Welfare and warfare an uneasy mix: personal experiences of and organisational responses to emotional and mental health issues in young ex-service personnel

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Literature Review and Methodology

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Rationale for the study

'Shell-shock', which is now known as Post Traumatic Stress Disorder (PTSD), was first identified during the First World War and since this time the mental health of service personnel has been an issue of concern, particularly during times of armed conflict. The deployment of British troops to Afghanistan and Iraq as part of the 'war on terror', has put the Armed Forces under-strain according to leading figures such as General Sir Richard Dannatt, Chief of the General Staff ('Army chief warns army is overstretched' Guardian 19.9.07) and Admiral Lord Boyce the former chief of the defence staff ('Under-strength and under strain as experienced soldiers queue to quit' Guardian 23.11.07). This has resulted in a growing clamour to address the mental health 'fall-out' of operational 'overstretch' among British service personnel.

Concern about the mental health of service personnel has been a regular feature in the media since the onset of the action in Iraq with regular newspaper articles such as those cited below:

- 'Seven veterans of Iraq War have committed suicide' Daily Telegraph 22.2.04;
- 'Iraq: the forgotten victims' Independent 12.2.06;
- 'Plight of traumatised soldiers ignored by Government' Independent 30.1.07;
- 'British soldiers go AWOL because army ignores mental health problems' Independent 26.3.07.

These articles and powerful television documentaries such as Channel 4's 'Forgotten Heroes: The Not Dead' broadcast on 12.11.07 describe the horrors to which combat troops are exposed, the impact it may have on their mental health, as well as the short and long term consequences of this both for their future military careers and for their psychological and social return to civilian life.

The level of resources for mental health services within the forces provokes regular debate across the political divide in the Houses of Parliament. In one exchange (Hansard 18 June 2005 c1057) Harry Cohen a Labour MP pronounced that mental health services were inadequate to cope with the "ticking time bomb" by which he referred to the many combat troops returning from Iraq and Afghanistan, a proportion of who have, or will go on to develop, combat-related stress. Conservative MP, Robert Key, agreed that it is "a problem that is going to grow and grow." (Hansard 18 June 2005 c1059).

Concern about the adequacy of military health care has been voiced by senior figures within the military. Former chief of the defence staff Field Marshall Lord Bramall said in 2006 that military health care had been "cobbled together" and was clearly not working ('Wounded soldiers get appalling health care' Daily Telegraph 3.10.06). A more recent Defence Select Committee report is more positive, describing clinical care as "second to none" and rehabilitation services as "exceptional" although mental healthcare is only judged to be "adequate" (House of Commons 2008).

In addition to combat-related stress, there have been persistent allegations of harassment and bullying of young service personnel, in the wake of the mysterious deaths of four

recruits at the Deepcut army barracks in Surrey between 1995 and 2002. The subsequent independent review, ordered by the government, concluded that there were failings in the Army's care of young recruits (Blake 2006).

It is clear that there is a high level of mental health need among service and ex-service personnel and it is not at all clear whether this need is adequately met. Whilst the media and politicians have been increasingly vociferous on this subject and there is a growing body of research that attempts to measure the scale of mental health need, there have been very few studies that have focused on an in-depth qualitative analysis of the perspectives and views of the military personnel themselves. This provides the rationale for this in-depth exploration, based upon the experiences and perceptions of young ex-service personnel, about their mental health needs during their time in the forces and following discharge.

Study Aims

This is an exploratory piece of research, the purpose of which is to provide information from a range of stakeholders, primarily ex-service personnel but also their families and welfare staff about the mental health needs of young military personnel. Specifically the research questions are:

1. From the perspective of young ex- service personnel, how has their military career impacted upon their mental health?
2. What impact has it had upon their lives since leaving military service?
3. How accessible and helpful is support perceived to be both during and after military service?
4. From the perspective of all stakeholders (ex-service personnel, their families and welfare staff), what unmet mental health needs do they identify?

Review of literature on the emotional and mental health needs of young military personnel

The Literature Search

A literature search was undertaken in May 2006 using the MetaFind meta search engine with keywords: Mental health, psychological health, emotional health, soldier, British army, army, ex-army, military, military personnel, armed forces, resettlement, impact, family relationship, divorce, health, support services. The search was applied to the following databases: EBSCO Host, CINAHL, Cochrane Library, Ingenta Connect, Medline, PsyArticles, PubMed, Web Of Knowledge, together with the specific journals American Journal of Psychiatry, British Journal of Psychiatry and ProQuest nursing journals.

110 relevant publications were identified and from these 61 papers were retrieved for further analysis. This literature was supplemented during the course of the study as other relevant material was published. These revealed a mixture of descriptive, prospective and retrospective quantitative studies using mainly self-report questionnaires with either pre-existing large scale cohorts or samples based on a military unit. There was a dearth of qualitative studies based upon the in-depth accounts of service or ex-service personnel to capture their experiences.

The mental health of current and ex-service personnel

War inevitably produces 'psychiatric casualties' (Wessely 2005). Combat is stressful and for some sufficiently traumatic to lead to the development of somatic symptoms which may become chronic, disabling and refractory to treatment (Clauw 2006). A systematic review of studies published between 1990 and 2001 of military personnel deployed to the Gulf concludes that there is increased prevalence of mental health problems of Gulf War veterans compared to the prevalence in a comparison group of active service personnel not deployed to the Gulf (Stimpson, Thomas, Weightman, Dunstan & Lewis, 2003).

There is a strong and positive association between the total killed and wounded in conflict and the number of psychiatric casualties (Jones and Wessely 2001). A US study reports that the proportion of study subjects with major depression, anxiety or PTSD is significantly higher after duty in Iraq than before deployment, particularly so for PTSD (Hoge, Castro, Messer, McGurk, Cotting et al 2004). They also have higher rates of use of mental health services (Hoge, Auchterlonie & Milliken 2006).However, preliminary findings from a British study of soldiers deployed to Iraq suggests that there is an improvement in mental health after returning from deployment (Hacker-Hughes, Cameron, Eldridge, Wessely & Greenberg 2005). This conclusion may though be premature as the post-deployment measures were collected only one month after return from deployment and many mental health problems may take longer than this to emerge (Jhingan 2006).

With operations in both Iraq and Afghanistan, British armed forces are 'over-stretched' in that "a significant number of personnel", particularly in the Army, are exceeding the length of time on deployment as set out in the 'harmony' guidelines'" (National Audit Office 2006).[1] Rona et al's (2007) study of British service personnel deployed for 13 months or

1 Each Service has set 'harmony guidelines' on the amount of time that personnel should spend away, which aim to ensure that service personnel and their families have a sustainable balance between time away and time at home.

longer over a 3-year period (which is in breach of 'harmony guidelines') show that this has an adverse impact on psychological health. Compared with troops deployed for shorter periods they are more likely to fulfil the criteria for PTSD, have higher rates of 'caseness' as measured by the General Health Questionnaire and there is a significant association between duration of deployment and severe alcohol problems.

A recent survey ('Wives claim husbands' service in Iraq and Afghanistan damaging family life' The Guardian 31.10.07) reports that 40% of soldiers' spouses, and over 30% of officers, say the behaviour of their partner had changed as a result of their experiences on military operations over the past two years. Some 70% report a negative, or very negative, impact on their family but the vast majority have not sought help.

The impact on mental health of security and peacekeeping duties have been less researched than combat deployments but studies suggest that soldiers on security duties report high levels of psychological morbidity (Lawrenson & Ogden 2003). Peacekeeping duties may carry long term psychiatric consequences (Gabriel & Neal 2002, Hotopf et al 2003). Furthermore, a US study shows that military personnel engaged in routine peacetime assignments report suffering from more job stress than civilian workers which provides convincing evidence that work stress in the military is not solely related to the stress of war (Planz & Sonnek 2002).

The evidence suggests that there is a high prevalence of mental health problems among service personnel with particular risks for younger personnel. Between 1984 and 2005 army males under age 20 had a statistically significant increased risk of suicide of about 50 per cent compared with the general UK population (Defence Analytical Services Agency 2006).

Lord Drayson, Minister of State, Ministry of Defence reported that between January 2003 and September 2006, 2,123 British military personnel (Regular and Reservists) deployed to Operation TELIC[2] were assessed by, and received treatment from, the Defence Medical Services for mental health conditions thought to be related to their deployment. This represents around 2% of personnel deployed to Operation TELIC over the same period. Of this number, 328 service personnel fulfilled the diagnostic criteria for PTSD and 904 were diagnosed with an adjustment disorder (Hansard 28 March 2007 cWA269).

The strong media interest and "the epidemic of stories about PTSD" (Wessely 2005) obscures the fact that other mental health problems notably depression and alcohol misuse are more common among service personnel (Rona, Jones, French, Hooper & Wessely 2004). A study of British aero-medical evacuees from Iraq reported that "in over 85% of cases evacuation was for low mood attributed to separation from friends or family, or difficulties adjusting to the environment" (Turner et al 2005 p476). A recent study found that excessive alcohol consumption was more common in the UK armed forces than the general population (Fear et al 2007).

Compelling evidence suggests that mental health problems are the leading category of discharge diagnoses among men and the second leading category among women. In one US study (Hoge et al 2002) 47% of those hospitalised for the first time for a mental disorder left military service within 6 months, compared to an attrition rate of 12% for those with other health needs. A prospective study that followed-up military trainees referred for

2 Operation (or Op) TELIC is the codename under which all British operations of the 2003 Invasion of Iraq and after are being conducted.

mental health evaluation during training found that two-thirds failed to complete their tour of duty (Cigrang, Carbone & Lara 2003).

Young service personnel

The UK recruits young people under the age of 18 to all three branches of the military, many of whom come from disadvantaged backgrounds. The recent adverse publicity over the culture of bullying and suicides at the military training establishment Deepcut and the 'beasting' episode involving a group of Marines ('Marine 'bullying' video condemned', BBC 2005) reveal what some vulnerable young military personnel may be experiencing. Furthermore, the UK is the only European country to reserve the right to deploy under-18 year olds in war fighting situations, which is against the spirit of Article 38 of the UN Convention on the Rights of the Child that recommends that signatories refrain from sending children into battle (see Harvey 2002 for a detailed analysis of the legislation relating to child soldiers in the UK). A Defence Select Committee report on the duty of care expresses concern that the “MOD is not accepting appropriate responsibility for under 18 year olds in its care” (recommendation 18) and that they should “examine the potential impact of raising the recruitment age for all three Services to 18” (recommendation 14) (House of Commons 2005).

Young military personnel may already have several predisposing elements for developing mental health problems as the demographic profile indicates that the majority of military recruits are from poorer socio-economic groups, from which a higher proportion of young people are at greater risk of developing mental health problems (Walker, Akister & Brunner-Routledge 2005). The evidence suggests that young service personnel may be developmentally and emotionally immature and thus more at risk of developing mental health difficulties under the strain of intense post-recruitment training or actual combat deployment (Walker 2003).

The World Health Organisation (WHO) recognises that young soldiers exposed to conflict situations can more easily develop PTSD leading to persisting patterns of problematic behaviour and functioning long after the end of military service (WHO 1996).

Responses to the mental health needs of soldiers

A range of assistance is available to military personnel, while in the services, at the point of departure and after leaving. Whilst in the services, there is support aimed at reducing the incidence of mental health problems including primary prevention to prepare and train those likely to be exposed to traumatising events, secondary prevention using a variety of psychological techniques and tertiary interventions to treat those with severe and enduring mental health problems.

Screening for mental health morbidity and vulnerability has been used in a number of contexts prior to recruitment, as well as pre- and post- deployment. The evidence suggests that it has limited value (Wessely 2005). Hoge et al’s (2006) population-based study of all soldiers completing a routine post-deployment health assessment finds that the post-deployment health assessment has limited utility in predicting the level of mental health need in soldiers. Single-session psychological debriefings are no longer recommended as there is evidence that they do not reduce psychological distress (Wessely & Deahl 2003)

and screening for psychological illness has little support among servicemen (Rona et al 2004).

There is evidence that support from informal social networks composed of family and peers is protective. A retrospective questionnaire cohort study of returning UK peacekeepers identifies support from informal networks as key (Greenberg et al 2003). Having such support and being able to talk about peace-keeping experiences is associated with less psychological distress.

A peer mentoring care and support system is a prevention strategy that has had some success in the British Royal Marines (Keller et al 2005). The intervention aims to educate junior non-medical personnel to provide support to their peers following critical events and facilitate referral to an appropriate treatment agency. Another preventative measure that is recommended in a Defence Select Committee report is the provision of 'decompression' following return from front-line duty so that there is time to assimilate and recover from combat experiences within a military environment in the company of those who have shared those experiences (House of Commons 2008).

A US study of an intervention to assist soldiers with emerging mental health problems demonstrates effectiveness of supportive mentoring and close monitoring particularly with young junior-grade soldiers without serious psychiatric diagnosis (Hassinger 2003).

Severe health problems may require hospitalisation. A case matched comparison of the efficiency of a military psychiatric hospital and a military training and rehabilitation unit (MRTU) at restoring soldiers to full active duty reports that conventional in-patient treatment is less effective (Neal, Kiernan, Hill, McManus, and Turner 2003).Since the closure of the military psychiatric hospital at Catterick in 2003, the MoD has had a contract with the Priory Group of hospitals to treat service personnel requiring psychiatric hospitalisation.

Within the Armed Forces, the main focus of health care is to keep soldiers fit for duty and those that are unable to perform their duties are, following detailed occupational and social reports, referred to a formal medical board which makes a final decision about whether or not they should be discharged (Turner & Neal 2003). The armed forces resettlement package is intended to help with the transition from military to civilian life. It consists of a cash payment for civilian training and advice on jobs, training, housing and finances. People discharged for medical reasons are entitled to the full resettlement package, irrespective of their length of service. 'Leaving the Services' (National Audit Office 2007), a report ordered by the House of Commons, recommends that all personnel who are medically discharged are assessed to identify any additional resettlement support they may need.

The focus of the resettlement package is more upon practical than emotional support. This is also the case with most of the 200+ organisations for ex-service personnel. However, the public concern over the likely mental health consequences of 'overstretch' due to simultaneous action in Iraq and Afghanistan, has led to mental health support having greater priority. Combat Stress, an organisation that provides support to ex-servicemen with combat-related psychological injuries has recently been assigned an additional £2.9 million ('Today in Parliament' 16.6.07) and in response to research that showed that reservists are more likely to display mental health problems than regular troops the MoD has introduced the Reserves Mental Health Programme to improve the overall healthcare for demobilised Reservists (Hansard 28 March 2007 cWA269).

Upon leaving the Armed Forces, responsibility for medical care passes to the NHS. There is a feeling that routine NHS treatment for ex-soldiers may not be appropriate for their specific needs and compares unfavourably with the US which has extensive military and veteran health services. However, a Defence Select Committee report endorses the treatment of secondary care in NHS Trusts as it enables the Defence Medical Services to work with the NHS to provide treatment in a "semi-military environment" (House of Commons 2008). In addition, a number of new initiatives are being implemented to improve the treatment of veterans suffering with mental health problems. For example, the UK health departments and Combat Stress have been working together to develop and implement a new community-based model for mental health services for veterans (Hansard 28 March 2007 c WA269). And it has recently been announced that war veterans are to become eligible for fast-track medical treatment by the NHS ('Priority NHS treatment promised to war veterans' Guardian 23.11.07).

Barriers to care

According to Greenberg, Langston and Gould (2007) the military environment may exacerbate mental health problems by creating barriers to care including stigma. Stigma generally denotes the possession of a trait that marks one out as different from others and is negatively regarded and is often a precursor to discrimination or unfair treatment. As well as stigma from others, those requiring help, will also stigmatise themselves as they are aware of the attitudes of their peers and share the cultural values that equate emotional stress with weakness (Greene-Shortridge, Britt & Castro 2007). This process of self-stigmatisation is strongly associated with low self esteem.

Stigma is identified as the major barrier to providing mental health support to service personnel (Greene-Shortridge et al 2007). Studies in the US report that seeking treatment for mental health problems is seen as a barrier to subsequent career progression (Stone 1998, Westphal 2004.) Psychiatric disorder is judged by 85% of British soldiers to be detrimental to careers (Cawkill 2002 cited in Greenberg et al 2007) and a US study showed that 40% would not trust a returning stress casualty (Schneider & Luscomb 1984 cited in Greenberg et al 2007).

There is clear evidence that stigma discourages service personnel from seeking treatment. It is estimated that up to 50% of military personnel who experience traumatic events and develop a subsequent mental health problem do not seek medical help (Gabriel & Neal 2002). Among US service personnel returning from Bosnia, admitting a psychological problem is perceived as much more stigmatising than admitting a medical problem and people who are referred with a psychological problem are much less likely to follow through (Britt 2000). A study of British armed forces reports less than 30% of those who screen 'positive' for a mental health problem accept a follow-up invitation to attend a medical centre (Rona et al 2004). Concern about stigma is disproportionately higher among those most in need of help from mental health services. Those scoring positive for a mental disorder are twice as likely as those who do not to report being stigmatised by others (Hoge et al 2004).

Consequences of failure to meet mental health needs

A longitudinal cohort study of 8195 service personnel who have left the British Army show that whilst most resettle into civilian life relatively successfully, those with mental health problems fare less well and are at far higher risk of social exclusion (Iversen et al 2005a). A further study following-up 496 of the cohort who are 'vulnerable' in terms of their mental health or lack of employment finds very high rates of depression, anxiety disorders, PTSD and alcohol dependence (Iversen et al 2005b). It also reports that only approximately half of those with a psychiatric diagnosis are seeking help largely attributed to the stigma and embarrassment of doing so compounded by having a universal health care system, without bespoke care for ex-service personnel.

Furthermore there is clear evidence of higher rates of homelessness, alcohol abuse, domestic violence, relationship breakdown and criminality among former military personnel with untreated mental health problems (Dandeker, Wessley, Iversen & Ross 2003). An in-depth study of homeless ex-service personnel reports high prevalence of alcohol dependency, mental health problems and relationship breakdown (Lemos & Durkacz 2005). This research confirms the existence of a link between armed service and homelessness, but does not necessarily attribute this to a failure of the armed forces in their duty of care during or after service. Instead, the research suggests that the link is partly explained by the types of people more likely to join the armed forces, as many come to the army with 'psychological baggage' from their childhood (Lemos & Durkacz 2005).

Army life has some features that result in ex-service personnel having difficulty and being unprepared for civilian life. A report by Dandeker et al (2003) lists among these:

- The 'dependency culture' in the armed forces leading to limited self-reliance
- Heavy alcohol use
- A feeling that their medical problems are not fully understood by civilian NHS services

These may both engender mental health of ex service-personnel and make it harder to provide an appropriate response to those with mental health problems. This highlights the vulnerability and the high level of need of ex-service personnel with mental health problems.

Methodology

Design

Although in recent years there has been considerable research interest in the welfare of both serving and former military personnel, there has been very little that has given a voice to the men and women who are most affected. Therefore for this study, a qualitative research design was used to develop insight into the experiences and perspectives of ex-military personnel with, or at risk of developing, mental health problems.

A preliminary review of the literature was carried out to develop a broad understanding of the field, with the intention of building on this as data collection and analysis progressed. In parallel with this, an interview schedule was developed, building on previous research and incorporating vignettes (hypothetical scenarios), to provide a focus for discussion (see Appendix 2 for details). This technique has been used effectively in previous research about young people's mental health (Burns & Rapee 2006).

Data were collected using a combination of in-depth, face-to-face interviews and a small number of telephone interviews where it was impractical to arrange a meeting. Both modes of data collection utilised an interview schedule that included questions about personal details, process of enlistment, military career, experiences following discharge and the vignettes to explore emotional and mental health issues in greater detail. The interview schedule, including the vignettes, was used flexibly according to the demands of the interview. In general, respondents were articulate and keen to share experiences and opinions facilitating free-flowing interviews.

The main focus was on the experiences of the young ex-service personnel themselves, but other key stakeholders such as their families and support staff working in voluntary and charitable welfare services were also included to provide different perspectives and an increased understanding of the context. The questions were modified accordingly for interviews with family members and welfare staff.

In addition valuable background information was obtained from meetings with senior representatives of benevolent organisations, as well as a publicly accessible, active online community of current and former service personnel.

Recruitment of participants

A variety of strategies were employed to make contact with potential participants. This approach was used in an attempt to maximise the geographic and demographic coverage of the sample. The strategy targeted organisations at national, regional and local levels. Participants interviewed were resident in North and South England, Scotland and Wales. Initially, welfare services known to be active in the support of veterans were contacted, both as primary sources of data, and to obtain 'signposting' to other organisations that might have been willing to inform the study or assist with recruitment. In addition, attempts were made at direct contact with ex-service personnel and their families via an online community. See Appendix 1 for full list of organisations with whom the research was discussed.

Sample

A purposive sampling method was used to maximise the inclusion of ex-servicemen aged 25 or under. In fact many of those we interviewed were over 25 as we were not able to identify a sufficient number of those who were younger. The precise sample size was dependent upon the availability of participants, and whether 'saturation' of data occurred, ie. where no new and relevant material arises. All interviews were recorded and transcribed apart from two, where the participant objected to such recording.

Several family members were also interviewed to provide multiple perspectives on the emotional and mental health of young service personnel. In addition, researchers interviewed a small number of welfare staff/managers from organisations involved in supporting ex- service people especially those experiencing mental health problems, homelessness, or alcohol and substance abuse.

The total sample interviewed comprised 3 welfare staff representatives, 6 family members (3 mothers, 1 father, 1 aunt, 1 partner) and 23 ex-service personnel (all but 1 of whom were ex-Army). The interviews were carried out between December 2006 and October 2007. Details of the ex-servicemen and women who participated are shown in Appendix 3. Respondents were predominantly male and white although they included two women and four men from ethnic minority groups.

Of the 23 ex-service personnel, six were receiving support from an organisation that assists those with psychological problems related to their armed service, eight were being supported by organisations assisting with integration back into civilian society, and five were living in a hostel for ex-service personnel. The remaining four were recruited via a social networking site and an advertisement.
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Data Analysis

Each interview was transcribed in full, after which accuracy of transcription was verified by the researchers by comparison with the original recording. A grounded thematic analysis of interview data and meeting notes was carried out in MaxQDA2007, a software package to assist the analysis of qualitative data. During familiarisation with the data the researchers identified key issues in the texts and jointly developed an initial coding frame based on their observations. This coding frame was independently applied by the researchers to a selected text. The coded samples were compared and discrepancies examined to develop a better mutual understanding of how codes were to be applied. There was good overall correspondence in the use of the coding frame by the researchers. The texts were divided between the researchers for coding. Analysis was carried out by thematic area, so that each researcher analysed data derived from all texts. On-going discussion between the researchers led to the further development and refinement of the themes that emerged.

References

Blake, N., 2006. *A Review by the Circumstances Surrounding the Deaths of Four Soldiers at Princess Royal Barracks Deepcut Between 1995 and 2002*., London: The Stationary Office.

Britt, T.W., 2000. The stigma of psychological problems in a work environment: evidence from the screening of service members returning from Bosnia. *Journal of Applied Social Psychology,* 30(8), p.1599-1618.

Burns,J.R. and Rapee, R.M., 2006. Adolescent mental health literacy: young people's knowledge of depression and help seeking. *Journal of Adolescence*, 29, p. 225-239.

Cigrang, J.A., Carbone, E.G., and Lara, A., 2003. Four-year prospective study of military trainees returned to duty following a mental health evaluation. *Military Medicine*, 168(9), p.710-4.

Clauw, D., 2003. The health consequences of the first Gulf war. *British Medical Journal*, 327(7428), p.1357-1358.

Dandeker, C., Wessley, S., Iversen, A. and Ross, J., 2003. *Improving The Delivery Of Cross Departmental Support And Services For Veterans,* A Joint Report of the Department of War Studies and Institute of Psychiatry, King's College London to the UK Ministry of Defence, July.

Defence Analytical Services Agency, 2006. Suicide and open verdict deaths in the UK regular armed forces 1984-2005. Available at http://www.dasa.mod.ac/natstats/natstatsindex.html.

Fear, N.T., Iversen, A., Meltzer, H., Workman, L., Hull, L., Greenberg, N., Barker, C., Browne, T., Earnshaw, M., Horn, O., Jones, M., Murphy, D., Rona, R., Hotopf, M., and Wessely, S., 2007. Patterns of drinking in the UK Armed Forces. *Addiction,* 102(11), p.1749-1759.

Gabriel, R. and Neal, L.A., 2002. Lesson of the week: Post-traumatic stress disorder following military combat or peace keeping. *British Medical Journal,* 324(7333), p.340-341.

Greenberg, N., Thomas, S., Wessely, S., Hull, L., Iversen, A. and Unwin, C., 2003. Do military peacekeepers want to talk about their experiences? Perceived psychological support of UK military peacekeepers on return from deployment. *Journal of Mental Health*, 12(6), p.565-573.

Greenberg, N., Langston, V., and Gould, M., 2007. Culture - what is its effect on stress in the military? *Military Medicine*, 172, p.931-935.

Greene-Shortridge, T.M., Britt, T.W., and Castro, C.A., 2007. The stigma of mental health problems in the military. *Military Medicine*, 172(2), p.157-61.

Hacker-Hughes, Cameron, F., Eldridge, R. J., Wessely, S., and Greenberg, N., 2005. Going to war does not have to hurt: preliminary findings from the British deployment to Iraq. *British Journal of Psychiatry*, 186, p.536-537.

Harvey, R. (2002). *Child soldiers in the UK: Analysis of recruitment and deployment practices of under-18s and the CRC*. Task Force on Children in Armed Conflict. Available at http://www.essex.ac.uk/armedcon/story_id/000028.doc

Hassinger, A.D., 2003. Mentoring and monitoring: the use of unit watch in the 4th Infantry Division. *Military Medicine*, 168(3), p.234-8.

Hoge, C.W., Lesikar, S.E., Guevara, R., Lange, J., Brundage, J.F., Engel, C.C., Messer, S.C., and Orman, D.T., 2002. Mental disorders among U. S. military personnel in the 1990 s: association with high levels of health care utilization and early military attrition. *American Journal of Psychiatry*, 159(9), p.1576-1583.

Hoge, C.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I. and Koffman, R.L., 2004. Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, 351(1), p.13.

Hoge, C.W., Auchterlonie, J.L. & Milliken, C.S., 2006. Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan, *Journal of American Medical Association,* 295,p.1023 - 1032.

Hotopf, M., David, A.S., Hull, L., Ismail, K., Palmer, I, Unwin, C. and Wessely, S., 2003. The health effects of peace-keeping in the UK Armed Forces: Bosnia 1992–1996. Predictors of psychological symptoms*. Psychological Medicine*, 33(01), p.155-162.

House of Commons Defence Select Committee Report, 2005. *Duty of Care*. London: The Stationery Office (HC 2004-5 HC63). Available at: http://www.publications.parliament.uk/pa/cm200405/cmselect/cmdfence/63/63.pdf

House of Commons Defence Select Committee Report, 2008. *Medical Care for the Armed Forces*. London: The Stationery Office (HC 2007-8 327). Available at: http://www.publications.parliament.uk/pa/cm200708/cmselect/cmdfence/327/327.pdf

Iversen, A., Nikolaou, V., Greenberg, N., Unwin, C., Hull, L., Hotopf, M., Dandeker, C., Ross, J. and Wessely, S., 2005a. What happens to British veterans when they leave the armed forces? *European Journal of Public Health*, 15(2), p.175-84.

Iversen, A., Dyson, C., Smith, N., Greenberg, N., Walwyn, R., Unwin, C., Hull, L., Hotopf, M., Dandeker, C., Ross, J. and Wessely, S., 2005b. 'Goodbye and good luck': the mental health needs and treatment experiences of British ex-service personnel. *British Journal of Psychiatry*, 186(6), p.480-486.

Jhingan, H.P., 2006. War and psychological health. *British Journal of Psychiatry*, 188, p.290.

Jones, E. and Wessely, S., 2001. Psychiatric battle casualties: an intra-and interwar comparison. *British Journal of Psychiatry*, 178(3), p.242.

Keller, R.T., Greenberg, N., Bobo, W., Roberts, P., Jones, N., Orman, D.T. 2005. Soldier peer mentoring care and support-bringing psychological awareness to the front. *Military Medicine*, 170(5), p.355-361.

Lawrenson, G. and Ogden, J., 2003. Security duties in Northern Ireland and the mental

health of soldiers: prospective study. *British Medical Journal*, 327(7428), p.1382.

Lemos, G. and Durkacz, S., 2005. Military History: The experiences of people who become homeless after leaving military service. *Housing, Care and Support* , 8 (3), p.4-8.

National Audit Office, 2006. *Recruitment and Retention in the Armed Forces*. London: The Stationery Office (2005-6 HC1633-1). Available at: http://www.nao.org.uk/publications/nao_reports/05-06/05061633-I.pdf

National Audit Office, 2007. *Leaving the services*. London: The Stationery Office (2006-7 HC618). Available at: http://www.official-documents.gov.uk/document/hc0607/hc06/0618/0618.asp

Neal, L.A., Kiernan, M., Hill, D., McManus, F. and Turner, M.A., 2003. Management of mental illness by the British Army. *British Journal of Psychiatry*, 182, p.337-341.

Planz, S., and Sonnek, S. 2002. Work stress in the military: prevalence, causes and relationship to emotional health. *Military Medicine*, 167,p.877-872.

Rona, R.J., Jones,M., French, C., Hooper, R. and Wessely, S., 2004. Screening for physical and psychological illness in the British Armed Forces: I: The acceptability of the programme. *Journal of Medical Screening*, 11(3), p.148-152.

Rona, R.J., Fear, N.T., Hull, L., Greenberg, N., Earnshaw, M., Hotopf, M. and Wessley, S., 2007. Mental health consequences of overstretch in the UK armed forces: first phase of a cohort study. *British Medical Journal*, 335(7620), p.603.

Rose, S., Bisson, J., and Wessely, S., 2003. A systematic review of single-session psychological interventions ('debriefing') following trauma. *Psychother Psychosom*, 72(4), p.176-184.

Shephard, B., 2000. *A war of nerves: soldiers and psychiatrists 1914-1994*. London: Jonathan Cape

Stimpson, N., Thomas, H.V., Weightman, A.L., Dunstan, F., and Lewis, G., 2003. Psychiatric disorder in veterans of the Persian Gulf War of 1991: systematic review. *British Journal of Psychiatry*, 182(5), p.391.

Stone, F.P., (1998). *Attitudinal and perceptual barriers to accessing mental health services among members of the United States Air Force.* Univ. of Utah.

Turner, M.A. and Neal, L.A., 2003. Military forensic psychiatry. *British Journal of Psychiatry*, 183, p.10-1.

Turner, M.A. Kiernan, M.D., McKechanie, A.G., Finch, P.J., McManus, F.B. and Neal, L.A. , 2005. Acute military psychiatric casualties from the war in Iraq. *British Journal of Psychiatry*, 186, p.476-9.

Walker, S., 2003. *Social work and child & adolescent mental health*, Lyme Regis: UK, Russell House Publishing.

Walker, S., Akister, J., and Brunner-Routledge, H., 2005. Applying Family Therapy.

Journal of Psychiatric and Mental Health Nursing, 2005(13), p.249-254.

Wessely, S. and Deahl, M., 2003. Psychological debriefing is a waste of time. *British Journal of Psychiatry*, 183(1), p.12.

Wessely, S., 2005. Risk, psychiatry and the military. *British Journal of Psychiatry*, 186, p.459-66.

Westphal, R.J., 2004. Fleet Mental Health: A Discourse Analysis of Navy Leaders' Attitudes about Mental Health Problems. Doctoral Thesis. University of Virginia.

WHO (1996) *The impact of armed conflict on children: a threat to public health*. Geneva: WHO

Media reports

Wounded soldiers 'get appalling health care'. Available at: http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2006/10/03/nsoldier03.xml [Accessed February 7, 2008].

Army chief warns army is overstretched | Special reports | Guardian Unlimited. Available at: http://www.guardian.co.uk/military/story/0,,2213152,00.html [Accessed February 7, 2008].

British soldiers 'go Awol because Army ignores mental health problems' - This Britain, UK - Independent.co.uk. Available at: http://www.independent.co.uk/news/uk/this-britain/british-soldiers-go-awol-because-army-ignores-mental-health-problems-441938.html [Accessed February 7, 2008].

Iraq: the forgotten victims - Health News, Health & Wellbeing - Independent.co.uk. Available at: http://www.independent.co.uk/life-style/health-and-wellbeing/health-news/iraq-the-forgotten-victims-466743.html [Accessed February 7, 2008].

Marine 'bullying' video condemned. BBC. Available at: http://news.bbc.co.uk/1/hi/uk/4475034.stm [Accessed January 17, 2008])

Plight of traumatised soldiers 'ignored by Government' - UK Politics, UK - Independent.co.uk. Available at: http://www.independent.co.uk/news/uk/politics/plight-of-traumatised-soldiers-ignored-by-government-431916.html [Accessed February 7, 2008].

Priority NHS treatment promised to war veterans' Guardian 23.11.07

Seven veterans of Iraq war 'have committed suicide - Telegraph. Available at: http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2004/02/22/wirq222.xml [Accessed February 7, 2008].

'The Not Dead'. Channel 4. Broadcast November 12, 2007. Available at: http://www.list.co.uk/article/5482-the-not-dead/ [Accessed February 7, 2008].

Under-strength and under strain as experienced soldiers queue to quit -Guardian Unlimited. Available at: http://www.guardian.co.uk/military/story/0,,2215841,00.html [Accessed February 7, 2008].

Wives claim husbands' service in Iraq and Afghanistan damaging family life. *Guardian*. Available at: http://www.guardian.co.uk/military/story/0,,2202186,00.html [Accessed February 8, 2008].

Appendix 1: List of organisations contacted to discuss project and/or recruit participants

Name of organisation	Description
April Centre, Colchester	Drop in centre for homeless people in Colchester
Beacon House, Colchester	Christian primary health care centre for homeless and vulnerable people
Colchester Borough Council	
Colchester Emergency Night Shelter	Registered charity helping homeless people
Colchester Garrison	
Combat Stress (Ex Services Mental Welfare Society)	Charity specialising in helping all ranks from the Armed Forces and the Merchant Navy suffering from psychological disability as a result of their service.
Emmaus Communities Projects - Mossley, Bristol, Cambridge, St Albans	Supported Community Housing and work for homeless people
Ex-Service Fellowship Centres, London (now Veterans Aid)	Charity for homelessness among veterans in the UK
Ex-Services Resettlement Project, London	Partnership between Royal British Legion and ARP to support ex-services
4Ex-Military.com	Web-based recruitment organisation helping ex servicemen and women
Ministry of Defence	
Open Road, Colchester	Support for substance misusers
Phoenix Recruitment	Employment agency for ex-services
Royal British Legion – London, Chelmsford, Colchester, Norwich.	Charity providing support to the serving and ex-Service community and their families
Queen Victoria Seaman's Rest, London	Charity providing accommodation and support for seafarers in the East End of London.
Shelter – London, Norwich, Cambridge	National charity campaigning on housing and homelessness
SPACES	Single Persons Accommodation Centre for Ex-Services, Catterick
SSAFA Forces Help – London, Colchester	Support for the serving men and women, those who have served, and their families and dependants.
St Mungo's, London	Charity for single homeless people in London who have been or are in danger of sleeping rough
The Army Rumour Service	Social networking site for anyone interested in or connected with the military
The Big Issue Foundation – London, Norwich	Support for homeless and socially excluded people
The Galleries Project, Richmond	Transitional accommodation for ex-services
The Oswald Stoll Foundation	Charity providing housing and enabling services to disabled and homeless ex-Service personnel and other people with disabilities
Training for Life – Project Compass	Works with homeless ex-service people who have experienced some difficulty in readjusting to civilian life. Its purpose is to get them into employment or education and to ensure their integration into society
Whitechapel Mission, London	Charity helping the homeless and rootless of London, particularly rough sleepers

Appendix 2: Vignettes presented to participants

Please take your time and read through these:

Scenario 1
Two weeks after returning to base from a deployment you notice one of your mates seems to be behaving differently. He is not his usual self. Instead of the lively, joking character he was he now seems much quieter and withdrawn. When you ask him what the matter is he reacts in an aggressive way, telling you to mind your f****** business. When you try to cheer him up by ribbing him he gets angry and kicks a door so hard his boot goes through the panel. At the week-end you spot him drinking alone in the pub, but when you go over to him he immediately leaves the pub. The next day you find out he was been involved in a fight with a civilian at a night club.

After respondent has read this scenario ask:
1. Do you recognise anything familiar in any of these situations? If so can you tell us more about the real situation?
2. What do you think is the matter in each case?
3. Is help available for the problem, and if so what? If not what help should be provided?
4. What advice would you give to the soldier?
5. Would you give the same advice if the soldier was female?

Scenario 2
Your unit has been deployed twice in the past three years- both times in direct combat operations where three young soldiers were killed. You have just been informed that another deployment has been ordered and you embark for Iraq in 3 weeks time. During the pre-deployment preparation one of your platoon tells you he has been having strange dreams and finding it hard to get to sleep at night. He looks pale and drawn and you notice his palms are a bit sweaty. He talks quickly- sometimes you find it hard to make out what he is saying, and he seems jumpy. You feel that something is wrong but you are not sure what it could be so you suggest he makes an appointment to see a medic. But he says he has already done that and they found nothing physically wrong.

After respondent has read this scenario ask questions 1-5

Scenario 3
Your unit has been deployed for 3 months and after initial orientation and establishing your base camp life has settled down into a routine. Although there are serious issues and stressful situations there is nothing happening that you have not been informed about or prepared for in advance. Morale among your platoon is quite high and there is a feeling of confidence about your ability to do the job at hand. One of your mates tells you he is feeling very homesick- his girlfriend has just had a baby and he badly wants to see her and his new son. He starts to behave in a moody, sleepy way and argues with a superior. He refuses to get out of bed and will not eat his food. He starts to complain about the camp facilities and says he is getting bad headaches.

After respondent has read this scenario ask questions 1-5:

After all 3 scenarios have been discussed ask:

6. If none of the 3 scenarios is recognisable can you recall a situation when you were worried about the behaviour of one of your pals? If so describe what happened, what advice if any was given.
7. How is such behaviour regarded by other soldiers and by commanding officers?
8. If you were ever behaving in such a way what help would you want?
9. Is such help available currently?
10. What could be done to prevent or reduce such problems happening in the first place?

Appendix 3: Profile of sample

Identifier	Status and Location	Age on enlistment	Years served	Age at interview	Gender	Ethnicity
Ex-serviceman 01	Ex-soldier Burnley	17	7	26	m	1
Ex-serviceman 02	Ex-soldier Stoke on Trent	26	5	33	m	1
Ex-serviceman 03	Ex-soldier Stoke on Trent	22	5	32	m	1
Ex-serviceman 04	Ex-soldier Nottingham	16	16	35	m	1
Ex-serviceman 05	Ex-soldier Stoke on Trent	18	5	23	m	1
Ex-serviceman 06	Ex-soldier Biddulph	17	13	31	m	1
Ex-serviceman 07	Ex-soldier Liverpool	18	9	28	m	1
Ex-serviceman 09	Ex-soldier Camberley	22	21	44	m	1
Ex-serviceman 10	Ex-soldier Romford	17	5	26	m	1
Ex-serviceman 11	Ex-soldier Middleborough	22	8	30	m	1
Ex-serviceman 12	Ex-soldier Inverness	16	10	26	m	1
Ex-serviceman 13	Ex-soldier Catterick	25	5	30	m	1
Ex-serviceman 14	Ex-soldier Catterick	21	1	24	m	1
Ex-serviceman 15	Ex-soldier Catterick	18	9	28	m	1
Ex-serviceman 16	Ex-soldier London	23	5	28	m	2
Ex-servicewoman 17	Ex-soldier Catterick	16	1	18	f	1
Ex-serviceman 18	Ex-soldier London	22	5	30	m	1
Ex-serviceman 19	Ex-soldier London	24	9	39	m	1
Ex-serviceman 20	Ex-soldier London	21	5	27	m	3
Ex-serviceman 21	Ex-soldier London	25	1	26	m	1
Ex-serviceman 22	Ex-soldier London	25	2	30	m	3
Ex-servicewoman 23	Ex-soldier London	26	1	28	f	1
Ex-serviceman 24	Ex-navy London	31	5	36	m	2

1 = White British, 2 = Afro-Caribbean, 3 = Commonwealth