-profit organisations such as Combat Stress. However, there are a number of issues specific to the provision of care for NI veterans (Armour et al., 2017):

- Due to the Troubles, the integration and social cohesion between veterans and the civilian population can be strained. Indeed, military Service is more politicised in NI than in other regions of the UK, making the implementation of legislation and policy which protects this group more contentious;
- Some NI veterans also live in the former theatre of operations in Operation Banner. This is likely to produce complex and specific challenges such as a fear of discrimination or reprisals for the veteran and their family;
- There appears to be less support for veterans compared with that which is available in the rest of the UK;

The Supporting & Serving Military Veterans in Northern Ireland (Armour et al., 2017) report found that there exists an infrastructure of support aimed at the veteran population; this is designed around the emergence of specific needs for veterans. This support comprises of a number of local and national voluntary and community organisations; several information-sharing networks within and across sectors; and regionally specific MOD funded services. These services supplement the wider provision of health and social services to which all citizens of NI are entitled. There is no veteran-specific statutory service outside of those provided by the MOD, and there is only minimal acknowledgement of the specific needs of veterans in NI in policy and/or practice from the statutory sector. Since the publication of Lord Ashcroft's 2012 *Veterans' Transition Review*, a lot of progress has been made in providing transitional support to Service Leavers in the wider UK. However, in his 2016 follow-up report, he stated that NI is still lagging behind and veterans residing in the region experience disadvantage. He went as far as to suggest that "*the MOD should warn those that are considering settling in NI that they will be at a disadvantage compared with their colleagues in the rest of the UK*" (p.17). There is relatively little research on NI veterans, and in particular, Troubles-related mental health. As noted in Chapter 2, the NI population as a whole was found to have more mental health difficulties compared to the rest of the UK due to the impact of the Troubles (Ferry et al., 2008) and therefore, one would expect similar findings in the NI veteran population. Little is also known about service leavers remaining in or returning to what was essentially their operational theatre, which is the case for many home service veterans in NI.

3.6   Barriers to Help-Seeking

Accessing mental health services can be problematic for veterans because their needs can be complex and come with a range of behavioural issues such as anger, excessive or problematic alcohol use, and prescription substance misuse that do not fit typical healthcare criteria (Greenberg, Langston & Gould, 2007). Whilst such problems might not be unique to NI veterans, nor differ from those experienced by some in the wider NI population, veterans' attitudes, perceptions and experiences may influence expectations and outcomes.

According to Greene-Shortridge, Britt and Castro (2007) military culture may hinder mental health help-seeking because emotional stress is often equated with weakness. Pietrzak, Johnson, Goldstein, Malley and Southwick (2009) found that some veterans worried about social stigma associated with mental health difficulties; similarly, a sign of weakness or being 'different'. Military culture may also mean that veterans self-stigmatise and so do not seek or accept help (Greenberg, Langston & Gould., 2007). Having said that, a recent interview study with 62 UK military veterans revealed that mental health stigma had a negative impact only on the initial interactions of veterans with the support services. Subsequent decisions to seek help were affected primarily by perceived need for treatment (Rafferty, Stevelink, Greenberg, & Wessely, 2017).

Issues of barriers between military and civilian populations, and a mismatch of expectations on public health services following military service, are also perceived to be an issue for veterans in seeking support. Some veterans reported civilian healthcare professionals as not understanding military-related injuries or ways of doing things (Greenberg et al., 2007). The FiMT (2015) commissioned report *UK employers' perceptions of employment and employability ex-Service personnel* showed some veterans as having unrealistic expectations about waiting times and service responses. Veterans report difficulties with scheduling appointments (Greenberg et al., 2007), and some may lack awareness and understanding about the options available to them and who provides them (FiMT, 2015). Negative attitudes and poor perceptions of the effectiveness of mental health interventions lead to reluctance to engage in treatment such as psychotherapy and cognitive behavioural theory. This could explain a higher rate of medication usage amongst veterans than amongst the general public (Pietrzak, Johnson et al., 2009).

Such factors mean that veterans with mental health difficulties will often not engage with, or fall out of, care pathways. Given that only around 20% of veterans with a mental health difficulty will seek help (Iversen et al., 2011), there is a clear need to understand more about veterans' perceptions, attitudes, and experiences of healthcare and other services in NI in order to improve engagement rates with this population. For veterans in NI, these issues are exacerbated by security concerns. Northern Ireland veterans in particular express concerns for their safety and that of their family if they reveal their former Service to healthcare professionals. Veterans in NI also express concerns about facing discrimination if they reveal their Service history to healthcare professionals (Armour et al., 2017).

Key Points:

- Little is known about the NI veteran population;
- No specific service provision for NI veterans due to Section 75 of the Northern Ireland Act 1998;
- Specific support for NI veterans provided by the VCS;
- Significant numbers of NI veterans may be vulnerable to mental health difficulties due to the Troubles;
- Barriers to help-seeking include: veterans' perceptions of personal security; issues engaging with healthcare services; military culture; absence of specific veteran healthcare provision; and service funding.

4 Methods

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Overview:

- Aims and Objectives
- Research Design
- Sequential Content Analysis
- Ethical Considerations
- Phase one: Service Provider Interviews
- Phase two: Veteran-Led Focus Groups

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The veteran population in NI is an under-researched area to date, and there exists very little work chronicling the experiences of veterans living in the region. Because of the political sensitivities and security concerns associated with this population, alongside the lack of existing data, it was important to develop a methodology which could gain insight across a largely unknown population, while reassuring participants of their safety and anonymity. This chapter outlines the steps taken to meet the aims and objectives of the research while adhering to the highest possible standards of academic rigour, research ethics, and anonymity and data protection.

4.1 Aim and Objectives

To date much of the literature focusing on the needs of military veterans has been conducted outside of NI; for example, the US (Tsai, Armour, Southwick, & Pietrzak, 2015; Pietrzak, Goldstein, Malley, Johnson, & Southwick, 2009; Seal, Bertenthal, Miner, Sen, & Marmar, 2007); Israel (Benyamini & Solomon, 2005; Karstoft, Armour, Elklit & Solomon, 2015), Denmark (Andersen, Karstoft, Bertelsen & Madsen, 2014; Karstoft, Armour, Andersen, Bertelsen & Madsen, 2015) and Australia (O'Toole & Catts, 2008). Research on veterans living within the United Kingdom has often focused more on veterans based in England, Scotland and Wales. Due to the unique situation of NI outlined throughout this report, there are subsequent complexities surrounding research with military veterans (see Armour et al., 2017 for further detail). Thus, researchers have until recently (notable exceptions include Armour et al., 2017; Patel et al., 2017) not included comprehensive analyses on NI veterans. For example, a report conducted by a team of academics from the University of York titled Meeting the Housing and Support Needs of Single Veterans in Great Britain highlights this:

> *"The research does not cover Northern Ireland because it was felt that the issues faced by veterans in Northern Ireland are more complicated than those faced by veterans in Great Britain. This was a highly sensitive area of research that might be better undertaken by researchers with an in-depth understanding of the situation in Northern Ireland"*
> *(Jones et al., 2014, p2)*

Therefore, this research is the first of its kind to fully explore the needs of the veteran community in NI from the dual perspective of veterans and service providers (veteran-specific organisations within the MOD and Voluntary sector and Statutory bodies providing support either directly or indirectly to veterans in NI). There is currently a services and issues related to transition back to civilian life). This report therefore aims to provide a detailed insight into the current and future needs facing the veteran community in NI.

The key objectives of the study are:

- To identify the prevalence and nature of veterans' support needs after their transition back to civilian life;
- To explore the possible contextual and explanatory factors underlying any barrier(s) to seeking help;
- To identify any challenges faced by service providers in meeting veterans' needs; and
- To identify any gaps in support provision from veterans' perspective.

4.2   Research Design

The research was cross-sectional, and designed to explore the current and future needs of the veteran community from the perspectives of both service providers and veterans. It employed a sequential qualitative approach, with an initial phase involving in-depth semi-structured interviews with individuals working for, or representing, either a veteran-specific organisation (MOD and voluntary sector) or a statutory agency who provide services to veterans as part of their remit but do not have a veteran-specific client base (Phase One). Phase two involved 13 focus groups with veterans (ranging between 3-8 veterans per group) who are resident in NI. Focus groups were pre-categorised by age to seek a spread of representation across the lifespan (see pp 54 - for a full breakdown of focus groups).

4.3   Sequential Content Analysis

The methodological approach chosen to best meet the research aim was a sequential qualitative design. This means the data was collected in stages. There were two phases of qualitative data collection, followed by content analysis of both data sets. The decision was taken to utilise qualitative methodology for both Phase One: Service Provider Interviews, and Phase Two: Veteran-Led Focus Groups, due to the overall aim of the study, which was to provide a rich descriptive spread of information into the needs of the veteran community in NI. Qualitative analysis is particularly effective with topics for which there is little previous research and where there may be variables that are difficult to identify or are not yet identified (Morrow, 2007). This has been successfully shown in previous research with veterans[9]. The purpose of rich description is that it creates statements that produce for the readers the feeling that they have experienced, or could experience, the events being described in a study. Thus, credibility is established through the lens of readers who read a narrative account and are transported into a setting or situation (Creswell & Miller, 2000).

In the financial climate in which support organisations, especially in the voluntary sector, operate, policy makers may intuitively concentrate on quantitative findings and how these statistics may map to areas of interest to them. They may, for example, focus on unemployment rates of veterans post-transition, or

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[9] A Pilot Study to Support Veterans in the Criminal Justice System (Fossey, Cooper, Godier & Cooper, 2017); UK Employers' perceptions of employment and employability of ex-Service personnel (FiMT commissioned report, 2015)

the number of veterans receiving disability benefit. However, by solely relying on quantitative inquiry, inevitably, there is a risk of losing the essence of what it is like to be a veteran living in NI, and what is it like trying to meet the needs of veterans living in the region. The qualitative component of the study is useful inevitably, there is a risk of losing the essence of what it is like to be a veteran living in NI, and what is it like trying to meet the needs of veterans living in the region. The qualitative component of the study is useful for capturing and understanding these experiences.

It should be stressed that this study is qualitative in nature, the report is an independent academic summary of the main views and concerns raised by individual participants. As a result, the research team are aware that there may be some assertions and views in this report, that perhaps do not accurately reflect current practice or the support services available to veterans in NI. This data therefore cannot be, and is not meant to be generalisable to the entire NI veteran population. User engagement and experience based research (Gilburt, Rose, & Slade, 2008; Pitt, Kilbride, Nothard, Welford, & Welford, 2007), however, is increasingly important to understand issues around health and social care access. These perceptions affect the ways in which user groups do or do not engage with services, which in turn affects outcomes. It is in these grey areas identified through qualitative work that interventions often fail, and as such they are essential to developing effective policy and service provision.

4.4   Process of Content Analysis

The data collected through interviews with service providers (Phase One) and veteran-led focus groups (Phase Two) was analysed using content analysis. Content analysis is a research method for making replicable and valid inferences from data to their context, with the purpose of providing knowledge, new insights, a representation of facts and a practical guide to action (Krippendorff, 1980). Only the manifest content (spoken word) of the collected data was analysed. There has been some debate as to whether latent meanings found in documents (e.g. silences, laughter, posture etc.) can be analysed, because their analysis usually involves interpretation (Morse, 1991, Robson, 1993). Guided by the research aims and objectives (to provide an evidence based into veterans' needs), latent analysis of the data was not undertaken in order to avoid any subjective reporting on this sensitive topic.

An advantage of content analysis is that large volumes of textual data and different textual sources can be dealt with and used to corroborate evidence. Figure 2 below presents the steps undertaken in content analysis:

Figure 2 Analytical Process

Immersion in raw data (interview and focus group transcriptions) → Open coding (identifying concepts/ themes within the data) → Developing of a coding frame → Grouping and categorisation → Abstraction
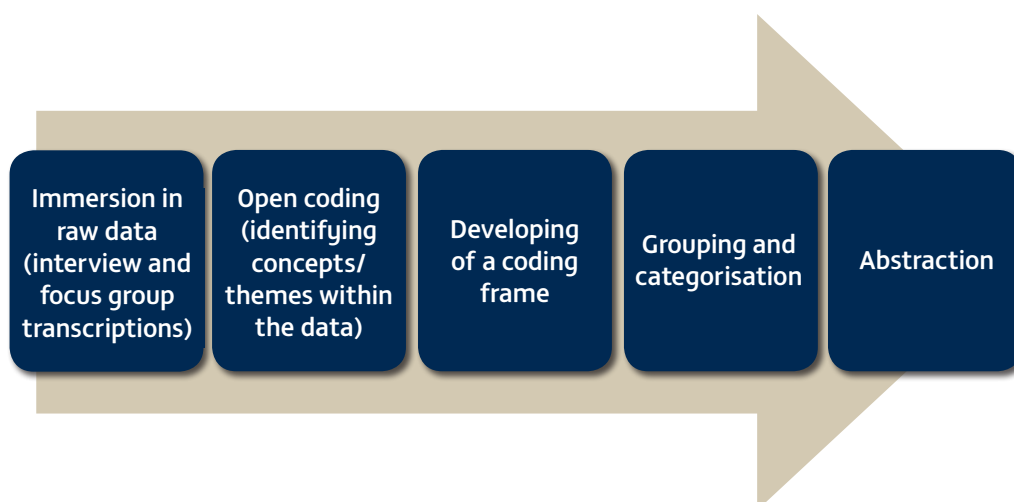
All of the data was input into software package NVivo 11 and the steps below were followed:

- *Immersion* – reading through written material several times to become familiar with the contents;
- *Open coding* – notes/memos from the written text and devising headings to best describe all aspects of the text content. The headings are then collected and placed into a coding frame;
- *Grouping headings* - this is a refinement process aimed at reducing the number of categories by collapsing together those that are similar and creating new categories under higher order headings (Burnard, 1991); The purpose of creating a coding frame and categories is to provide a structured means of describing the content of written material, to increase understanding (Cavanagh, 1997);
- *Abstraction* - generating a concise description of each category using content-relevant words (e.g. barriers to support). An example of the abstraction process is shown in Figure 3:

Figure 3 Example of Abstraction Process

MAIN THEME	GENERIC CATEGORY	SUB CATEGORY
BARRIERS TO SUPPORT	ACCESSIBILITY	Visibility and Awareness Service approach Geographical location
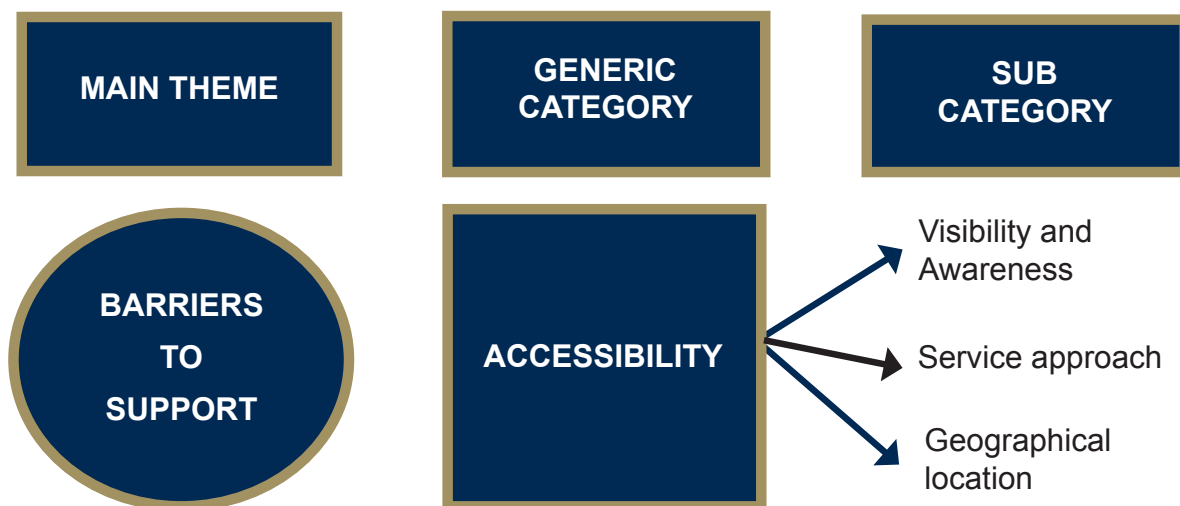
Integration is an essential feature of the study and refers to the stage in the research where mixing occurs (Ivankova, Cresswell, & Stick, 2006). In the present study, integration of the results from both phases took place during the interpretation of the outcomes of the entire study. A visual representation of the study design is presented in Figure 4 below to illustrate the integration of the two phases of the study.

4.5   Ethical considerations

This research required careful consideration, planning and attention to relevant ethical protocols, especially in conducting focus groups with veterans who might be considered a vulnerable group. Ethical considerations are often organic, complex and on-going issues; however, it was necessary to account for some of the formal issues before the data collection could commence. Our application to Ulster University Research Ethics Committee followed the British Psychological Society's (2014) *Code of Human Research Ethics*.

Figure 4: Visual Model of Qualitative Design and Integration of Study Phases

PHASE ONE	PHASE TWO
Service Provider Interviews	Veteran-led Focus Groups

ANALYSIS OF DATA FROM PHASE ONE	ANALYSIS OF DATA FROM PHASE TWO

INTEGRATION OF PHASE ONE AND TWO DATA

Overall aim of the study: To provide a detailed insight into the current and future needs facing the veteran community in Northern Ireland.
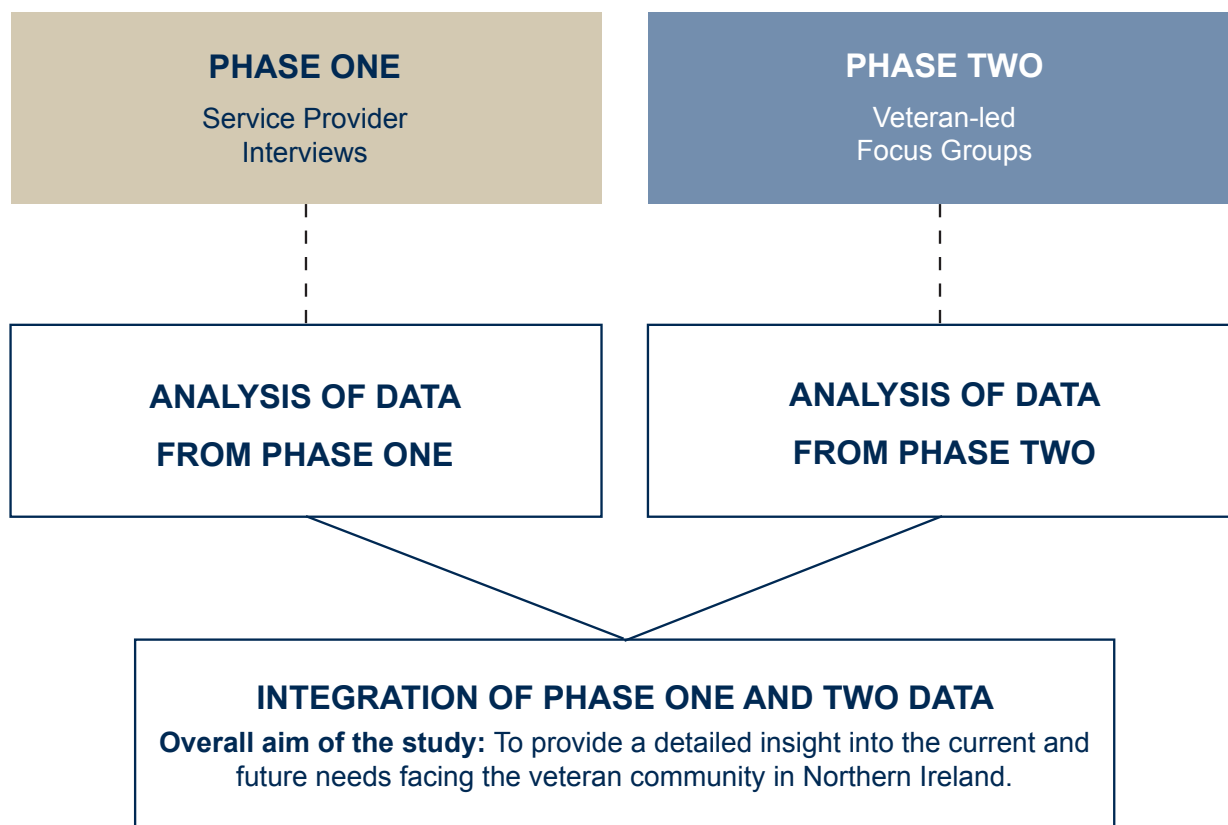
- Ensuring that all those who participated did so voluntarily. We advertised the research and asked participants to make contact with the researchers if they wish to discuss their possible participation and to ask any questions they may have;
- Ensuring that each participant who freely opted to join the research was fully informed of the research aims and objectives, what they would be required to do, what their rights were, what the potential risks were (if any), what would happen to their data, and where the research findings would be disseminated. This was done by providing them with a participant information sheet and asking them to confirm they had understood what was required of them at each stage of their participation, and their rights, by signing a consent form;
- Ensuring that any data the participants provided remained confidential and that any data used in the reports would be anonymised;
- Providing them with additional information and contact details of supporting organisations should any unforeseen issues arise. Participants were also provided with the contact details of those in the research team, and senior figures at Ulster University, should they wish to raise any issues or ask additional questions; and
- Offering to provide participants with a summary of the research findings and / or the URL / hyperlink to the published report.

Once ethical approval had been granted we advertised the research via social media platforms, through service providers, and word-of-mouth inviting potential participants to make contact with the researchers if they wished to discuss their possible participation and to ask any questions they may have had.

4.6   Phase One: Service provider Interviews

Data Collection

Interviews were conducted at the interviewees' offices where possible and lasted on average one hour. Prior to each interview, the consent form and confidentiality agreement were signed. Participants were also reminded that taking part was completely voluntary and they were free to withdraw at any time, without giving any reason and without their legal or employment rights being affected.

Inclusion/Exclusion Criteria

Those organisations that had been identified and collaborated with in the preceding NIVHWS scoping report as meeting the below inclusion criteria were approached and sent an electronic letter of invitation to participate in an interview. The inclusion criteria were as follows:

- The organisation is funded to deliver a service specifically for veterans;
- The organisation includes veterans in their aims, objectives or mission; and
- The public sector organisation has an individual or a department that holds a specific remit for veterans.

According to the first report from this study, the public sector is the main service provider to veterans in NI (Armour et al, 2017). However, because public service organisations are not permitted to have a specific remit under Section 75, almost no public sector organisation met the stated criteria. To deal with this issue, we used the guidance of key stakeholders alongside our team's previous research to identify appropriate stakeholders in the public sector who were deemed to be most likely to deal with the veteran population.

Informed consent was sought by providing each interviewee with an information pack including a participant information sheet explaining the nature of the research and the intended use for the data to be collected, and a set of interview guidelines. A consent form and a confidentiality agreement were signed by each interviewee and counter-signed by the researcher before the recorded interview commenced. All interviewees had the right to withdraw from the research and this was made clear on a regular basis throughout the study.

Participants

A total of 20 interviews were carried out between October 2016 and February 2017 with representatives from the following organisations:
- Andy Allen Veterans Support NI (AAVSNI)
- Belfast Health and Social Care Trust
- Beyond the Battlefield
- BLESMA
- Castlehill Foundation
- Combat Stress
- Decorum NI
- Department of Health

- Help for Heroes
- Housing Executive
- Not Forgotten Association
- Royal Air Force Association
- Royal British Legion
- South East Fermanagh Foundation (SEFF)
- Somme Nursing Home
- SSAFA
- The Ely Centre
- UDR & R IRISH (HS) Aftercare Service
- Veterans UK

The above list includes statutory, voluntary and MOD aligned organisations. Figure 5 shows the breakdown by sector:

Figure 5: Service Providers by Sector

Voluntary
Statutory
MOD
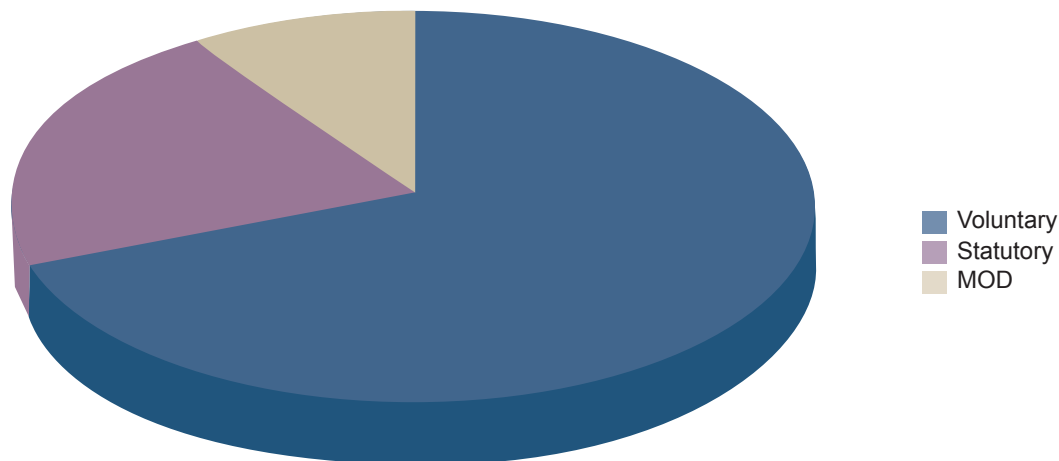
4.7   Phase Two: Veteran-Led Focus Groups

Introduction

Focus groups generate qualitative data that can be both descriptive and explanatory. It is easily used as supplementary evidence to other qualitative and quantitative data. Data generated from focus groups is also often used in needs assessment, developing themes for surveys, and in providing insights into particular populations (Krueger & Casey, 2014). Conversation during focus groups may be enhanced by benefiting from the interaction and conversation from other group members. Thus, the audio-recorded conversation collected during the focus group can provide a rich source of analytical data on a variety of attitudes, perceptions and experiences.

The success of any focus group is dependent on the participants. Participants should feel more comfortable expressing their views when they share similar backgrounds and experiences with the other group members (Krueger & Casey, 2014). Smaller groups are also deemed to increase comfort levels (Morgan, 1996). The size of the focus groups in this study ranged from 3-8.

Recruitment

Participants were recruited using a variety of methods, ranging from general social media, to targeted recruitment of specialist groups (i.e. wounded, injured and sick veterans). Figure 6 outlines the primary recruitment strategies

Figure 6: Focus Group Recruitment Strategies
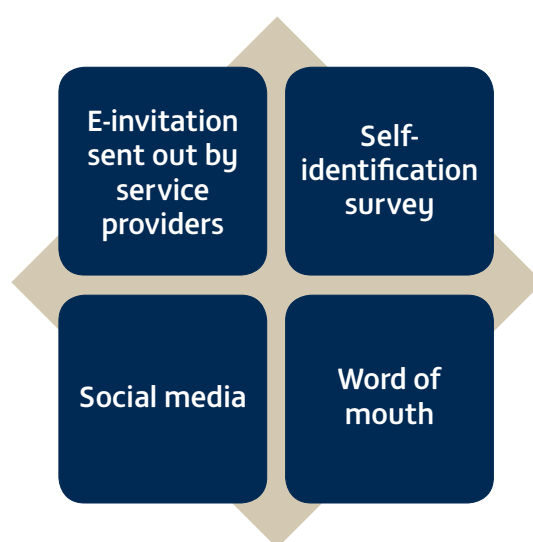
Recruitment strategies:

- Emailed letters of invitation were sent to service providers on behalf of the NIVHWS team for distribution amongst their respective client bases. Interested veterans then contacted the research team directly using details provided in the invitation pack.
- Using contact details collected through the NIVHWS self-identification survey[10], direct contact was made with veterans who previously expressed an interest in participating in the wider study. Contact details were left either in the form of: telephone number(s); email addresses or both. A member of the research team contacted each potential participant inviting them to participate in a focus group. A pre-approved script and letter of invitation were utilised by all members of staff involved in this method of recruitment
- Using already established relationships with people firmly embedded in the veteran community (mostly those linked with veteran-specific services) our notice of recruitment was posted onto private Facebook pages or to their friends. All veterans interested in participating were sent an information pack, which contained a participant information sheet explaining the nature of the

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[10] This survey forms part of the quantification work package, which forms part of the overall NIVHWS' research aims.

research, the intended use for the data to be collected; a set of interview guidelines; a consent form and a confidentiality agreement).

- Finally, several tweets were sent out from the official NIVHWS Twitter account (@NIVeteranStudy) requesting participation in focus groups. An example tweet is provided below:

"RT! We need #veterans: aged 18-24, 25-44 (non) medically discharged for focus group participation. Get in touch" [embedded link containing contact details].

These varied recruitment methods ensured that participants from a range of backgrounds, needs, and level of connection to the sector were reached, thus improving the representativeness of the data collected.

Participants

A total of 13 veteran-led focus groups were conducted between April 2017 and October 2017. Focus group size ranged from 3-8 participants.

Age

The majority of the participants were male (96%). The mean age of participants was 56 years. Separate focus groups were conducted based on pre-designed age bands: 18-24; 25-44; 45-64; 65-84; and 85+. Figure 7 displays the age breakdown for the whole sample[11].

Figure 7 Age distribution of veterans
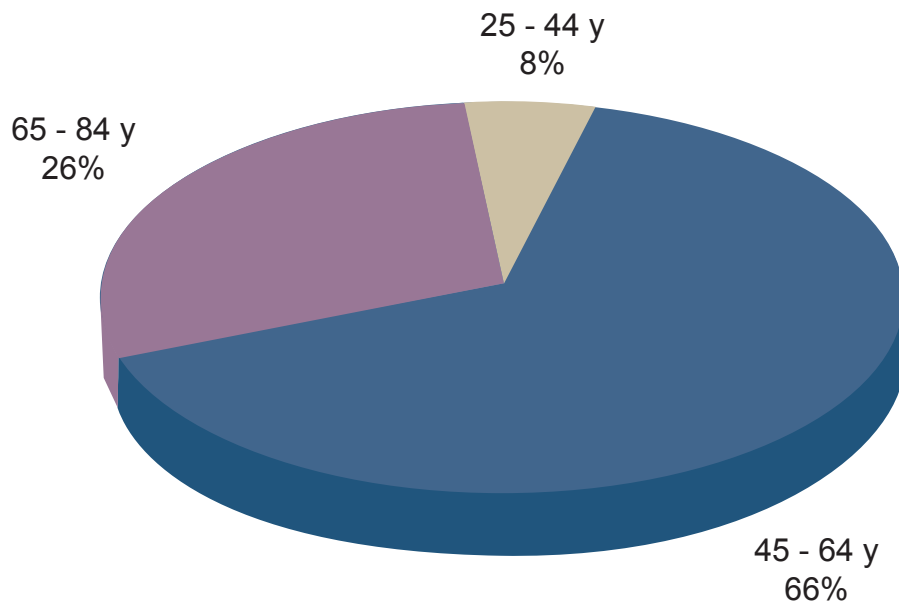
Branch of military service

The majority of participants were Army veterans. Figure 8 displays the service breakdown of the focus group sample. The average length of service was 19 years (range: 3 years – 43 years). Seventy-six percent (38 participants) stated that during service they had deployed outside of NI. Examples of operational tours given included Cyprus, Hong Kong, Iraq and Germany.

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[11] Please note that we were unable to recruit veterans aged 18-24 and those aged 85+ and these are therefore omitted from Figure 7

Figure 8 Military service breakdown

Royal Air Force
4%

Royal Navy
4%

Royal Marines
2%

Army
90%
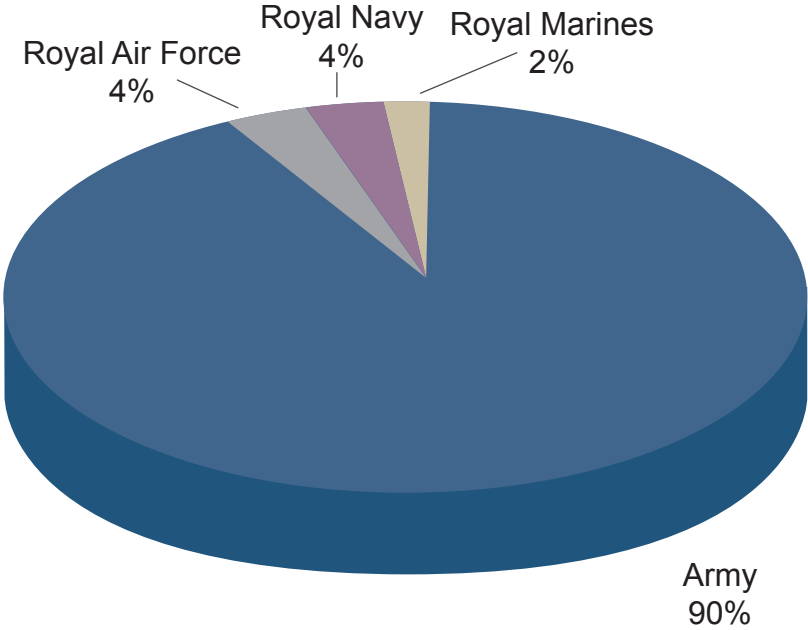
Country of birth

The majority of participants (60%) stated that they were born in NI; Figure 9 displays the full breakdown of participants' country of birth. UK denotes a participant not specifying a particular country within the UK

Figure 9 Country of birth breakdown

UK
12%

Scotland
4%

England
24%

Northern Ireland
60%
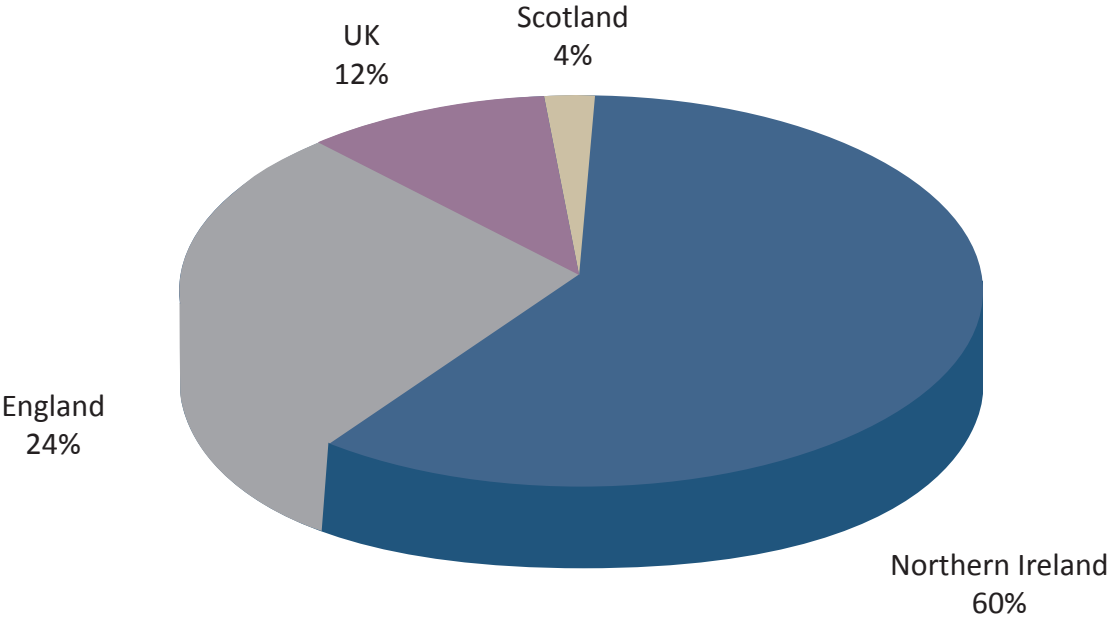
Support services

Participants noted if they had engaged with support services since becoming a veteran; 60% stated that they had. Common examples of support given included Combat Stress, RBL, SSAFA and UDR & R IRISH (HS) Aftercare Service.

Procedure

Veterans willing to participate in a focus group were sent a short screening tool, which was used to place each participant into the most suitable group based on age and military discharge status. All focus groups were held at one of the four UDR & R IRISH (HS) Aftercare sites:

- East field site (Palace Barracks, Holywood);
- South field team site (Portadown);
- North field team site (Coleraine);
- West field team site (Enniskillen).

Participants selected the venue most convenient for them to attend. The research team were also cognisant of military rank and when organising the groups, every effort was made to cluster together participants of similar rank, where possible.

Prior to each focus group, the consent form and confidentiality agreement were signed (initials only). Focus groups lasted between 45 minutes to 1 hour 40 minutes. Before each focus group commenced, participants were given an informed consent form and a confidentiality form to read and sign (initials only). These included the disclosure that the focus group would be audio recorded. It also explained that any data arising from the focus groups would be anonymised and may be used in future publications. Participants were reminded that taking part was completely voluntary and they were free to withdraw at any time, without giving any reason and without their legal or employment rights being affected.

The areas explored during focus groups with NI veterans centred on their attitudes, perceptions and experiences of their transition from military to civilian life and the support they did / did not receive. Also posited were questions around what support they would have liked to see put in place, or how things could be done differently in future.

Data Management

Data protection and management were of the utmost concern; all procedures followed, in line with the maximum standard required by Ulster University. Additional precautions were taken where deemed necessary, given the security concerns of this particular cohort.

Consent forms

Consent forms and other hard copy files are stored in a locked desk in an office which can only be unlocked by electronic access as allocated to members of the project team and other key university staff. In accordance with Ulster University governance procedures, consent forms will be kept for up to a maximum of ten years after this project terminates. All records will then be disposed of as confidential waste.

Quality assurance

A system for consistent naming of files, file sharing and structuring of folders was agreed by the project team at the outset. A version number and date was added to the title and filename of all documents, derived datasets, new datasets, transcripts and NVivo files. Audio files from interviews and focus groups were checked against typed transcripts for accuracy. Transcripts were anonymised using pseudonyms, labelled with a unique identifier, and were preceded by a cover sheet detailing the context to data collection and those who participated (e.g. age, gender, location etc.).

Back-up and security of data

All versions of confidential documents, datasets, transcripts and audio recordings are stored on Ulster University's networked file store in a private folder which is only accessible to the research team. The University computing network is protected from viruses and data piracy by virus checkers and firewalls. All raw data and transcripts from interviews and focus groups were analysed on either the University's Coleraine or Jordanstown campuses. Audio files were transcribed by members of the research team. A system for version control of files and documents was agreed by the project team and included: unique file identification using a systematic naming convention such as inclusion of date and author's initials in filename; recording version and status of files; maintaining master files if several versions were developed in parallel; and keeping a master file of data.

Data Analysis

Audio recorded focus group discussions were transcribed verbatim by members of the research team and checked for accuracy by the researchers collecting the data. Analyses were informed by grounded theory (Glaser & Strauss, 1967), which is an inductive approach that allows theory to emerge from the data collected, thus grounding the theory in data, rather than selecting a theoretical framework or hypotheses from existing literature. The codes represented concepts within questions from the focus group guide and concepts that emerged during the group discussions. The researchers who collected the data developed the codebook, coded the transcripts, and then revised the codebook. Data was analysed using the NVivo11 software. Any disagreements between coders were discussed until consensus was reached. We adopted a content analysis for the analysis (Guest, MacQueen & Namey, 2012). Foremost is the need for deep immersion in the data, which involves listening to the audio-recording, reading and re-reading the whole transcript alongside field notes and sharing observations and preliminary analytical insights within the research team. Themes were often composed of several sub-themes that identified multiple influences of the life as a NI veteran now, their current needs, and their likely future needs. After the identification of themes, the transcripts were reviewed again to select representative quotes for each theme. The transcripts were reviewed a final time for additional supporting and disconfirming evidence of themes. We identified three master themes, which make up the following three chapters: the current needs of NI veterans; barriers to help-seeking; and NI veterans' likely future needs. Within each of these section we identified several themes and sub-themes and we show the number of times they were referenced and the number of focus groups where the themes emerged.

A Note on the Presentation of Extracts

We present exemplars of the themes and sub-themes we identified during our interviews and focus groups in our findings below. These are presented verbatim where possible in order to maintain the

service providers' and service users' intended sentiments. We also add context and narrative to these. However, given the sensitive nature of our data, we deemed it appropriate to anonymise our dataset as far as possible in line with the Ulster University Research Ethics Committee and the British Psychological Society (BPS) guidelines (BPS, 2014) for researching human participants. This means that some extracts are truncated and some names, locations and other in-text personal details or references have been redacted / removed. Where focus group conversation exemplars are presented, individual veterans' identification has been replaced with P1 (Participant 1), P2 and so on and referenced as 'veteran'. All service provider extracts are referenced as 'service provider'.

Key Points:

- **DATA WAS COLLECTED OVER TWO PHASES:**
  - **PHASE 1 – SERVICE PROVIDERS INTERVIEWS**
    20 interviews:
    - MOD – 2 INTERVIEWS;
    - STATUTORY – 4 INTERVIEWS;
    - VCS – 14 INTERVIEWS.

  - **PHASE 2 – VETERAN-LED FOCUS GROUPS**
    13 focus groups:
    - 18-24 – NO PARTICIPANTS;
    - 25-44 – 2 GROUPS;
    - 45-64 – 8 GROUPS;
    - 65-84 – 3 GROUPS
    - 85+ - NO PARTICIPANTS.

- Interview and focus group data was coded and co-analysed using NVivo software package
- All ethical and data protection protocols were strictly adhered to during data collection and analysis. Any following excerpts taken from interview and focus group transcripts have been fully anonymised.

5 Veterans' Current Needs

Overview:

- Complex and Overlapping Needs
- Physical and Mental Health Needs
- Issues Associated with Ageing
- Finance, Welfare, Benefits and Pensions
- Social Support and Comradeship
- The Shock of Transition
- Safe Space

Previous research has highlighted the complexity of veterans' need(s), especially in relation to mental health problems (e.g., Iversen, Dyson et al., 2005; Iversen & Greenberg; Murphy, Ashwick, Palmer, & Busuttil, 2017). Discussions with service providers and veterans about the current needs of veterans living in NI produced a varied list of needs ranging from seeking information and guidance to those requiring specialist mental health treatment. Most service providers described veterans' needs as complex, with new issues unfolding throughout the casework process. This multi-layered nature of need characterised responses from veterans in the focus groups, though they did not identify it as plainly as the service providers. There was significantly more emphasis on social support and family components from these respondents, and issues related to finance, benefits and pensions were clearly a key area, where support is needed. This chapter will outline the perceived current needs of the veteran population according to both those service providers who come into regular contact with this population, and the veterans themselves. It will reflect on the differences and similarities between perceptions of the two groups.

5.1   Introduction

Respondents described a complex, variable set of needs. These often ran parallel to those issues facing the wider population in NI, though specific needs or complexities regularly emerged as associated with their service. Some service providers discussed how 'trigger' events (e.g., security threats reported in the news) could precipitate the onset of need within veterans, especially among the ex-UDR & R IRISH (HS) populations. Service providers (both large and small) who deal directly with veterans on a daily basis appeared more cognisant of veterans' needs on the ground. Some statutory organisations that have no 'direct' link with veterans, but who provide services to them as part of their remit, spoke about veteran need from a general, hypothetical stance in relation to their Departmental aims. Table 1 presents an overview of the main current needs in the veteran community from the perspective of veterans and their service providers[12][13].

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[12] This list is not exhaustive.

[13] With reference to mental health needs, some of these were reported by non-specialist service providers and so may not carry a confirmed clinical diagnosis.

Table 1: Veterans' Current Needs

Themes	Sub-Themes
Complex and Overlapping Needs	Employment; health; social; domestic; emotional
Health Needs	Mental health; PTSD; anxiety; guilt; physical health; prosthetics; ageing
Issues Associated with Ageing	Isolation; healthcare; care; mobility; care
Finance	Funeral costs; domestic bills: food, rent, home-heating oil, unemployment, training courses, benefits
Welfare, Benefits and Pensions	Financial assistance; scheme entitlement; money management; entitlement; applying; remote vs Troubles
Social Support and Comradeship	Shared culture; membership organisations; comrade organisations; like-minded people; feeling like part of a family and part of a network; feeling comfortable; mutual understand; not being judged
The Shock of Transition	Career Transition Partnership; vocational skills training; identity management; entitlement; cultural adjustment
Safe Space	Trust; non-judgemental; like-minded people; drop-in centre

5.2   Complex and Overlapping Needs

One of the key findings from service provider interviews was that veterans' needs were complex, and that those who sought support often did so for multiple or overlapping issues. Many described taking a holistic approach to those with whom they came into contact in order to address the spectrum of need, recognising that often what people come in with may indicate other problems:

So when we, when we get our hands on a veteran, eh, he or she tends to have complex or composite issues, so it's not a single issue. Although that might be what they present with so "I need an oil fill," turns out to "I am poor and need an oil fill." But why are you poor? Because you've lost your job. Why have you lost your job? Because you've got relationship problems or substance dependency and that's caused by stress which is caused by your mental health and so forth (Service provider)

From the perspective of service providers, current problems experienced by a veteran often stem from another issue and can affect other areas of the veteran's life as described above. The complexity and multiplicity of veteran need has been found elsewhere (e.g. Karstoft, Armour, Andersen et al., 2015). For example, in a study assessing reintegration problems among Iraq-Afghanistan veterans, Sayer et al. (2010) found that veterans faced challenges in multiple domains of functioning. Left untreated, these problems were found to have deleterious effects not only on the individual, but also on his or her family; a finding similar to that found in this research. While veterans themselves did not directly outline the complexity of need as an issue, it was evident in the nature of their responses, where often one issue fed into another and so on. This becomes apparent through some of the findings discussed below, but is particularly the case, where issues around trigger events and the Troubles are concerned.

5.3   Health Needs

There is a large body of research detailing a prevalence of mental health problems among military veteran populations (e.g., Iversen, Dyson et al., 2005; Iversen & Greenberg, 2009; Murphy et al., 2017). Mental health is now regarded as one of the four most significant causes of ill health and disability in NI (Department of Health, 2011). NI has higher levels of mental ill health than any other region in the UK and one in five adults in the region have a mental health condition at any one time, which is a 25% higher overall prevalence of mental illness than England (Department of Health, 2014). It has been inferred that because of what we know about military populations and NI more generally, it is likely that veterans living in NI could be vulnerable to mental ill health. This was indicated to be true amongst service providers and veterans alike, both of whom listed mental health and seeking help for mental ill health as key issues facing the veteran population in NI.

Prevalence of Mental Health Issues

The prevalence of these issues in the NI veteran population is consistent with the above findings, according to service providers. The most commonly reported disorders were PTSD, depression, anxiety, guilt or a co-morbid presentation. Service providers noted that the demand for counselling and talking therapies was increasing among their client bases:

> *I'd say the bulk of the work, most referrals that we're receiving are all for mental health-related issues. And they're quite severe. Most people coming forward, as opposed to just one diagnosis, they could dual, triple, in some cases four. So, that is pressing. That has increased from last year. I would say the increase in that is about 25-30% of increasing referrals in mental health alone (Service provider)*

> *We've seen a major increase in needs of mental health provisions, um, especially a lot of individuals, um, indicating to us, um, concern and wary that some of the other organisations scaling back and indeed we've had a number of individuals who plan to come to us from other organisations that have scaled back. So that would be the predominant area now where we're focusing on is, uh, mental health provision and, uh, counselling (Service provider)*

Veterans also discussed the issue of mental health as being a prominent one in their experience. Discussions with veterans covered several different aspects of mental health support and delivery, including responsibility, information sharing, and service-user-health-professional interaction.

Before being discharged, military personnel receive a psychological assessment[14] which aims to identify mental health issues so that support can be put into place if necessary. However, veterans argued that there should be scope for follow up assessments, for reasons such as mental health issues not surfacing until years after leaving the military:

The problem is most guys don't have that problem until about ten years after (Veteran)
I didn't need any help at all. But at a later stage, I, I had a lot of mental problems and
received absolutely no help until about, uh, fourteen years later down the line (Veteran)

Once a veteran leaves service, provision of mental health care becomes the responsibility of the NHS. Because veterans can delay seeking help for a significant period of time after their discharge, many veterans believed that the military should still bear the responsibility for treating mental health issues resulting from their service:

Well the army itself when dealing with the final medical when people are leaving is
woeful, the record keeping is appalling, that continues and that is something that really
needs to be addressed from within the army, as regards the overall approach once an
individual leaves the forces, in many ways it's the forces responsibility, but there needs to
be an organisation to look after veterans' needs and it seems to me , now , in the last year
or two, there's now an awareness of it but it's still not there and that's what needs to be
addressed (Veteran)

In addressing mental health problems, and accounting for the fact that a large proportion of the veteran population in NI is ex-UDR & R IRISH (HS), there is a unique set of mental health problems to tackle.

Mental Health and the Troubles

The NI Assembly report titled Mental Health in Northern Ireland: Overview, Strategies, Policies, Care Pathways, CAMHS and Barriers to Accessing Services (Betts & Thompson, 2017) found a high prevalence of mental health problems in NI, which were attributable to the Troubles. O'Reilly and Stevenson (2003) examined the impact of the Troubles on the mental health of the general NI population by analysing data collected as part of the 1997 Northern Ireland Health and Well-being Survey. Overall, 21.3% of respondents said that the Troubles had either 'quite a bit' or 'a lot' of impact on their life or the lives of their family. The authors concluded that the Troubles represented a significant and additional impact on the mental health of the NI population. Another study (Ferry et al., 2014), utilising data from the Northern Ireland Study of Health and Stress and examining the relationship between the exposure to different types of traumatic events and their associated PTSD burden, has revealed that traumatic events specifically related to the Troubles accounted for the greatest public health burden of PTSD (relative to non-Troubles-related traumatic events). The study concluded that despite the conflict officially ending in 1999, a substantial proportion of the adult population continue to suffer the adverse mental health effects associated with chronic traumatic exposure (Ferry et al., 2014).

14 https://www.gov.uk/government/groups/defence-medical-services

The Troubles in some way, through direct exposure in service, living through it or having friends or family affected by it, affect most of the veteran community in NI. One service provider commented:

> *We haven't met anybody yet who's lived in Northern Ireland and in the Army who hasn't had a Troubles-related experience. It's very, very few. And when you search or look, you'll find it's there*
> *(Service provider)*

Service providers funded by the VSS, who work with veterans who served during the Troubles, warn that these experiences, and the legacy of the past, have an enduring effect on the mental health of some veterans in NI:

> *Someone's mental health and state of mind cannot be treated in isolation from their absolute quest for a form of accountability around what has happened. You cannot treat the two in isolation. And that is why the policy makers are still up the left in terms of thinking that this place will ever get to a, a point of consolation for those folks, unless until the past in some way is able to be dealt with (Service provider)*

The Bamford Review (Department of Health, 2006) found evidence that the traumatic experiences and exposure to violence related to the conflict in NI lead to adverse mental health not only for the person themselves, but also for their children and grandchildren. The result is a trans-generational cycle, which impacts upon the well-being of subsequent generations. However, there is minimal research as to the longer-term consequences of this trans-generational trauma or of its impact on children of those living in deeply divided, sectarian communities.

Veterans who develop mental health problems are at a higher risk of suffering from a range of related problems, such as social exclusion, unemployment (Iversen, Nikolaou et al., 2005), homelessness (Perl, 2015), and personal relationship problems (Pietrzak, Goldstein et al., 2009). All of these issues were discussed frequently in the focus groups.

Physical Health

Physical health emerged as a theme amongst service providers and veterans, though this was isolated to specialist issues and issues related to ageing. A small number of service providers, some representing specific client bases (e.g. limbless and elderly veterans), reported physical health needs as being a prevalent need. These needs centred around mobility issues and pain management, while other physical health problems, such as musculoskeletal, cardiovascular and respiratory problems, were not explicitly reported as main needs within the veteran community.

5.4   Issues Associated with Ageing

Consistent with the findings of the Royal British Legion's Household Survey (2014), many of the problems faced by the increasingly elderly veteran population are similar to those faced by the UK's elderly population as a whole: isolation, physical health problems and difficulties with mobility and care. These needs were also reported by some charities as challenges facing veterans in NI:

Their needs again are different, and they're elderly again. And all I do is have people who are just going to do hospital visits and just go for a chat and a cup of tea and everything… that's not financial, that's just looking after, that's loneliness really. Preventing loneliness (Service provider)

As stated in a Briefing Paper to the NI Assembly in June 2016, in NI, between 2010 and 2025, the number of people aged over 65 is expected to increase by 40%, and the number of the very elderly group (over 85) is expected to almost double (Thompson, 2016). This means that more people will be living with long-term illnesses and disabilities, which may have implications for how, and where, people will be cared for. One service provider specialising in nursing care commented on the challenge of trying to keep elderly veterans in their own homes for as long as possible, and with that, seeing a growing need for respite services for carers of ageing veterans.

NI, like many countries, must adapt its health and social care services in the context of increasing demands placed on services by the ageing population, increased numbers of people living with co-morbidities and constrained resources. Over the past decade in NI, policy has aimed to shift service provision away from hospitals and towards care in the community. In 2005, the Department of Health, Northern Ireland (2014) set out a 20-year strategic framework for primary care recognising the demographic trend heading towards a larger (and older) population, which would require the development of community-based alternatives to in-patient hospital care. The policy direction in NI for older people is to support them to maintain independence and manage daily living in their own home or in assisted housing, as opposed to in an acute setting or long-term care. This will remain an on-going challenge for service providers and Government alike

Our main challenges, well, firstly they mirror the whole challenge there is to elderly social care … trying to get to grips with this whole aging population and how we look after people and living longer and all the rest of it (Service provider)

5.5   Finance

An apparent challenge faced by veterans once they leave the military is achieving financial security. The ability to 'make ends meet' and thrive financially is eluding many veterans, and according to service providers, some are struggling to even cover their basic needs (e.g., requests for food vouchers). Voluntary sector service providers described veterans approaching their organisations requesting financial assistance for home heating oil, rent, food, white goods, funeral costs and more

Most of them are coming for financial advice, so that would maybe be looking for rent or rental deposit. And then that works right into maybe getting funeral costs, getting white goods, things like that (Service provider)

Previous research has noted that veterans are not immune to the economic downturns faced by civilian society (Elbogen, Johnson, Wagner, Newton, & Beckham, 2012) and the knock-on effect that it has on securing and maintaining employment, which ultimately creates financial strain. Other financial problems identified include mismanagement of, or lack of experience of handling finances:

From the home Service perspective, they were all paid off, they were given lump sum payments, some of them were given pensions, some weren't. They were all rich for a couple of years, they weren't re-trained, so the money ran out. So as a result of that, financial problems start (Service provider)

Given the findings, it may be important for veterans, as part of their resettlement package, to be given financial management advice. Veterans in focus groups spoke of the resettlement programme providing them with some advice on money management. What they pointed out was that the military life was all some knew before they were discharged, and thus, had little experience of money management in the civilian domain:

I left school on a Thursday and I joined the Army on the Monday…The Army's been my life. I've been turned into this person because I was so young, I was moulded into this person. So, after sixteen years…and then I come out—it doesn't prepare you for coming out…You just haven't got a clue. You've to manage this and you manage that. Okay, yes, you look after your own finances but it doesn't prepare you for civvy street (Veteran)

This concurs with the findings of Elbogen et al. (2012) who reported that although veterans face the same financial challenges as civilians, they experience additional financial difficulties in their transition to civilian life. The authors found that money mismanagement was common regardless of the veterans' level of income.

5.6 Welfare, Benefits and Pensions

Some service providers described an increasing need among veterans to get assistance with war pension entitlement and to seek information regarding the changes to the welfare system currently being rolled out across NI. One large UK-wide charity revealed that their caseload (covering NI-based clients only) was one of the largest across the whole organisation, which is significant, given the other, much larger, geographical areas that the charity covers:

I'm the only part-time war pension's rep, actually. In the national team, I think there's one in the south for London, there may be a, there is a part-timer there. I would have statistically one of the biggest caseloads (Service provider)

Recent changes in welfare reform have included, amongst other things, the introduction of Universal Credit, which replaces various tax credit schemes, housing benefit and Jobseeker's Allowance. Universal credit is being introduced for new claims on a phased geographical basis across NI from September 2017 to September 2018[15] and this has led to a surge in veterans approaching service providers seeking information about how this will affect their situation:

Well I suppose with, with welfare and benefits service particularity, with obviously PIP[16] and all that's coming through the universal credit system, there has been an avalanche of you know, new people coming forward because when your benefits are taken off you, or there is a threat of it, people will present (Service provider)

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[15] Welfare changes in Northern Ireland https://www.nidirect.gov.uk/campaigns/welfare-changes (Accessed on 23rd November 2017)

[16] Personal Independence Payment is a new benefit replacing Disability Living Allowance (DLA) for people aged between 16 to 64 years in NI.

Veterans raised issues relating to a range of welfare assistance. Several veterans talked about a disparity in the financial support different veteran groups received. In the following example the participant talks about the pension entitlement of veterans who served during Operation Banner (and receive Armed Forces Pension Scheme 1975) compared to subsequent Armed Forces Pension Schemes 2005 and 2015[16](GOV. UK, 2016)

P1 The guys of Op Banner, I mean, the vast majority—well, anybody I speak to— they got a big lump sum. They've got no mortgages. They've got a handy wee job with their good pension that they all seem to have got to keep them ticking over (Veteran)

P2: Yeah. Same. Op Banner seems to get preferential treatment on everything. 'Cause, like, I've tried to get a pension for my back and my knees. And nigh on impossible. I don't know how anybody got a pension leaving the Army 'cause it's, like, there's boys I know fit and well, running about, the best with the big pension, house paid for. So much for hearing loss and so much for this and that. You know (Veteran)

The Forces Pension Society[17] (an Armed Forces pension watchdog) acknowledges that the changes in pension schemes mean that some veterans have experienced unintended consequences and disadvantages. We are not aware of the scale of any impact these changes might have had on NI veterans in particular. It is important to note as well that while the above examples cite perceived advantages experienced by Operation Banner Veterans, veterans who served during the Troubles in NI expressed a range of specific issues, which will be outlined later in the report.

Focus group participants also expressed difficulties in accessing the War Pension Scheme and advice and information on social housing and welfare benefits, such as Employment and Support Allowance. The consensus was that advice and information did not always tally with veterans' entitlements or how military-related support might impinge on what additional sources of support they could access. Some veterans expressed a desire to have a central point of contact:

If I had somewhere where I could go, where people understood what I'm going through, where I could sit and freely, where they would genuinely help me regards benefits (Veteran)

It is important to note, when discussing benefits, that many of the respondents understood that they could go to a jobcentre, but indicated that they would need to feel that wherever they went to seek advice with benefits and pension, it would need to be a place where they were safe and could discuss their ex-military status without consequence.

5.7   Social Support and Comradeship

Tsutsumi and Kawakami (2004) raised the importance of social roles and belonging to a significant group as a buffer against stress. Military veterans, like other uniformed occupations such as police officers, firefighters, and medical doctors, do benefit from a strong culture of comradeship (Crawley, 2004) and

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[17] Pensions for veterans https://www.gov.uk/guidance/pensions-and-compensation-for-veterans (Accessed on 23rd November 2017)

trusting in and feeling safe around your immediate colleagues is a powerful cohesive force against a stressful work environment (Walker, 2015). According to many respondents, maintaining friendship circles post-military and during transition could play an essential role in helping to adjust to civilian life:

We call it the military cocoon and eh yes, they want to be inside the bubble and there are various ways of doing that. There are membership organisations, comrade organisations like the Legion… where you can wear your medals and tell your war stories and have a pint in the company of like-minded people (Service provider)

Other needs that former military have is, is really feeling like part of a family and part of a network, that they have comrades that they have served with um, and colleagues that they feel comfortable with; that they feel understood, that they don't feel judged (Service provider)

Military sociologists have pointed to the importance of comradeship in military institutions for their successful operation, so it was not surprising that veterans expressed a desire to maintain those relationships in their civilian lives (King, 2006). The following example was a common sentiment:

You don't realise the camaraderie until you leave the military. I only left last year but, um, even if you're away on operations or operations within Northern Ireland, you depend on the person beside you to save your life if need be. And they depend on you (Veteran)

However, some veterans said that these organisations were not always within the near vicinity. Some even described forming groups of their own:

We've started in our town, there, a veterans' group of our own. There's about forty members and they all come from every Service of the British Army. There's Marines, Paras, Royal Irish, UDR, all the regiments and we just come together every so often. Once a month for the camaraderie side. Just to get together and have talks and maybe organise a day here and a day there. You know, just a wee bit of an outing or something (Veteran)

Veterans also described creating and utilising online spaces; using veteran-specific social media websites such as Facebook to engage other veterans. These were often reported to have moved to offline contexts, evolving into in-person meetups and group outings.

Maintaining military comradeship has been shown to have great importance after discharge because military personnel tend to be at greater risk of isolation when those relationships end abruptly (Westwood, Black, Kammhuber, & McFarlane, 2008). Black and Papile (2010) pointed out that veteran isolation contributes to other problems such as family difficulties, and alcohol and substance misuse. The key reasons expressed by participants for maintaining some level of camaraderie was the opportunity to talk to others with similar experiences transitioning from military to civilian life. The distinction between military and civilian culture, and the related adjustments required to move from one to another, was cited repeatedly as a significant issue. Some veterans reported that maintaining military networks was important when there was either an absence of information, or when they did not know where to access that information. For example, many said they used the knowledge of other veterans when applying for a War Pension. Veterans talked openly about how the military provided clear structure in their lives, and what a change that is from civilian life, where they must incorporate this structure themselves.

5.8   The Shock of Transition

We discussed in Section 3.2 how Armed Forced personnel leaving the Services can seek help with the transition and resettlement process from the CTP. The services on offer include support on preparing for civilian employment, successful transitioning to employment, and advice on getting vocational education, full-time education programmes, and help for those planning to retire (MOD, 2012). Practical support might include vocational training and CV writing skills, for example. Other veterans discussed issues with getting onto the resettlement programmes especially when they had been injured during Service

There was resettlement but because I had injuries and I had to go for operations before
they let me out, I was told I could do my resettlement once I've come out because I had to
go to hospital......So, when I come back from hospital six weeks later I was discharged and
when I applied to do my resettlement I was told I couldn't because
I should have done it in the job (Veteran)

We do not know how widespread such experiences are. However, what was a widely expressed sentiment by these veterans was that there should be more support for the 'cultural shock' of transitioning from a military to a civilian culture (Ray & Heaslip, 2011)

I left school on a Thursday and I joined the Army on the Monday...I don't know anything
else. The Army's been my life. I've been turned into this person because I was so young,
I was moulded into this person...So, after sixteen years...and then I come out—it doesn't
prepare you for coming out...Yeah. You just haven't got a clue. You've to manage this and
you manage that. Okay, yes, you look after your own
finances but it doesn't prepare you for civvy street (Veteran)

Section 3.5 above showed that military culture tends to encourage self-help rather than help-seeking (Greenberg et al., 2007; Greene-Shortridge et al., 2007; Pietrzak, Johnson et al., 2009), and so veterans might find it difficult approaching health professionals, welfare providers, and those in the charitable sector. This is likely to be exacerbated by veterans' perceptions of how they are viewed by the wider NI population. Whilst military Service is highly politicalised in NI, arguably it is more so for those that served in the UDR & R IRISH (HS) (Potter, 2001). Indeed, far fewer navy and air force personnel served in NI during the Troubles than their army counterparts (MOD, 2017b). Some veterans indicated that this might be a reason for different experiences by those in the army, navy and air force. Others thought there may be a disparity in the quality and level of resettlement and support available to the different Services

...you never hear of an RAF boy or navy boy sleeping rough on the streets and the reason
for that is because our organisations are better at looking after our people rather than the
army....whatever happens to people you know when they come out? The army boy ends
up living on the street in a cardboard box...there must be something wrong in the army as
opposed to the rest. The navy doesn't have a problem and the RAF doesn't have a problem
(Veteran)

It is difficult to ascertain whether there are in fact real differences in what is available within each service or whether this is just a perception. However, what is clear from mental health studies (Gulliver, Griffiths

& Christensen, 2010; Pietrzak, Johnson et al., 2009) is that veterans' perceptions of services do influence help-seeking behaviours.

5.9   Safe Space

Safety and trust were key issues raised by the veterans in our focus groups. Some veterans discussed needing a space in which they could feel safe. For example,

P3: Always. But, you know, you want something where, somebody, if they're
feeling a bit low one day or they're feeling a bit suicidal or if they feel a bit
and they need somewhere to go and I feel safe.

P2: A safe place, yeah.

P3: I'm feeling emotional, I'm feeling, I want to cry. I need somewhere to go
where I can just sit there and there will be somebody there who'll say
'do you want to talk? Do you want to talk?' Um. But you know I just think somewhere you,
a safe location, a drop-in centre where nobody will judge you.
If you want to come and talk, come and talk (Veterans)

There have been several studies conducted in other countries that have looked into various aspects of veterans' perceptions of safety. These have looked at issues such as whether home is a safe space for veterans or their families (Basham, 2008), feelings of safety when veterans transition to college (Elliott, Gonzalez & Larsen, 2011), and veterans' perceptions of safety in group therapy sessions (Westwood, McLean, Cave, Borgen, & Slakov, 2010). However, to our knowledge there are no studies that focus specifically on the feasibility of a safe 'drop-in centre', what a centre might look like, its likely location, who would staff it, fund it and so on. We engage with some of these issues later in our section on veterans' future needs.

5.10 Conclusions

Although they are not an amorphous group with homogenous needs, those veterans who are in contact with support agencies are relatively consistent about the needs with which they present; and these needs are normally multiple, interrelated, and sometimes at odds with each other. Mental health continues to be an issue, but not one with which the majority of veterans are forthcoming. Many of the issues, such as financial difficulties and those complexities facing an ageing population, are consistent with the issues facing the general population. The ex-Service population is one for which comradeship and belonging play a major part in mental and emotional wellbeing, and moving forward; as such support providers would do well to incorporate social elements in responsive service provision.

Key Points:

- Veterans can often have multiple and competing needs at any one time;
- The majority of mental health difficulties go undisclosed;
- The majority of physical health issues are centred on mobility and pain management;
- There is a significant demand for financial intervention and support for everyday items;
- Veterans express issues with entitlement for benefits;
- Support from other veterans was expressed as a key coping resource;
- Additional support is required to help with the 'culture shock' in transitioning from a military to civilian life;
- The availability of health resources for veterans and their families could be widened;
- Veterans would like a 'safe space'.

6 Barriers to Support

Barriers to help-seeking for military personnel and veterans have been examined extensively, primarily in the US and in the wider UK (e.g. Coleman et al., 2017; Jones et al., 2016; Iversen et al., 2011; Ouimette et al., 2011). Common barriers for prospective use of services include: access; stigma; and a lack of trust in health professionals and care providers. These barriers are consistent with those found among the sample of NI-based service providers as factors which interfere with veterans seeking help, and many were mirrored by veteran respondents. This chapter will describe those barriers in more depth.

6.1 Introduction

Problems around accessing services and barriers to access were mostly raised by participants working in the Voluntary sector and Veterans themselves. Service providers described several multifaceted barriers inhibiting veterans in seeking support services, and frequently pointed out the personal/psychological barriers of veterans themselves. Across responses from service providers and veterans, the main barriers can be classified as either structural or psychosocial. Key structural barriers related to the practical accessibility of services; this encompassed disconnect around the roles and responsibilities for 'who does what' in managing veterans' support needs. Other practical barriers included fragmentation of services due to geographical location [of the veteran] and a current lack of information about what services and support exists for veterans. Of the psychosocial barriers, stigma and fear/trust over personal safety were noted as the major inhibitors to seeking treatment. This chapter will focus on the personal, social and practical barriers. Institutional and systemic issues will be discussed in Chapter 9.

Table 2 - Barriers to Support

Themes	Sub-Themes
Armed Forces Covenant	Recognition of Service; Recognition of special needs
Accessibility	Geographical location; Client engagement and awareness; acceptability of modes of service
Stigma	General stigma associated with mental health; Stigma related to military culture
Military Culture	Cultural understanding; mental health stigma; labelling; Service identity; recognition of Service
Trust	Expectations of service provider and service user; Hypervigilence and the legacy of the Troubles

6.2 Armed Forces Covenant (AFC)

As noted in Section 2, the AFC has not been implemented in NI as it might impinge on Section 75 of the Northern Ireland Act 1998 (House of Commons Northern Ireland Affairs Committee, 2013). Thus, NI veterans are not currently entitled to any additional support other than that provided by NI public services. All of the veterans in our focus groups thought they should be entitled to the same treatment as veterans in England, Scotland and Wales, because they had taken inordinate risks serving their country.

The following extract is an example of their consensus

> *I'm not political so I don't wish to slate any political party but, you know, I put my life on the line. These other three gentlemen put their life on the line. I believe, I believe personally, regardless of political persuasion here in Northern Ireland, I believe the British government,regardless of who they are, which party, must grab that nettle and say: 'Armed Forces Covenant, it's in Northern Ireland as well' (Veteran)*

The non-implementation of the AFC in NI and Section 75 of the Northern Ireland Act 1998 (House of Commons Northern Ireland Affairs Committee, 2013) means NI veterans do not enjoy specialist services or privileged access to services. We noted in our scoping review (Armour et al., 2017) the existence of some specific provisions or protocols that relate to veterans in certain statutory services, but they are generally about the reinforcement of the equality of access rather than any veteran-specific support.

Most veterans reported mixed success with public services and VCS. Whilst most said that staff were friendly and tried to be helpful, respondents did not believe that these service providers were fully aware of veterans' needs. For example, many veterans said statutory and non-military VCS service providers did

not know how to apply for a War Pension, how to find out what their entitlement might be, or the impact of the war pension on their other benefits. Veterans expressed a need for a service specific to veterans where they could go to access the information specifically related to them. Indeed, many reported that they had to look for information in several different locations such as charities, health professionals, military associations, the MOD, public and private services, and other veterans. This suggests that there might be a need for centralised service where veterans can go to access the information and support they require. We cover this in more detail in Chapter 8.

Whilst most NI veterans we spoke to were generally supportive of the services provided by the VCS, some concerns were raised. For example, the following participant expressed concerns regarding entitlement to services such as education and training courses:

I was only told of the British Legion, SSAFA, the Royal Irish Aftercare, which I'm not entitled to anything because I left before the disbandment so I'm not entitled to any courses. But someone who's done three years is entitled to everything. I do sixteen years; I'm not entitled to a thing (Veteran)

Some veterans raised issues with organisations based outside of NI

Not one person's from Northern Ireland. There's London, Manchester, every single one. Everywhere else apart from Northern Ireland. So, you can get a mentor and I don't think that would work for a lot of people because to be honest when I looked at all the mentors, they're all civilian mentors. So, like, people on the other side (Veteran)

Indeed, the first report of the Northern Ireland Veterans health and wellbeing study, *Supporting and Serving Veterans in Northern Ireland* (Armour et al., 2017) found that nearly 45% of Armed Forced charities had headquarters outside of NI compared to the vast majority of organisations in the NI VCS that had locally based headquarters with a local remit.

Other concerns were raised about the level of staffing of some VCS and their understanding of issues related specifically to NI veterans: "*voluntary organisations don't understand where we've been and what we've done*". Similar sentiments were expressed in relation to civilians and in particular those that have direct contact with NI veterans such as healthcare professionals and those who provide welfare services.

6.3 Accessibility

The accessibility of support for veterans is affected by a number of issues including geographical location, awareness and acceptability. This full range of accessibility issues arose from interviews with service providers.

Geographical Location

There exists across the UK, and even Europe, an urban/rural gap in availability and quality of public service provision. NI shares these issues, with significantly more investment in services in the greater Belfast area. The discrepancy in service availability is often felt acutely for those living 'west of the Bann'; the colloquial term for those in the Western and Southern Health and Social Care Trust areas. Based on the 2016 mid-year

population estimates (NISRA, 2017a) Fermanagh and Omagh district council had an estimated population of 115,800. Belfast, the regional capital and largest city in NI, had an estimated population of 339,600; nearly triple that Fermanagh and Omagh. Given the shift towards population-based services (Thompson, 2016), these numbers will be crucial to the distribution of services commissioned by the Health and Social Care Board for those areas.

This east/west imbalance is reflected in the regional spread of organisations set up to meet veterans' needs, as the majority of cross-sector services dedicated to helping veterans are clustered around Greater Belfast (Armour et al., 2017). This disparity was recognised by service providers as potentially leading to gaps in service provision, which may disadvantage veterans living in the Western counties

We always talk about the West of the Bann factor, whereby west of the River Bann there seems to be less access to the services that they think they need (Service provider)

The concentration of services has significant implications for those who need to regularly travel for specialist treatment. For example, specialist services for cancer diagnosis and treatment are delivered primarily within the Belfast Health and Social Care Trust. This, coupled with poor transport infrastructure, may mean that individuals living in rural areas of Co. Fermanagh are at a disadvantage

..if you live for instance out in be Belleek, well to even get in a car and drive from there to the city hospital [in Belfast], you're talking 2 and a half hours. Now you imagine someone in their 70's who's suffering from cancer, and that they would have to get into Enniskillen to begin with, to get on a bus, to go to Belfast and then get back and all that nonsense. It's 11 hours, the quickest it can be done (Service provider)

Previous research by Hoerster and colleagues in 2012 found that access-related barriers among veterans included inadequate transportation and having difficulty getting time off work to attend appointments. Where a veteran resides in NI may also influence how they can access services and what physical services are available to them within their local area,

Getting, getting the right support right across the, to the furthest reaches of the province is difficult. Um. And I can understand where therefore, you know, out in the far west, down in County Down, um, you know, around the edges of border where, you know, organisations sprung up themselves to help. Perhaps that's a reflection that the, the rest of us are not able to fill the gap as yet (Service provider)

It is clear that living in rural areas, particularly in the West, may be a major problem for veterans when trying to seek help. This could be exacerbated by differences in the availability of transport networks between east and west. Almost all of NI's 54 rail stations are located to the east of the River Bann (the province's loosely traditional mid-way point), with the west (n=3 stations) left very poor in comparison. Previous research has identified perceived barriers, such as transport and location, as significant predictors of help-seeking behaviour (Carpenter, 2010; Janz & Becker, 1984). Improving accessibility to services among veterans would need to include addressing geographical barriers to accessing care, especially for veterans residing in Western and rural communities.

Visibility and Awareness of Services

Lack of information about healthcare services has been found to be a major barrier to accessing care in both military and non-military populations (e.g. Elnitsky, Andresen, Clark, McGarity & Kerns, 2013; Lester, Tritter & Sorohan, 2005; Washington, Kleimann, Michelini, Kleimann & Canning, 2007). A lack of information, or an inability to utilise information on service providers, may inhibit individuals from making informed decisions about who to approach for help. This was an observation made regularly by service providers:

Part of the problem is lack of understanding what is out there and available to, to reach out to, you know, um, I mentioned about the welfare case in which we done yesterday, that just happened to be mentioned maybe in passing but, um, could anything be done? And, and I then advised him to get in touch so the, these two individuals weren't aware of what support was out there (Service provider)

Service providers claimed that the lack of understanding among veterans in NI about available services can be linked to military life, where there is little opportunity or requirement to proactively seek services and information:

Whenever they leave the army or whatever service, there really is a general lack of knowledge onhow to deal with life beyond their Service…so when they get out it just hits them you know, everything isn't on their doorstep and they have to do certain things for themselves (Service provider)

Some of these interpretations are somewhat infantilising in their nature, implying veterans have been taken care of up to now, and as such can't take care of themselves:

You see the things is, probably when people are used to being in Service, they've got a roof over their head, they're being fed, they've been clothed. I suppose they've never really had to do anything for themselves. And then they suddenly get into the big wide world and you've got bills to pay and food to buy (Service provider)

Gust, Kennedy, Shui, Nowak and Pickering (2005) examined how the role of information affected attitudes towards healthcare providers and found that perceived lack of information was associated with negative attitudes towards healthcare providers. Most service providers were cognisant of the fact that more needed to be done to better disseminate information among both veterans and other organisations delivering services to veterans, but none indicated that it was their job to do so. Ensor and Cooper (2004) noted that providing education and information to individuals and communities is an effective way of dealing with informational gaps, and according to Gust et al. (2005), there is an ethical responsibility on each service provider to deliver information. However, among our sample, there was uncertainty about whose responsibility this was:

Who does that? Who provides that central core that can, uh, let everybody know about everybody else? There isn't that there at the moment (Service provider)

Some service providers showed a desire to do more to disseminate information about existing support services, but stated that fear of advertising their services due to security risks was a barrier unique to NI:

*Well it's getting us awareness really so that, I mean, it's very difficult for us to advertise
ourselves or put up posters in all the places that the people in England can't put up posters
[…] And that's probably a big thing in people not coming forwards, because we can't put
ourselves out there, as much as they can in the mainland (Service provider)*

Service providers described how information about where to get help is mostly spread through ex-military friendship circles and word of mouth:

*I think then people find themselves in a distressed manner or maybe suffering with, uh,
mental health and they turn, they try to turn to the first point of contact, they may have a
friend who, um, mentions to them the first organisation that comes to their head because
they've had dealings with them or in the past (Service provider)*

*Our people in here learn more from each other, you know, they'd be sitting chatting, about
30 of them and on a coffee morning they'd go are you aware you can get such and such through
and such and such and they go no I didn't know about that and they pass on information
to each other which is one of our biggest strengths (Service provider)*

Service providers, especially from the Voluntary sector, noted that although they have a clear role in helping the veteran community, they are not operationally set up to actively 'seek out' veterans in need, nor should they be perceived as an emergency service. Despite this, several charitable organisations believed some veterans may expect service providers to make a direct approach offering help

*I think there's a lot of expectation that you know, maybe [veterans] can sit in their house
and somebody's going to knock on their door. Um but obviously that's not going to happen
because we need people to come forward and identify themselves and say that they need help
(Service provider)*

There was a sense that this was not the responsibility of service providers, however, and that ultimately responsibility lies with the individual:

*No we try our best you know we, we got on the discharge packages, we put our
information on the discharge paperwork and stuff like that. So we do as much as we can
really. It's up to the individual if they want to use us or not (Service provider)*

The Health and Social Care Board in NI has recently set out a new Regional Mental Health Care Pathway, which outlines the importance of service providers working together. Veterans should be able to seek advice from their service providers and they in turn should be fully up-to-date with what services are on offer across all sectors. Yet a lack of information could jeopardise this reciprocal relationship meaning that there are times when things fall through the gaps:

I would like to think that if a GP or a mental health professional was confronted with a complex case of a veteran and that person felt that additional help was required, that they would contact the board and see what help was available. But to what extent this has been publicised amongst GPs and Trusts, I'm not entirely sure (Service provider)

Appropriateness of Service Approach

Current service providers' modes of operation, which relies on veterans personally seeking out help themselves, may not be an effective means of ensuring that veterans get access to the appropriate care that they need. This is a particular risk for those with mental health problems. It is at this stage that an individual may need direct encouragement to engage with services. However, constraints on resources (funding and staffing in particular) were stated as reasons why adopting a face-to-face working model is not viable, or at least sustainable. Most of the large funded voluntary organisations utilise less labour-intensive and cheaper means of communicating with veterans: online-based FAQ's and national helplines as first points of contact. Smaller service providers from the voluntary sector who deal directly with veterans on a daily basis understood that a more effective way to communicate with a potentially distressed veteran is to engage face-to-face:

I've always operated on the view that writing things in documents or newsletters, or that type of approach, to be honest, doesn't reach people. What they need is a personal touch. And that's someone taking the time to go out and see them a couple times and just engage in general chat to be honest and build a bit of trust (Service provider)

My preferred working model is to have a person and that person goes out and sees you [...] but that's not the preferred working model, it's all done by helplines (Service provider)

Veterans also raised the importance of more informal, face-to-face, organic support work. The following is an extract from a veteran discussing a drop-in centre, which he had visited in Scotland:

They have a drop-in centre in the centre of Glasgow. And there's always someone—there's a careers advisor, there's a CV writer. There's a chef. You get a full fry for about £3 and a cup of tea. You've got someone to talk to. If you're feeling down, there's someone to talk to or if you want to speak about something there's always someone from each department. Like, if it's housing, if it's jobs, if it's benefits. There's always someone there. England's, England has got a couple of them. Wales has got one in Cardiff, one in Swansea, one in Wrexham. I think there's one more. Us over here have got nothing (Veteran)

This veteran was referring to the Armed Forces Veterans Association (AFVA) drop-in centre in Dumbarton Central Station, which was opened in 2015. Staffed by volunteers who work alongside Scotland's veterans' organisations, the centre aims to provide support, and access to health, education, housing and transport services. Its central location helps to make it accessible to veterans.

Veterans discussed the usefulness of drop-in centres in NI and suggested that any that were set up might need to consider a wider remit, better opening hours, appropriate location and staffing. The following is a short conversation between four veterans on what this centre might look like:

P1: I suppose, I mean, I would advocate strongly, um, a centre for veterans in Northern Ireland.

P3: Totally agree.

P2: Manned by veterans.

P4: Manned by veterans...if I was running it, it should be, we should offer a mentoring type of support. There's lots of consideration, safe locations but just a place where you can be who you are. There's that safety blanket, you can come in, you can cry, if you do, and again it goes into a combination. A guy comes down, 'I'm homeless, I've been kicked out for the night, domestic issue.' 'Fine, here's resources that we have.' And it goes from mental health, to emergency funds, to mentoring, to using a telephone number, doctors and mental health provision. So, you have a point of access...And they have everything, that you, and I'm talking everything, everything from A through to Z. One source, one-stop shop. Working in collaboration with the health service and local authorities, housing. All these sorts of things (Veterans)

The location of organisations was an issue that was raised several times by veterans and particularly in relation to face-to-face contact. For example, veterans discussed the use of online services such as the new Veterans' Gateway and their limitations:

P1: I find when you go online to read about it and in particular I don't know if you guys have checked out the new Veterans' Gateway site. Um. They explain it all to you but one of the thoughts that come to my mind when I was reading that is somebody suffering from PTSD does not want to sit down and read that.

P4: No, they don't.

P1: They need to talk to somebody, they don't want to sit down and read all that. Maybe people need to be approached too, as an aftercare thing, in the army. Maybe the army needs to go and approach them after a couple of years. 'How are you doing?' (Veterans)

This suggests that typical access routes to veteran-specific services may not be appropriate for all veterans and therefore, there may be a need for a variety of ways for veterans to engage. Many veterans said they preferred face-to-face interaction with those of a military background rather than telephone or Internet communication, but they also voiced concerns about the limited opening hours of some VCS organisations, particularly in the evenings and during weekends.

Given the apparent interest in a NI veterans' drop-in centre, it would appear that whilst public services in NI provide essential support for veterans, they cater for them as members of the general population rather than a particular group that has specific needs. One might draw the analogy of having a hip replacement attended to by a general practitioner rather than orthopaedic surgeon. Thus, a centre that caters specifically for the needs of NI veterans might help tackle some of the barriers to help-seeking that veterans discussed. However, given the paucity of research on NI veterans, we know little about the feasibility of such a centre in NI. The feasibility and desirability of a veterans' centre in NI is part of our

fourth work package, anticipated in Spring 2018. This piece of work will use feedback from focus groups, interviews and a large-scale survey to outline reactions to the idea of a veterans' centre in the region.

Increasingly, health and social care favours collaborative relationships between service provider and service user [veteran], working together to develop quality services and care through the identification of clear roles and responsibilities in the management of treatment (e.g. Regional Mental Health Care Pathway, Northern HSC Trust, 2014). Some respondents believed this would be an effective method for veterans. Better education pre-transition about how to access care, could help to empower veterans to have more control over their difficulties, the services they avail of and their own lives through self-management.

6.4 Stigma

Stigma surrounding mental health is still an issue generally in society and is an important influencing factor

in someone seeking professional help (Rüsch, Angermeyer & Corrigan, 2005). The World Health Organisation (WHO) stated, *"The single most important barrier to overcome in the community is the stigma and associated discrimination towards persons suffering from mental and behavioural disorders."*[18] A key review published by Clement et al. (2015) identified different types of stigma, which deter a person from seeking help from formal services. Included in these were:

- *Internalised stigma* – holding stigmatising views about oneself; and

- *Treatment stigma* – the stigma associated with seeking or receiving treatment for mental ill health.

The review found that internalised stigma and treatment stigma had consistent negative associations with help-seeking. Several systematic reviews (Clement et al., 2015; Coleman, Stevelink, Hatch, Denny, & Greenberg, 2017, Sharp et al., 2015) have been conducted examining the prevalence of stigma amongst the armed forces personnel. Sharp et al. (2015) found that one of the highest stigma-associated concerns within the military was related to being seen as 'weak', highlighting the importance of internalised stigma that may dissuade service members or veterans from seeking help or disclosing mental health problems. In addition, a systematic review published by Coleman et al. (2017) found that there was substantial evidence of a negative relationship between stigma and help-seeking for mental health difficulties within the Armed Forces.

Historically, the military has been steeped in the traditions and practices of masculinity. For example, Binkin and Bach (1977) suggested that soldering is viewed as a masculine role – the profession of war, defence and combat is defined by society as men's work. In the present day, the most recent statistics reveal that the number of women serving in the UK Regular Forces was only 10.1% as of 1 April 2015[21]. According to Clement et al. (2015) shame, embarrassment and employment related discrimination were among the key factors in preventing disclosure of a mental health problem. These factors were also described by service providers as substantial and multifaceted barriers to accessing support for mental ill health:

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[18] The World Health Report 2001: Mental Health, New Understanding, New Hope (2001); World Health Organisation available: http://www.who.int/whr/2001/en/

[19] Ministry of Defence UK Armed Forces Quarterly Personnel Report (2015a): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/426880/QPR_Apr2015.pdf

You come to the military, probably male macho type of organisation. Um. And despite what the military say, um, there clearly is a culture there that you do not disclose having psychiatric emotional problems. It's a death knell for your career. Um, the military don't want to carry people who have emotional psychiatric problems, um, because if a soldier isn't able to fight, he's no good (Service provider)

Participants described the lengths they have seen veterans go to in order to avoid seeking help for their problems:

We've had a case whereby an individual's ended up in the hospital due to malnourishment before he would reach out, um, for help... So, it, I think information's key, uh, and breaking that stigma around pride. It's a similar stigma around the, the mental health, as well, you know, people being able to reach out, so on (Service provider)

Based on the perceptions of service providers, breaking down the barrier of stigma should focus on countering the stereotypes of 'weakness', potential employment discrimination and shame/embarrassment. As disclosure issues were found to be particularly prevalent according to services providers, interventions that could aid decision making around disclosure would be useful. Davis, Byers and Walsh (2008) found that care that is welcoming and preserves clients' dignity and the use of terms that reflect the clients' understanding of their problems is a hallmark of good quality care. Service providers could ensure that they offer less stigmatising care by providing more non-clinical approaches; for example, help in the community and talking-based care, which may encourage a veteran who is experiencing mental health problems to come forward and seek help.

Whilst we know little about stigmatisation of NI veterans (including self-stigmatisation), we do know that anticipated public stigma associated with a mental health consultation is a common barrier to care and support-seeking for UK military veterans (Greenberg et al., 2007; Iversen et al., 2011). Indeed, Vogt's (2011) literature review of UK veterans' concerns about mental health stigma found that nearly 50% of respondents believed that admitting a mental health issue would cause a co-worker to maintain distance, around a third were concerned about public stigma and its effects, and 70% feared being labelled as having a mental disorder. This was reflected in our focus groups (and service provider interviews):

It's a stigma. Mental health is a stigma. No one's interested in it. If you were to apply for a job and they say, 'Right, you've got a—do you have a mental health problem?' and you tick 'yeah'. Straight away, you're branded. Straight away (Veteran)

The perceived lack of understanding was cited by some veterans as a reason for being reluctant to seek some forms of help; for example, help for mental health difficulties. Some suggested that this was due to the risk of being stigmatised or labelled. In particular, veterans had concerns about the potential knock-on effect of a mental health diagnosis in other areas of their lives:

Where do you go? You know? Your GP? But then you're going down the route then of, you know, maybe people's got PTSD or whatever but then you're labelling yourself and you have to look and say, 'Look, I'm only thirty-nine here. You know, I'm going to have to work here 'til I'm seventy. So, if you're labelled, if you get diagnosed or, or labelled with PTSD, what employer's going to look at you? (Veteran)

This anticipation of negative consequences for mental health diagnoses is a strong reflection of the self-stigmatisation and the perception of public stigma around mental ill health.

6.5 Military Culture

All experiences, perspectives and attitudes originate from particular cultural contexts. That is, from the particular language, mannerisms, behavioural norms, belief systems, and rituals of that culture (Dass-Brailsford, 2007). The cultural context of the military and its impact on veterans is no exception (Fenell, 2008). There are three specific aspects of military culture shown to impact on help-seeking behaviour; secrecy, stoicism, and denial (Hall, 2011).

Military personnel are trained to keep their work separate from their home life for matters of security. However, it may lead to less psychological openness with others; especially with those who do not have a military background. This is one reason why the comradeship expressed in Section 6.2 remains important for veterans; it allows them to open up to those they are comfortable with and those that understand their cultural values and practices. The veterans in the focus groups talked about the military culture remaining a strong part of their identity once leaving the Armed Services.

> *You're a soldier, first and foremost, you were a soldier. No matter what, you kept that. No matter what your job, you have that. It's been instilled into you, this pride in what you are, and you're a man and all the rest of it. Or a woman, whichever, that you are able to deal with everything (Veteran)*

The point this veteran makes "you are able to deal with everything" was a common sentiment. This idea of <u>emotional invincibility</u> has previously lead to the secrecy of personal issues (Hall, 2011). Indeed, many veterans said that they, their friends and former colleagues found it difficult to talk openly about personal issues and so were reluctant seek help "there are people who don't come out. *Don't want any help. Don't understand it's there*".

Stoicism is another key aspect of military culture that helps to maintain the appearance of stability and the ability to manage stress. This constant preparedness for any eventuality that might befall someone in the Armed Forced means that emotions such as fear become suppressed (Hall, 2011). Thus, seeking help for physical or emotional pain may be viewed as a personal weakness:

> *A lot of veterans in our generation won't seek support because it's the mind-set that they will have. It's weak (Veteran)*

According to Prochaska and DiClemente (1983) in their Stages of Change model, an individual may be aware that a problem exists, but have no commitment or intent to take actions. Research (e.g. Iversen et al. 2010; Vogt, 2011) shows that many veterans have complex perceived barriers to help-seeking, for example surrounded by a macho military culture, avoidance in seeking help, lack of understanding by civilians, shame, stigma and guilt.

This type of mind-set can lead to denial: 'I don't have a problem'. Therefore, a military culture which discourages the expression of feelings and the sharing of fears means that help is either not sought or goes

unnoticed. In the following extract the veteran highlights the disparity between the availability of support, support uptake, and self-help:

Uh. Well, the current, currently I don't see that I've any great needs because, uh, my problem seems to have lessened, I've learned to live with them but, uh, there was no help offered. There, again, uh, if you don't seek help, sometimes you won't get it (Veteran)

It would seem then that the learned military culture during Service can become a barrier to help-seeking once military Service has ended. But for some veterans, maintaining an element of military culture, supported through veteran networks and support groups, is a means to managing psychological stresses and preserving military honour (Fenell, 2008). Researchers such as Hall (2011) have suggested that those who work closely with veterans need to acknowledge the many unique characteristics of the military culture in order to be in a position to work effectively with veterans and adequately intervene and offer care.

6.6 Trust

All service providers stated that trust is an issue when it comes to veterans' help-seeking behaviour in NI. Veterans' lack of trust in service providers is a two-way barrier, as it also makes it difficult for organisations to help if veterans are 'hiding'. A lack of trust in service providers is as a barrier to accessing care among military veterans more generally (Iversen et al. 2011; Owens, Herrera, & Whitesell, 2009). Many of the examples we presented in Section 5 indicated that there was an element of mistrust for those who work in public services and that they had little awareness of veterans' needs. Some veterans suggested that a drop-in centre staffed by military or ex-military personnel might be useful. These sentiments relate to concerns expressed around insufficient understanding of military-related injuries (e.g. PTSD), the management of a former military identity (e.g. on CVs), referrals to military-specific support (e.g. VCS), and military-related welfare (e.g. War Pension Schemes) (also see Black & Collier, 2014; Iversen et al., 2011). Some also expressed a similar sentiment for the NI civilian population as a whole: "*There is a lack of civilian understanding. A big lack of it*".

In Northern Ireland, there is added complexity to trust as a barrier when taking into consideration the legacy of The Troubles. During The Troubles, the UDR & R IRISH (HS) was comprised specifically of local NI residents. One of the biggest challenges for veterans living in 'post-conflict' NI is therefore the real and perceived threat to their personal security:

Trust is still a big thing with a lot of our veterans. They're very wary of where they go, I mean that's one of the symptoms of PTSD, a lot of them are living still in the 1970s. So they're finding it very difficult to go to somewhere they can trust (Service provider)

A number of trust-related factors that interfere with treatment seeking were identified. Service providers discussed that a lack of trust was mostly directed towards statutory service providers and GPs. Openly confiding in an individual or service provider (who was specifically non-military) and trusting them with personal details was the antithesis of what they were taught during the Troubles:

And I mean, it's across the whole of Northern Ireland is this eh, real or perceived fear of the statutory bodies because they don't want to give away any information and they've been trained not to do that in their past life. But if you have to declare, and this is especially prevalent for mental health, if you have to declare that your circumstances are caused by military Service, then they very often suffer in silence (Service provider)

There is a consistent body of research showing that exposure to combat is associated with an increased risk of post-deployment psychiatric injury (Iversen et al. 2008; Kulka et al. 1990; Lee, Vaillant, Torrey & Elder, 1995). One of the most commonly reported disorders by service providers in this study is PTSD. According to one specialist service provider, hyper-vigilance (a common symptom of PTSD) may actually perpetuate a veteran's desire not to seek help. This is compounded in NI by the fact that hypervigilance is deemed a positive trait in a place where there could indeed be an ongoing threat to those with military connections

I've had people who don't want their sleep disorder treatment, they don't want their hyper-vigilance treated 'cause they want to be ready the next time someone comes to try kill them. While it's very disruptive to their life and their family and their functioning, they still view it as an adaptive sort of thing (Service provider)

Other issues which seem to affect those associated with The Troubles will be explored in more depth in Chapter 8.

6.7 Health Services

Given Operation Banner was the largest and longest commitment of UK military personnel (Armour et al, 2017), it is likely that the demands for physical and mental health services are going to continue into the foreseeable future. Competition for services is likely to remain high given the NI population as a whole was found to have more mental health difficulties compared to the rest of the UK due to the impact of the Troubles (Ferry et al., 2008). However, most veterans were supportive of the NHS and the service it was providing given the limited resources it is operating with.

Veterans raised several issues and we have touched on some of these elsewhere in the report. For example, other than their GP, veterans said they did not know where else to go to access information. Some suggested that they knew about other health services because they had heard about them by word-of-mouth:

I've a brother-in-law...and he was able to tell me, 'You're entitled to this, you're entitled to that.' I had no knowledge of that (Veteran)

Whilst accessing information was a key consideration for veterans, the greatest issues seemed to be around trusting the health professional, the health professional understanding the veterans' needs, and how the health issue will be viewed by the health professional and others. For example, the following veteran discussed issues around trust and disclosure:

I'd no difficulty but I can certainly understand where (some) could have severe difficulties.
They don't know who the doctor is, who the staff are, the health centre and everything else
and you're disclosing that you had been in the UDR and if need be people know
where you live, etc. (Veteran)

This veteran's concerns are related to personal security and we have noted this concern elsewhere (also see Armour et al., 2017). This would suggest then that more needs to be done to reassure veterans that those who work in the health professions and those that support the health professions are trustworthy. Currently, all clinical staff (GPs, nurses, healthcare assistants) in the UK need to have a Disclosure and Barring Service (DBS or AccessNI) check. However, there is no such requirement for non-clinical staff (reception or administrative staff) who might also have access to personal data.

Veterans also expressed concerns that those who work in the health professions do not understand military culture. We have covered this in more detail earlier, but it is worth reiterating veterans' sentiments:

So, I had to go to the health service. It's not the doctor's fault over here. They haven't got a
clue. They're not trained in how us lot work (Veteran)

Hall (2011) argued that all of those who are likely to work closely with veterans should acknowledge and understand the many unique characteristics of the military culture in order to be in a position to work effectively with this population and adequately intervene and offer care. This would suggest then that awareness training for health professionals and others (e.g. welfare and social service staff) might help. Veterans also talked about improving communications, where possible, between organisations such as the military, health and VCS, in order to improve the services provided to veterans. However, some veterans pointed to the difficulties in doing so. For example, one veteran talked about how an organisation was contacted by parents of a veteran addicted to prescription drugs. The veteran claimed that the parents asked for support, because they feared that their son was 'killing himself'. However, he claimed that the organisation was limited on what they could do because of the Data Protection Act 1998 and the Human Rights Act. Thus, another veteran suggested perhaps a statutory organisation for all public health matters might be the answer:

The Public Health Agency is a focal point for everything and I think if there's going to be
any sort of statutory organisation, then the PHA, the public health authority, because they
can give advice on drug addiction and this and health and mental health and everything
else. So, if there was to be consideration for some sort of body within Northern Ireland to
be based then I think they should be working hand in hand in partnership with the likes of
the PHA because that's where you should be going for all public health matters (Veteran)

Other veterans responding to this suggested that such an organisation might need to be military-specific; alluding to previous concerns that public services tend to be one-size-fits-all and so are not able to adequately attend to the needs of veterans (military-related injuries, communication, modes of operating – see previous chapters). Whilst this suggests that veterans and their families might require a central point to access veteran-specific services, perhaps with governmental or legislative oversight, they are still likely to face similar issues over security and privacy concerns (Clifton et al., 2004), which might impinge on the delivery of care. Clearly, further research would be required to see if such a statutory body was indeed feasible and whether it could provide the level of centralised medical care these veterans require.

6.7 Conclusions

Based on the description of the barriers to accessing care given by service providers, veterans - particularly those with mental health problems - may require more targeted outreach in order to meet potential need across NI. Service providers should work to break down those barriers that interfere with getting access to care and interfere with service utilisation among veterans. Although each veteran will be an individual with different military experiences, they may face similar barriers to care. These barriers are well known to service providers, and therefore it may not be enough for service providers to just 'exist' – practical improvements are needed to make it easier to get access to help and more needs to be done to foster the trust and confidence of those who are in need.

Expectations serve as a major determinant in a client's service quality evaluation, their satisfaction, and future decisions on whether or not to engage with a service again (Caruana, 2002). If misunderstandings in the roles and responsibilities between service users and service providers persist, this could lead to veterans having unrealistic and unmet expectations, which in turn may lead to poorer engagement with services, highlighting the need for veterans to be better informed (at the point of discharge) about what the roles and expectations are when accessing support services.

Key Points:

- There is a disconnect between client and service provider role expectations in relation to meeting client need;
- The veteran community in NI do not fully know, or are unsure about, what services and supports are available to them;
- There is a lack of information about healthcare services; this is major barrier to accessing care;
- There are rural-urban differences in access to and utilization of support services;
- Differences in the East / West Veterans transport network impinges on some veterans accessing help;
- Veterans with mental health issues may face social stigma and self-stigmatise;
- Given the complexities around trust it is often difficult for veterans to receive help and for service providers to provide help;
- Disparities between military and civilian cultures impinge on veterans seeking support;
- Disparities between military and civilian cultures impinge on the level of support veterans receive;
- Security concerns can deter help-seeking behaviour;
- Support seeking may be hindered by mental health stigmas and self-stigmatisation.
- Organisational structures may not fully incorporate the NI context;
- The provision of support might need to be bi-directional.

7 Veterans' Future Needs

Overview:

- Introduction

- Mental Health

  - Recognising the dynamic of mental health needs

  - Increasing awareness of mental health

  - The need for continued investment and reflection

- An Ageing Population

- Families in the Spotlight

- Alternative Support Services

- Conclusions

Many respondents struggled with the idea of predicting future need, but they were able to discuss it at length indirectly. Most service providers anticipated issues with an ageing population and recognised the time-lag in the discharge from the military and help-seeking for mental health, while veterans themselves tended to focus on their families and alternatives to 'normal' types of support. Respondents were aware of the urgency required in thinking about how the needs of veterans will change and the impact this will have on how support organisations operate and on the creation of policy.

7.1 Introduction

Perspectives on future needs of veterans varied between respondents. For veterans, age and life stage impacted on responses, whereas for service providers, issues varied between sectors. For example, younger veterans were more interested in issues related to future careers (e.g. training, employment), whereas older veterans were more focused on pensions and retirement. However, younger veterans did claim that older veterans, those of Operation Banner, seemed to get more financial benefits than those who had served overseas. We discuss this in more detail in Chapter 8. From a statutory perspective, there needs to be continued investment in mental health services, which is consistent with the needs of the population as a whole. From the veteran-specific service perspective, mental health is also of paramount concern. Given the lack of UK involvement in any major global conflicts, participants believe that investment needs to be made in tackling the stigma of coming forward with mental health problems (see *Heads Together*[22], a mental health initiative led by The Duke and Duchess of Cambridge and Prince Henry of Wales). Encouraging self-referral and breaking down barriers associated with such is deemed to be a priority in moving forward. Across the sectors, an ageing population is deemed to be a key problem facing

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[22] https://www.headstogether.org.uk/ (Accessed on 24th November 2017)

those serving veterans in NI, and services need to be responsive to this significant demographic change and all that comes with it. In some cases, ageing and mental health overlap, and the intersection of the two issues will also be addressed in this report. Veterans were more likely to focus on personal issues and family support, and showed a desire for more adaptable, holistic and non-traditional services. This was one of the biggest areas of divergence between veteran and service provider responses, with only mental health as a shared theme. Table 3 covers the four main themes and sub-themes on veterans' future needs:

Table 3: Veterans' Future Needs

Themes	Sub-Themes
Mental Health	The dynamic nature of mental health needs; increasing wider awareness; long-term investment in mental health services
Ageing	Physical health; mobility; infrastructure
Family Services	Welfare; pastoral; health; emotional; child-support
Alternative Support Services	Dogs for veterans;, outreach programmes

7.2 Mental Health

When thinking about the service provision for future needs within the veteran community, service providers discussed the need to look at mental health issues across the life course, and as they develop over time. The need to invest in public awareness raising, as well as long-term investment in mental health treatment and services, were key to respondent feedback.Veterans mirrored many of these views.

Recognising the dynamic nature of mental health needs

Representatives from veteran support organisations spoke about the importance of reflecting on how the needs of veterans will change. They recognised the impact this may have upon how organisations operate and the services that they provide. Previous research of UK military populations has suggested that, on average, it can take veterans nearly 11 years after leaving Service to seek support (Murphy et al., 2015). According to some service providers, the younger cohort of veteran are focused on the 'here and now' in addressing their immediate need:

> *I think a lot of them are very much focused on just getting themselves sorted...for the moment. And I don't think they look further beyond, you know maybe for the greater good of everybody out there. It's just what they need, what they need now, what their needs are, how can you fix this for me (Service provider)*

If you're talking about the thousands of individual veterans, eh, most of them want a sort of quick fix, as and when they engage with us, and then they don't foresee a need for us in the future (Service provider)

Yet, Buckman et al. (2013) have found that younger individuals (e.g. ESLs) are at increased risk of experiencing mental illness and so the time lag between transitioning from the military and engaging with support services could see a potential rise in demand for mental health services in the future. This concern was also felt by service providers:

A lot of the guys, our memberships are fifties, sixties and seventies. They've been out of the Forces fifteen, twenty years. If you go by the research, after twenty years or so, these symptoms—things start to rear their head. So, yeah, I do see that as still being a big need. Mental health will continue for a long time (Service provider)

Their injuries are gonna catch up with them. Their mental health problems are gonna catch up with them. I would say it's gonna be twenty years before we can actually successfully say we have completed our job and done our job (Service provider)

Research has found many factors that can influence why some veterans may take longer to seek out help. For example, Murphy et al. (2017) examined the profile of UK veterans seeking support for mental health difficulties and found that those veterans who seek support for mental health difficulties after transition may have joined the military with existing pre-Service vulnerabilities and this was also noted by a specialist service provider:

I suppose a lot of them have pre-existing problems before they joined the military. Some of which are then obviously sorted out in the military but many of them then continue to trouble them when they leave the military (Service provider)

This association between childhood adversity and adult mental health difficulties has been well established in both general and military populations (Buckman et al., 2013; Iversen et al., 2007; Kessler et al., 1997; Molnar et al., 2001;).

Increasing awareness on mental health

Across the UK in recent years, significant progress has been made to raise awareness about mental health issues. A recent example includes 'Heads Together', which is The Duke and Duchess of Cambridge and Prince Henry of Wales, which combines their campaign to tackle stigma and change the way people talk about mental health. Some service providers did acknowledge that more is being done to address mental health stigma:

*Um, previously what I certainly would have recognised was on the ground you would have been the norm for anybody who served in Northern Ireland and previous conflicts it would take them a lot longer to come forward and reach out for help. And I think that had a lot, a lot to do around the stigma of mental health. But we're now starting to see a lot of great work being done to tackle that stigma
(Service provider)*

The need for continued investment and reflection

Many service providers recognised the need to always be reflecting on best practice and preparing for future investment around mental health. One service provider warned against 'resting on laurels' in a seemingly well-functioning sector:

It's fantastic when we can say how great we are, but we're all just as good as our last case we weren't able to deliver on. So I think we should be, we should be expressing those and saying well this is where we're finding difficulty or this is where we're finding more of a need and it's going to come a time when we're not going to be able to deliver that need and we need to look at it for future provision (Service provider)

From a Statutory perspective, the need for continued investment in mental health services across the whole of NI was deemed to be a significant concern; not in terms of convincing legislators of the need, but rather finding the appropriate resources to invest:

Yeah we certainly know every dot of what we need to do in the future to meet these needs. Um we have been really making a hard case for our investment in mental health. I think it's agreed. No one disagrees with us. The key decision makers, up to the minister agree that it's just a matter of finding it (Service provider)

In a Briefing Paper presented to the NI Assembly in January 2016, the Public Accounts Committee noted that a key challenge for reform was to put the Health and Social Care Trusts on a sustainable financial footing, highlighting that the Trusts have no authority to move money from one year to the next; thus impeding their ability to undertake longer-term financial planning (Public Accounts Committee, 2015). However, when interviewed, statutory sector representatives did point out that some long-term initiatives are already in place. In October 2015, a 10-year initiative to transforming health and social care was launched. It is entitled 'Health and Wellbeing 2026: Delivering Together' (Department of Health, 2016), and it is envisaged that this plan will help to transform health and social care across NI, including mental health provision:

So um, Bamford has been the last decade, for the next decade, it will be delivering together - will be the key policy driver, together with the programme for government. I'm talking here as if everything's going to be up and running. So um delivering together and programme for government. And there is a specific indicator for the programme for government to improve mental health (Service Provider)

This policy commitment has not yet borne fruit, and as discussed in Chapter 3, there remain concerns about the future of mental health investment in the statutory sector in NI.

7.3 An Ageing Population

Population ageing is now recognised globally as an issue of increasing importance, and has many implications for health care (Lloyd-Sherlock, 2000). Within NI, between mid-2015 and mid-2016, the population aged 85+ represented 2% of the whole population. The rate of growth among this age group

was almost six times that of those under 85 years of age (NISRA, 2017c). Within the 'Delivering Together' initiative (Department of Health, 2016), there was acknowledgement of the needs of a rapidly changing and ageing population within NI, as we noted in Section 2. A population with an increasing life expectancy is a positive change, but presents a growing challenge for service providers across all sectors in terms of demands on health and social care services. The veteran population is also experiencing an increasingly ageing demographic. The veteran population is also experiencing an increasingly ageing demographic.

The complexity of needs presented by an ageing veteran population was raised by several service providers. The sophistication of care that we have to provide is a challenge, um, because we are now catering for people with much, much more complex medical conditions than what we would have done in the past (Service provider)

In addition to increased complexity of needs, decreasing mobility and the impact that this has on accessing services poses issues for service providers and users alike:

It's a lot of mobility issues. Getting around. I mean we run lots of events but if you can't drive because you've mobility problems or whatever there's no point in having events if you can't get there (Service provider)

Poor infrastructure (already discussed as a barrier to support services) and a lack of outreach by many of the existing organisations, coupled with an ageing veteran population, presents a real challenge for service providers when thinking about the future needs of veterans in NI. Moreover, the long time between leaving the military and help-seeking (Murphy et al. 2015) and the delayed onset PTSD (Horesh, Solomon, Zerach, & Ein-Dor, 2011) may mean that although veterans' needs are ever changing, many of the core issues [discussed in depth in Chapter 6] will continue:

You're always gonna have a regular pattern of the needs, as you have, um, veterans that are served personnel still transitioning through those services and coming out the other end. You're still gonna have the employability, you're still gonna have people falling upon hard times whether that be through benefit sanctions or just general difficulty to live (Service provider)

7.4 Families in the Spotlight

There is a reasonable amount of literature on the support needs of military families (e.g., Gewirtz, Erbes, Polusny, Forgatch, & DeGarmo, 2011; Hoshmand & Hoshmand, 2007), though much of it refers to families of serving personnel. The importance of family to the mental health and wellbeing of veterans was evident across the focus groups. Veterans referred frequently to their family life when discussing their future needs:

But you go on a six-month, uh, and during the middle of the six months, you will get an hour, an hour break—if they still do that—and, uh, you'll come home and see your family for a very short period. Um. There is no doubt that at the end of those tours…they suffered the effects of it, I think. Um. But there is no doubt that that has had an effect on families in terms of their cohesiveness on the terms of their relations between not just husband and wife but between parent and child and that can be not just the serving soldiers but that can be the abandoned wife (Veteran)

Clearly, support is necessary for families of serving military personnel, especially during deployment. Arguably, too, support needs to be available for families of veterans. For example, Dekel and Goldblatt's (2008) study of the intergenerational transmission of trauma found that children who experienced a parent with PTSD had an increased risk of emotional and behaviour problems. Given such risk, we were surprised to find little research focusing specifically on the support needs of veterans' families. Where veterans' families are covered, it tends to be in relation to veterans recently returning from deployment (Sayer, Farrow, Ross, & Oslin, 2009), intimate partner violence (Marshall, Panuzio, & Taft, 2005), and the support families can provide veterans in their resettlement to civilian life (Sizemore & Marshall, 2013). To our knowledge, there is no research that looks specifically at the support needs of NI veterans' families.

The need to focus on the provision of support for veterans' families was an issue raised by respondents:

What about families of veterans? Those are particularly children who were brought up, uh, in the system of, um, now. You could have, I would imagine, residual matters arising. Certainly from that period of time. You can imagine children being brought up in a home where suddenly a knock comes to the door and they're told you've got to pack everything up, you've got to move house. Right? Because, you know—I'm sorry, I don't mean that from the point of view of a threat coming from somebody that used to live across the road from here. I mean it actually as the police or security services coming and telling you have to go. The effects of children and interrupted education, the effects of children…who have interrupted education in those days (Veteran)

It would appear then that more research needs to be done to identify the needs of veterans' families and what their needs might be and in particular, the needs of the more vulnerable recent leavers and the ESL groups (see Godier et al., 2017 for more on ESLs). A range of support might be provided, including advice and guidance on relationship issues, health, childcare, housing, and support related to financial matters, especially when a veteran is suffering from health-related issues. For example, the following veteran talked about waiting for support with finance post-medical discharge, which posed financial difficulties for his family:

Got my medical discharge, waited a bit more and nobody came near me. The next thing, the wife comes one day and she says, 'do you not think you better do something here? Our savings is gone, everything's gone, the mortgage is due in a fortnight's time; we've no money'. And that's when it hit home (Veteran)

Families might also need help and support dealing with a veteran who has health-related issues as this veteran pointed out:

*One of the things that we don't get, particularly with mental health, our families don't get
support. Nobody sits down with the wife of somebody who's been seriously injured and
checks to see if they need anybody to talk to or anything like that. Nobody sits down with
the children of those who have been badly injured or have indeed lost their lives. Um. And
the only avenue open to them is the NHS (Veteran)*

Armed Forced charities in NI do provide some support for veterans' families; however, this support is centred on the needs of the veteran. This might include accessing care for the veteran, respite and financial assistance. There appears to be little direct support for families' experiences and direct personal needs. As this veteran points out, the indirect support gained through sharing experiences with military families, pastoral support and the development of support networks are important things which are increasingly unavailable:

*Um. Yes, there was a thing called a wives' club and all the rest of it. None of that will
exist in the future. So, therefore, it will exacerbate the situation in terms of the welfare of
families and individuals and how are you going to gather them together into the mantle of
pastoral, or whatever you want to call it, care? And that's, that is, for the future, is, I think,
a huge problem (Veteran)*

More research would need to be undertaken to explore the needs of veterans' families and identify possible interventions and support programmes that might help to resolve psychosocial issues related to military Service. Indeed, the families of NI-based veterans in particular are unique compared to their UK counterparts in that their family member's former theatre of operation might also be where they now live. Galovski and Lyons' (2004) literature review of the impact of PTSD on veterans' families found that they were prone to 'secondary traumatisation' and therefore marital/family interventions had the potential to improve the mental health of the veteran and their relationships with their family.

7.5 Alternative Forms of Support

Family-specific support and mental health care were key themes the veterans expressed during the focus groups. However, veterans also spoke about alternative forms of support, which do not follow the typical patterns veteran-specific services. We pointed out in Section 6 the difficulties some veterans find seeking help; particularly related to statutory or clinical therapies. As such, it may prove fruitful to explore alternative methods for engagement and support provision. The following are short extracts from a veteran discussing how some veterans have responded to the use of emotional support dogs:

*There was a massive change in him because he's got that dog…he wouldn't leave the
house without that, that's his support. [And] this woman who is a veteran… slowly it's
helping her, she never left the house whereas now she's got to leave the house. So, she's
changed…It helped me as well because I love dogs…I can talk to a dog; a dog doesn't judge
me. Doesn't judge me at all. I could talk, I talk to my dog, my Labrador when I had him, is
dead now, but he stopped me from blowing my head off because he just put his nose under
the gun (Veteran)*

In NI, the organisation called Assistance Dogs NI[21] provides trained assistance dogs to children with autism spectrum disorder and individuals with mobility-related disabilities to increase their quality of life. One of their future aims is to train dogs to assist people with other disabilities. Recently, a not-for-profit community organisation, called PTSD Dogs NI, has been set up in the region to provide support to sufferers of PTSD with the use of dogs in need of homes. The first dog was paired up with a NI veteran, who had served for 18 years and was experiencing mental health difficulties, earlier this year and has been providing him with comfort ever since (Beattie, 2017). Empirical evidence on the effects of companion animals on individual's mental health is scarce, but some positive findings in relation to loneliness (especially with animal-assisted therapy) have been reported in a systematic literature review conducted by Gilbey and Tani (2015). The authors, however, cautioned that there is a need for more rigorous randomized controlled trials before any firm conclusions on the effectiveness of companion animals-type interventions can be drawn.

Service providers also spoke of the usefulness of alternative therapies, and some service providers attempted to offer these wherever possible. This is one potential response to the resistance to more clinical treatment approaches which carry a certain level of stigma for some veterans (as outlined in Chapter 6). Many of the alternative therapies offered relied up on therapists providing the services on a voluntary basis, or specifically approaching organisations. The development of an evidence base on the efficacy of these methods would be useful in determining whether or not this is a potential area for future investment.

7.6 Conclusions

Looking to the future, the needs of the veteran community in NI will remain a complex, evolving network of issues and service providers will need to adapt to these changes if they are to meet needs; especially in relation to ageing and mental health problems. Based on the descriptions given by veterans about their current and future needs, better support for the veteran's family unit should be more readily available. Other alternative forms of support described included the use of dogs for emotional support. Although there was acknowledgement from service providers that some positive steps have been taken (e.g. breaking down barriers to stigma, long-term statutory health and social care plans), more needs to be done to ensure that veterans and their families are able to access support, which will best suit their needs.

[23] http://www.adni.org.uk/ (Accessed on 24th November 2017

Key Points:

- Delayed onset of mental health issues is likely to place additional demand on the public and the VCS;

- Increasing demand for services is likely to require additional resources (e.g. staffing and financial);

- Ageing veterans are likely to have increasing mobility issues;

- Mobility issues are likely to be impacted by local and national infrastructure;

- Services that support the unique requirements of veterans' families might need to be developed;

- There needs to be increased awareness of military culture, military support services, security issues, and social stigma for veterans in NI health services;

- There needs to be better communication and data sharing between organisations that support veterans;

- Alternative forms of support that reach out to veterans should be considered;

- Veteran drop-in centres and online gateways could provide veterans with an array of specific support.

8   The Legacy of the Troubles in Northern Ireland

Overview:

- Introduction

- Perceptions of Operation Banner Veterans

- Perceived Threats to Safety

- Conclusions

In addressing the needs of the veteran community in NI, service providers, especially those funded by the VSS within the voluntary sector, delineated additional layers of complexity for veterans who served in NI during the Troubles compared with veterans who served in remote operational theatres (e.g., Iraq and Afghanistan). Many respondents differentiated between veterans who served during Operation Banner and those who did not, and ultimately implied that the former experienced more significant barriers.

8.1 Introduction

The general consensus from service providers was that Operation Banner and the UDR & R IRISH (HS) were respectively a 'forgotten war' and 'forgotten army'. The main factors, which affected Home Service veterans, are specifically related to the impact of the legacy of the Troubles and because of this, their experiences of being a veteran in NI may differ from other military veterans residing in the country. Issues around Operation Banner veterans' own role justification, their perceptions of public demonisation of their military service, ongoing perceptions of threats to their own safety and the legacy of training and conditioning around secrecy perpetuated during their work through the Troubles all act as barriers to help-seeking and affect the health and wellbeing of this particular population.

8.2 Perceptions of Operation Banner Veterans

Due to the political context within NI, service providers described a perception among the UDR & R IRISH (HS) veterans that their military contribution in Operation Banner has been 'demonised' and 'criticised':

> *But Operation Banner was yesterday's war and they get the impression they are the forgotten, it's the forgotten army and that what they did isn't appreciated. They're now being castigated as part of the problem and not the solution. They are seeing history trying to be re-written. They are the bad guys, not the good guys and they are fearful that you know, everything they stood for, everything they believed in is going to be pulled from under them. And that irritates them and irks and causes anxiety, big style (Service provider)*

> *If you were to talk down here to a former UDR member, and you were to say to them, 'what is your most pressing concerns at this point in time?' and do you know what they will turn around and say? They won't say 'about my financial woes,' 'about my general health and wellbeing,' they will say about how the force that I was a member of is being demonised (Service provider)*

The development of problems, which require professional interventions, will undoubtedly be influenced by many factors, including those 'triggers', which precipitate the onset of a problem and those factors that maintain the problem. According to Horesh et al. (2011), PTSD onset is associated with prolonged exposure to real or perceived threats. Veterans who served and resided in NI during the Troubles were faced with the causes of PTSD as well as some of their triggers (e.g., security threats, bomb scares). Arguably, these real or perceived threats remain today or some veterans:

> *You've got individuals who served here and have lost colleagues, comrades. Um, um, and those trigger points are still there, uh, and a lot of these sort of ground signs are here in the province. So for them it's a lot more difficult and a lot more difficult, a lot more difficult to adjust, I believe. So I, I personally have found that those who live here and served here have found it a lot more difficult to adjust and come to terms with things (Service provider)*

8.3 Perceived Threats to Safety

A further difference made apparent between those who served in NI and those who did not, was that they might not face the same perceived security threats:

> *I suppose for the younger veteran who hasn't served here, maybe they feel the risk from dissident Republicans is less. Because they would feel that they weren't their enemy, as such (Service provider)*

> *I mean okay you go to Afghanistan, Iraq, it's awful but the things you're gonna leave there and come back home to somewhere it's safe. These people are living beside the people who are trying to kill them (Service provider)*

> *There is a distinction because the people who served Op Banner who had this unrelenting pressure or stress caused by the threat never going away feel like they are a different category from the hero coming back from Afghanistan missing a leg. And the guy who comes back from Afghanistan missing a leg is very often the guy who will be happy for his image to be in the paper wearing his medals and so on. Whereas the Op Banner veteran tends to be the hidden community (Service provider)*

Perceiving oneself to be under threat has been shown to have an adverse impact on mental health outcomes (Holbrook, Hoyt, Stein, & Sieber, 2001; Schmid & Muldoon, 2013). Research investigating the perception of life threat during deployment has concluded that veterans' reports of perceived threat were associated with a wide range of Axis I diagnoses[22] (Mott, Graham, & Teng, 2012). These experiential differences within the veteran community mean that there is not a 'one size fits all' approach when it comes to meeting veteran need in NI. This may be especially pertinent when it comes to how ex-UDR & R IRISH (HS) veterans get access to services. It is important to remember, however, that while these differences were expressed in some of the focus groups, not having served in The Troubles does not necessarily preclude individuals from being under threat from Dissident attack; as evidenced by the relatively recent murders of two serving British soldiers outside the now closed Massereene Barracks in County Antrim in 2009 (Cadwallader, 2009).

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[24] Axis I: All psychological diagnostic categories except mental retardation and personality disorder. Axis II: Personality disorders and mental retardation. Axis III: General medical condition; acute medical conditions and physical disorders. Axis IV: Psychosocial and environmental factors contributing to the disorder (Mott, Graham, & Teng, 2012).

These barriers are, in part, the result of "heavily engrained" warnings from within the military at the height of the conflict to keep one's veteran status concealed and now the challenge to allay any fears and encourage veterans to seek help is proving difficult:

> *The Troubles has brought up a kind of unique conundrums in so much that if you were UDR Royal Irish or a serving soldier over here, you are told to speak to nobody apart from, besides your own military link. You didn't tell, you didn't get a doctor involved, 'by the way I'm a corporal of the UDR'. You just didn't do that. You were engrained in your head that you check your car every day, you don't have regimental stickers on your car and attract attention to yourself because it could be, like, threatening for you and we engrained that into them. So we've engrained that isolationism into these people over forty years and now we're saying 'everything's okay, away go and talk to your doctors and citizens' advice in Londonderry when you don't really know who they are (Service provider)*

We have also previously shown that security remains a key concern for NI veterans. For example, one veteran reported hiding for several days when he was recognised as having served in the military during Operation Banner. Similar concerns mean that some veterans find their military background a hindrance when applying for work:

> *There are certain jobs I couldn't, I couldn't apply for 'cause they were in certain parts and some people were saying, 'well, don't put down you're a soldier.' How can I hide sixteen years of my life? (Veteran)*

Others talked about how perceived security issues impacted on seeking medical assistance:

> *Even today, even today, guys who are out as long as I am, you know, the better part of twenty-five, thirty years have a problem, they will not when they go to the GP tell them that they hurt this elbow…when they were in the army. That they hurt this knee jumping out the back of a Land Rover and you can't tell them that. You cannot persuade them (Veteran)*

Such sentiments were also found in our scoping review of veteran support services (Armour et al., 2017). Due to the legacy of the Troubles and a continued level of threat directed towards security services, some veterans seem reluctant to seek help. Extra vigilance around personal safety and security and a self-perceived fear among veterans about 'who they are speaking to', can often mean that they disengage with public services and those in the general population they do not know or trust. Thus, perceived and real security issues can act as a major barrier. This may not be problematic when accessing some public services, where previous employment or health history disclosure is not required, but it does appear to be a particular problem for those veterans who need to access mental health or welfare services.

NI veterans thought that public support for them was mixed. Some said that compared to the public support for veterans in the rest of the UK, they had been forgotten about. However, some did acknowledge that there was support in some areas, but as one veteran pointed out "*a lot of people don't like showing their support in case of reprisals with other people.*" Veterans also talked about potential discrimination from employers, public service officials, health professionals and other members of the public if they disclosed that they had served in the military.

The politicisation of military service in NI is perceived to be an issue by some veterans. One veteran pointed out that they believed because of this politicisation their Service was frequently not recognised:

Remembrance Sunday at the Cenotaph in London is a prime example. They talk about all the wars but Northern Ireland is never mentioned. We're just flung to the side. Every time
(Veteran)

Despite the general sentiment that most people either did not have a very supportive view of NI veterans, or were not comfortable in expressing their support, some veterans did talk about how new recruits were "very keen to associate themselves with those who served here during the Troubles" because they were aware of how difficult it was to live and work in one's theatre of operations. Thus, as Ryan, Carlstrom, Hughey and Harris (2011) pointed out, veterans' needs are much easier to provide for when people are made aware of the role they have played in national security.

8.4 Conclusions

While equality legislation protects veterans from disadvantage and creates a legal barrier to discrimination against this population, the legacy of the Troubles in NI and the ongoing security threats against security personnel in the region mean that public perception and personal concerns act as barriers for those who served in this conflict in seeking support from public services. While it is important to avoid the development of a two-tiered system of support, or differentiating too much between groups of veterans based on where they served, the impact of the Conflict in NI cannot be ignored when attempting to mitigate against barriers to improving the wellbeing of veterans in the region.

Key Points:

- Veterans of Operation Banner feel they have been 'demonised' and 'criticised';
- Home Service veterans believe they do not receive adequate recognition for their service;
- Home Service veterans have perceived security concerns for themselves and their families; these risks mean that many veterans of Operation Banner do not seek help.

9   Organisational, Systemic and Institutional Challenges

<table>
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Overview:

- Introduction
- Resources
  - Relationship to funders
- The Health Service
- Communication
- Conclusions

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Both service providers and veterans themselves pointed to challenges to meeting veteran need related to institutional barriers, communication across sectors, and resource limitation. While the majority of the feedback in this chapter is from the data collected during interviews with service providers, the impact of these issues is apparent in some of the reflections from focus group respondents.

9.1 Introduction

A fundamental organisational challenge when striving to improve is to engage in continuous growth and development which balances and coordinates change throughout the organisation (Lam, 2004). All service providers discussed key factors that can and do affect service delivery. The main challenge was working with limited resources (e.g. funding and staffing). The nature of this organisational challenge requires constant adaptation, with funding/budgetary constraints being the largest and most significant factors faced across all sectors.

Table 4: Organisational Challenges

Themes	Sub-Themes
Resources	Funding; staffing; organisation/funder relationship
Health Services	Mental health support and delivery; family; information sharing; service-user-health professional interaction
Communications	Collaboration; competition

9.2 Resources

Working within budgetary constraints, or adapting service delivery in the face of budget cuts, was the largest and most significant organisational challenge reported by all service providers. An additional pressure, most strongly felt within the voluntary sector, was that funding (or lack thereof) was seen

not only a pressure, but also a threat to operational survival; one voluntary service provider described thecompetition for funding in this regard as being 'cut throat'. Within the voluntary sector, many of the larger UK-wide charities benefit from experience acquiring significant external funding and large supportive public donations (see Armour et al. 2017 for a summary of voluntary sector funding). The Statutory sector, whilst under current financial pressures, also benefits from a guaranteed source of funding through Westminster. However, smaller, local voluntary organisations, especially those who rely on fundraising events, or niche organisations who are funded by the NI Executive, are in a more vulnerable position when it comes to uncertainty around finances and annual budgets. These organisations reported that they often faced 'tremendous scrutiny' in how and where money is spent.

As part of Northern Ireland Council for Voluntary Action(NICVA)'s latest State of the Sector Report, organisations were asked to give their views on a number of operational and structural areas, which may have an impact on the sector and their organisations over the next 12 months. A high proportion of respondents (66.3%) expected the economic condition of the VCS to worsen in 2016. In addition, delays in 2016/2017 departmental budgets being finalised may have also heightened feelings of financial insecurity amongst organisations across the sector (Northern Ireland Council for Voluntary Action, 2017):

And especially this year, with Stormont having a, with the budgets with nothing happening because there will be no money. And then because there's no money, yes we could say self-fund for a period of time and claim it back, but that's not the way the VSS works, so you'll have a period of 5 months or so were we will not have services for people. They can't just stop, which is very very difficult for people depending a lot on your therapists, so it's difficult to run anything and plan for that (Service provider)

It was noticeable that the organisations represented in this study derive their considerable impact from their relationships with veterans and the fervent pursuit of their cause. Many of the service providers that participated do not command large staff teams and operate, as already noted, within strict budgets. Therefore, veterans rely on support organisations whose future may be untenable due to a lack of funding:

We had members who were absolutely stressed out for we were told we were closing. So now, we've got onto the VSS funding. But what the point I'm making is that we had so many people stressed out, they thought the place was gonna disappear, a lot of people come in here, get their day in by coming in here, chatting and doing wee bits around the building (Service provider)

Statutory sector bodies, including the Department of Health, which is responsible for health and social care across NI, are also affected by budget cuts and under-resourcing. Interviewees representing the statutory sector felt that both investment and reform are needed to help ensure that statutory health and social care targets are met:

It's not rocket science to say that we need more investment in specialist services, we need more investment in psychological therapies, we need to do more for carers, including families of veterans. The growing waiting lists with psychological therapies, mental health services are evidence if it was needed, of the need of wide scale reform, across health and

social care. I'm talking here as if everything's going to be up and running. So, um Delivering Together[23] and Programme for Government. And there is a specific indicator for the programme for government to improve mental health. (Service provider)

It is important to note that in relation to service provision across the statutory sector, with the Delivering Together initiative (for example), there are long-term strategies in place to help meet the changing health and social care demand.

In order to cope with the range of needs that the veteran community have in NI, the number of voluntary organisations has grown leading to greater competition for limited resources (both financial and human). Lack of resources is a challenge, which can affect the capability to deliver a quality service. Some service providers described changes in their operational approach due to a lack of funds, with a particular reference to the centralisation of services:

Well eh from a...perspective of course, I believe the centralisation of services with helplines and websites is, unfortunately is away ahead. It's what will happen. The having people like...to go out to your house and have tea and sympathy is anachronistic now and we, we're, we will die out or we will be unfunded soon because it's not the preferred model. (Service provider)

The move towards more remote 'faceless' contact has already been highlighted as a barrier for some to accessing care, so while helplines and automated services may cut costs on the one hand, it could be detrimental to those more vulnerable individuals in need.

Relationship to funders

An emerging issue, stated by several respondents as an ongoing challenge, was the relationship between organisation and funder, which on occasion was viewed as a considerable irritant, and the sense of conflict between the job at hand and keeping the funder happy was apparent across a number of respondents:

It's understandable you know but it's not healthy. You should be able to say what you think within bounds. Eh and then maybe if more people were more honest, but we're all afraid to say it because we're tied by whatever organisation pays us and looks after us and all the rest (Service provider)

The continued military hierarchy and the way it plays out in related voluntary organisations also emerged as an issue for some:

If I am relying on funding from..., I ain't gonna say the veterans are being looked after crap because they'll say hang on a wee minute, do you know where you're funding comes from, you're still answering to a brigadier or a colonel. And that's creeping into Northern Ireland (Service provider)

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[23] Refers to Health and Wellbeing 2026: Delivering together, a 10-year strategy for transforming health and social care produced by the Department of Health in the NI Executive.

The tension between organisational objectives and funding is not isolated to the ex-forces sector. Scott (2003) noted on the impact of funding within non-profit and voluntary organisations that funders are adopting an increasingly targeted approach to funding. Service providers described how by funders capping budgets, they have certain control over what an organisation can offer and how they offer it:

Funding is going to be a problem. Um. It's trying to access mental health provision, to do it properly and to do it right, costs. We don't want to bring in, we want to bring in the best people because we think, and I think, that veterans deserve the best. So, we want the best people and to get the best people you have to pay them. So, that automatically increases the costs and sometimes our funders just benchmark the costs and say well that's the cost for that and you aren't getting more. Our organisation is run on buttons compared to what some of the military charities have got. (Service provider)

There were mixed perceptions between larger voluntary organisations who have a complement of paid and salaried staff in terms of how they are meeting client demand. A representative from a well-established charity reported no concerns where resourcing was an issue in role fulfilment. However, another representative working for a charity specialising in veterans' mental health reported how a lack of staffing and resources meant that needs were not being met:

It's very difficult, you know. And we don't have the sort of staff here locally, community staff, to treat them otherwise. Now, we have over the last couple of years increased the pool. Appointed a part-time cognitive therapist and appointed an OT. But it's still nowhere near to meet the need of those individuals. (Service provider)

Smaller charities also described the challenges associated with relying on volunteers. Volunteers cannot be considered to be one large, homogenous group (Wymer, 1998), as volunteers are of all ages and diverse backgrounds with a range of experiences and skills. The key to an organisation's success in recruiting and retaining volunteers is to have an understanding of the motives of its group of volunteers (Bussell & Forbes, 2002). Within NI, the voluntary sector has become a respected advocate for marginalised sections of the community and for those suffering from the effects of violence (Birrell & Williamson, 2001). This is especially pertinent due to the wide-reaching effects of the Troubles conflict seen across NI. However, despite the well-meaning agenda of those freely giving up their time, Jackson (1999) noted that voluntary organisations are now striving to recruit from a decreasing pool of volunteers. Volunteers are crucial for small organisations in terms of service delivery, for example, befriending in rural regions down to allowing some premises to be physically open. However, as volunteers are not contracted staff, working hours may be ad hoc and limited, which could result in piecemeal service delivery:

The problem is, if we have more clients, we need more volunteers. It's very very difficult to get volunteers so as we are we are not coping with the numbers. (Service provider)

Because we have all our volunteers, it's the volunteers that maybe go out and meet with organisations and gives little talks and things like that so you know, it's maybe getting out to these organisations but you're relying on a volunteer to go out and do that which isn't always ideal because maybe the person has other commitments or they can't do it or something like that you know. (Service provider)

In discussing the challenges of human resource management in the voluntary sector, Cunningham (1999) wrote that managers may find increased formalisation of the organisation's relationship with volunteers through meaningful induction and training may provide a means of retaining such a valuable source of labour, which may help to ameliorate the effects of short staffing.

9.3   Communications

One of the main obstacles to maintaining solid lines of communication for service providers was organisational overcrowding, specifically in the voluntary sector, because of perceived gaps in service provision. These gaps have resulted in the terrain of voluntary sector undergoing incessant changes, with specific reference to the emergence of more organisations 'springing up' to fill those gaps:

There's so many people, because there's a void, there's another group springs up and says we'll look after this then another charity springs up says we'll look after this. And because there's a void everybody's trying to do their own thing. So it becomes very disjointed (Service provider)

All of the organisations supporting veterans claim to be the best and the most effective. And all are stove piped, eh the big charities to their national headquarters, and that's human nature. They've all came into existence because of a perceived gap in capability […] Communications between them are very poor. Um because, it's not in their own vested interest to pass on people to each other (Service provider)

Due to the array of organisations mostly operating independently across NI, service providers are not adequately informed about each other's specific scope and remit, which has led to feelings of uncertainty amongst them:

The whole difficulty where there's so many service organisations and we don't know who the good ones are, if there's bad ones, who's, uh, operating as mavericks or whatever (Service provider)

If we treated someone with PTSD and that someone was having problems, I would struggle to know who I would refer to them to. Apart from the NHS. Because I wouldn't have confidence in other organisations (Service provider)

The majority of service providers reported a lack of formalised communication with each other and described a reliance on more informal networking and idiosyncratic connections when it came to information sharing. In certain instances, this manner of communication worked well:

Well I mean there is no communication unless I make communication. I mean there's no set, there's no, uh, that's one, that's when I was talking earlier about networking. The only way I can communicate is by networking. I mean I would use… a lot because me and him gets on well together. This is what I was saying right at the start, the informality. There's no, if I went tomorrow that link would be broke probably until somebody else struck up a relationship (Service provider)

While there are difficulties and risks involved in a more informal process, some respondents who had previously worked in a more ad hoc way found that more obstacles existed when trying to formalise communication:

"It used to be… and ourselves for example had a very, very close working relationship because we all knew each other and we all soldiered together. You're phoning up a mate and saying could you do me a favour or could you take this on? Now, that's all gone and we have to go through a very formal and artificial process where you, you have to make sure that you're not causing any reputation or risk to anybody. And you have to do everything very properly and very primly and it takes more time and more effort to do it."
(Service provider)

However, as previously reported by Armour et al. (2017), there are a number of formal mechanisms within NI set up to facilitate information sharing between voluntary and statutory sectors. These include the Armed Forces Liaison Forum; Confederation of Service Charities (Cobseo); Northern Ireland Veteran Support Committee (NIVSC); and the Northern Ireland Veterans Advisory and Pensions Committee. Figure 8 presents an overview of the links between Cobseo and the NIVSC.

Figure 10 Linkage between NIVSC and Cobseo organisations

COBSEO

COBSEO Membership + Full NIVSC Membership
TRBL
SSAFA
Combat Stress
NFA
RAFA
RNA

COBSEO Membership + Co-opted NIVSC Membership
H4H
Blind Veterans UK
BLESMA
AAVS
The Ely Centre

NIVSC
Veterans UK
38 (Irish) Brigade
RFCA (NI)
VA&PC
UDR RIRISH (HS)
Aftercare Service

NIVSC Co-opted Membership
Castlehill Foundation
Decorum NI
MAPS
SEFF

No Membership
Beyond the Battlefield
The Somme Nursing Home
The Milbern Trust

Adapted from Armour et al. (2017)

Alongside the good linkage amongst the larger Cobseo charities, NIVSC, for example, was established to improve existing co-operation between organisations (both statutory and voluntary) that are committed to the delivery of support to veterans. The committee aims to optimise the above flow of support to

veterans in NI through signposting and exchanging best practice. However, a lot of 'talking' is conducted at a strategic level and so little knowledge about these bodies trickle downwards to those working with veterans:

> *There is the, what's it called? The Armed Forces Liaison Group or something...At which*
> *the veterans' charities and the NHS meet, you know, quarterly or something like that, you*
> *know. I went to it once, it's at sort of a level, you know, among sort of senior managers*
> *where how much it percolates down to low levels, I don't know. I mean, I never knew of it*
> *when I was in the NHS, for example, you know*
> *(Service provider)*

Currently, within the voluntary sector, there is representation in Cobseo from the UK-wide charities operating in NI, but no charities specific to the region have full membership. The committee aims to represent the interests of veterans and one way this is achieved is by exchanging and coordinating information internally (Cobseo, 2017). All Cobseo member charities in NI avail of a *Form Alpha*, which is used when conducting casework with a veteran to assess their financial needs. Subsequent confidential case notes are stored on a shared computer system; this is a useful means of expediting a veterans' case to successful outcome and a good example of the benefits of information sharing. The form of practical communication was a hallmark of case management that all charities should adopt:

> *Most of the charities and...use a thing called Form A, which is the common, the case*
> *management system. And in theory, if we all bought into that, that would be a joined up*
> *way of talking to each other about individual cases (Service provider)*

Smaller voluntary-sector service providers found that when trying to gain membership to Cobseo or engage with larger charities for case-working purposes, barriers were put up to prevent any effective communication:

> *There's actually a pro forma of things that you, targets you have to meet for to become*
> *a member in that [Cobseo]. Um, and to be honest, I, we, we just decided look instead of*
> *jumping through all their hoops to try to get on it we'll continue to do what we're doing.*
> *There's too much red tape and bureaucracy (Service provider)*

According to De Laine (2000), for example, gatekeepers are those who have the power to grant or withhold access to people. Within the voluntary sector in NI, a simple exchange approach between organisations could be problematic due to a number of factors that are not supporting engagement. For instance, any risk associated with engagement may not be immediately tangible or applicable in every case. The perception of risk is highly subjective and what is perceived as a risky venture for one gatekeeper may not be considered risky for another (Lee & Renzetti, 1993). Perceptions of risk were also shown to be inhibiting, where lack of engagement with some organisations was associated with the potential risk of breaches of data protection:

> *We've had examples where we've reached out to other organisations and they've either*
> *quoted an action as not, as being a reason not to engage even though we've quite clearly*
> *told them we've got a, a form, which is used by...also and it clearly gives us permission to*

engage on this individual's behalf with other organisations. Uh, so data protection isn't in fact a, a barrier but they just, um, put up a barrier up and say look no we can't engage, we can't discuss the case with you (Service provider)

Well I just think that, um, sometimes we are over-phased by the interpretation of data protection and what you can say and what you can't say. And about things you can share, and I think we get lost inside it. And, um, and I think just that they are, the practice of sharing the information and communicating has perhaps been, uh, stifled in the past (Service provider)

More effective communication between service providers could help to dispel any poor understanding or uncertainty about an organisation and ensure optimum service delivery and continuity of care for veterans by harnessing the mix of professional skills drawn from each organisation.

Concerns about military 'record keeping' also extended to information sharing between the military and civilian health professionals. For example:

P2: When I took my medical notes to my GP, which were sort of equal to two inches thick, he just looked at me and he goes, 'what am I supposed to do with these?' and I says, 'well, due to the fact that I have a Service complaint ongoing, I would ask you to file them somewhere until it's finished and then what you do after that is entirely up to you'. But he's just looking at me going, 'that is the biggest greatest load of garbly-goosh'. Right? Because the military systems are not in line or in date with the medical systems that are currently running today.

P1: Yeah, their computers don't talk to each other (Veterans)

This interaction suggests that there might be a need for greater information sharing and that any barriers to accessing former Service personnel records by civilian medical personnel might impinge on the delivery of care. Currently, when military personnel are discharged, they are issued with a discharge letter and an intermediate summary of their in-Service medical care. These can be passed on to NHS GPs. These letters also tell the GP how to obtain their patient's full military medical records if required. Once the GP has registered, and the patient has provided consent, the GP is informed about the patient's status as a veteran (Lancaster, 2017). But, despite this process, it would appear that there are still some difficulties and these may be due to the sharing of sensitive data. Some veterans eluded to medical records having sections missing or 'blacked out'. Clifton et al. (2004) argued that information sharing and data integration in the public, private and not-for-profit sectors is hampered by legitimate and widespread concerns over security and privacy concerns, and the costs of seeking consent to data share. It would appear then, that more research in this area is required in order to examine any challenges to data sharing.

Veterans also spoke about improvements to mental health services. Many of these issues have been raised in other reports (see, for example, Armour et al., 2017; FiMT, 2015). Issues include veterans not knowing where to seek help *"Whenever I have sought help, you seem to be going from place to place, you're being passed from person to person to person. There doesn't seem to be somewhere where you can go and get*

the information"; lengthy waiting times to see health professionals "*well, it's going to take nine to fifteen months to get somebody to look at your knee*"; difficulty scheduling appointments; issues with referrals to other services; location of treatment "'*We're going to see maybe about physio but you have to go for an assessment in… And I says, 'I can't even get up to…on a flaming good day''*"; a lack of resources "*There's no resources in Northern Ireland for a start. Where do you go?*"; and stigma "*Now, if I go down the PTSD route, that's me finished. Because you're stigmatised.*"

Many of these issues are also likely to be experienced by the wider NI population as a result of underfunding of mental health-services (see the Bamford, 2006 review). However, there are two unique differences. Firstly, some veterans believe that there are still security risks if they reveal their military background to health professionals, and secondly, health professionals are largely perceived to not be fully aware of military-related injuries:

> *P1. The sad fact is that the vast majority of injured, be it physical or mentally injured, Service people in the UDR stroke Royal Irish, the vast majority of them won't talk to their GP. They don't know their GP well enough to trust…And that might not be intentional. Although it's just, it's a trust matter, it's a trust exercise that when you go to seek help, in particular for mental health issues, you need to be 100% trustful of the person who's sitting across the table from you*

> *P2. I tried speaking to the doctor. The doctor hasn't got a clue. So, he just writes a thing and he refers you. That's it (Veterans)*

Such perceptions are likely to hinder help-seeking behaviour despite the availability of resources. We discuss such perceptions in more detail in the section on barriers to help-seeking and look at what might be done to build trust so that veterans are comfortable approaching health professionals in the Section on the future needs of veterans.

9.4   Conclusions

Service providers and veterans put forward several multifaceted factors that pose a challenge to implementing service delivery. Funding, across all organisations and sectors, was stated as the most common challenge in service delivery. The centralisation of services within the voluntary sector, implemented to be more cost-effective and efficient, may not be the most effective way to reach out to veterans in need. Moreover, voluntary organisations that rely on volunteers or a small staff pool are in a precarious position when it comes to being able to meet demand. Communication within and between organisations, and externally towards veterans, was highlighted as needing improvement. Large umbrella organisations, such as Cobseo, should do more to ensure that smaller organisations are given opportunity to join up, which would improve information sharing within the sector across NI. Service providers also need to better disseminate their information to veterans to reassure the veteran community that their cases will be fully understood and kept confidential. Greater communication and engaging with internal and external partners to build working relationships would help with developing signposting routes for veterans and enhance an organisation's capacity to deliver constructive support.

Key Points:

- Funding (and budgetary constraints) is the most significant challenge for organisations across all sectors;

- Veterans need more information to make informed choices about their health and wellbeing;

- Service providers should do more to reassure the veteran community about understanding and confidentiality;

- Communications between organisations needs to be improved to prevent disjointed service provision across sectors.

10 Discussion

All of the participants in the study purported to have the health and wellbeing at the heart of their concerns. All had strong feelings about how this could and should be achieved; some of these overlapped where others were divergent or even contradictory. This chapter will discuss some of the key findings, and examine the similarities and differences in the perspectives and experiences of service providers and veterans.

10.1 Introduction

This report has shown that NI veterans have many of the same needs as veterans in the rest of the UK. What is different for NI veterans is that they are not entitled to the additional support provided by the AFC, and there are additional perceived and real threats as a result of the legacy of the Troubles. Indeed, on the whole, military Service is more politicised in NI than in England, Wales and Scotland. At the moment, there is no available evidence suggesting that NI veterans have worse outcomes than their UK counterparts. However, consistent with the findings of the first report in this study (Armour et al, 2017), there are clear differences in the way the two veteran groups access the statutory and voluntary services available to them, and their levels of direct representation in local and regional government. There are also some clear differences in the barriers to help-seeking and help-providing. As a result, the current and future needs of veterans in NI cannot be examined without careful consideration of this context.

10.2 (Dis)Similar Perspectives

Service providers operate in a competitive environment with increasing demands to become more efficient and effective due to resource constraints and rising demand for their services. Thus, organisations must consider their market, their competitors, their customers, and the resources they have available when considering the services they provide, how they provide them, and to whom. Veterans, on the other hand, will need to consider the services that are available to support their needs, their family's needs, or those of other veterans at any given moment. This can create similar and divergence of perspectives.

There were a number of similarities in perspectives on veterans' current and future needs. These are outlined below:

- The Armed Forces Covenant should be implement fully, so that NI veterans can enjoy the benefits other UK veterans receive;
- There should be access to a range of specialist support services that are aware of the unique health and welfare needs of NI veterans and their families. For example, applying for jobs and finance management;

- Additional resources are required to support the VCS and public services in delivering additional services NI veterans require. For example, localised support for the hard to reach veterans, and additional drop-in centres;
- Local support groups for veterans and their families would help reduce loneliness and isolation, and facilitate support, advice and information sharing;
- Improvements in public and VCS services are required to avoid lengthy waiting times for treatment or referrals;
- There is a need to increase access with marketing and communication, information sharing, extended opening hours and so on;
- Tackling stigma associated with mental health problems is a priority – including stigma in the military culture and the wider public;
- Trust issues are the product of stigma and personal security concerns. For example, veterans are hesitant to divulge their former military background when applying for work of seeking medical or welfare support.
- Veterans and service providers suggested that alternative ways of supporting NI veterans should be considered in order to reach those veterans who are unlikely to seek help. This would be effective both offline and online and via a variety of different channels.

However, there were areas where views diverged, contradicted one another, or where one group saw a problem which the other did not:

- Veterans thought public and VCS providers needed to be more aware of military culture in order to improve communication and understanding with NI veterans.
- Veterans thought service providers should have additional awareness training or have some former military personnel employed as staff;
- Veterans highlighted poor information sharing and communication between public, military and VCS service providers as a barrier to appropriate care. For example, when requiring medical care for a military-related injury from public service, health professionals are unable to access the veterans' former medical records during service;
- Some veterans requested improved access to public and VCS services with more regional offices or points of contact and a range of opening hours;
- Support for families of veterans that relate to their service was advocated by veterans. This would include issues related to trauma, disruption, relocation and so on;
- Service providers thought that as veterans aged (in particular those deployed during the Troubles), their needs would expand to include age-related physical and mental healthcare.
- Service providers also thought that more could be done to reduce the competitiveness in the marketplace and improve communication between veteran service providers.

Clearly, there is work to be done to improve the range of services, their availability, and how they are delivered to NI veterans. This is likely to require a concerted effort from all the multi-level governance structures of the NI devolved government (Gormley-Heenan & Birrell, 2016), the VCS, and some public sector services. NI veterans and their families are also likely to be involved in developing those support and care pathways.

10.3 Implications

Our analysis has shown that NI veterans have multiple and diverse needs, some of which are unique to NI (Armour et al., 2017). During the interviews and focus groups, the participants identified positive aspects of the support already provided to NI veterans (financial support, mental health treatment, advice and guidance), whilst acknowledging that NI veterans required additional support (improved organisational communication, wider variety of services, a greater awareness of veteran-specific needs). There was also a sense when discussing the experiences of NI veterans in comparison to other UK veterans that their experiences were unique but, to some degree have been less prominent given the political and social context of NI. Veterans provided accounts of how they managed their needs by identifying the relationships, networks and support they used (word-of-mouth, veteran groups, hiding military identity, self-management of issues) in the absence of specialist support-services. However, the use of more informal sources in the absence of specialist knowledge (see Epstein, 1995 for more on informal knowledge) can lead to unfavourable outcomes, such as avoiding help-seeking, self-medicating (Seal et al., 2012), criminal behaviour (Elbogen et al., 2012), alcohol misuse (Burnett-Zeigler et al., 2011), and suicidal behaviour (Gibbons, Brown & Hur, 2012).

It is evident from the findings that NI veterans' experiences of help-seeking are complex. They may have security and trust issues and concerns about social and self-stigma. They may also face additional challenges when accessing the appropriate services and information; either from living a considerable distance from the services or not having the resources to travel. Indeed, there seems to be some confusion over where to seek information about appropriate services, especially when local authority services might not be trusted. We saw that this often meant that veterans relied on word-of-mouth from other veterans, family members or those who they trusted in the local community. Thus, it would seem that services need to be more localised or that there should be a reasonably local, trusted, point of contact.

10.4 Strengths and Limitations

Participants were detailed in their responses and shared a lot of personal information, which was a key strength of the current study. Asking NI veterans to think about their needs before coming along to the focus group enabled them to think about what aspects of their stories to share. Some indicated that the process was cathartic, and enjoyable. Similarly, asking service providers to think about the services they provide and how that fits with NI veterans' current and future needs before participating in the interviews enabled them to consider the strengths and limitations of their own organisations.

There were also limitations inherent in our work. We recognise that with focus groups, members of the research can influence the data as facilitators of the focus groups, and that this may have impacted on the data. This was mitigated to a certain extent by the pre-determined interview schedule/topic guides, from which there was little divergence. The accounts also come from a limited number of former Service personnel, so we do not know how far their responses would generalise to other NI veterans. Indeed, since we invited NI veterans to express their current and future needs, those that participated may not have expressed a balanced view of the current services available to NI veterans. Further research could examine this through access to a wider group of NI veterans from varied geographical areas, age groups, gender (more female veterans), Service histories (home vs abroad Service), and experiences with different forms of support, to enable greater understanding of possible diversity in views and different care and support pathways.

11   Conclusions and Recommendations

In this final section, we conclude with some thoughts on improving the support provided to NI veterans. We have already, in earlier chapters, presented some of the key issues for NI veterans and those who provide support services to them, namely, legal and governmental, resourcing, access to services, barriers to help-seeking and service provision, organisational and institutional communication issues, and personal perceptions and attitudes. Some of these overlap. Here, we continue from those themes and issues to consider specific conclusions and propose recommendations for consideration by NI legislators, public service providers and their employees, VCS, NI veterans, and potentially also the private sector.

11.1 Introduction

Key actions moving forward should include changes in legislation, finding ways to recognise veterans' service, improvement in communication between different organisations that work with veterans and between their employees and the veterans, resourcing to improve the services that can be delivered, and exploring alternative forms of reaching out to veterans and engaging with veterans. Recognising that there is a paucity of research and knowledge of the experiences of NI veterans vis-à-vis veterans in other parts of the UK, we conclude with some suggestions for further research highlighting what might be gained in exploring them.

11.2 The Armed Forces Covenant

Central to any discussion about the current and future needs of NI veterans is the Covenant. The Covenant has been adopted in England, Scotland and Wales, but at the time of writing, it has not been implemented in NI due to concerns that the second principle of the Covenant contravenes the equality framework set out in Section 75 of the Northern Ireland Act 1998. Actions taken in the spirit of the AFC across GB have resulted in former Service personnel receiving assistance with education and family well-being, housing, beginning a new career, healthcare, and financial stability. While there is not yet any concrete evidence that there are inequalities in outcomes for veterans in NI versus the rest of the UK, there is also no evidence to refute that notion. This report, however, does provide significant evidence that failure to implement the Covenant in NI has significant bearing on the perception of inequality experienced by veterans in NI. This has the potential to impact upon help-seeking behaviours and mental health and wellbeing for this

population, and could cause difficulties in the relationship between those organisations with connections to the armed forces.

11.3 Recognition of Service

Connection to the armed forces in NI is highly political and divisive due to the role that the UK military played in the Troubles. As a result, public recognition of service is often avoided. Even wearing a poppy on Remembrance Sunday in NI can be contentious, because of its association with the British Armed Forces. Awareness raising and recognition of the role that the NI veterans' played in national security is important to many veterans for developing and strengthening the civil–military contract (McCartney, 2010), despite differing perspectives regarding the legitimacy of deployment. This is a challenging issue in a post-conflict society, and will need careful consideration moving forward. However it is important to acknowledge the impact this has on the wellbeing of veterans in the region, and the knock-on effects it could have on help-seeking, community integration, isolation and wellbeing.

11.4 Communication

Communication between the military, public bodies, and the VCS is regarded by veterans and service providers as key to the appropriate delivery of services to veterans in NI. Effective communication stands to serve a number of functions: ensuring optimum service delivery; information and resource sharing; preventing overlap and duplication; promoting efficiencies in resource allocation and distribution; and making best use of available evidence and best practice. Communication across and within these sectors also has the potential to relay the needs of the veteran community to policy-makers, and promote accountability and good governance to agencies supporting this population. At present, information sharing in the sector is made up of a range of formal mechanisms and informal relationships. Whilst there are mechanisms through which information can be shared and which provide networks between veteran support organisations and the MOD, across the VCS, and between the VCS and the statutory sector, there is a clear absence of communication and information sharing between the military and public health bodies. These findings have mirrored many of the conclusions drawn in the *Supporting and Serving Veterans in Northern Ireland* report.

11.5 Coordination of Services

Supporting and Serving Veterans in Northern Ireland (Armour et al, 2017) highlights the need for a well-resourced, formally recognised body in NI where key stakeholders in the region could meet to develop recommendations, provide responses to consultation and engagement exercises, and support key agencies in developing guidance and protocols which affect veterans in NI. That report made a number of recommendations about what that structure might look like, and how it could help operationalise coordinated support for veterans in NI. The findings of this report have validated the need for this improved coordination, and highlighted the issues associated with services which are delivered in a more ad hoc manner and without regular and responsive communication across the and within the voluntary and statutory sectors. Some movement has been made towards the establishment of such a body; building on existing provision and networks through the Northern Ireland Veterans Support Committee, Cobseo, the Northern Ireland Office, and NI Executive. This has been based on recommendations from the *Supporting and Serving Veterans in Northern Ireland* report.

11.6 Resource Improvement

Service providers, particularly those in the VCS, have indicated that the services they provide are limited by the resources to which they have access. This is also consistent with the recommendations from Supporting and Serving Veterans in NI (Armour et al, 2017), which highlighted the need for improved funding across local organisations through review of the administration of Covenant Funds to the region, and coordination between larger, UK-wide organisations and those developed through grassroots movement in NI.

Awareness raising and public recognition also have an impact on the level of VCS resources. Giving to charities takes two major forms: volunteering and monetary donations. Whilst traditional views of giving have focused on education and income level, more recent studies have pointed to gender, ethnic, demographic, socioeconomic, and psychographic variables (Lee & Chang, 2007). For example, men tend to give more to political causes than women. Psychographic variables (attitudinal-based factors) are likely to play an important part in NI charitable giving due to its troubled past. Thus, a sense of social responsibility, empathy, and awareness and knowledge of the role the NI veterans played in national security is likely to lead to higher empathic dispositions and stronger awareness of military charitable organisations that serve NI veterans and as such, may lead to greater generosity and sympathy. Information on public perceptions of veterans in NI will be available in 2018, when the NIVHWS team report on the findings of the Northern Ireland Life and Times Survey, which included questions on the armed forces for the first time in its history after support from Forces in Mind Trust[24].

11.7 Capacity Building and Awareness Training

Good interpersonal skills are key in the delivery of healthcare (and other public services) and help to develop good relationships, trust, understanding, compliance, and service satisfaction. The British Medical Association, Board of medical education (2004) recognises this and advocates that doctors and other health professionals are trained to consider their communication with those that have a chronic or complex disease, a terminal illness or those for whom there is no diagnosis, those with sensory impairments or speech problems, those with language barriers or learning, difficulties, patients from different ethnic groups, socioeconomic and cultural backgrounds, religious and regional differences. Given the military/ civilian cultural difficulties in interacting with public services and the VCS, that the NI veterans have expressed, it would seem that the inclusion of this type of awareness in training would prove useful in improving communication, trust and understanding between NI public services and veterans and could help to increase the rate of help-seeking for some services (Hall, 2011).

11.8 Age-Related Support

Like the rest of the UK ageing population, veterans are likely to place a greater demand on public services and VCS. These needs might be related to their former military Service; for example, underlying mental health issues resurfacing due to age (e.g. isolation and loneliness due to the loss of a partner) (see de Jong Gierveld, van Tilburg & Dykstra, 2016 for more on the social impacts of ageing and loneliness), or increasing demand as prosthesis need replacing (e.g. artificial limbs, knee replacements following kneecapping, hip replacements and so on) (see Brown et al., 2010 for more on combat-related injuries requiring a prosthesis). Thus, there is likely to be increasing pressure on some service providers, especially those that

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[24] The findings from the NILTS will be released in June of 2018. The NIVHWS team will present an overview of headline findings related to public attitudes towards veterans and the armed forces.

provide healthcare, and additional resources may therefore be required. Almost all of the physical health issues raised across interviews and focus groups related to problems associated with ageing, and an ageing population was the most commonly relayed issue when discussing future need. In spite of this, specialist provision for ageing veterans remains limited in NI, and is largely restricted to residential care for those requiring around the clock care. Given the increasing emphasis on care in the community and supported living solutions to aged and infirmed individuals, the creation of specialist support for ageing veterans based in the community could be an important step moving forward. This should also be considered in the context of the known delay in mental health help-seeking, and emerging evidence on the connection between things such as trauma, traumatic brain injury and dementia (Shively et al, 2012).

11.9 Alternative Support

There would appear to be presupposition with some service providers that if a veteran wants help they will seek it. But, based on the barriers such as trust, perceived security, cultural awareness, service accessibility and availability, and so on, described by veterans seeking support and care from public services and VCS, this does not appear to be the case. Two key conclusions could follow from this finding: 1.) Service providers must be more proactive in identifying those individuals in need of support; and 2.) More consideration should be given to the funding and delivery of alternative, less clinical, forms of care and support.

Many service providers pointed to the responsibility of Veterans in reaching out if they need support, while simultaneously pointing to the obvious reasons why they may be unlikely to do so. More work needs to be done to proactively encourage engagement from veterans. With appropriate resource, organisations must recognise the need to not only provide the services, but to ensure they are appropriate and accessible.

Some veterans responded favourably to the idea of a designated veterans' centre, which would provide a range of support, services, and referral and information services. They also highlighted the value of such a centre as a place where veterans could 'pop in for a chat'. The importance of having those who understand the veteran experience was raised consistently, Exploring the feasibility of a veterans' centre will be explored in more depth through the next stage of the NIVHWS, and a report will be released on the subject in Spring of 2018.

Given word-of-mouth information from those trusted by veterans is often key in help-seeking and accessing it is likely to prove useful to develop a network of local community outreach liaison officers. These could be veterans that are able to make annual contact with other veterans living in their local area to see if there is any support they need. Having a personal local point of contact might enable those hard to reach veterans to reach out to someone trusted in times of need.

11.10 Recommendations

Reflecting on the key findings of this report, and following on from the previous work carried out in Supporting and Serving Veterans in Northern Ireland, we have developed a number of practical recommendations based on the experiences relayed to us throughout this research to date. These recommendations are for the consideration of policy-makers in MOD, Northern Ireland Office,and the NI Executive. There are also recommendations for service providers and care commissioners across the statutory and voluntary sectors.

Key Area	Recommendation	Implications
The Armed Forces Covenant	Key officials should undertake a public engagement exercise with veterans in NI to establish potential solutions to the lack of implementation of the Armed Forces Covenant in the region.	While the political sensitivities around the Armed Forces Covenant are such that implementation of the Covenant is a complex, issue a public engagement exercise may help identify innovative solutions, and provide an opportunity for veterans to express their wishes/concerns surrounding these issues.
Community Integration	Local Authorities should work with Armed Forces Charities to identify ways in which community integration activities could be undertaken and where service might be recognised in a safe space for veterans. For example, the Armed Forces Day can be used as an example for how the public may be able to engage with veterans in a meaningful way.	Help develop veteran and community cohesion, trust, and understanding in order to help strengthen and normalise relationships.
Communication	A centralised resource (whether the NIVSC, Veteran Support Office or related agency) should support the facilitation of increased communication and information sharing between military charities, statutory services and the wider VCS. To support this, we recommend the adoption of the model proposed in *Supporting and Serving Veterans in NI* (Armour et al, 2017)	Improved information sharing can support better access and appropriateness of services as veterans are more easily referred to the appropriate provider, and resources can be pooled and shared to serve the population.
Resourcing	Recommendations around improving resources to local organisations outlined in	Improving resources to grassroots organisations has the potential to improve overall

Key Area	Recommendation	Implications
Resourcing	*Supporting and Serving Veterans in NI* should be adopted.	service provision to veterans in NI.
Awareness Training	A programme of training should be made available to public sector service providers, with particular emphasis on mental health professionals. This awareness raising could be done through one-off workshops or online provision, and could provide insight into the differences between military/civilian culture.	Training has the potential to improve understanding of veteran related issues in public sector service providers, and in turn improve the quality and efficacy of the services.
	Cobseo should support the development of a standardised volunteer induction programme, of which smaller charities could avail. This should be accessible to all veteran-related charitable services in this region.	Standardised volunteer training supports a high standard of volunteer capacity, with minimal resource investment.
Age-Related Support	Ex-service charities should begin to develop pro-active strategies to prepare for changing demographics. This should include liaison with statutory community care providers in order to support the delivery of veteran appropriate services where required.	Service providers may be able to be more responsive to changing demographics if they are able to plan ahead.
	Further research on potential relationships between veteran-related issues and dementia should be explored.	A greater understanding of relationships between PTSD and dementia or TBI and dementia could support the development of improved services to this population.

Key Area	Recommendation	Implications
Alternative Support	Services which centre the importance of social and peer support should be funded and promoted. Some potential options include: - Providing training to veterans to deliver peer support to those dealing with mental ill health - Identification of less clinical approaches to mental health support and supporting their implementation (i.e., Men's Shed for veterans, veteran specific running clubs or training groups)	Providing alternative forms of support allows veterans to access the support they need in spite of the stigma and social barriers they face in seeking help. Providing opportunities for social support helps reduce isolation and facilitate the comradeship so many veterans expressed missing in civilian life.
Access to support	Organisations should acknowledge the importance of more pro-active outreach to identify and engage hidden or hard to reach veterans.	Allow less able and or reluctant veterans to get the help and support that they need.
Increased support for Transition in NI	More work should be done to support the long-term employment needs of veterans in NI. While the CTP programme is available to veterans in NI, it is not clear that there is sufficient resource to deal with the complex issues facing some veterans entering the civilian workforce in NI. A piece of work should be undertaken around the transition process as it relates to NI, recognising the specific issues facing veterans in this	Improved resources for CTP and associated programmes in NI could allow for more regionally specific adaptation and could reduce both underemployment and unemployment in this population. Research on the transition process in NI would provide insight into the needs of NI veterans during this time, and support the improvement of

	region. This work should also include the experiences of families during transition, given the prominence given to family support in focus groups.	of transition support for this population.

11.11 Further Research

The relative absence of research specifically on NI veterans and their specific needs is a key finding of this report. In the context of limited information, there are a number of potential avenues for further research:

- o *Explore public and health service professionals' perceptions of NI veterans:* NI veterans talked about security issues with divulging their former military identity to those in public and health services. Interviewing public service and health professionals to identify their attitudes, perceptions and experiences of NI veterans might help to identify possible interventions that would help develop trust in the services they provide;
- o *Explore alternative ways to support and engage NI veterans:* Given Iversen et al. (2011) suggested that only around 20% of veterans with a mental health difficulty will seek help, feasibility studies could explore the development of veteran drop-in centres and the employment of community liaison officers. A systematic literature review might also shed light on alternative means of outreach to veteran populations;
- o *Support needs of military veterans' families:* The importance of family support networks, and the specific needs of families in NI was raised throughout the study. Research exploring how the different sectors can best provide support relevant to families of NI veterans would provide further insight.
- o *Veterans' help-seeking behaviours:* Given that little is known about patterns of veterans' help-seeking (Murphy et al., 2015), we would recommend an exploratory study like this one that invites those veterans who have sought help to discuss their personal experiences. This would be a more specific and detailed exploration of some of the points raised during the focus groups in this study;
- o *Online mental health support:* Bristol University INTERACT study (http://www.bristol.ac.uk/ psychiatry/research/interact-delphi/) has shown that the online administration of Cognitive behavioural therapy (CBT) can be a low cost effective way to treat depression. Therefore, it would be useful to explore whether this form of treatment would benefit those veterans who either have access issues or are reluctant to seek face-to-face support.

11.12 Concluding Remarks

This study seeks to provide insight into needs of veterans living in NI based on their experiences, and the perceptions of those who come into direct contact with this group. Given the personal nature of this research, it is important that the detailed information provided by participants will be used to contribute to the continuation of present and development of new health and social support for NI veterans and their families. Information on the way services are accessed, their availability and the barriers to utilising these services. NI veterans' express needs similar to many of the rest of the veteran population in the UK, but

also identify a unique set of issues related to living where they were formerly deployed. Issues related to trust, social stigma, and a desire for public recognition of military service are significant for NI veterans (as opposed to their UK counterparts) and as such, different methods of engagement and interventions may be required. The findings of this report validate many of the inferences made in Supporting and Serving Veterans in NI (Armour et al, 2017), and the recommendations are designed to complement and build upon those made in the previous report. Future work packages from the NIVHWS will develop these issues further; exploring the idea of a veterans' centre, providing the best possible estimate of the number and location of veterans in NI, and finally exploring the mental health and wellbeing of the population through a large-scale survey. Taken as a full study, this compliment of research will provide a substantial evidence base upon which policy-makers and service providers can draw to develop flexible and responsive health and social support for this population.

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