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Lives in Transition

Returning to civilian life with a physical injury or condition

Interim report

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Glossry of Terms

Armed Forces Compensation Scheme	Provides compensation for any injury, illness or death that is caused by Service on or after 6 April 2005.
Career Transition Partnership (CTP)	The CTP is the resettlement support service that assists the transition of those leaving the Armed Forces into the civilian labour market, with support including advice and guidance, vocational training and a range of employer brokerage activities.
Commanding Officer (CO)	The officer in command of a major military unit.
Employment and Support Allowance (ESA)	Introduced in 2008, ESA replaced Incapacity Benefit and Income Support for those who are ill or disabled. Entitlement is determined by a Work Capability Assessment (WCA: see below). Income-based ESA is currently being phased out and replaced by Universal Credit (UC) (see below).
Enhanced Learning Credits (ELCs)	An initiative to promote lifelong learning amongst members of the Armed Forces. It provides financial support in each of a maximum of three separate financial years for higher-level learning towards nationally recognised qualifications (i.e. Level 3 or above).
Individual Education and Resettlement Officer (IERO)	Advises on educational opportunities during career and on leaving Service.
Jobseeker's Allowance (JSA)	JSA can be paid to claimants who are unemployed and looking for work. It is available for men and women aged 18 or older but below State Pension age. JSA is currently being phased out and replaced by UC (see below).
Medical Board	A Medical Board is a panel of military medical staff that assesses medical restrictions on employability (including physical and mental capacity) and can make a recommendation regarding discharge. It commonly includes an occupational health specialist.
Military Career Management (MCM) Division	Responsible for career development and the staffing of military units.
Ministry of Defence Research Ethics Committee (MoDREC)	Ensures all research involving human participants either undertaken, funded or sponsored by the MoD meets nationally and internationally accepted ethical standards.
Musculoskeletal disorders (MSDs)	Conditions that affect muscles, bones and joints.
Officer Commanding (OC)	Commands a sub-unit or small military unit and is responsible for training, welfare and administration.
Personal Independence Payment (PIP)	PIP replaced Disability Living Allowance for people with a disability who are aged 16 to 64. PIP is designed to contribute towards some of the extra costs associated with living with a long-term health condition or disability.
Personnel Recovery Officer (PRO)	Provides non-clinical support to the recovery of wounded, injured and sick personnel.
Personnel Recovery Unit (PRU)	Non-clinical facility providing dedicated command and care for Service Personnel (SP) with the most complex Recovery needs.
Resettlement	The process of leaving the Armed Forces and entering the civilian job market. Resettlement programmes are available to assist with making a successful transition to employment or another desired outcome.
Traumatic brain injury (TBI)	An injury to the brain from an external force, possibly leading to permanent or temporary impairment of cognitive, physical and psychological functions.
Universal Credit (UC)	UC replaces four of the existing means-tested social security benefits and the two tax credits for working-age people (Income Support, income-based JSA, income-related ESA, Housing Benefit, Child Tax Credit and Working Tax Credit). Claimants on UC with health conditions or disabilities may be subject to a WCA (see below) to determine their required level of support and engagement.
War Pension Scheme (WPS)	The WPS compensates for injury, illness or death that was caused by Service or worsened by Service before 6 April 2005.
Welfare Officer	Responsible for delivering welfare services to military personnel.
Work Capability Assessment (WCA)	The WCA is the test used to determine eligibility for ESA and UC. The WCA assesses how a person's health condition or disability affects their ability to complete a range of functional activities and has three potential outcomes. Claimants are classified as either 'fit for work', having 'limited capability for work' but deemed likely to become capable of work in the future, or having 'limited capability for work and limited capability for work-related activity'. These classifications determine both the amount of benefits received and the conditions attached to them.
Wounded, injured and sick (WIS)	Those who have received battle injuries (wounded) or other injuries or have become sick during military Service.

1. Introduction

The physical injuries or conditions acquired as a result of, or during, Service are diverse and complex. While much research has focused on the important issue of mental health, data show that the percentages for physical injuries or conditions leading to discharge are much higher than those attributed to mental health and behavioural health issues[1]. For some there may be a requirement for medical discharge, whereas for others there may be an initial downgrading of their role, with them subsequently medically discharged or choosing to leave Service. Notwithstanding the process through which they leave, it is important to recognise the challenges that Service personnel with physical injuries and conditions may face during the transition to civilian life. However, there remains limited research focusing specifically on the experiences of those who have left Service with a physical injury or condition.

1.1 Project summary

This report presents the interim findings of an ongoing project funded by the Forces in Mind Trust (FiMT) called Understanding the transition to civilian life for ex-Service personnel with physical conditions as a direct result of Service or acquired whilst in Service. This two-year project (2019–2021) represents the first substantive qualitative longitudinal research (QLR) to explore how Service leavers experience the transition to civilian life when they have left the Armed Forces with a physical injury or condition. More specifically, it aims to provide an understanding of the support and provisions that are available during the transition into civilian life (including benefits and financial compensation, education and training, employment, health and housing) and make recommendations for further or better support that could be offered to this cohort during the transition from the UK Armed Forces[2]. Central to our work is a desire to establish an original evidence base to inform future policy and practice. This will be achieved through two rounds of qualitative longitudinal interviews with ex-Service personnel who have left or are in the process of leaving the Armed Forces with a physical injury or condition, together with consultations with key stakeholders.

1.2 Structure of this report

This report is structured as follows:

- **Chapter 2** briefly outlines the background and context for the research.
- **Chapter 3** provides a brief overview of the methods, including information about the sample.
- **Chapters 4–7** present an overview of the emerging findings relating to reflections on the following: the discharge and resettlement process; support accessed during transitions to civilian life; intersections between physical and mental health; and areas where further support could have been provided.
- **Chapter 8** provides some concluding comments and outlines the next steps for the project.

1 MoD (2019) Annual medical discharges in the UK Regular Armed Forces, 1 April 2014 to 31 March 2019. July 2019. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/816158/20190708_-_MedicalDisBulletinFinal_-_O.pdf

2 Please note that his study is not providing a review of those experiencing very serious injuries or of battlefield casualties requiring life-long medical support from a clinical perspective, as this is being undertaken elsewhere (see, for example, ADVANCE study: https://www.advancestudydmrc.org.uk/)

2. Background

Each year approximately 14,000 personnel leave the Armed Forces, of whom about 2,000 are wounded, injured and sick (WIS). With reference to physical conditions, while much research has focused on mental health[3], data demonstrate that the percentages for physical injuries leading to discharge are much higher than those attributed to mental health and behavioural health issues[4]. For example, between April 2018 and March 2019 the MoD reported that musculoskeletal disorders (MSDs) and injuries were the main cause of medical discharge, accounting for 56% of those discharged from the Navy, 56% of those discharged from the Army and 49% of those discharged from the RAF[5]. Over the period from April 2014 to March 2019, musculoskeletal injuries accounted for 59% of discharges from the Navy, 59% of discharges from the Army and 48% of discharges from the RAF[6] (see Figure 1).

In this chapter we offer a very brief overview of some of the physical conditions that are recorded as causes of medical downgrading or discharge.

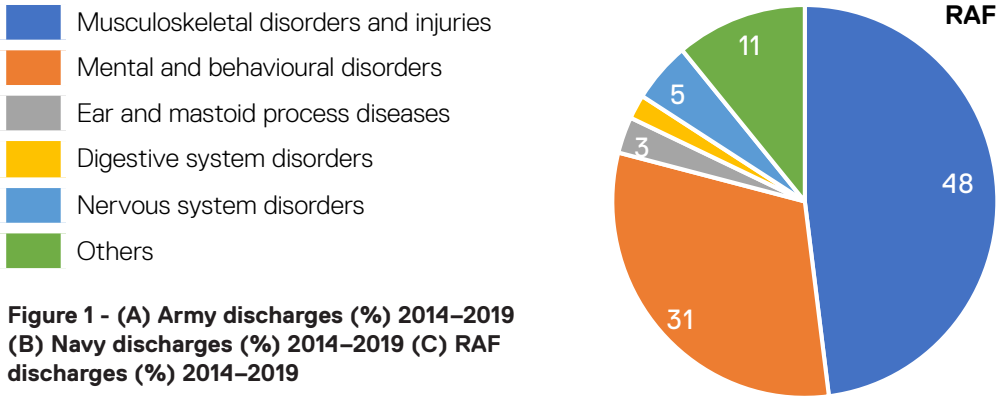

Figure 1 - (A) Army discharges (%) 2014–2019 (B) Navy discharges (%) 2014–2019 (C) RAF discharges (%) 2014–2019

3 See, for example: Browne, T., Hull, L., Horn, O., Jones, M., Murphy, D., Fear, N.T., Greenberg, N., French, C., Rona, R.J., Wessely, S. and Hotopf, M. (2007) 'Explanations for the increase in mental health problems in UK reserve forces who have served in Iraq', British Journal of Psychiatry, 190(6): 484–489; Buckman, J.E.J., Forbes, H.J., Clayton, T., Jones, M., Jones, N., Greenberg, N., Sundin, J., Hull, L., Wessely, S. and Fear, N.T. (2012) 'Early Service leavers: a study of the factors associated with premature separation from the UK Armed Forces and the mental health of those that leave early', European Journal of Public Health, 23(3): 410–415; Samele, C. (2013) The mental health of serving and ex-Service personnel: A review of the evidence and perspectives of key stakeholders. Forces in Mind Trust (FiMT) and Mental Health Foundation. Available at: https://www.mentalhealth.org.uk/sites/default/files/the-mental-health-of-serving-and-ex-service-personnel.pdf

4 MoD (2019) op. cit.

5 Ibid.

6 Ibid.

Musculoskeletal disorders (MSDs)

MSDs include conditions that can affect the joints (e.g. knee pain, arthritis), bones (e.g. fractures), muscles and spine (neck and back pain) and inflammatory diseases (e.g. connective tissue disorders). It is recognised that military personnel can experience an additional likelihood of the development of MSDs attributed to the intensive physical training, physical exertion and physical trauma associated with military activities[7]. Across the three Services, the greatest proportions of discharges due to MSDs and injuries were linked to the leg (below and including the knee) and the back[8]. However, each Service has its own particular physical demands (e.g. climbing ladders and working on a moving platform in the Navy, marching/training on hard ground carrying heavy loads in the Army). Data suggest that there is also a higher rate of discharge due to MSDs amongst female personnel[9].

2.1 Limb loss

Limb loss is not unique to the Armed Forces; however, the environments in which military personnel operate, where blast injuries and shrapnel/fragmentation injuries can cause extensive and complicated soft tissue and skeletal damage, put them at significantly higher risk[10]. Between April 2013 and March 2018 176 UK Service personnel sustained an amputation, of whom 25% were medically discharged. However, this rate is higher for the full span of recent conflicts, e.g. 297 personnel suffered amputations from operations in Afghanistan between October 2001 and March 2018, of whom 75% have been discharged[11]. Amputation entails a long rehabilitation period often followed by long-term contact with the healthcare system, particularly for those requiring ongoing prosthesis adjustments[12].

2.2 Acquired/traumatic brain injuries

A frequently reported form of trauma received while serving is acquired brain injury, which may be caused by a variety of exposures such as blasts, shrapnel and road traffic accidents. Acquired and traumatic brain injuries (TBIs) have a vast range of associated symptoms (both short- and long-term) including physical symptoms (headaches, convulsions and numbness), physiological symptoms and behavioural symptoms (mood changes, agitation and aggression)[13]. Mild traumatic brain injuries (mTBIs) are common, though under-reported, in both military and civilian populations; however, military, and specifically combat, activity may increase the risk of their acquisition[14]. For example, mTBI has been viewed as a further 'signature injury' of the Iraq and Afghanistan wars, with data suggesting that approximately 4.4% of a sample of Service personnel who were deployed to Iraq and/or Afghanistan had suffered an mTBI, with an association between length of deployment and the incidence of mTBI[15]. Of the 2,440 casualties from Afghanistan and Iraq, 19% (464) were TBI casualties, of whom 402 (87%) had moderate–severe brain injuries[16]. It is important to note that an acquired/traumatic brain injury can cause dysfunctions in other areas of the body that may not have been directly harmed; for example, photosensitivity, problems with hearing and balance and neuropsychiatric symptoms[17]. A TBI can also increase the likelihood of experiencing a stroke[18] and chronic pain

7 Allcock, P. (2008) Synopsis of causation: soft tissue injury of the lower limb. Available at: https://www.gov.uk/government/publications/synopsis-of-causation-soft-tissue-injury-of-the-lower-limb

8 MoD (2019) op. cit.

9 MoD (2019) op. cit.

10 See, for example: Gentleman, D. (2008) Synopsis of causation: head injury. Available at: https://www.gov.uk/government/publications/synopsis-of-causation-head-injury; Jain, A.S. and Robinson, D.P.H. (2008) Synopsis of causation: amputation of the upper limb. Available at: https://www.gov.uk/government/publications/synopsis-of-causation-amputation-of-the-upper-limb

11 MoD (2018) Afghanistan and Iraq amputation statistics: 1 April 2013 to 31 March 2018. Available at: https://www.gov.uk/government/statistics/uk-service-personnel-amputations-financial-year-201718

12 See, for example: Krueger, C.A., Wenke, J.C., Ficke, J.R. (2012) 'Ten years at war: comprehensive analysis of amputation trends', Journal of Trauma and Acute Care Surgery, 73(6): S438–S444; Clasper, J. and Ramasamy, A. (2013) 'Traumatic amputations', British Journal of Pain, 7(2): 67–73.

13 NICHD (2016) What are common TBI symptoms? Available at: https://www.nichd.nih.gov/health/topics/tbi/conditioninfo/symptoms

14 See Chapman, J.C. and Diaz-Arrastia, R. (2014) 'Military traumatic brain injury: A review', Alzheimer's & Dementia, 10(3): S97–S104; Regasa, L.E., Thomas, D.M., Gill, R.S., Marion, D.W. and Ivins, B.J. (2016) 'Military deployment may increase the risk for traumatic brain injury following deployment', Journal of Head Trauma Rehabilitation, 31(1): E28–E35.

15 Rona, R.J., Jones, M., Fear, N.T., Hull, L., Murphy, D., Machell, L., Coker, B., Iversen, A.C., Jones, N., David, A.S., Greenberg, N., Hotopf, M. and Wessely, S. (2012) 'Mild traumatic brain injury in UK military personnel returning from Afghanistan and Iraq', Journal of Head Trauma Rehabilitation, 27(1): 33–44.

16 Hawley, C.A., De Burgh, H.T., Russell, R.J. and Mead, A. (2015) 'Traumatic brain injury recorded in the UK Joint Theatre Trauma Registry among the UK Armed Forces', Journal of Head Trauma Rehabilitation, 30(1): E47–E56.

17 See, for example: Scherer, M.R., Burrows, H., Pinto, R., Littlefield, P., French, L.M., Tarbett, A.K. and Schubert, M.C. (2011) 'Evidence of central and peripheral vestibular pathology in blast-related traumatic brain injury', Otology & Neurotology, 32(4): 571–580; Capo-Aponte, J.E., Urosevich, T.G., Temme, L.A., Tarbett, A.K. and Sanghera, N.K. (2012) 'Visual dysfunctions and symptoms during the subacute stage of blast-induced mild traumatic brain injury', Military Medicine, 177(7): 804–813; Akin, F.W. and Murnane, O.D. (2011) 'Head injury and blast exposure: Vestibular consequences', Otolaryngologic Clinics of North America, 44(2): 323–334; Fausti, S.A., Wilmington, D.J., Gallun, F.J., Myers, P.J. and Henry, J.A. (2009) 'Auditory and vestibular dysfunction associated with blast-related traumatic brain injury', Journal of Rehabilitation Research and Development, 46(6): 797–810.

18 Burke, J.F., Stulc, J.L., Skolarus, L.E., Sears, E.D., Zahuranec, D.B. and Morgenstern, L.B. (2013) 'Traumatic brain injury may be an independent risk factor for stroke', Neurology, 81(1): 33–39.

syndrome[19] and, within an acute intensive care period, developing acute lung injury and/or acute respiratory distress syndrome, which may lead to chronic conditions[20].

2.3 Hearing, visual and other impairments

Acoustic trauma (noise exposure) can give rise to temporary hearing loss, tinnitus, permanent hearing loss and other disorders and can also cause vertigo, dizziness, loss of balance and spatial disorientation. Data suggest that its causes and severity differ across the Services, with the largest proportion attributed to the Army[21], and that military veterans are over three times more likely to have hearing loss in comparison with the overall population[22]. Loss of vision and blindness are also potential consequences of military activity, with an increase arising from the conflicts in Iraq and Afghanistan[23].

Additionally, there are other physical conditions that can occur while people are in Service and may require medical treatment and rehabilitation, medical downgrading or even medical discharge. These include, but are not limited to, circulatory issues, diabetes, respiratory problems, cancers, obesity and addictive behaviours such as alcohol abuse.

It is acknowledged that these health challenges are similar to the challenges faced by the civilian population[24]; however, if such conditions result in someone leaving the Armed Forces there is equally a need to understand how they experience that transition.

2.4 Summary

The physical injuries or conditions acquired as a result of, or during, Service are diverse and complex. For some there may be a requirement for medical discharge, whereas for others there may be a downgrading of their role, with them subsequently medically discharged or choosing to leave Service. Notwithstanding the process through which they leave, it is important to recognise the challenges that Service personnel with physical injuries and conditions may face during the transition to civilian life. Despite the prevalence of physical conditions and injuries as a factor in leaving Service, little is currently known about this cohort. As such, we recognise that behind the statistics outlined above are the lived experiences of those who are making the transition to civilian life. The purpose of our research is to give voice to some of these experiences.

19 Meyer, K.S., Marion, D.W., Coronel, H. and Jaffee, M.S. (2010) 'Combat-related traumatic brain injury and its implications to military healthcare', Psychiatric Clinics of North America, 33(4): 783–796.

20 Rincon, F., Ghosh, S., Dey, S., Maltenfort, M., Vibbert, M., Urtecho, J., McBride, W., Moussouttas, M., Bell, R., Ratliff, J.K. and Jallo, J. (2012) 'Impact of acute lung injury and acute respiratory distress syndrome after traumatic brain injury in the United States', Neurosurgery, 71(4): 795–803.

21 MoD (2014) Noise induced hearing loss in the UK armed forces. Response to FOI request (dated 13 Jan 2014). Available at: https://www.gov.uk/government/publications/noise-induced-hearing-loss-in-the-uk-armed-forces

22 The Royal British Legion (2014) Lost voices: A Royal British Legion report on hearing problems among Service personnel and veterans, London: The Royal British Legion.

23 Broderick, K.M., Ableman, T.B., Weber, E.D., Enzenauer, R.W., Wain, H.J. and Wroblewski, K.J. (2017) 'Non-organic vision loss in the Afghanistan and Iraq conflicts', Neuro-Ophthalmology, 41(4): 175–181.

24 See, for example: Bergman, B.P., Mackay, D.F. and Pell, J.P. (2015) 'Motor neurone disease and military service: evidence from the Scottish Veterans Health Study', Occupational and Environmental Medicine, 72(12): 877–879; Bergman, B.P., Mackay, D.F. and Pell, J.P. (2017) 'Lymphohaematopoietic malignancies in Scottish military veterans: Retrospective cohort study of 57,000 veterans and 173,000 non-veterans', Cancer Epidemiology, 47: 100–105; Bergman, B.P. and Miller, S.A. (2000) 'Unfit for further service: Trends in medical discharge from the British Army 1861-1998', Journal of the Royal Army Medical Corps, 146(3): 204–211.

3. Methods

The research involves two main methods: (1) QLR with Service leavers; and (2) interviews with policy and practice stakeholders. A brief overview is provided below.

3.1 Qualitative longitudinal research with Service leavers

QLR is a valuable approach that enables the exploration of people's experiences over a period of time. Our research is being undertaken over two years (April 2019–April 2021) to enable us to complete two waves of interviews with Service leavers. The Service leaver participants will be drawn from two distinct cohorts: those who have already left the Armed Forces (i.e. having left within the last eight years); and those who are in the process of leaving. Recent approval received from the Ministry of Defence Research Ethics Committee (MoDREC) (March 2020) enables us to recruit the second cohort, the experiences of whom will feature in our final report. As such, the analysis and discussion in this interim report are based on the baseline interviews completed with the first cohort (i.e. those who have left Service). A total of 16 Service leavers were interviewed between October 2019 and March 2020. These interviews established a comprehensive picture of participants' health conditions and how they have affected people's lives to date and also provided important reflections on experiences of the discharge and resettlement process.

Purposive non-random sampling techniques[25] were used to recruit our participants through a range of organisations. The inclusion criteria for the research were having served in the Armed Forces, having left Service since 2012, and having a physical condition as a direct result of Service or acquired whilst in Service. The interviews lasted approximately 60–90 minutes, and the majority took place face-to-face; however, a small number (three) were undertaken via telephone. Each participant received a £20 shopping voucher as a thank you for their time.

3.2 Interviews with policy and practice stakeholders

In addition to our interviews with Service leavers, we also undertook 11 interviews with policy and practice stakeholders representing a range of third-sector organisations providing support to the Armed Forces community. These interviews lasted approximately one hour and included a mix of face-to-face and telephone interviews.

The interviews (with both Service leavers and policy/practice stakeholders) were audio recorded, with permission from the participants, and transcribed verbatim. The interviews were analysed thematically, and each participant was given an identifying code, Service leavers beginning with 'WIS' and stakeholders beginning with 'S'.

The research has ethical approval from the University of Central Lancashire Ethics Panel and complies with the ethical governance procedures at both the University of Central Lancashire and the University of Salford. The research also has approval from the MoDREC (received March 2020).

3.3 Background to our participants

The chapters that follow present the key findings from our first wave of interviews with the cohort who have already left, or were on the point of leaving, Service. As a qualitative project, our research does not claim to be representative of the Service leaver population. Rather, we have aimed to reflect the diversity of physical injuries or conditions that can be acquired during Service. Table 1 below provides an overview of the sample to which the analysis in this report relates. The 'Injury summary' section of the table lists the conditions that participants stated were attributed to, or had been acquired during, Service.

25 Mason, J. (2002) Qualitative researching. London: Sage.

Table 1: Overview of participants and injuries

Participant code	Gender	Age	Armed Forces Service	Service length (yrs)	Time since leaving Service	Injury summary
WIS 1	Male	39	RAF	8	8 years	Foot injury.
WIS 2	Male	Not given	Army	38	4 years	Osteoarthritis in legs and thighs, hip degeneration, spinal degenerative disease of the neck.
WIS 3	Male	31	S	4.5	4.5 years	Complications after leg surgery for a suspected varicose vein, PTSD.
WIS 5	Female	Not given	RAF	12	4 years	Downgrading due to pregnancy. Voluntary discharge.
WIS 6	Male	40	Army	16	7 years	Hearing loss.
WIS 7	Male	40	Army	18	Discharge imminent at time of interview	Ankle injuries, hip fracture, quad damage, nerve damage, hernia.
WIS 8	Male	34	Army	15	Discharge imminent at time of interview	Back injury.
WIS 10	Female	37	RAF	10	1 month	Breast cancer, chronic fatigue syndrome.
WIS 12	Male	42	Army	17	4 years	Back injury, PTSD.
WIS 13	Male	44	Army	20	2 years	Back injury.
WIS 14	Male	38	RAF	18	1 year	Back injury, slipped discs, Achilles injury, knee injury.
WIS 15	Female	42	RAF and Army	22	1 year	Hip problems, tendonitis, mental health.
WIS 18	Male	47	Army	21	4 years	Knee injury, heel injury, back pain, mental health, PTSD.
WIS 19	Male	56	Army	39	4 months	Knee injury.
WIS 21	Male	47	Royal Navy and Royal Marines	7	19 years<?>	Double knee injury, spine damage, slight loss of hearing and sight, PTSD.
WIS 22	Male	Not given	Army	10	Discharge imminent at time of interview	Dislocation of shoulder.

4. Reflections on discharge and resettlement

This chapter presents a discussion of Service leavers' reflections on their experiences of being medically downgraded and/or discharged – through Medical Board and related processes – and experiences of the resettlement process. We explore their experiences of injury in the Armed Forces and how their injuries were managed by the Armed Forces to shape their experiences of transition.

4.1 Injuries and their consequences

As previously discussed, Armed Forces personnel can be downgraded or discharged or choose to leave Service as a result of a wide range of injuries or conditions on a spectrum of severity. At this point of the study, none of the interviewees who had a physical injury/condition from Service appeared to be at the most severe end of this spectrum; however, they were nevertheless dealing with the life-changing consequences of their injuries/conditions (see Table 1). In all the interviews, people described having to learn to adapt to their condition and having to make adjustments in their everyday lives. For a number of people, it was evident that their physical condition or injury imposed particular restrictions in everyday life:

> I massively have to restrict my lifestyle now. I used to go and do a lot of running. I don't do that so much... and then just making sensible life choices. I bought my car, I got an automatic, I just found it easier. Emptying the tumble dryer, I've got a little stool thing like that that I sit on, and just little things, don't stand in one position too long, don't sit too long (WIS 8).

For some participants, although their physical impairment was life-changing, comparisons were made with others who were perhaps in a worse situation. For example, one participant, who was discharged because of loss of hearing, felt that the impact of his injury wasn't so bad relative to others:

> It's not terrible. I wear two hearing aids. I struggle in noisy environments, and I do get frustrated at times with it, but, in short, it's life. I just get on with it! I'm one of the lucky ones in that respect. Things can be a lot worse, I suppose (WIS 6).

However, the impacts on managing day-to-day life did not just relate to the ongoing management of people's health conditions. It was evident that there were often significant knock-on effects on other aspects of people's lives, for example, relationships with spouses and children. The account of the participant below illustrates this in detail. This participant had recently been discharged because of a back injury, which had required surgery. He also had secondary issues relating to his knees and Achilles tendon. His changing physical condition had fundamentally changed his life, including impacts upon his role as a father and upon his spouse, who needed to maintain the household income and provide care for him:

> I wake up in pain. Getting down the stairs, the house I'm going to have to buy now is a bungalow, because I can't go up and down stairs easily. In fact, coming downstairs is getting harder and harder... I get up in the morning, and then I go downstairs, and then I don't go back upstairs until I go to bed, which is hard because I've got kids and, at the moment, my wife's working, so I'm the sole care provider, really for my one-year-old, which is all right because he just stays downstairs... I can't go for long walks, I can walk maybe not even half a mile without being in pain, no more than 200 metres without being in pain, but I can walk to the shop and back, and then I have to sit down for a while, and then obviously that affects what I then do with my son. I can't pick my [four-year-old] daughter up, which, that's horrible for anyone. When I used to throw my eldest son around the pool in Cyprus, I can't do any of that with any of the children. Basically, I can't really cook because I can't bend down into the oven. My wife's my carer, really (WIS 14).

4.2 Medical Board and discharge process

Service personnel with conditions or injuries that affect their ability to perform their duties will generally be referred to a Medical Board for an examination and a review of their medical grading, according to a number of frameworks (including functional/physical capabilities and Medical Employment Standards). In cases where the individual's medical grading falls below the Service employment and retention standards for their branch or trade, the Board will recommend either transfer to alternative duties or medical discharge. If the condition is likely to improve, the Board may recommend temporary downgrading to allow treatment, recovery and rehabilitation. However, if individuals do not make a recovery, the Medical Board may recommend permanent downgrading or medical discharge. As part of this assessment, individuals are allocated a 'P grade', which indicates their fitness for Service (see Table 2 below for details of the description for each P grade).

Unsurprisingly, given its central role in the discharge process, a lot of discussion in our baseline interviews reflected on experiences of the Medical Board: how it was carried out and the role it played in shaping people's experiences of transition. One participant was deeply frustrated by the unclear and chaotic

process of his Medical Board, which left him to spend a significant amount of time that should have been spent on resettlement disputing the length of time he had been given by the Medical Board and following up on why and how that decision had been made and how it had been communicated and managed between key parties. He highlighted the discrepancy (from his perspective) between the medical care he had received following his injury and the Medical Board and discharge process he had been through:

> The medical chain have been really good. I mean, that's one thing you can't knock the Armed Forces about... the medical care has been second to none. I can't complain about that one little bit... The one aspect of the medical chain that I'm not happy with is the Med Board side of things... That was, from start to finish, my Med Board was a disaster, and I've got so many issues with it, and it's put me in a really bad position (WIS 7).

Within many accounts there appeared to be confusion about what had happened at the Medical Board, which often related to a lack of understanding about how decisions had been made in relation to recommending discharge. One Service leaver, for example, felt that there was a lack of transparency in the process. She had had breast cancer and had undergone a number of operations. Although she had initially felt supported by her Commanding Officer, she had subsequently felt betrayed and surprised at being diagnosed by the Medical Board with chronic fatigue syndrome:

> I'd been downgraded for the breast cancer side of it, but then I could understand if they'd kicked me out or discharged me because of that. I wouldn't have agreed with it because that's not something I can control, but I could have understood it more, but to then go to the Med Board, and they're saying because you're tired all the time we're getting rid of you, and I was like, 'Yes, I know I've been tired, but is that not down to all the surgeries?', and then that was like, 'Well, no, it's this chronic fatigue syndrome, you can't work, certainly not in the short term, so you're not fit for purpose'. I was like, 'What does that mean? What is chronic fatigue?' Because I hadn't really understood it... if I look at it from an employer's point of view, at what I was probably like at work, then, yes, I probably wasn't fit for the job, but I think there were better ways they could have dealt with it (WIS 10).

The criticisms raised did not relate to the behaviour of those on the Medical Board; rather, they were about the speed at which a decision could be made and also the formality of the process. This was reiterated in the stakeholder consultations by an individual whose role involved acting as a supporting witness at Medical Boards:

> It's a very formal, formal process. You're sat in front of a table of very, very high-ranking officers. For those who are of a more junior rank that is a very daunting experience, and, as much as they try to make it friendly, it's very difficult for them. A lot of the time it's all done very quickly and spoken, they try to explain it in layman's terms what's going on, but obviously it's a hard pill to swallow (S14).

With regard to the discharge process more broadly, concern was expressed by a number of our participants around the lack of transparency and poor communication within the discharge process. It was evident that some interviewees had experienced what they perceived as a 'chaotic' discharge process. For example, one participant didn't even know that he had been discharged and found out during an informal conversation with a speaker at an event about resettlement:

> I was like, 'No, that can't be true', so she had to print it out for me, print my discharge letters out for me, and I was like, 'wow, this is news to me, I don't know, I've been left in the Army, I'm in limbo because I don't know what's going on' (WIS 3).

Another participant felt a sense of 'disbelief' that relevant people in key roles such as Personnel Recovery Units (PRUs) had not been informed of the decision of

Table 2: P grades and descriptions

P grade	Description
P0	Medically unfit for duty and under medical care (not used in the Navy)
P2	Medically fit for unrestricted Service worldwide
P3	Medically fit for duty with minor employment limitations
P4	Medically fit for duty within the limitations of pregnancy
P7	Medically fit for duty with major employment limitations (i.e. restricted duties in the UK only)
P8	Medically unfit for Service

the Medical Board[26]. Although this participant was in agreement that he needed to be discharged, having sustained multiple ankle injuries in addition to a number of other issues requiring multiple operations, he felt the process was 'broken':

> So the process is broken. Well, there isn't a process... the IERO [Individual Education and Resettlement Officer], for example, is claiming that she didn't know anything about this. So what's happening, then, is that the left-hand side, being the PRU, isn't communicating with the right-hand side, being all the other agencies. So there's no effective communication between the two (WIS 7).

Some participants were also unhappy about having been discharged in the first place; however, it should be noted that this was felt by a minority of participants and often related to not wanting to leave the career that they loved:

> I was doing my job. I was getting on with it. Yes, I was in pain, but I can manage it... All I ever wanted was to do my Service, I wanted to do my full 22. I never ever wanted to leave (WIS 21).

4.3 Resettlement

For those considered medically unfit for Service (P8) or unfit for duty and under medical care (P0), support is provided through the Defence Recovery Capability (DRC). Founded in 2010, the DRC is an initiative led by the MoD and delivered in partnership with Help for Heroes, The Royal British Legion and other Armed Forces charities and agencies to ensure that WIS personnel have access to the services and resources they need to help them to return to duty or make the transition into civilian life. The DRC comprises the Naval Service Recovery Pathway (NSRP), the Army Recovery Capability (ARC) and the RAF Recovery Capability (RRC). The three Services all have their own definition of WIS and differ in their criteria for who receives support. The DRC runs in parallel to the Defence Transition Service (launched in 2019), and, at the time of writing, the MoD was undertaking a review of the DRC. Table 3 below provides a brief overview of some of the support and resources available as part of the DRC.

The CTP and, more specifically for WIS Service leavers, the CTP Assist programme are designed to support those in transition to gain skills in order to seek employment post-Service. CTP courses can last from one day to several months and can be undertaken before and/or after a Service leaver's discharge date. CTP Assist offers personalised support to WIS Service leavers through a network of Specialist Employment Consultants.

Although the resources and support outlined above are significant, our interviews suggested inconsistencies in people's ability to access the support they were eligible for. A common theme throughout the interviews was the perceived lack of time participants had been given to prepare for leaving Service, which was felt to have had a knock-on effect in terms of the support and/or education and training that people could access during resettlement (see also Chapter 7). For example, one participant described an exchange they had had during their Medical Board:

Table 3: Resources and support available within the Defence Recovery Capability (DRC)

Support/resource	Description
Individual Recovery Plan (IRP)	The purpose of the IRP is to support an individual back into service or achieve a successful transition if they are deemed unfit for further military service.
Personnel Recovery Units (PRUs)	Specialist military units for the command and care of WIS personnel with the greatest needs.
Personnel Recovery Centres (PRCs)	Offers recovery courses and activities but not medical facilities.
Career Transition Partnership (CTP)	Provides specialist employment support to those leaving the Armed Forces, with CTP Assist focusing specifically on those who are WIS.

26 A representative of a PRU indicated that this appeared to be an unusual experience. They stated that every 28 days a PRU CO is mandated to conduct a detailed case conference, which involves a range of experts including Clinical Facilitators who are trained nurses and have access to medical records, Social Workers and Personnel Recovery Officers and specialist Employment Consultants. The purpose of the case review is to review progress against the person's Individual Recovery Pathway. They also stated that PRU CO's know if, and when, a service personnel is likely to go to Full Medical Board (FMB) and the outcome. Letters of discharge are issued to individuals and copied into CO's.

> She [referring to Medical Board] had this piece of paper, and she has options on the length of time that she can give you to be discharged... I think there's four boxes you can tick: four, six, nine or 12 months... So she gave me six months. I said, 'That's not enough time'. I said, 'That's clearly not enough time'. She laughed at me, and she said, 'What do you want, an infinite amount of time?' I said, 'No, I want an appropriate amount of time...' If she'd have ticked the 12-month box... That makes a whole world of difference. The stress wouldn't be there (WIS 7)[27].

Another participant reflected on having had insufficient time to book or complete the courses that he wanted to, which was largely due to him having been told by his superior that he was to be retained rather than discharged, even though he had been told by a surgeon that his back injury wasn't 'fixable'. His account suggested that the timeframe he had eventually been given had even surprised the staff delivering the resettlement support:

> ...so the courses I was looking at doing were all booked months in advance. I did my Career Transition Workshop in September, and there was people on that that were getting out in a year and a half, two years' time, sorting out, because that's how early you're started. People at the end of their career... If I'd signed off and just said, 'I want to leave', and put my papers in, I'd get 12 months... When I went and seen the, in the education centre to book my resettlement courses... he's like, 'When are you out?' I said, 'November'. He said, 'You're joking, it's August'. He's like, 'Why are you just coming to me now?' I said, 'I'm being med discharged'. He said... 'When were you first considered for med discharge?' I said, 'February'. He's like, 'Well, you should have come to me then'. I said, 'I know that. I tried to but wasn't allowed' (WIS 8).

For some, attending significant numbers of medical appointments up until their point of discharge had also affected their availability to undertake relevant courses and training:

> I haven't had any opportunity to do my resettlement because I've had operations, I've had – every week I had physio, doctors' appointments, I had PRU appointments... So every week I'm filled – my days are filled with medical appointments, which means I can't do any resettlement (WIS 7)[28].

The stakeholder consultations also reiterated some of the perceived gaps in how the discharge process is managed:

> I think there are some people who slip through the net... There are some people who are entitled to other provision, and for whatever reason they're just shown the gate, and they're out. They're not told, by the way, go on to this website, apply here, and you're entitled to that (S9).

However, it was recognised that the process and the support provided were significantly better than they had been a number of years previously but that in many cases this related to the approach of senior staff within an individual's unit:

> In 2006 we were literally bunged in a room, given a CV template and told to put our name at the top, and that was basically our discharge. Now they are doing more courses for the WIS, whether they go PRU or not, so that is a lot better, but it's down to units, and it's just to make sure that COs, OCs and welfare officers get a lot more training to understand how the transition, or the lack of transition, affects that individual (S13).

4.4 A bitter end to Service?

Though this could not be said for all participants, difficult experiences with the discharge process had left some people with a feeling of bitterness or sadness in terms of how their careers had ended. One participant reflected on feeling "aggrieved... very bitter" (WIS 3) on leaving the Army, and another, who had served for almost 39

27 A representative of a PRU provided detail on how the process should work, indicating that the individual should be informed of resettlement entitlements and are to begin resettlement activity as soon as medical discharge becomes a possibility. They stated that the length of time awarded is determined by an assessment of treatment timeframes. When the completed Full Medical Board (FMB) documentation is considered by APC, additional time is included for outstanding resettlement entitlements, invaliding leave and termination leave. This would normally be no more than 12 months as a FMB must be convened for individuals at the latest after 12 months Temporarily Non-Effective (TNE). In circumstances where an individual has good prospects of a return to duty after further clinical interventions, periods in excess of 12 months can be awarded. It should be noted that periods of TNE for the same condition are aggregated.

28 A representative of the PRU indicated that there is a process in place to enable early engagement and appropriate career management, including the option of applying for an Extension of Service (EoS) if medical interventions are restricting resettlement training time. The representative stated that in the case of this participant, this should have been identified at the Unit Health Committee or 28 Day Case Review.

years and reached the rank of Lieutenant Colonel and had been discharged following hip and spinal injuries and subsequent deterioration in mental health, was left feeling "completely abandoned" and undervalued:

> What hurt me more than anything else, what really hurt me, was the Army just abandoned me. They didn't know what to do with me. They just send you home, 'Go away, we'll be in touch sometime', and just completely threw you out the door; threw you out the gates, took everything. They stripped you of your identity. You're not allowed to go into work, you're not allowed to go anywhere; not allowed to communicate with anybody. 'Go away.' In an organisation that I'd served for nearly 39 years, completely abandoned you... I don't want people to roll the carpet out for me. I don't want somebody to open the door for me or a big badge that says, 'I have priority everywhere, I'm really special', I don't want that... I want the organisation that bloody looked after me, that I served, I want them to be able to turn around and say, 'Can we help? You've been out now for two years or whatever. You're still ill, we see. You're still poorly... How's it going, mate?' Rather than just shoving it over to a charity to do (WIS 2).

It was evident that our participants had had extremely positive experiences during their time in the Armed Forces, with many having hoped that they would be able to remain in that career. Therefore, when they experienced difficulties in the discharge and resettlement process it was often felt to be a sad way to end a career that up until that point had been very rewarding and enjoyable:

> Very disappointed and a sad way to end. I look back on, for the most of my career, I've loved it, brilliant, but I'll just, it will be tainted now by my memories of this last year-and-a-half period (WIS 8).

> [M]y experience... wasn't a good one. It takes away the joy of the good memories and the good times I've had in the army because it happened to end on a bad note, and a very distasteful one actually, to be honest (WIS 3).

5. Navigating civilian life

This chapter presents a discussion of experiences by those service personnel, who as a result of physical injuries and impairments are discharged from (or choose to leave) the Armed Forces. The focus is on the lived experienced of this cohort, and more specifically on the impact of their physical injury/impairment as they leave Service and navigate through various aspects of civilian life. More specifically, we focus on experiences of accessing the following: employment, education and training, health and medical support, housing and income and social security benefits. As highlighted earlier, we are presenting emerging findings from baseline interviews with a cohort of individuals who had already left the Armed Forces and were reflecting back on their discharge experiences. A number of these had left recently (within the last month), whereas others had left several years previously. So, to some extent, many participants were still getting to grips with navigating these civilian systems. These are early insights into some of the challenges Service personnel referred to, which we will be able to revisit in our follow-up interviews. In addition to the voices of Service leavers, we also draw upon some of the views of key stakeholder who are supporting Service leavers. As such, we recognise the huge contribution made not only by the Career Transition Partnership (CTP Assist, in particular) but also by the Service charity sector.

5.1 Education and training

The discussions on education and training focused primarily on what was accessed during discharge/resettlement rather than post-Service. There appeared to be a relatively equal split between those who spoke positively about the education and training opportunities provided during resettlement (and also more broadly about the opportunities available to those who choose a career in the Armed Forces) and those who spoke in more negative terms. Those who reflected positively referred to the financial packages available for training courses and also the vocational nature of courses (NEBOSH and electrical engineering being a couple of examples given), which were vital in helping individuals access post-Service employment. Reference was also made to the flexibility applied to people's Enhanced Learning Credits (ELCs), which had allowed some participants to defer because of their health conditions and provided additional time to consider the best use of these resources (for example, some were considering using their ELCs for a degree in the future).

However, there appeared to be inconsistency in the deferment of ELCs. One participant, for example, felt that at the time when they were being discharged, their combination of physical and mental deterioration had affected their ability to make decisions relating to their post-Service career. They felt that they had received limited information about their options to defer resettlement:

> I was in no fit state to start making career decisions, so I did no resettlement. Every time I went to a careers adviser they'd say, 'Did the MCM division not defer your resettlement?' I went, 'No one's even mentioned it to me. No one's ever spoke to me'. To this day, I am very angry with the whole thing (WIS 2).

For others, the perceived lack of time available for resettlement, combined with limited knowledge of civilian careers appropriate to their skill set, meant that they simply chose courses because of their availability at a given time:

> There was no other course that you could do, because it's a rush as well... there's a workshop, CTP Workshop... where you have people talk to you about the possible employment or jobs that you can land yourself into. The easier option, with the money available at the time, was the CCTV, it's not something I desired to do, but because I didn't know what was out there for me (WIS 3).

5.2 Employment

At the time of the interviews, ten participants were in paid employment and six were unemployed. The types of employment varied and included the Civil Service, police service, health and safety, engineering, fitness and security. Some participants were in managerial positions across these different types of occupation. For those who were working, it was evident that they had had to be proactive during resettlement in terms of identifying opportunities. That said, some had still experienced difficulties with the short resettlement timeframe and also with adjusting to their physical injury/condition:

> You sit back and you think, 'what am I going to do, it's like I can't work on tools any more, I can't work overhead, I've got to be careful with the weather when it's cold...' You're trying to mitigate all the problems that you're going to face... I can't do any of that ever again [referring to roles within the Armed Forces], and I'm now in office work. Luckily, I've gone into management, so it's similar things that are transferable... I was lucky that I started networking when I did. I was lucky I met the people that I did, ended up in the posting that I got and got this opportunity (WIS 22).

For those who were unemployed, there were various reasons for this. As has been highlighted in other studies[29], concerns were raised by some participants about the difficulties faced in transferring military skills and qualifications to the civilian labour market. As one participant suggested, navigating the contemporary civilian labour market can be daunting for those who have spent a number of years in Service. They felt that more support was needed to help people identify where their skills could be matched to civilian jobs:

> When you look at a job specification and it says you must have this qualification, it's the essential and the desirable criteria, you almost have to discount that somehow and say, 'well, I haven't got that'. However, I've got this, and you can list this long list of stuff that you have, but it would put a lot of people off, especially if you've been in the Forces... and you've not had to do a job interview. It was intimidating for me even to do it after 12 years, but if that's all you've ever known, it's a very intimidating world, especially when you don't know what you want to do, what you're qualified to be able to do as well, and almost that you need, I don't know, in an ideal world, like a recruiter for the civilian side, to say these are the qualifications to do this list of jobs. These are the people [employers] that would accept you (WIS 5).

This was reiterated in the stakeholder interviews, which highlighted a need for employers to be educated on the significant skills that military personnel can bring to the workplace:

> So I think perhaps the government could do a better job in helping the general public and businesses understand the massive transfer of skills that people in the Forces have, so man management, logistics, project management... A lot of them have huge skills that would cost a fortune to nurture in civilian life, so I think we could do a better job of advertising that (S1).

> I think there's a whole thing around, just by the fact that somebody has had to leave their career in the Armed Forces and are wounded, injured and sick and they've had some injury, that absolutely does not mean to say they've got nothing more to give... completely the opposite, they've got so much more to give, and they are very good in the workplace, their personal stories can be inspirational (S9).

Perhaps unsurprisingly, people's health conditions had an impact on their ability to secure work. For some of those who had left Service more recently and were in the position of looking for work, there were concerns about the impact of their injury on the type of job they could do and also on the willingness of employers to take them on if adjustments were required, whether relating to the physical environment within the workplace or the hours of work expected:

> So maybe I could go into logistic management again with a company that knows I've got a disability and will adapt around me... can I find an employer that will do that? Have I got the time to find an employer that will do that? Who's going to pay my bills? (WIS 13).

> I'm on this, it's called CTP Assist, Career Transition Partnership, but I'm on the Assist side purely because it's going to take me more to get a job... you look on there and it's all full-time jobs... I think it's a good idea, but again I don't think it's suitable for everybody... I know that I'm comfortable with three hours, whereas if I'm doing eight hours I know that will be too much and it will knock me out, probably for a day (WIS 10).

Some stakeholders raised concerns that sometimes less was known about the needs of those who have been out of the Armed Forces for longer:

> I think the provision in Service and going out is pretty good, as long as people do their jobs, and they're identified properly. I think there is more of an unknown after people are outside the CTP period (S9).

For those participants who had been out of Service for longer periods, it was evident that, although they had been working, a deterioration in their health sometimes led to a change in their employment circumstances or required periods of recovery. For example, two participants with back injuries referred to previously having had driving jobs but having had to give these up as their condition had worsened over time. One had found a new job through an Armed Forces charity (after a short period of time claiming Jobseeker's Allowance); the other was unable to work and was claiming Employment and Support Allowance (ESA). Another participant, also with back problems, had changed to a lower-paid but more accessible job as they could no longer manage the commute to work, while another was working as a porter part-time and often spent his non-work days recovering from work:

> All my days off I usually spend in recovery because my knees lock up, my thighs and my ankles are killing me (WIS 19).

Although paid employment was important in some people's transitions, stakeholders suggested that volunteering also offered a pathway back into employment, particularly for some of those who had sustained quite significant injuries, and in some cases had featured in the recovery plans of those whom they were supporting:

29 Heaver, L., McCullough, K. and Briggs, L. (2018) Lifting the lid on transition: The families' experience and the support they need. Naval Families Federation, Army Families Federation and Royal Air Force Families Federation.

> Volunteering was part of their individual recovery plan, so I would liaise with the PRO and then make sure we do all the forms... They did seem to be the most broken, yet the ones who seemed to want to make changes more. I don't know if they had a bit more, I don't know, possibly a bit more resilience (S13).

5.3 Health and medical support

Chapters 3 and 4 have provided significant detail on the nature and impacts of people's health conditions. Although there were significantly negative views on the downgrading and discharge processes (see Chapter 4), there were often positive views on the health/medical support people received when they sustained their injury and within the specialist recovery units. This related not just to the treatment of injury but also the opportunity for peer support that was experienced when recovering alongside other military personnel:

> We almost supported each other more than what the course did, because we all felt that we understood each other without discussing it, because we all went through the same thing, whether that was lack of sleep, or whether it was just being in discomfort or just not being yourself, you know, not being like you were before the injury and this or whatever. A lot of it was about mindfulness, getting your head round what the problem was... we just understood because we were all in the same boat (WIS 10).

As highlighted at the beginning of this chapter, a significant number of participants had relatively recently left the Armed Forces. Therefore, they were just beginning to navigate the civilian health system. For some, concerns were raised about a lack of handover from military healthcare to the NHS:

> There was no handover to the NHS, nothing. I was entitled for six months with DCMH post-discharge, end of the six months they went, 'Bye, off you go'. 'What do I do now?' They went, 'Right, just go to your GP and they'll refer you, and you'll just carry on'. [No written information] only what was on my medical documents at the time, which were well out of date. That was it, really (WIS 2)[30].

From the perspective of stakeholders who were providing specialist health support, it was reiterated that it is important to be able to be involved at an early stage and also that they have timely access to medical information:

> The earlier we can be involved in that rehab journey, so that from the beneficiary's perspective it's seamless and joined up, the better. What they don't need is a confusing picture, where they're having to repeat information all the time and where there are disconnects, that is damaging... The big challenge that we have is access to medical data, in-Service medical data, and that remains a big challenge today... it's a hindrance not being able to get hold of that data. Now, the individuals will have their own medical notes and what have you, which will be passed across, but what they don't have is comprehensive notes that give the history or the story behind particular events (S12).

In addition to difficulties with the handover to the civilian health system, others appeared to be experiencing difficulties with expectations of healthcare; for example, difficulties with the longer waiting periods for appointments and care and also the perceived need to pay for prescriptions (even though these are in fact covered if relating to a compensated condition):

> The beauty of being in the military is your physio is there. You can see a doctor in the morning, and, if you're lucky, you're seeing a physio in the afternoon. If not, you're seeing a physio some point next day or that week, whereas NHS physio are like what?... Transitions, Intervention and Liaison Service [TILS] is good, but it took me seven months to get on, not seven weeks (WIS 18).

> The Army has been paying for my prescriptions and everything, but now I'm expected to. They kicked me out, and now I'm expected to pay for it... I'm like, 'But I can't afford £30, £40 a month on painkillers...' If you're serving, you're covered, but surely you'd think if it was caused by Service, they should be required to carry on that treatment for that injury (WIS 22).

Managing expectations of the difference between military and civilian healthcare was reiterated in the stakeholder interviews:

> You're used to being able to get time off in work to go to the physio who is on the station, and it's free, and you can go to the physio five days a week, and it's not a problem. When you go into the [civilian] world, you can't do that, you can't do that on the NHS, and you can't afford to do that privately because that would be £500 a week. Again, it's understanding how you manage your condition, because you're not going to get the level of physical support that you got in the military, because that doesn't happen in the civilian world (S4).

30 A representative of a PRU indicated that this should be part of the Individual Recovery Plan, and that PRUs aim to ensure that, where applicable, clinical transfer to the NHS has taken place.

5.4 Housing

The participants were living in homes with a mix of tenures, both renting and owner-occupation. Housing experiences appeared to feature less within people's accounts than other issues; however, those who discussed housing often raised quite significant issues. For example, it was suggested by a small number that they had been 'evicted' from military quarters, with subsequent experiences of homelessness. It was not clear whether they had breached the conditions required to retain military accommodation or had reached a stage where they were no longer eligible; however, these participants had often then been housed within socially rented accommodation, often with the intervention of local authorities or other stakeholders. One participant referred to buying a house through the Armed Forces Help to Buy Scheme. The stakeholder consultations suggested that sometimes limited guidance was provided on housing options or how to access housing, as one respondent stated:

> Money, they would go to Veterans UK, and then they would learn about Army Welfare Service, what they could do, but it never really has anything about housing, renting, Council Tax or any of that support (S13).

5.5 Income, pensions and social security benefits

All current and former members of the UK Armed Forces, including Reservists, may submit a claim for compensation for injury or illness that has been sustained as a result of Service. The War Pension Scheme (WPS) compensates for injury, illness or death that occurred before 6 April 2005, while the Armed Forces Compensation Scheme (AFCS) provides compensation for injury, illness or death that is caused by Service on or after 6 April 2005. Claims can range from relatively minor injuries (e.g. fractures) through to amputations and other more serious conditions, including mental health conditions. The AFCS offers two main types of benefits: (1) a tax-free lump sum, the size of which reflects the severity of the injury or illness (ranging from £1,200 to £570,000); and (2) for those with the most serious injuries and illnesses, a tax-free index-linked monthly Guaranteed Income Payment, which is paid from the point of discharge for life[31].

Although this financial support is available, financial security was a significant concern for many participants, particularly when coming to terms with the impact of their physical injury/condition on their employment prospects (as above). Although some had secured employment, in some cases this involved a reduction on their in-Service income:

> Well, yes, you're going from a Sergeant who's got a house that he pays about £90 for with his family in and earning nearly £40,000 a year to getting out and earning about £20,000 a year and having to find somewhere to rent (WIS 6).

For a number of other participants, however, at the time of the interview uncertainty about their WPS and/or AFCS claims appeared to be a key concern. Although many indicated that the payments would be sufficient to give them some financial stability, they were experiencing anxiety while in a period of limbo:

> The biggest thing was knowing I was getting money but not knowing how much I was getting, and I only knew about three/four weeks before my discharge date. To me, that's too late, because you can't plan... [even if] they [could] give you an estimated value (WIS 10).

One participant had incurred debts (including housing arrears) because of a delay in receiving his War Pension:

> I had stress in my life, stress in my marriage, stress financially because we are financially crippled now. All of my pay-out, right, not just from the military side of it, but my normal pension, I had to use all of that to clear debt that I had built up when I was injured because we couldn't afford childcare, so my wife had to give up her job and care for me. We had to sell our cars (WIS 14).

Only two participants were in receipt of social security benefits (one claiming Universal Credit, the other ESA), with another participant referring to having previously claimed benefits but at that time working. As has been found in other recent research[32], they had experienced difficulties with understanding what they were eligible to claim and also the processes involved in assessing eligibility. One participant, for example, expressed frustration at having to undergo multiple assessments for financial support:

> I had a PIP assessment, ESA assessment, a War Pension assessment and something else assessment. I had seven assessments in the space of three months... [that was] within the last five years (WIS 21).

It was evident, however, that in some cases, although people had been eligible to claim social security benefits, they had chosen not to. This related to issues of pride and stigma and also the anxiety of navigating a new system:

31 MoD (not dated) The Armed Forces Compensation Scheme explained. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/20277/AFCS_leaflet.pdf

32 Scullion, L., Dwyer, P., Jones, K., Martin, P. and Hynes, C. (2019) Sanctions, support & Service leavers: Social security benefits and transitions from military to civilian life. Available at: https://www.fim-trust.org/wp-content/uploads/2019/06/20190610-FiMT-Final-Report-WEB.pdf

> I was advised to go for PIP and all that, but because I'm a bit, I've got personal pride (WIS 19).
>
> It's that anxiety side of it is that if I go then I've got to go to the Jobcentre, and then it's like not knowing the environment and it's all that side of it. Where if I don't claim it I've not got to put myself through that, but at least if I do go and I get it then at least I'll get a bit of money... My dad keeps going, 'Go and get Jobseeker's', and I'm like, 'Yes, but that's admitting to myself that I can't get a job' (WIS 10).

This issue of pride and stigma has been raised in previous research relating to military transitions and help-seeking behaviour[33], and a number of stakeholders reiterated this issue in relation to seeking not just financial support, but also other forms of support to which Service leavers are entitled:

> I think their first barrier is the individual, because they're generally all too proud... that's the resilience that's been instilled in them, so I think we have to recognise that's the nature of the beast that we're dealing with, and so how do we overcome that? (S4).

33 See, for example, Sharp, M.-L., Fear, N.T., Rona, R.J., Wessely, S., Greenberg, N., Jones, N. and Goodwin, L. (2015) 'Stigma as a barrier to seeking health care among military personnel with mental health problems', Epidemiologic Reviews, 37(1): 144–162.

6. Intersections between physical and mental health

Previous studies have shown that some Service leavers may experience frustration, confusion and poor psychosocial integration as a result of discharge following a physical injury. These experiences can arise from a number of factors, including the discontinuity between military and civilian health services[34], a shift in ability – with a corresponding shift in identity – from being 'able-bodied' to becoming disabled[35] and the disruption of an enforced career change for health reasons. Further impacts on mental health related to transition but not necessarily related to injury – specifically, the loss of identity related to leaving the Armed Forces – are also documented[36]. This chapter presents a discussion of some of these issues drawn from the accounts of our participants, which reflects on the importance of considering the intersection between physical and mental health.

6.1 The impact of injury on mental health

A common theme across many of our interviews was the subsequent impact of the physical injury or condition on participants' mental health, with many describing a deterioration in their mental health. As with previous research, for many participants this related to adjusting to a changed identity (i.e. being 'disabled'), as one participant illustrated:

> I'm now officially disabled as well, so I've got my blue badge, and I get government PIP and stuff, which is fine, but it's a kick in the teeth, bearing in mind three years ago I was kicking about the desert doing soldier stuff, being a very active person, running marathons, doing everything I love doing (WIS 7).

It was also evident that for some the impacts on their mental health were not just felt once they had left Service. In some cases, particularly where someone had tried to continue their normal duties for a period of time while injured, the deterioration in mental health had begun while they were still in Service. In the following quote, for example, one participant described his breakdown during his rehabilitation period:

> In one year, I did two operational tours and I was put into four different jobs to try and sort stuff out, and I just broke. I just couldn't cope any more. I'd been for rehab after surgery, and I broke down in that. I was broken. I was absolutely broken. My mental capacity had just gone (WIS 2).

Although the highly pressured nature of this person's role had been a factor, he made it clear in the interview that the injuries to his hip and spine – and the consequent loss of ability – had been the catalyst for his breakdown. He went on to describe how he lived with a constant sense of anxiety:

> My anxiety, I can't deal with people. I suffer with road rage. I suffer with shopping trolley aisle rage, anybody in my way, anybody stopped; I can't deal with people. I get panic attacks around people; my temper goes up. I've never done anything wrong, I've never hit anybody, don't get me wrong. I feel sometimes I want to just smash people out of the way. I have no tolerance for anybody, nothing. I used to be one of the most tolerable, likeable blokes. I look in the mirror and I don't know who I am. I hate myself every day for what I've become (WIS 2).

It was also evident that part of the emotional difficulty of dealing with physical injury related to not just the inability to undertake normal duties but also a sense that people were consequently 'letting their colleagues down'. One participant spoke of his perception of an environment that was not tolerant of injury:

> For the first 13, 14 years of my career, I was volunteering to go everywhere, deploying on everything, all the tours, keen as mustard... Just loved it, loved deploying, and then, when my injury got bad and I was saying, 'Look, I need to, this is what I need to do now', just it becomes a different, nasty, horrible environment. Psychologically, that's bad. It makes you feel really low, you have low self-esteem... You're just stood there, and people are running past you going, 'Look at the biff'. It's just such a bad, negative environment if you're injured in the Army (WIS 8).

In some of the more extreme cases, people made reference to suicidal thoughts, although none of the participants had attempted suicide:

34 Christensen, J., Langberg, H., Doherty, P. and Egerod, I. (2017) 'Ambivalence in rehabilitation: thematic analysis of the experiences of lower limb amputated veterans', Disability and Rehabilitation, 40(21): 2553–2560.

35 Caddick, N. and Smith, B. (2017) 'Exercise is medicine for mental health in military veterans: a qualitative commentary', Qualitative Research in Sport, Exercise and Health, 10(4): 429–440.

36 Brunger, H., Serrato, J. and Ogden, J. (2013) '"No man's land": the transition to civilian life', Journal of Aggression, Conflict and Peace Research, 5(2): 86–100; Christensen et al. (2017) op. cit.

> I think I'm still a little bit depressed now, to be honest about it, because your back plays up and you're thinking, 'well, I'm letting my family down, letting myself down', but it's not my fault I understand that. At one stage in my transition I thought about ending it, but... with no real conviction. I thought, 'I'd be better off if I weren't here'. I had a couple of rough days thinking, 'what am I going to do...?' I miss the Army every day (WIS 13).

For other participants, their physical injury and intersecting issues in relation to their mental health had knock-on effects on their relationships, including, in some cases, the breakdown of their marriage:

> Then that changes the whole way you live your life, basically, and so now, because I'm a different person, it stopped, really, between me and my wife (WIS 14).

Linking with the issues raised in Chapter 4, a small number of participants attributed their poor mental health to the difficulties they had experienced with the discharge and resettlement process, particularly where they felt that inadequate support had been provided during that time and where they had felt 'pushed out':

> ...transition itself into civilian life, it's been a very difficult one for me... There's time when I've come to the point of feeling suicidal; since then, I'm still on antidepressants. Things are really bad at the moment... (WIS 3).

> I fell through a lot of cracks, which obviously didn't do my head too well. As I say, with this constant pushing from my line manager saying I was leaving, that led to the start of the anxiety issues and the low mood. A month or so before I came out, I started being treated for that low mood, depression aspect of things, because I just felt broken inside, not just physically, but mentally as well (WIS 1).

The experiences of a number of our participants reiterated the findings of other research that has highlighted the need to improve the mental health assessment of those who are being discharged for a physical injury[37]. However, it should also be noted that, despite the deterioration in some participants' mental health, many participants appeared to demonstrate remarkable resilience in adjusting to the impact of their life-changing circumstances.

6.2 Adjusting to loss of identity

As highlighted in previous research, a loss of identity when leaving the Armed Forces can affect people's mental health, as some people are left feeling in 'no man's land' and experience difficulties with constructing a new identity in civilian life[38]. This was evident for a number of our participants, who described this sense of loss very vividly:

> I don't know what my identity is as a person now... I don't know who I am now... I'm on that transition to becoming a civilian, although in my mind I'm always going to be a veteran, because the process goes: civilian, military, veteran. It doesn't go: civilian, military, civilian (WIS 18).

One participant described a particularly humiliating experience when his ID card was taken from him, which was felt all the more deeply because of his length of Service (39 years) and the inextricable link between his Service and his identity and also his sense of dignity:

> I have lost all dignity. I've lost my identity. The guy laughed at me when he cut my ID card up in front of me, the clerk, the Private clerk that stood there, and I gave my ID card over the counter, and he laughed and cut it and went, 'That's you off then, another one gone, bye'. That, for somebody that devoted my life to serving my country... From 16 years of age I absolutely swallowed a tablet. I believed it. I lived every day. I woke up every day serving, putting my uniform on, and to have a Private laugh when he cut my ID card up and watch me walk out the gates, it was humiliating... I have no sense of purpose. I have no reason to get up in the morning apart from my own inner discipline (WIS 2).

Some participants suggested that issues of 'loss of identity' needed addressing as part of the resettlement support that was provided. At present, however, it was felt that this was largely absent, with support being criticised for being generic and 'tick box' in nature (see also Chapter 7):

> Go and do Career Transition Workshop – tick. Have you done the financial benefits course? No – tick. Have you done the housing course? Do you need that? No. Okay – tick. At no point do they turn round and help you understand your identity as a human, as a person... Those people who sit in the wounded, injured and sick medical discharge bracket, it's a shock to them, so they haven't had time to think about that identity (WIS 18).

A final issue that emerged from the interviews related not just to loss of identity but also the creation of new identities. It was recognised – by Service leavers and stakeholders – that some of those with physical injuries/conditions go on to achieve incredible physical feats as disabled athletes (e.g. in the Invictus Games). Indeed, one participant who had multiple, significant and complex injuries was preparing to participate in an international event involving sponsorship and publicity. However, a note of caution was offered in relation to this narrative, which was felt to relate to a minority of those who leave Service with a physical injury:

> Not everybody is going to be a hero. Not everybody is going to be able to break world records and to do some extraordinary things. In fact, most won't. If that's how we support them to identify their success, what happens in the period after? (S12).

37 Help for Heroes (2019). Improving the medical discharge process. Available at: https://www.helpforheroes.org.uk/media/yenp2mov/2019_0053-medical-discharge-policy-paper-v3.pdf

38 Brunger et al. (2013) op. cit.; Christensen et al. (2017) op. cit.

7. Improving the experience for those leaving Service with a physical injury

The previous chapters have sought to provide an overview of the key issues and concerns that emerged from the baseline interviews. As highlighted earlier, as a qualitative project, our research does not claim to be representative of the Service leaver population who have physical injuries/impairments and we recognise that our analysis presents the lived experiences and perceptions of a small cohort of this wider population. Again, we also acknowledge the significant contribution of various statutory and charitable organisations in supporting people's transitions to civilian life. Nonetheless, the accounts still provide important reflections from participants on how their experience of leaving the Armed Forces with a physical injury/condition could have been improved, particularly in relation to ensuring people have adequate time, personalised support and financial security.

7.1 The importance of adequate time

Overwhelmingly, the issue of time was raised by participants. As described in Chapter 4, it was evident that a significant number of people had experienced a reduction in what was perceived to be the appropriate resettlement period. Some related this to requirements to continue fulfilling particular duties, while others related it to their experience of a perceived 'chaotic' discharge period. Having limited time affected people's ability to prepare for life post-Service, particularly as people were leaving because of injury and not necessarily through choice. In some of the more extreme examples, limited time to prepare appeared to have had some more devastating consequences in the transition to civilian life, as one participant highlighted:

> It came as a shock to me because I didn't have anything planned... They mentioned to me that if I didn't get well it's a possibility of being medically retired, but I wasn't informed at the time... Everything to me just came as a rush. When I found out I went to the Welfare Officer and made a complaint. My discharge was actually less than three months, and in those three months I was supposed to do everything... [the] transition to civilian life was very difficult. It was a tough one for me, mentally and physically; financially as well, it was draining. I ended up homeless (WIS 3).

However, even for those whose discharge process appeared to have occurred in a more structured manner, the issue of time was still raised. As such, it was suggested that an appropriate period of time was required to enable people to appropriately prepare for leaving the Armed Forces:

> From being discharged I think it should be at least 12 months, to support people and just try and identify if somebody is struggling early, to maybe signpost and get [Armed Forces charities] involved (WIS 5).

7.2 The need for increased and personalised support

Recently, the Armed Forces personnel in transition Integrated Personal Commissioning for Veterans (IPC4V) framework has been introduced[39]. This policy suggests the need for a personalised approach for those Armed Forces personnel who have complex and enduring physical, neurological and mental health conditions that are attributable to Service. It aims to provide more choice and control over how their care is planned and delivered. From the participants in our study, there was a strong message that increased support was required for those who were leaving Service with a physical injury/condition and that this support needed to be less generic in content and more personalised:

39 NHS and MoD (2019) Armed Forces personnel in transition: Integrated Personal Commissioning for Veterans (IPC4V). Available at: https://www.england.nhs.uk/wp-content/uploads/2019/03/armed-forces-in-transition-ipcv-framework.pdf

> It's great going to do this course, this course and that course, but there's no real individuality to it, you're just one of 30 people in a room (WIS 13).
>
> It should be based around an individual. It should be individually programmed, not just a generic 'Captain Bloggs needs this, so that means Corporal Harris needs it', because we're different people. We've got different needs, we've got different problems, different injuries (WIS 14).

Stakeholders were broadly in agreement and felt that, although the CTP provided a good generic service, it could do more:

> So when it comes down to the likes of the CTP, the CTP is a very good basic support system. It does a lot of the generic stuff, which is great. From my experience of it, however, if you want to move away from just 'I want to be Joe Bloggs, working at such-and-such company, I want to have a more personalised CV', things like that, that's where I think the CTP comes unstuck. They don't have the ability to really expand on anything other than just 'here's the CV template, go away, sort it out and then come back to me, and then we'll see what jobs might fit around it'. If a person is looking for something more specific, that's when they aren't necessarily as adaptive, if that makes sense, looking at an individual's needs (S14).

The issue of the rank structure was also raised in relation to the resettlement workshops. For example, one participant commented that although people attended in civilian dress and were going through the same process, the rank structure could still dominate the dynamic in workshops, with some perhaps feeling unable to contribute.

Related to the issue of support, it was also highlighted that more information was needed to help people navigate the significant number of organisations that are available to support the transition to civilian life. Identifying the first point of contact was sometimes confusing for people:

> You've got the Veterans' Gateway. You've got Combat Stress 24-hour helpline. You've got the RBL case helplines. Which one am I meant to go to? I don't know. The Veterans' Gateway was meant to come in to mean one point of contact, but I can still ring RBL and Combat Stress... It is so confusing how it works (WIS 18).

This was reiterated in the stakeholder consultations:

> ...it's a distorted sector in the sense that you've got large charities that haven't changed very much, and they continue to do what they're doing, and you've got a plethora of small charities that are filling gaps that they've recognised that the large charities aren't dealing with. For the veteran in the middle of this mêlée life can be very confusing, and it's a postcode lottery as well, it depends on where you happen to be (S12).

Although the provision of increased and personalised support appeared to be a key message in the interviews, the reciprocal side of this support was flagged up by some participants and stakeholders who reflected on the role of individual responsibility. It was suggested that some Service leavers needed to engage more with the opportunities and support that were available:

> Maybe if I'd have probably got my head down a little bit more and studied a bit more and done some more courses and used that time wisely then I would've probably had a backup plan, and I never did, so I think that's the main key, isn't it? Having a backup plan and making sure that you're ready (WIS 12).
>
> They do tend to think, 'well, I'm ex-Army or RAF or whatever, I'm getting out, everything is going to be okay'. It's not till further on down the line when they're a WIS veteran. That's where they seem to struggle, and they realise life isn't as easy as what they thought it was going to be (S13).

7.3 The need for financial security

As highlighted in Chapter 5, a number of participants were still awaiting the outcome of their financial settlement. While some indicated that they were able to manage financially for the time being, for others this had created financial difficulties. As a result, there were criticisms of the length of time taken to receive a decision on their financial settlement, with suggestions that financial matters should be prioritised and resolved within the resettlement period:

> I can't get my money until they finish the paperwork, and when are they going to finish the paperwork? I've no idea. I'm sitting in limbo, just hanging on for them to do what they need to do, and, in my opinion, they should have all this done by the time you leave. In August [20]18, when I had my Medical Board, they should start the process, and in June [20]19, when I left, it should be done in that time. That's a long enough" (WIS 14).

8. Concluding comments and next steps

As highlighted earlier, this project is being undertaken over a two-year period to enable us to track the experiences of Service leavers over time. The Service leaver participants will be drawn from two distinct cohorts: those who have already left the Armed Forces (i.e. having left within the last eight years); and those who are in the process of leaving. This report has presented the emerging key findings from our first wave of interviews, which primarily focused on the cohort who have already left Service. As stated previously, as a qualitative project, our research does not claim to be representative of the entire Service leaver population. Rather, we aim to reflect the diversity of physical injuries or conditions that can be acquired during Service. Although we have used a diverse group of organisations to support the recruitment of our sample, we recognise that there may be a higher proportion of people within the sample who have had more negative experiences. However, this does not diminish the importance of their experiences or the lessons that may be learnt from hearing their accounts. Furthermore, the inclusion of our stakeholder consultations has provided useful additional insights that reiterate some of the key concerns raised by our participants.

It should be noted again that participants spoke about their time in the Armed Forces with a significant sense of pride and many appreciated the support provided by both the MoD and the charitable sector. However, there were areas where they felt their experience could have been improved. The key points that emerged from our baseline interviews can be summarised as follows:

- Participants articulated the need for a clear and transparent discharge process, including better communication of decisions between all relevant people and supporting agencies. Participants requested that an appropriate timeframe be given for those who are discharged because of injury to enable the completion of appropriate resettlement courses and also to facilitate wider preparations for civilian life.
- Linking in with the above issue, participants requested greater clarity in relation to the post-Service support they could access to avoid confusion in navigating the multiple organisations that can provide support.
- Participants' accounts demonstrated a need to provide greater mental health support to those discharged with a physical injury/condition, including helping people to adjust to both the 'loss of identity' associated with leaving the Armed Forces and being perceived as no longer 'able-bodied'.
- Given the nature of challenges faced by Service leavers with a physical injury/condition, it was felt that support was needed on a longer-term basis to ensure that people haven't 'fallen through the cracks' or to support those who may not experience any immediate issues upon discharge but may encounter difficulties a few years down the line.

8.1 Next steps

As above, the analysis presented here is based on the first wave of interviews completed with our first cohort of Service leaver participants. As such, this represents the starting point rather than the end point of our project. A second wave of interviews will be undertaken with these participants in approximately 9–12 months, and, following approval from the MoDREC in March 2020, we will now begin recruitment of the second cohort (i.e. those currently in the process of leaving/being discharged). This second cohort will also take part in two waves of interviews. This longitudinal approach will provide a meaningful way to explore the experiences of our participants as they navigate their transitions over time. In addition, we will be continuing our consultations with policy and practice stakeholders. We encourage organisations and individuals to come forward to give their views. The final report, incorporating the two waves of interviews with both cohorts of Service leavers, will be published in autumn/winter 2021.

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