The cost of poor military-to-civilian transition among the UK Armed Forces community

Findings from 'Understanding the Transition from Military to Civilian Life'

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Preface and acknowledgements

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Abbreviations

APMS	Adult Psychiatric Morbidity Survey
AUDIT	Alcohol Use Disorders Identification Test
CMD	Common Mental Disorders
CTP	Career Transition Partnership
FiMT	Forces in Mind Trust
GDP	Gross Domestic Product
GHQ	General Health Questionnaire
KCMHR	King's Centre for Military Health Research
NAO	National Audit Office
NI	National Insurance
NHS	National Health Service
ONS	Office for National Statistics
OVA	Office for Veterans' Affairs
PTSD	Post-Traumatic Stress Disorder
RAF	Royal Air Force
RN	Royal Navy
RM	Royal Marines
TMS	Transition Mapping Study

Chapter 1.   **Introduction**

Approximately 15,000 people leave the Armed Forces each year, with most experiencing a positive transition to civilian life.[1] However, a minority of ex-Service personnel experience challenges during transition, including those due to the unique circumstances of military life.[2] Adverse transition outcomes can include unemployment, poor mental health, harmful drinking, homelessness and interactions with the justice system.[3] For some Service leavers, these challenges may be minor, such as a brief period of unemployment, with limited impact on their lives. For others, poor outcomes can significantly affect their well-being and that of their families. While the prevalence of specific adverse outcomes, such as unemployment, is comparable to the civilian population, others, such as harmful drinking, are notably higher among ex-Service personnel.[4]

Experiencing poor outcomes of military-to-civilian transition – such as unemployment, housing insecurity or mental health challenges – can have significant negative impacts not only on Service personnel and their families, but also by increasing costs to the government and the sector supporting the Armed Forces community. These costs can be direct, such as investment in support services, or indirect, such as when poor transition outcomes lead to a loss of income tax and National Insurance (NI) contributions.

This report details RAND Europe's analysis of the cost of poor transition from military to civilian life and the corresponding value of reducing the prevalence of poor transition outcomes, yielding savings for taxpayers and delivering broader social benefits.[5] The analysis builds on the Transition Costs Model, first developed in the 2013 edition of the Transition Mapping Study and refined in the 2017 edition.[6] Specifically, it focuses on the financial impact on government and the third sector resulting from adverse outcomes, such as unemployment or harmful drinking, experienced by individuals in the four years following their departure from the Armed Forces.[7] This research is part of the wider *Understanding the Transition from Military to Civilian Life* research, funded by the Forces in Mind Trust (FiMT). It examines the contemporary transition process and the experiences associated with it (see Box 1.1 for the complete study objectives).

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1   Ministry of Defence (2025a).

2   These unique circumstances can include, among other factors, geographic mobility, oversees relocation, unique occupational risks including the risk of injury and death, and accommodation on or in close proximity to military bases.

3   For example, see Brewer & Herron (2022).

4   See Table 3.1 for more information on the comparison between ex-Service personnel and civilians.

5   Costs to businesses (e.g. due to lost productivity or absenteeism) are excluded from the model and calculations.

6   The Futures Company (2013); Kantar Futures (2017).

7   The research team agreed on the four-year timeframe with FiMT to account for costs and adverse outcomes after statutory transition support ends.

Box 1.1. *Understanding the Transition from Military to Civilian Life*: objectives

Understanding the Transition from Military to Civilian Life seeks to understand:

- How the transition process currently works across the three Service branches (the British Army, Royal Air Force and Royal Navy).

- How the transition process is communicated to Service leavers and their families.

- How the transition process is viewed by stakeholders, recent Service leavers and their families.

- The progress made over the last ten years in the available transition support.

- The remaining challenges and the potential impact or cost of not addressing them.

- The value to the Armed Forces community and society of enabling a successful and sustainable transition for all ex-Service personnel and their families.

- The areas where support could be improved or resources invested and how this might be achieved.

- The current UK external environment and its impact on transition.

Although this study follows the methodology of previous Transition Mapping Studies, the model presented here is not directly comparable to earlier versions; many data sources used in prior studies are no longer available, and changes in government policy have necessitated adjustments to the model's cost inputs. For example, the introduction of prevention and relief duties for households at risk of homelessness has altered cost calculations. Additionally, the model has been adapted to estimate costs based on Service leavers' experiences of each outcome across the four years post-Service.[8] Consequently, although the estimated costs of poor outcomes are higher than in previous models, they aim to better reflect the true financial impact.

As with all models, this analysis is subject to assumptions and limitations. While many assumptions were implicit in earlier studies, this report explicitly outlines them to enhance transparency. Chapter 2 includes additional discussion of the model's limitations, and Chapter 3 outlines our assumptions for each outcome. However, two primary assumptions underlie the entire model:

- The prevalence of adverse outcomes among Service leavers (those who left the Armed Forces within the last four years) is equal to that of all veterans.

- The prevalence and costs of adverse outcomes are consistent across England, Wales, Scotland, Northern Ireland and sub-regions within them.[9]

The structure of this report is as follows:

- **Chapter 2** provides an overview of the model.

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8   While some policy and research restrict the definition of 'transition' to two years following a Service person's discharge, the research team have adopted a four-year timeframe in consultation with FiMT to reflect that many transition-related challenges are unlikely to occur straight after discharge and may instead take some time to materialise.

9   The data on the number of Service leavers includes those who are now resident in Northern Ireland and Scotland. However, the data available on most outcomes reported in this document are collected only in England, or England and Wales. The model assumes that cost and prevalence are similar in Scotland and Northern Ireland and that there are no substantial sub-regional variations in either.

- **Chapter 3** discusses the data on prevalence and cost estimates for each outcome used in the model.

- **Chapter 4** presents results on the estimated costs of poor transition.

- **Chapter 5** presents a sensitivity analysis to explore how results vary under different modelling assumptions.

- **Chapter 6** summarises and discusses the analysis's overarching conclusions.

Chapter 2. **Overview of the Cost of Transition Model**

The Cost of Transition Model estimates the financial impact on the government and the third sector of individuals experiencing poor transitions out of the Armed Forces. Although only a minority of Service leavers experience adverse outcomes, avoiding these could yield significant cost savings and substantial social benefits.

At its core, the model calculates the cost of poor transitions by estimating the number of Service leavers experiencing a range of poor transition outcomes (see Chapter 3) and multiplying that number by the cost associated with that outcome. Building on this principle, the model employs a Monte Carlo simulation, using probabilistic sampling from a PERT distribution to estimate costs for each outcome.[10] Prevalence rates for each outcome are derived from static data sources, such as surveys and censuses, which capture snapshots of the population at a given point in time. However, the data does not provide insights into when Service leavers experience these outcomes or how they evolve. Consequently, the model assumes that a consistent proportion of personnel experience each negative outcome across the first four years after leaving Service. This assumption accounts for variability: some individuals face unemployment immediately after leaving, for example, while others may encounter it later. This does not assume that the same Service leaver will necessarily experience the outcome for all four years. However, on average, the same proportion of Service leavers will experience the outcome for all four years.

Unlike earlier deterministic versions, this model incorporates uncertainty by sampling costs from a distribution rather than relying on fixed values. This approach acknowledges that costs vary depending on the duration, severity and individual circumstances of each Service leaver. For instance, one individual experiencing Post-Traumatic Stress Disorder (PTSD) during transition may have mild symptoms requiring no treatment, while another may experience severe symptoms necessitating hospitalisation and extensive support.

To estimate the total cost of transition, the model iterates through each calendar year (2025−2030), year since discharge (1−4), gender (male and female, as prevalence differs for some outcomes) and poor-transition outcome. The model calculates the cost for each group and outcome (as shown in Figure 2.1) and then aggregates them to produce the total cost for each outcome per year.

The model is a stochastic simulation that estimates the cost of each adverse outcome based on the expected number of Service leavers who will experience it and does not consider the causes or interrelationships among the outcomes. As such, the model does not consider how changes in one outcome could affect other outcomes (e.g. how changes in unemployment could affect mental health outcomes) or whether there are potential root causes that affect multiple outcomes (e.g. poor

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10   For more information on the PERT distribution, see RiskAMP (2025).

mental health impacting both unemployment and homelessness).[11]

The primary results we report here do not account for changes in prevalence or cost out to 2030, but assume that they will likely remain similar to current values. While this may be true for outcomes where there has been little change in prevalence or cost in recent years, there have been substantial increases in the cost of imprisonment and homelessness within the same period. The sensitivity analysis in Chapter 5 estimates the cost of these outcomes if the cost per person continues to increase as it has recently.

Chapter 3 details the evidence on the percentage of Service leavers who experience

each adverse outcome and the estimated cost per person who experiences the negative outcome. The estimated number of Service leavers each year is drawn from RAND Europe's modelling for the RAF Benevolent Fund, Greenwich Hospital and the Royal British Legion to estimate the size and demographics of the Armed Forces Community.[12] These projects used Bayesian hierarchical modelling and stocks-and-flow models to project forward the inflow numbers and outflow rates of the different cohorts within the Armed Forces Community out to 2040 and estimate the number of individuals in each cohort for each year out to 2040.[13]

Figure 2.1. Cost of poor transition model

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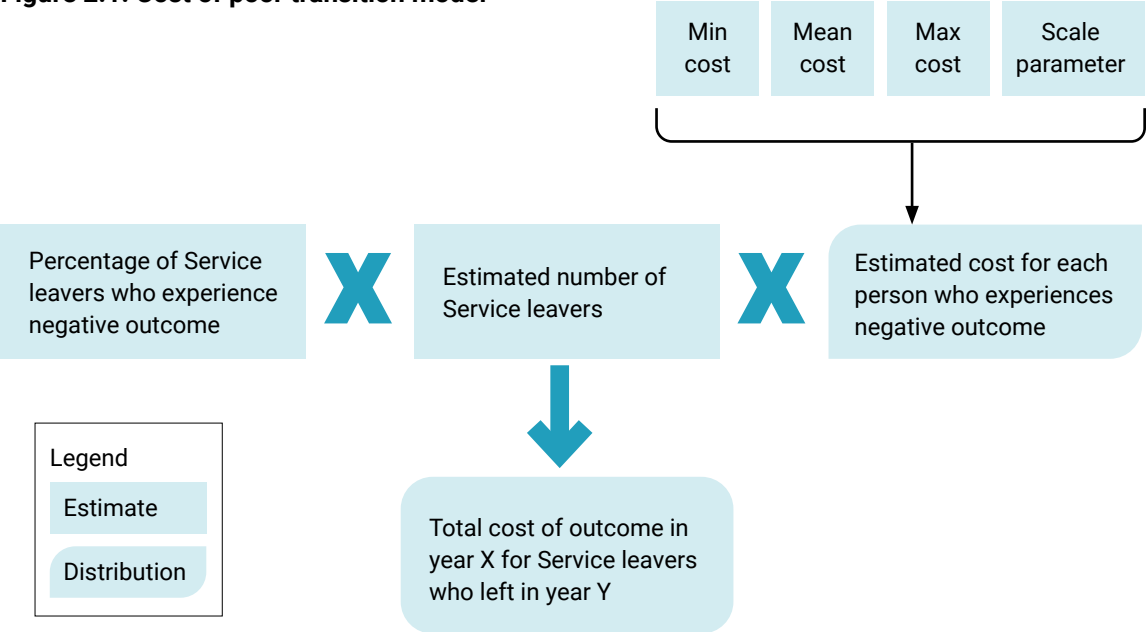
11   We did not include overlapping outcomes in the model as insufficient information was available on the prevalence and cost overlaps for all outcomes. However, the model could be adapted to include these overlaps if sufficient data is collected for future research.

12   Slapakova et al. (forthcoming); Slapakova et al. (forthcoming); Galley & Slapakova (forthcoming).

13   The cohorts in this research include Service (Army, Royal Air Force (RAF), Royal Navy (RN) & Royal Marines (RM)), Rank (Officers and Other Ranks Personnel), Gender (Male and Female), Service Category (Regulars, Volunteer Reserves, Veterans) and Age Group (18–29, 30–34, 35–39, 40–45, 46–50, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80–84, 85–89 and 90+).

Chapter 3. **Model inputs: The prevalence and cost of poor transition outcomes**

The Cost of Transition Model attempts to quantify the cost of a poor transition across six adverse outcomes. In addition to detailing the research informing the cost and prevalence data for each outcome included in the model and highlighting the underlying assumptions, this chapter also details the research on the inclusion and exclusion of particular outcomes in the model. Specifically, we excluded four outcomes from the previous Cost of Transition Models in this one due to overlap with other outcomes (see Box 3.1) and/or insufficient up-to-date prevalence data. We also investigated two outcomes for inclusion, but ultimately excluded them due to data limitations. Table 3.1 summarises the prevalence and cost data for each outcome, and the remainder of the chapter details the sources and methodology we used to calculate these estimates.

Box 3.1. Mitigation of double-counting costs in the model

There is a substantial overlap between the outcomes included in the model. For example, many individuals experiencing homelessness also experience unemployment, harmful drinking, drug dependency and mental illness. The model has tried to identify the prevalence and cost of each outcome separately (for example, the cost of unemployment due to mental illness is not included in the cost of mental illness, as costs related to unemployment are captured in the unemployment outcome). The research team has thus aimed to avoid 'double-counting' costs, which would superficially increase the cost of a poor transition but cannot account for instances in which costs differ across individuals with multiple poor outcomes, particularly where this affects the outcome's duration or access to treatment. As a result of concerns about double-counting, we excluded costs relating to PTSD and drug dependency from the model based on their substantial overlap with mental health and criminal offending, respectively.[14] This exclusion makes it impossible to estimate the total number of individuals with a poor transition outcome by simply adding the number who experience any given outcome, because their prevalences overlap substantially.

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14   Nevertheless, we included the estimated costs of these outcomes to illustrate the potential cost savings from improving them, despite their overlap with other outcomes in the model. For further discussion of the overlap between outcomes, see Sections 3.7 and 3.8, respectively.

Table 3.1. The prevalence and cost of negative outcomes

Outcome	Indicator used in the model	Prevalence	Prevalence data source	Average cost (per person)	Cost range (minimum-maximum)	Cost estimate data source
Unemployment	Unemployment rate	3.4%	Armed Forces: Career Transition Partnership (Ministry of Defence, 2025b). Civilian population: Office for National Statistics (2025c).	£22,985	£4,685–40,450	The model uses a methodology from the Institute for Fiscal Studies (Dilnot & Morris, 1981) and data on foregone tax revenue and benefits from the Office for National Statistics (2024c), Gov.uk (2025), Government Digital Service (2025b) and Government Digital Service (2025c).
Mental health	Prevalence of common mental health disorders	27.2% (Men), 35.5% (Women)	Armed Forces: Phase 4 of the King's Centre for Military Health Research cohort study (Sharp et al. 2024) Civilian population: 2014 Adult Psychiatric Mortality Study (McManus et al. 2016)	£2,172	£0–4,344	Estimated by the research team using data from the Centre for Mental Health's report, *The Economic and Social Costs of Mental Ill Health* (Cardoso & McHayle, 2024)
Harmful drinking	Prevalence of harmful drinking	8.7%	Armed Forces: Phase 4 of the King's Centre for Military Health Research cohort study (Sharp et al. 2024) Civilian population: 2014 Adult Psychiatric Mortality Study (McManus et al. 2016)	£12,957	£0–25,914	Estimated by the research team using data on the total cost of harmful drinking from *The Costs of Alcohol to Society* report by the Institute of Alcohol Studies (2024) and the number of people who drink harmfully published by the Office for National Statistics (Davies et al. 2023).
Criminal offending	Percentage of veterans who committed an offence post-Service	6.1%	McManus et al (2019) study linking questionnaire data from a random sample of UK military personnel with national criminal records.	£7,471	£668–143,325	Home Office report *The Economic and Social Costs of Crime* (Heeks et al. 2018), using updated data on the level of crime from the Office for National Statistics (2025a), Office for National Statistics (2024a) and Office for National Statistics (2023).

Outcome	Indicator used in the model	Prevalence	Prevalence data source	Average cost (per person)	Cost range (minimum-maximum)	Cost estimate data source
Imprisonment	Percentage of veterans in prison	0.17%	2021 England and Wales Census (Knipe & Hill 2023a).	£51,108	£45,130–84,855	HM Prison & Probation Service Annual Reports and Accounts 2022–2023 (HM Prison & Probation Service, 2024).
Homelessness	Percentage of veteran households receiving prevention or relief duty	0.16%	Armed Forces: data from the Ministry of Housing, Communities and Local Government (2024a) and the 2021 England and Wales Census (Knipe & Hill 2023a) Civilian population: Data from the Ministry of Housing, Communities and Local Government (2024a), Office for National Statistics (2024c) and Office for National Statistics (2024d)	£4,637	£1,995–22,987	Local Authority data on the cost to local authorities of providing temporary housing (Ministry of Housing, Communities and Local Government, 2024b)
PTSD[15]	Prevalence of PTSD	10.5%	Armed Forces: Phase 4 of the King's Centre for Military Health Research cohort study (Sharp et al. 2024) Civilian population: 2014 Adult Psychiatric Mortality Study (McManus et al. 2016).	£1,423	£0–20,820	Data from Mavranezouli et al. (2020).
Drug dependency[16]	Prevalence of drug dependency	0.8%	The 2007 and 2014 Adult Psychiatric Morbidity Surveys (Woodhead et al. 2011; McManus et al. 2016)	£27,000	£400–54,000	2020 Independent Review of Drugs (Black, 2020)

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15   Not included in the total estimate of the cost of poor transition due to concerns about double-counting.

16   This research focuses on the cost of the prevalence of Class A drug use, as these have the most significant harm and are less likely to be used recreationally without impacting the user's life significantly. We did not include the cost associated with this outcome in the total estimate of the cost of poor transition due to concerns about double-counting.

3.1. Unemployment

The model uses data from the Career Transition Partnership (CTP) to estimate the prevalence of unemployment among Service leavers. This data shows that 89.3% of Service leavers with known employment outcomes were employed six months after leaving Service, while 3.4% were unemployed and 7.3% were economically inactive.[17] However, this data covers only the 59% of Service leavers whose details were shared with the CTP provider, who utilised a billable CTP service and whose employment status is known. If these individuals differ significantly from other Service leavers, the employment outcomes may be inaccurately represented. Furthermore, the data captures only the first six months post-Service, whereas the model considers Service leavers for up to four years. This limitation means it does not account for those who initially secure employment but later face unemployment.

Additional evidence from broader veteran populations suggests the CTP estimates are an accurate indicator of unemployment among Service leavers over a longer period. The King's Centre for Military Health Research (KCMHR) cohort study (Phase 4) reported an unemployment rate of 4.7% among veterans in their sample data (2022–2023).[18] Meanwhile, the 2021 England and Wales

Census indicated that 79.1% of working-age veterans (aged 16–64) were employed or self-employed, 3.2% were unemployed and 17.7% were economically inactive. These results align with the CTP data from the same period (February 2021), which showed that 85% of recent Service leavers were employed, 5% were unemployed and 11% were economically inactive. This consistency suggests that the six-month timeline used by CTP is suitable for the model.

The model estimates the cost of unemployment to the government using methodology from the Institute for Fiscal Studies,[19] which the research team calculated as £22,986 per unemployed person per year. This figure accounts for lost income tax, NI contributions (both employee and employer) and the cost of benefits received. We used the median UK salary (£37,430 for full-time employees) to estimate each cost component. An individual earning this salary would pay £4,970.20 in income tax and £1,988.80 in NI, while their employer would contribute £3,909.54 in NI.[20]

Benefit costs include Jobseeker's Allowance (up to £90.50 per week, or £4,706 annually) and Universal Credit (£617.60 per month, or £7,411.20 annually for a household with two adults over 25, assuming savings below £16,000).[21] Together, these benefits total

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17   Economically inactive individuals are people who have not sought work in the last four weeks and/or are unable to start work within the next two weeks. This category includes individuals who are retired, in full-time education or looking after family. As a result, these individuals are not considered to have a poor transition outcome. However, some individuals may be economically inactive due to health conditions that prevent them from working. While this could indicate a poor transition, we have not included it in the model as it does not address poor transitions due to health-related issues or outcomes for those who have been medically discharged. By comparison, the UK unemployment rate in 2024 was 4.3%. Source: Ministry of Defence (2025b); Office for National Statistics (2025c).

18   This longitudinal study examines a large cohort of individuals who served during deployments to Afghanistan and Iraq. The Phase 4 data, collected between 2022 and 2023, includes responses from 4,101 individuals. Source: Sharp et al. (2024).

19   Dilnot & Morris (1981).

20   Office for National Statistics (2024c); Gov.uk (2025).

21   Government Digital Service (2025b); Government Digital Service (2025c).

£12,117.20 per unemployed person annually, excluding other potential benefits such as council tax reduction or housing assistance, which vary by individual circumstances.

To create a cost distribution, the model also estimates minimum and maximum costs. For an individual earning the 10th percentile salary (£22,763) and claiming no benefits, the cost to the government would be £4,685.91. Conversely, for an individual earning the 90th percentile salary (£72,150) and claiming both Jobseeker's Allowance and Universal Credit, the cost would rise to £40,560.10.

The prevalence and cost estimates rely on several assumptions in addition to those outlined in Chapter 1, as detailed in Box 3.1.

Box 3.1. Assumptions about unemployment data

- The distribution of lost salary among unemployed Service leavers mirrors the national salary distribution, ignoring geographic differences (e.g. veterans are under-represented in London) or demographic differences (veterans are likely to be older and male, so may have a different average salary than the wider population).

- The unemployment rate for Service leavers remains consistent over four years post-Service, as it does at six months (e.g. there is no reason to assume that the unemployment rate will be consistently lower or higher for Service leavers at different points of the four-year transition period).

- Employment rates for Service leavers using CTP services and reporting outcomes are similar to those who do not.

- This analysis does not include other costs that vary by individual circumstances.

- Indirect tax revenue losses due to reduced spending by unemployed individuals (e.g. on VAT goods, petrol, alcohol) are not included.

- Economically inactive individuals are not considered.

- Lost revenue or benefits for part-time or underemployed individuals are not included.

- Pension contribution losses are excluded.

- As the unemployment rate forecasts published by the Office for Budget Responsibility do not show substantial changes out to 2029, the research team assumes the unemployment rate of Service leavers remains unchanged out to 2030.[22]

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22   Office for Budget Responsibility (2025).

3.2. Mental health

The model incorporates data from Phase 4 of the KCMHR cohort study to estimate the prevalence of common mental disorders (CMD) among Service leavers. This study found that 27.9% of former Regulars reported experiencing a CMD, with notable differences by gender: 35.5% of female ex-Regulars reported a CMD compared with 27.2% of male ex-Regulars.[23],[24] KCMHR identified a statistically significant increase in CMD prevalence compared with their Phase 3 cohort, in which 21.5% of ex-Regular respondents reported a CMD. This rise may partly reflect the impact of the COVID-19 pandemic, which negatively affected the mental health of adults across Great Britain.[25]

The model uses cost estimates from the Centre for Mental Health's report, *The Economic and Social Costs of Mental Ill Health*. This report calculated the annual economic cost to the government of mental ill health at £17.718bn, which the research team estimates at £2,171 per person when adjusted for inflation. These figures account only for direct treatment costs.[26] When broader economic and social costs such as lost productivity and social care are included, the estimated annual cost rises to £34,890 per person. Representing an average across all individuals with mental illness, these costs can vary significantly depending on the severity of the disorder and individual circumstances, such as unemployment or homelessness.

Box 3.2. A note on treatment-seeking behaviour among veterans

Murphy and Busuttil's research on treatment-seeking veterans with mental health difficulties highlighted key differences between those who do and do not seek treatment.[27] Notably, PTSD was the most common mental health condition among treatment-seeking veterans, despite CMDs' higher prevalence in the wider veteran population. This result suggests that many veterans with a CMD may not seek treatment. Additionally, the study found that, on average, veterans waited 11 years after leaving Service to seek formal support for mental health difficulties. However, veterans who served in more recent conflicts sought help sooner after discharge. Consequently, the costs associated with CMD treatment may be lower than suggested by CMD prevalence rates as a substantial number of individuals with CMDs may not be seeking treatment.

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23   The KCMHR study identifies an individual as having a CMD if they score 4 or more (out of a maximum of 12) on the General Health Questionnaire (GHQ) 12. The GHQ-12 indicates the presence of one of the following mental disorders: current depression, dysthymia, agoraphobia, panic disorder, generalised anxiety disorder, somatisation disorder, neurasthenia (chronic fatigue) and hypochondriasis. Source: Goldberg et al. (1997).

24   Sharp et al. (2024). For comparison, the most recent Adult Psychiatric Mortality Study (2014) found that 19.1% of women and 12.2% of men had symptoms of CMD, and that 9.8% of women and 6.4% of men had symptoms of CMD severe enough to require treatment (McManus et al. 2016).

25   Vizard et al. (2020).

26   Costs relating to NHS community and hospital health services, GP expenditure, Local Authority social services and mental-health medication. This is calculated by dividing the total estimated of government expenditure for treatment of mental ill-health (£17,718,704,371) by the estimated number of individuals who experienced a common mental illness (8,607,981).

27   Murphy & Busuttil (2017).

Box 3.3. Assumptions about mental health data

- The prevalence of common mental disorders among Service leavers is assumed to be similar to that reported by ex-Regulars who served during the Afghanistan era. Although the prevalence of CMDs increased between Phases 3 and 4, we assume this is due to the greater number of ex-Serving personnel in the sample and that the rate of increase is unlikely to continue through to 2030.

- The distribution of mental illness within the Service-leaver population is assumed to mirror that of the broader English population, with similar percentages of unemployed or homeless individuals, and similar severities of mental illness.

- Individuals with mental illness are assumed to have comparable access to mental health services and treatment, including the assumption that Service leavers actively seek treatment, despite evidence indicating that many veterans delay seeking mental health treatment for over ten years.

- These costs do not account for lost revenue due to unemployment or housing costs for homeless individuals with mental illness.

- Costs are calculated across the entire population and may differ for the working-age population.

- The data does not show how these costs are likely to vary per person. However, we assume a minimum cost of £0 per person (for an individual receiving no treatment) and set the maximum at double the average cost (for an individual receiving a higher-than-average amount of medication, NHS and community services).

3.3. Harmful drinking

The model uses data from Phase 4 of the KCMHR cohort study to estimate the prevalence of harmful drinking among Service leavers. We found that 8.7% of ex-Service personnel exhibited alcohol misuse, with rates of 9.0% among male ex-Regulars and 5.0% among female ex-Regulars.[28] While comparisons with earlier phases of the cohort study suggest a possible decline in harmful drinking, this reduction is not statistically significant.

To estimate the economic cost of harmful drinking, the model uses figures from the Institute of Alcohol Studies and the National Audit Office (NAO)'s report, *The Costs of Alcohol to Society*,[29] which estimates the annual cost at £12,957 per person. This figure includes direct costs for NHS services, healthcare and social care. When broader costs, such as alcohol-related crime, lost working days and reduced productivity, are included, the annual cost rises to £48,581 per person.

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28   We do not specify the prevalence by gender in our model as the difference between genders was not statistically significant (Sharp et al. 2024). For comparison, the most recent Adult Psychiatric Mortality Study (2014) found that 3.1% of their sample had harmful/mildly dependent drinking or probably dependent drinking (AUDIT 16+; McManus et al. 2016).

29   Institute of Alcohol Studies (2024); Davies et al. (2023). The Institute of Alcohol Studies estimated the total cost of alcohol harm in England at £27.44bn annually, or £485 per person in the English population. This includes £4.91bn for NHS and healthcare, £14.58bn for crime and disorder, £5.06bn for wider economic impacts and £2.89bn for social services. Rather than assessing cost in relation to everyone in the English population (i.e. taxpayers), our model adjusts the cost of harmful drinking to the total cost divided by the estimated number of individuals with alcohol dependency. To estimate this, the model uses prevalence data from the NAO for England. In 2019, the government estimated that 602,000 people in England were dependent on alcohol, though an estimated 82% of these individuals were not receiving treatment. While these individuals do not contribute to treatment costs, they still impact the total cost of alcohol harm through NHS expenses like alcohol-related hospital admissions and costs to the wider economy, crime and social services.

Box 3.4. Assumptions around harmful drinking data

- The prevalence of harmful drinking among Service leavers is assumed to be similar to that of ex-Regulars who served during the Afghanistan era and is not expected to change significantly by 2030.

- The severity and consequences of harmful drinking among Service leavers are assumed to be similar to those in the broader English population, with similar rates of unemployment, injury and criminal offences.

- It is assumed that additional mental or physical health conditions do not significantly alter the prevalence or cost estimates of harmful drinking among Service leavers.

- These costs do not include business-related expenses and crime-related costs (which should be categorised under criminal offences).

- It is assumed that all individuals with harmful drinking have equal access to treatment services, regardless of geographic location or socioeconomic status, and that treatment effectiveness is consistent across the population.

- The prevalence and severity of harmful drinking have remained relatively unchanged since the 2019 NAO report.

- Although there is likely an overlap in the prevalence and costs of common mental health disorders and harmful drinking, this is assumed to be minimal for two reasons. Firstly, the KCMHR Phase 4 Cohort Study found that of the respondents who experienced CMD, PTSD or alcohol abuse, 25% were case-positive on two of these outcomes and 4% were case-positive on three. Given the substantial comorbidity between PTSD and CMD (89% of respondents with probable PTSD were also case positive for CMD), it is likely that the overlap between CMD and alcohol misuse is low (< 10%). Secondly, the costs of alcohol include alcohol-related hospital admissions costs, outpatient visits, alcohol-related accident and emergency visit costs, alcohol-related ambulance call-out costs, alcohol-related healthcare appointments costs, alcohol dependency drug costs, specialist treatment for alcohol costs and other alcohol-related healthcare costs. These costs are likely different from those associated with mental illness, which include NHS and community health services, general practitioner expenditure, local authority social services and mental health medication, though there may be some overlap.

- There is a substantial overlap between individuals who drink harmfully and other adverse outcomes, including mental illness[30] and homelessness.[31] We have not included the costs of these co-occurring outcomes in the cost of alcohol harm. However, the co-occurring factors could impact the costs of alcohol harm if they impact the severity, duration or cost of treatment for harmful drinking.

- Intangible costs, such as impacts on relationships or personal well-being, are not included.

- The data makes it challenging to estimate the minimum and maximum costs per person. We estimate the minimum cost as £0 (for an individual whose harmful drinking is not substantially affecting their life) and the maximum cost as double the average cost (£25,914) to represent individuals whose harmful drinking results in higher-than-average use of health and social services.

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30   Among the wider population, 71% of those starting treatment for drug or alcohol abuse between April 2022 and March 2023 had a mental health treatment need (Office for Health Improvement and Disparities 2023).

31   Among the wider population, 20% of those starting treatment for drug or alcohol abuse between April 2022 and March 2023 had no permanent home and 9% were at risk of homelessness within eight weeks (Office for Health Improvement and Disparities 2023b).

3.4. Criminal offending

McManus et al.'s 2019 study linking questionnaire data from a random sample of UK military personnel with national criminal records found that 6.1% (315 of 5,386) of ex-Service personnel in the sample committed an offence after leaving the military.[32] Among male respondents, 18.9% had committed an offence at some point, compared with 4.8% among female respondents, though these figures include offences committed before joining the military. Of those who offended post-Service, 26.2% had also committed offences prior to joining, and 49.3% had offended while still in Service.

The cost of criminal offending is estimated at £7,471 per crime, based on the Home Office report *The Economic and Social Costs of Crime.* This report estimated that serious victim-based crime in England and Wales cost £59bn in 2015/2016.[33] The calculation includes costs incurred in anticipation of crime (e.g. spending on burglar alarms and CCTV), costs as a consequence of crime (e.g. the value of damaged or stolen property, health and victim services, and lost productivity), and costs in response to crime (e.g. police and criminal-justice-system expenses).

To update these figures for 2024, we adjusted the unit costs for each crime type to 2023 currency using the Gross Domestic Product (GDP) deflator,[34] and used data from the Crime Survey for England and Wales and the Commercial Victimisation Survey for 2023/2024 to estimate the total number of crimes by type.[35] Multiplying the unit cost of each crime type by the total number of crimes yields an estimated total cost of crime of £44.7bn, based on 5.99 million crimes recorded. This results in an average cost of £7,471 per crime. The model's minimum and maximum costs were £668[36] and £143,325,[37] respectively.

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32   MacManus et al. (2019). By comparison, approximately 22% of the UK population have a nominal record on the Police National Computer, though this should not be used to imply that 22% of the UK population commit a crime each year (Ministry of Justice 2024).

33   Heeks et al. (2018).

34   The GDP deflator for 2018 to 2023 was 0.82396 (HM Treasury 2025).

35   Values from the Crime Survey for England and Wales and Commercial Victimisation Survey for 2015/2016 are slightly different from those reported in the Economic and Social Costs of Crime. Since this should not affect the cost per crime, we have not investigated this further. Due to a lack of available data, commercial criminal damage is not included (Office for National Statistics 2025a; Office for National Statistics 2024a; Office for National Statistics 2023).

36   This is the cost of the lowest cost crime (cyber-crime) in 2023 currency.

37   This is triple the cost of the crime, with the second-highest cost (rape) in 2023 currency. This allows for repeat offences in a year. However, we do not include the cost of homicide in the maximum cost as the cost is extremely high (£3.9m) and the incidence is extremely low (562 in 2023/2024). There is one report of homicide by an Armed Forces Veteran in recent years (Kyle Clifford), and using homicide as the maximum cost of criminal offending would skew the cost distribution significantly.

Box 3.5. Assumptions around criminal offending data

- The average cost of criminal offending reflects the cost of committing a single crime and does not account for individuals who may commit multiple crimes per year. It also does not consider the potentially higher costs of re-offending. However, the maximum cost allows for multiple criminal offences in one year, as this is three times the maximum cost of the most expensive crime (excluding homicide). The exclusion of pre-Service and in-Service crimes is assumed not to affect the cost estimates for post-Service offending.

- It is assumed that criminal offending by Service leavers is similar to that of the broader veteran sample in the study by MacManus et al., comparable to offending in the general population in England and Wales and is unlikely to change out to 2030. However, this likely underestimates the actual cost per person among the Service leaver/veteran population, as evidence suggests veterans are more prone to violent offences, which are costlier than non-violent offences.

- The estimate does not include 'victimless' crimes, such as drug use or crimes against the state. It does, however, include crimes committed by an individual experiencing drug dependency (e.g. theft).

- Indirect costs, such as impacts on community safety or social cohesion, are not included.

3.5. Imprisonment

The 2021 England and Wales Census revealed that 4.86% of individuals residing in prisons, detention centres and approved bail or probation premises were veterans.[38] This figure shows an overrepresentation of veterans in these facilities, with 0.17% of the veteran population residing there, compared to 0.14% of non-veterans. Similarly, a Ministry of Justice report noted that, as of 30 June 2022, 3.6% (1,627 out of 49,610) of the prison population were ex-Service personnel.[39] Assuming this percentage applies to the entire prison population, it

suggests approximately 2,946 veterans were imprisoned from 2022–2023. Given that the total veteran population in England and Wales was estimated at 1,853,112 by the 2021 Census, it suggests that approximately 0.15% of veterans were incarcerated.

The prison population has grown significantly over the past thirty years and is projected to continue rising. The Ministry of Justice forecasts an increase from 83,687 in February 2023 to 94,400 by March 2025, with projections ranging between 93,100 and 106,300 by March 2027.[40]

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38   Knipe & Hill (2023b).

39   Ministry of Justice (2022).

40   Ministry of Justice (2023).

According to the *HM Prison & Probation Service Annual Reports and Accounts 2022–2023*, the annual economic cost of imprisonment is £51,108 per prisoner.[41] This figure is based on overall resource expenditure, including direct and net costs at regional and national levels for the HM Prison and Probation Service. Given variations in costs in prison categories, the model sets the minimum annual cost of imprisonment at £45,130 and the maximum at £84,855.[42]

Box 3.6. Assumptions around imprisonment data

- Veterans and Service Leavers are assumed to be equally likely to be part of the prison population, with offence types similar to those committed by non-veterans, potentially affecting sentence lengths and costs.

- The percentage of veterans in the prison system is assumed not to have changed substantially since the data were collected in 2021 and 2022 and is expected to remain similar through 2030.

- The costs may underestimate the true cost of imprisonment, as they do not include the income loss of unemployed inmates.

- It is assumed that veterans have similar rates of rehabilitation and recidivism as non-veterans, potentially influencing future imprisonment rates and costs.

- Veterans are assumed to be evenly distributed across various correctional facilities, such as prisons, detention centres and probation premises.

- It is assumed that all veterans are accurately identified within the prison system, although this may not account for those who do not disclose their veteran status.

- We assume that the cost of imprisonment remains constant. However, as the cost per prisoner has increased substantially from £32,510 in 2015–2016 to £51,108 in 2022–2023, a 57% increase (approximately 7% year-on-year). The sensitivity analysis thus calculates and tests the change in total cost if imprisonment costs increase by 7% each year.

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41   HM Prison & Probation Service (2024).

42   The cost per prisoner at a male open prison is £45,130. The cost per prisoner at a female open prison is £84,855. We did not include the cost per prisoner in young offender institutions in the minimum or maximum, although it is included in the average cost per prisoner (HM Prison & Probation Service 2024).

3.6. Homelessness

Statistics on statutory homelessness in England for 2023/2024 show that of 324,990 households owed a homelessness prevention duty, 2,270 required support due to Armed Forces Service.[43] This figure indicates that 0.7% of these households were ex-Service households. However, this may not fully account for households with ex-Service personnel who did not report a specific support need. Additionally, 64,690 households were owed a main duty.[44] Assuming the proportion of veterans is consistent between those receiving prevention duty and main duty, approximately 453 veteran households received main duty. Accounting for communal establishments and households with more than one veteran, it is estimated that 2,723 veterans were owed a homelessness duty in England, representing 0.16% of the veteran population.[45]

Local Authority expenditure data for 2023/2024 shows £1.7bn in spending on homelessness services, including funding for temporary accommodation and costs associated with the Homelessness Reduction Act.[46] This figure suggests an average cost per household of £4,637.[47] However, costs vary significantly depending on the type of support provided: £405m was spent on bed and breakfasts, while £29m was spent on hostels. For the model, we estimated the minimum cost per household at £1,995,[48] and the maximum at £22,987.[49]

However, these figures only reflect costs to local authorities and exclude related expenses such as increased NHS costs – approximately four times higher for individuals facing homelessness[50] – or lost revenue. Homelessness costs have risen substantially in recent years. A 2024 NAO report highlighted that local authorities spent £2.44bn on homelessness services in 2022/2023, an increase of 113% since 2010/2011.[51] This rise was primarily driven by increased spending on temporary accommodation due to a shortage of social housing. Additional factors, such as the

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43   Some 54% of households owed a homelessness duty had a support need (Ministry of Housing, Communities and Local Government 2024a). By comparison, approximately 1.3% of the population of England received a homeless duty (324,990 households * average 2.4 people per household / 57,690,300 population of England - Office for National Statistics 2024b; Office for National Statistics 2024d).

44   Statutory homelessness support includes three types of support: prevention duty where the local authority must take reasonable steps to prevent an applicant becoming homeless, relief duty where the local authority must take reasonable steps to help the applicant secure suitable accommodation (typically lasts for 56 days) and main duty where the local authority must secure suitable accommodation for a homeless applicant (typically after the relief duty has expired).

45   2,723/1,737,775 * 100 (Knipe & Hill 2023a).

46   A £1.7bn net current expenditure and £3.06bn total expenditure (Ministry of Housing, Communities and Local Government 2024b).

47   Calculated as £1,806,780,000/(324,990 + 64,690).

48   For the minimum cost, we estimated the cost per person of support provided under the Homeless Reduction Act, which is the lowest per-person cost in the Local Authority data. Local Authority Net Expenditure on Homeless Reduction Act: Administration, Prevention, Relief & Support (£430,166,000)/Number of Households owed Prevention or Relief Duty (324,990).

49   For the maximum cost, we estimated the cost per person of support providing temporary bed-and-breakfast accommodation, including the associated administration costs. Local Authority Net Expenditure on bed-and-breakfast hotels, including shared annexes (£404,880,000)/Number of Households in temporary bed and breakfast accommodation (18,380) + Local Authority Net Expenditure on temporary accommodation administration = (£118,046,000) / Number of People in Temporary Accommodation (123,100).

50   Crisis UK (2025).

51   Davies (2024).

cost-of-living crisis, have further exacerbated homelessness costs. This financial strain has led some councils to issue Section 114 notices, indicating that their spending will exceed available resources within a financial year. Average costs will likely continue rising through to 2030.

An alternative way to understand the costs of homelessness is to consider the economic impact of social housing. For example, the Centre for Economics and Business Research estimated that each household moving into social housing generates £11,634 in annual socio-economic benefits.[52] These include improved labour market outcomes, increased tax receipts, reduced universal credit claims, savings to health services, lower homelessness service expenditure, reduced crime rates and fewer educational disruptions. While this reflects the benefits of reducing homelessness rather than its costs, it suggests that we may underestimate the financial impact of homelessness if we consider only local authority costs.

Box 3.7. Assumptions around homelessness data

- The statistics on households claiming a homelessness duty and requiring support due to military Service are assumed to fully capture the extent of homelessness within the veteran community. Specifically, the model assumes accurate reporting and identification of veterans within households owed a homelessness duty, which may not account for those who do not disclose their veteran status or are not identified as such. It does not include veterans who do not engage with formal support systems or those who do not report a support need.

- The rate of homelessness is similar between veterans and Service leavers.

- There is a likely overlap with issues such as alcohol/drug abuse, financial instability, unemployment, criminal activity and mental health challenges, which could change the cost and prevalence of homelessness. However, this is not considered in the model.

- Each veteran household facing homelessness contains only one veteran.

- The rate of homelessness is assumed to be constant across local authorities and regions, without accounting for regional variations in housing availability, affordability or the accessibility of support services. The costs associated with homelessness are assumed to be constant, but are likely higher in areas lacking available housing (including social housing) due to the need for expensive temporary accommodation.

- Indirect costs, such as impacts on community safety, social cohesion or long-term health, are not included.

- The prevalence and cost of homelessness are assumed to be constant out to 2030. However, given the known increases in the cost of homelessness, sensitivity analysis explores the impact of potential cost increases following historical patterns. The 113% increase in local authority expenditure on homelessness costs between 2010/2011 and 2022/2023 was approximately 10% per year. The sensitivity analysis thus tests how costs would change if they continued to increase by 10% per year.

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52   Centre for Economics and Business Research (2024).

Box 3.8. Consideration of housing benefit

The previous study included the cost of housing benefits. However, since 2017, housing benefits for working-age individuals have been replaced by universal credit, resulting in significant overlap between unemployment costs and housing support. Additionally, the introduction of the Homelessness Reduction Act in 2018 established prevention and relief duties for individuals at risk of homelessness. While these costs are captured in the homelessness expenditure discussed earlier, and do not fully replace housing benefit costs, there is likely some overlap between the two.

3.7. PTSD

We considered treating PTSD as a separate outcome from mental illness, per previous iterations of the TMS model.[53] However, there is a substantial overlap between PTSD and CMDs: 88.9% of individuals with probable PTSD also reported a CMD in the KCMHR cohort. There is also likely to be overlap in the treatment costs between the two outcomes: both include medication, appointments, and social services. As a result, the research team do not include PTSD in their total estimates of the cost of a poor transition to avoid likely double-counting: it is reasonable to assume that the costs for an individual undergoing treatment for both CMD and PTSD are not double that of an individual undergoing treatment for just a CMD or PTSD. Nevertheless, the research team does estimate the financial cost of PTSD as reducing the prevalence of PTSD or improving treatment could potentially have significant cost savings.

The model uses data from Phase 4 of the KCMHR cohort study for the prevalence of PTSD among Service leavers. This study found that 10.5% of former Regulars had probable PTSD, while 6.5% reported complex PTSD.[54]

KCMHR also observed an increase in reported probable PTSD compared to Phase 3 (2014–2016), where 7.5% of ex-Regulars reported probable PTSD.[55]

The economic cost of PTSD may differ from that of CMD due to different treatment requirements. Mavranezouli et al. calculated the weighted average cost of PTSD at £1,173 per person, based on the percentage of individuals using various treatments/services (from the 2014 Adult Psychiatric Morbidity Survey [APMS]) multiplied by the cost of each treatment/service.[56] This figure includes 52.1% of individuals in the APMS who did not receive any treatment. When focusing solely on treatment costs, the average cost (including those receiving no treatment) is £284 per person, largely due to the high proportion of individuals receiving only medication. However, the annual cost rises to £1,140 per person when considering recommended treatments such as Eye Movement Desensitisation and Reprocessing therapy and Trauma-Focused Cognitive Behavioural Therapy, as advised by the National Institute for Health and Care Excellence.

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53   The Futures Company (2013); Kantar Futures (2017).

54   Sharp et al. (2024). For comparison, the most recent Adult Psychiatric Mortality Study (2014) found that approximately 4.4% of the civilian population had PTSD at the time of the survey, of which 50.9% were receiving mental health treatment (McManus et al. 2016).

55   Stevelink et al. (2018).

56   Mavranezouli et al. (2020).

If all individuals with PTSD were to receive treatment, the average cost would increase to £2,029 per person.[57] Additionally, a 2021 article in the *British Medical Journal* estimated the cost of PTSD at £1,173 per person, with additional treatment costs of £1,710 for Improving Access to Psychological Therapies and £3,052 for specialist trauma therapy.[58] For this study, the model uses the average cost of PTSD from Mavranezouli et al., adjusted to £1,423 at 2024 prices. To incorporate cost distributions, the model assumes a minimum cost of £0 per person (for individuals receiving no treatment) and a maximum cost of £17,153 (£20,820 at 2024 prices).[59]

Box 3.9. Assumptions around PTSD data

- This analysis assumes that the prevalence of PTSD among Service leavers is similar to the prevalence observed among ex-Regulars in the KCMHR sample. Although the prevalence of PTSD increased between Phases 3 and 4, we assume that this is due to the increased number of ex-Serving personnel in the sample, and that the rate of increase is not likely to continue out to 2030.

- It is assumed that the severity of PTSD among Service leavers corresponds to levels reported in academic studies, and, therefore, that the cost of treatment and illness reflects the costs for Service leavers.

- It is assumed that all individuals with PTSD have equal access to treatment, regardless of geographic location or socioeconomic status, and that treatment efficacy is consistent across the population.

- Intangible costs, such as impacts on relationships or personal well-being, are not included.

- Additional costs stemming from PTSD, such as unemployment, homelessness, and addiction support, are not accounted for.

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57   With 50% receiving Eye Movement Desensitisation and Reprocessing therapy and 50% receiving Trauma-Focused Cognitive Behavioural Therapy, and all other support/treatment remaining constant.

58   Hogan et al. (2021).

59   This is calculated using the cost data from Mavranezouli et al and includes a 31-day inpatient stay (average length of stay for an individual with PTSD * average cost-per-bed day of £404), nine visits (the average with someone with PTSD) to a GP in the last year, a one-hour consultation with a psychiatrist, a one-hour visit with a psychological therapist, five nurse visits, twelve social worker visits, five homecare visits, five visits from a family social support worker, eight-weeks care at a community day-care centre and one course of treatment using Trauma-Focused Cognitive Behavioural Therapy and Selective Serotonin Reuptake Inhibitors. Given that this calculation uses Mavranezouli et al's average cost and duration for many services, it likely substantially underestimates the true maximum cost of treatment and health support required for an individual with PTSD.

3.8. Drug dependency

The previous TMS reports included drug dependency as an outcome of a poor transition. However, we excluded drug dependency from the total cost of a poor transition due to limited data on the prevalence of drug dependency among Service leavers and substantial overlap between drug dependency and criminal offending. Nevertheless, we included a stand-alone estimate of the cost of drug dependency in Chapter 4 to indicate the potential cost of reducing drug dependency among Service leavers.

There is limited data on drug dependency among Service leavers or veterans more broadly. Analysis of the 2007 APMS found that 5.2% of male veteran respondents were dependent on drugs, compared to 3.5% of male non-veteran respondents.[60] No female veteran respondents reported drug dependency, compared to 1% of matched female non-veterans.

Research by Combat Stress on users of the Veterans' Substance Misuse Service revealed that 81.6% of users had alcohol problems, while only 18.8% used drugs.[61] As this data is based on a treatment-seeking population, it is difficult to generalise to the broader veteran cohort. However, assuming a similar ratio of alcohol to drug misuse in the broader veteran population, it suggests that approximately 2%

of veterans may have drug-dependency issues. These findings indicate that drug dependency prevalence among veterans is comparable to that of the general population, though veterans may be slightly less likely to use drugs overall.

The majority of drug-dependent individuals are dependent on cannabis only (2.3% of APMS respondents), with just 0.8% dependent on other drugs.[62] Since this study focuses on the cost of harm from drug dependency, the model follows previous TMS iterations by concentrating exclusively on Class A drugs.[63] Given the limited data on veterans dependent on Class A drugs, we assume that 0.8% of Service leavers are dependent on these substances.

The model uses estimates from the 2020 *Independent Review of Drugs,* which estimated the direct cost per user of heroin and/or crack cocaine at £27,000 and the direct cost per user for other drugs at £400.[64]

The 2020 *Independent Review of Drugs* also calculated the total societal cost of drug use at £19.3bn. Table 3.2 shows the breakdown of the direct and total costs of drug dependency.[65] While indirect and intangible costs contribute to the societal burden, we excluded them from the model because they were not included in previous TMS studies, and comparable costs for other aspects of failed transitions are unavailable.

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60   Woodhead et al. (2011).

61   Ashwick & Murphy (2018).

62   McManus et al. (2016).

63   Class A drugs include cocaine, crack cocaine, ecstasy, heroin, LSD, magic mushrooms, methadone and methamphetamine (Government Digital Service 2025a).

64   Black (2020, p.15).

65   Black (2020).

Table 3.2. The direct and total costs of drug dependency

Cost component	Direct costs (£bn)	Total costs (including direct, indirect and intangible costs in £bn)
Drug-related crime	6.20	9.28
Drug-related death and homicides	0.29	6.27
Adult family and carers	0.04	1.04
Other costs	0.48	0.89
Enforcement	0.68	0.68
Children's social care	0.62	0.62
Community treatment and prevention	0.55	0.55
Total	**8.87**	**19.32**

Source: Black (2020).

The total includes £6.7bn in intangible costs, representing non-monetary valuations of pain, grief, suffering or loss of the length and/or quality of life.

It is worth noting that 86% of these costs are attributed to approximately 300,000 people in England (0.5% of the population) who use the most harmful drugs, such as opiates and/or crack cocaine.[66] Additionally, there are 976,000 users of powder cocaine, 2.5 million users of cannabis and 864,000 users of synthetic drugs. According to the NAO, around 3 million people in England and Wales report using illegal drugs annually, though many may not suffer from drug dependency.[67]

Finally, many individuals seeking treatment for heroin dependency are older users who began using heroin in the 1980s and 1990s. This suggests that heroin dependency among Service leavers may be significantly lower than in the general population, potentially reducing the overall cost of drug dependency for this group.

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66   Black (2020).

67   National Audit Office (2023).

Box 3.10. Assumptions around drug-dependency data

- The prevalence and patterns of drug dependency among Service leavers have remained stable over the period analysed and have not been significantly affected by changes in drug availability or societal attitudes. Though limited, the available data is assumed to accurately reflect the prevalence and characteristics of drug dependency among Service leavers and veterans.

- The profiles of those with drug dependency are assumed to be similar between Service leavers and the broader population, particularly concerning the proportion of individuals using illicit opiates and/or crack cocaine.

- This analysis focuses on Class-A drug use and does not include costs relating to recreational or non-problematic drug use.

- It is assumed that all individuals with drug dependency have equal access to treatment services, regardless of geographic location or socioeconomic status, and that treatment effectiveness is consistent across the population.

- The presence of additional mental or physical health conditions is assumed not to significantly alter the prevalence or cost estimates of drug dependency among Service leavers.

- The data makes it challenging to estimate the minimum and maximum costs per person. We estimate the minimum cost as £400 (the estimated cost per person for persons using other drugs (not opiates and/or crack cocaine)) and the maximum cost as double the average cost (£54,000) to represent individuals whose drug dependency is resulting in higher-than-average use of health and social services.

- There are substantial overlaps with other outcomes in this model, primarily criminal offending. As such, the cost of drug dependency is not included in the total estimated cost of transition to avoid potential double-counting.

- Intangible costs, such as the impact on relationships or personal well-being, are not included.
  - » Overlap with other sectors is not included, such as:
  - » £4,032,000,000 due to unemployment
  - » £335,000,000 due to long-term prescribing of dependency-prone medicines
  - » £105,000,000 due to mental health
  - » £31,000,000 due to homelessness.[68]

3.9. Excluded measures

3.9.1. Debt (financial insecurity)

The previous TMS included problem debt as an indicator of the financial dimension of transition, using data from a 2007 NAO review of resettlement provision. This review found that 13% of UK Service leavers reported experiencing problem debt, with an average debt of £10,219.[69] Debt issues were most prevalent among those compulsorily discharged (47%), lower ranks (28%) and young Service leavers (32%). However, the age of this data, challenges in defining problem debt and significant changes in the UK economic

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68   Black (2020).

69   National Audit Office (2007).

context make replicating this measure in the current study problematic.

No data on the prevalence of problem debt among Service leavers or veterans appears to have been collected since the NAO review. In 2023, RAND Europe reviewed existing research on financial stability among military populations, understood as a function of income and financial resources.[70] The evidence base was mixed, with no conclusive or up-to-date data on financial instability as an indicator of poor transition. Although the study collected primary data on financial stability from military families, the sample was non-representative, and the measures used did not indicate related help-seeking.

The Office for National Statistics (ONS) and Office for Veterans' Affairs (OVA) Veterans Survey collected data on income and finance-related issues among veterans. However, the survey did not address the prevalence of debt or problem debt. Regarding financial well-being, 11% of respondents strongly agreed and 18.7% agreed that they had experienced money worries in the last month.[71] However, using this data as an indicator of poor transition presents several challenges:

- Firstly, the survey was administered during the UK cost-of-living crisis, during which there was a recorded increase in money worries among the general population. Therefore, the cost-of-living crisis represents a periodic outlier and experiences of financial concerns recorded in this period are unlikely to indicate longer-term trends.

- Secondly, as the survey only asks about income and short-term perceived money worries, it does not indicate longer-term financial well-being or insecurity, which would cause Service leavers or veterans to access support services.

- Thirdly, as it was a survey of the veteran population, it is impossible to establish the prevalence of perceived money worries among recent Service leavers compared with veterans who transitioned a long time ago.

- Fourthly, the survey was not representative of the broader veteran population, as veterans with a disability were overrepresented. Given existing evidence that individuals with a disability are likely to have lower income, the prevalence of money worries among the sample may not be representative of concerns among the wider veteran population.

Given these limitations, RAND Europe and FiMT agreed to exclude this outcome from the model. However, the research team recommends additional research and funding to better understand the prevalence and causes of financial instability and problem debt among Service leavers and veterans.

Understanding the costs associated with problem debt and alternative financial indicators also presents challenges. The previous study included two cost measures: (1) the average cost of debt advice and (2) lost income tax and NI contributions due to debt issues.[72] These measures excluded the value of hardship grants provided by military charities to members of the Armed Forces community facing financial struggles. Hardship grants represent a key direct cost of debt and financial difficulties for the third sector,

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70   Slapakova et al. (2023).

71   Office for National Statistics & Office for Veterans Affairs (2025).

72   Patel (2025).

but their collective value remains unclear; this may warrant further exploration through data collation from relevant charities. It is also important to recognise that hardship grants may be linked to other aspects of poor transition, such as mental health challenges, problem gambling, relationship breakdowns or similar issues. This overlap could lead to double-counting of costs in the model, further complicating efforts to quantify the financial impact of poor transitions.

3.9.2. Family breakdown

The previous study included the cost of family breakdown in its model. However, due to the scarcity of data on the prevalence of family breakdown among Service leavers and the significant challenges in estimating its costs, RAND Europe and FiMT agreed to exclude family breakdown as an outcome in the current model to avoid compromising the model's results.

According to the 2021 Census for England and Wales, 15% of working-age veterans were divorced, with an additional 4% separated.[73] These figures indicate a higher rate of separation or divorce among veterans compared to the KCMHR Cohort Study, which reported that only 13.9% of ex-serving respondents were single or had ended a relationship.[74] Furthermore, the divorce rate among working-age veterans is nearly double that of working-age civilians (15% vs 8%).[75]

In contrast, data from the Armed Forces Continuous Attitude Survey show much lower rates of divorce and separation among Service personnel: only 2% of 2024 respondents reported divorce, and another 2% reported separation.[76]

These discrepancies raise several critical questions about relationship breakdown among Service leavers:

- **Accuracy of estimates:** Are the differences between Service personnel and working-age veterans accurate, or are they influenced by the data sources (e.g. census data vs sample data)?

- **Population differences:** Are there significant differences between Service leavers and working-age veterans that could affect estimates of relationship breakdown?

- **Timing:** If these results are accurate, when do relationships typically break down? Is the increase during the transition to civilian life, or does it occur later?

- **Vulnerability:** Are certain groups of Service leavers more susceptible to relationship breakdown?

Estimating the cost of family breakdown is equally challenging. Previous versions of the transition model used the *Cost of Family Failure Index* from the Relationship Foundation (2008

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73   Author's analysis of England and Wales Census data: 133,926 divorced working-age (16–64) Veterans, 33,711 separated working-age veterans and 870,612 working-age Veterans (Office for National Statistics 2025b). This data was created using the create a custom dataset option, with the variables 'England and Wales, Age (3 categories), Marital and civil partnership status (6 categories) and UK armed forces veteran indicator (5 categories)'.

74   Note: this data is not directly comparable to the census data due to differences in included questions and populations (Sharp et al. 2024).

75   Author's analysis of England and Wales Census data: 2,939,823 divorced working-age non-Veterans; 90,035 separated working-age non-Veterans; 36,632,418 working-age non-Veterans (Office for National Statistics 2025b). This data was created using the create a custom dataset option, with the variables 'England and Wales, Age (3 categories), Marital and civil partnership status (6 categories) and UK armed forces veteran indicator (5 categories)'.

76   Ministry of Defence (2024).

and 2016), which included a wide range of costs associated with relationship breakdown:

- Increased use of tax credits and benefits, as single parents generally have lower incomes and less wealth than dual-parent families.

- Costs related to emergency housing and support for domestic abuse victims.

- Decreased physical health among children of separated/divorced parents, domestic abuse victims and divorced/separated adults engaging in risky behaviour.

- Increased interactions with children's social care systems.

- Increased need for adult social care, as single parents may be less able to support ill or elderly relatives.

- Decreased mental health among families experiencing relationship breakdown.

- Increased interactions with the criminal justice and prison systems.

- Costs associated with court services, legal aid and child support administration.

- Increased educational needs and missed education for children experiencing parental relationship breakdown.[77]

While many of these costs are legitimate, some are peripheral (e.g. increased reliance on adult social care) or already addressed in other areas of the model (e.g. criminal justice). Additionally, simply adjusting the original costs for inflation is insufficient to update the current model, as significant changes have occurred in underlying costs, such as those related to the benefits system and child support administration.

Moreover, there is no evidence on how the prevalence of specific costs might differ between Service leaver and civilian families. For example, differences in the incidence of domestic abuse or interactions with children's social care systems may exist between these groups. However, no data is currently available to support such comparisons.

3.9.3. Harmful gambling

As part of this research, we considered including harmful gambling as an outcome of poor transition, given the growing interest in its prevalence among veterans. However, due to substantial uncertainty regarding the prevalence of problematic gambling and significant overlap between the costs of harmful gambling and other outcomes already included in the model, RAND Europe and FiMT agreed not to include harmful gambling as a separate outcome.

The *United Kingdom Armed Forces Veterans' Health and Gambling Study* found that veterans were ten times more likely than civilians to experience gambling harms and to gamble as a coping mechanism. In a survey of over 1,000 veterans and 1,000 age-and-gender-matched civilians, 43.1% of veterans had Problem Gambling Severity Index scores indicating problem gambling, compared with only 6.5% of non-veterans.[78] Problem gambling was more prevalent among veterans with shorter military careers and those who had left the military more recently, suggesting that gambling harm may be higher among Service leavers than the broader veteran population. The study also identified co-morbidities with poor mental health outcomes, alcohol use and nicotine dependence.

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77   Lynas et al. (2008); Relationships Foundation (2016).

78   Dymond et al. (2021).

Earlier research using data from the 2007 APMS also found a higher prevalence of problem gambling among veterans compared to non-veterans (1.4% vs 0.2%).[79] Although this study is older, its estimates of problem gambling prevalence among non-veterans align more closely with other sources, such as the *Health Survey for England 2016* (0.5%) and the *Health Survey for England 2018* (0.4%).[80] This consistency suggests that the Health and Gambling Study's estimate of problem gambling prevalence among veterans may be more accurate.

In addition to uncertainties around prevalence, the costs of gambling harm overlap significantly with the costs of other adverse transition outcomes. The primary research on gambling harm costs, *The Economic and Social Cost of Harms Associated with Gambling in England*, estimates these costs by calculating the excess number of individuals experiencing outcomes such as homelessness, depression, alcohol dependence, illicit drug use, unemployment and criminal activity due to harmful gambling.[81] However, given the co-morbidity between harmful gambling and other adverse outcomes, the methodology used in this study already accounts for individuals experiencing these outcomes, regardless of whether gambling is a contributing factor.[82] Including harmful gambling as a separate outcome would therefore risk double-counting costs.

3.9.4. Physical health

We also investigated including physical health as an outcome of poor transition. However, we identified potential challenges in understanding the prevalence of poor physical health and identifying appropriate costs. There are two potential sources of data on poor health among Service leavers. The first is data on medical discharges, which show that approximately 1.5% of Serving personnel are medically discharged each year, of which approximately one quarter are due to mental and behavioural disorders and one half to musculoskeletal disorders and injuries. These figures equate to approximately 12% of Service leavers. Another data source on the prevalence of poor health among veterans is the 2021 England and Wales census, which found that 5% of working-age veterans reported 'bad' health and 1% reported 'very bad' health (conversely, 13% reported 'fair' health, 38% reported 'good' health and 43% reported 'very good' health).[83] These results suggest that approximately 6% of Service leavers are in poor or very poor health, which is lower than estimates based on medical discharge data. However, not all veterans who were medically discharged would likely identify as having poor health, particularly if specific injuries or disorders impact their life less as a civilian or become less impactful as the time since they left the Armed Forces increases. Indeed, ONS analysis of the 2021 census data found that while there is a correlation between respondents reporting a chronic health condition and reporting poor

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79   Conolly et al. (2018); Dighton et al. (2018).

80   Conolly et al. (2018).

81   Office for Health Improvement and Disparities (2023a).

82   For example, our methodology for estimating the prevalence and cost of homelessness includes estimates of all Service leavers experiencing homelessness for any reason (including gambling-related reasons). Thus, if we include a cost relating to excess homelessness due to gambling in an estimate of the harm resulting from gambling, we would likely be double-counting individuals experiencing homelessness due to gambling.

83   Authors analysis of census data.

health, there is still variation: 88% of people who identified as being in 'very bad' health had a history of at least one chronic health condition, compared with 26% of those in 'very good' health.[84] However, neither of these data sources is particularly clear, making it challenging to understand the impact of poor health on Service leavers, the government and the third sector, particularly as there are likely to be non-medically discharged individuals who experience poor health after leaving Service.

Furthermore, limited evidence is available on the cost of poor health. While we initially intended to estimate the cost of poor health using the additional number of, and costs due to, extra GP and hospital visits by individuals in poor health (compared to those in good health), we were not able to identify suitable evidence on the average number of hospital visits between individuals in good health and poor health. We did, however, find evidence that having an illness lasting more than 12 months was significantly associated with a higher number of GP visits for physical health problems, with an odds ratio of 3.05.[85] We also investigated the cost of poor health by focusing only on musculoskeletal conditions, as these are the most prevalent among medically discharged personnel (and because the model already considers mental health as an outcome). However, the most recent research on the cost of musculoskeletal conditions in the UK was from 2012/2013, and costs have likely increased substantially over the last decade.[86]

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84   Pawelek et al. (2023).

85   Song et al. (2023).

86   The cost in 2012–2013 due to musculoskeletal conditions was £3.8bn (Department of Health and Social Care 2013).

Chapter 4.   Model results: The cost of poor transition

Our model estimates the total cost of poor transition in 2025 to be approximately £258m. However, this could range from £63m to £546m, depending on how individuals experience poor transition outcomes (e.g. symptom severity, whether they seek help and the type of treatment they receive).[87] As shown in Figure 4.1, we expect these costs to remain around £250m out to 2030, albeit with a slight decrease in total costs over the period, assuming no substantial changes in policies or unit costs.[88] There are two reasons for the variance in costs over time: small changes in personnel outflow numbers each year and the random sampling from the cost distributions for each outcome in each year.

Figure 4.1. The estimated cost of poor transitions: 2025–2030
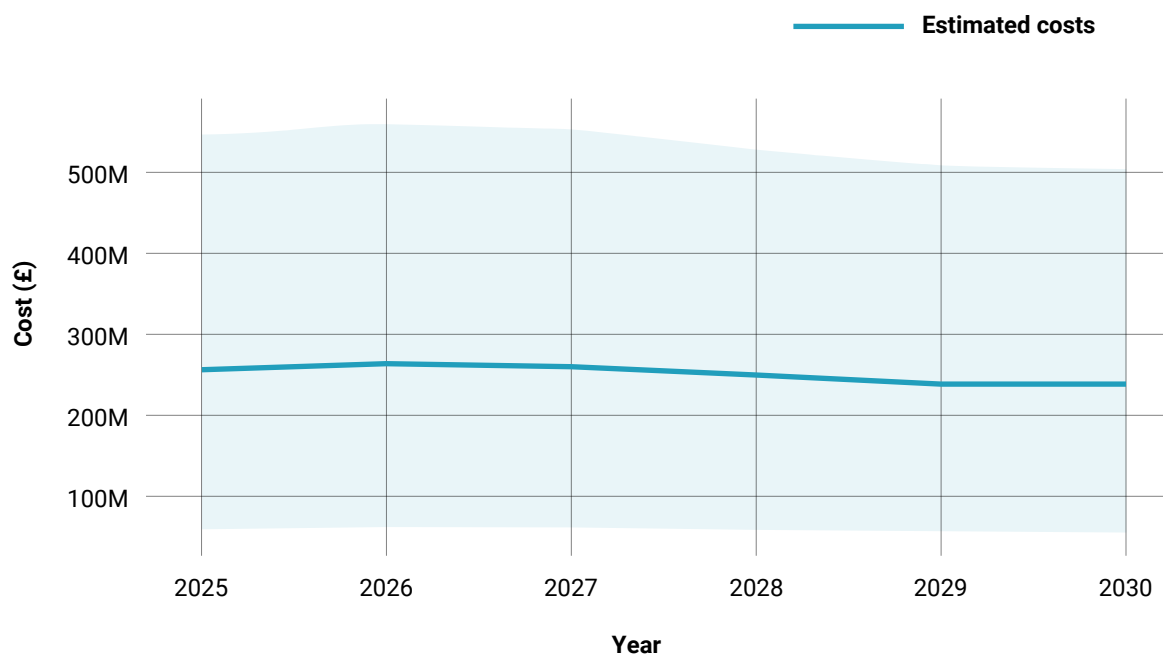
Note: The shaded area represents the 95% credible interval.

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87   This cost is the estimated total cost of adverse outcomes for all Service leavers who left between 2021 and 2024 (inclusive): approximately £3,500 per Service leaver (n=72,900, though it is important to note that most of this cost is incurred by a small proportion of Service leavers).

88   Following previous iterations of TMS, the research team has not discounted future costs (as per Green Book guidance for cost-benefit analysis). To use the results reported in this study for cost-benefit analysis, the estimates for future years should be discounted by 3.5%.

Figure 4.2. The estimated cost of each outcome in 2025
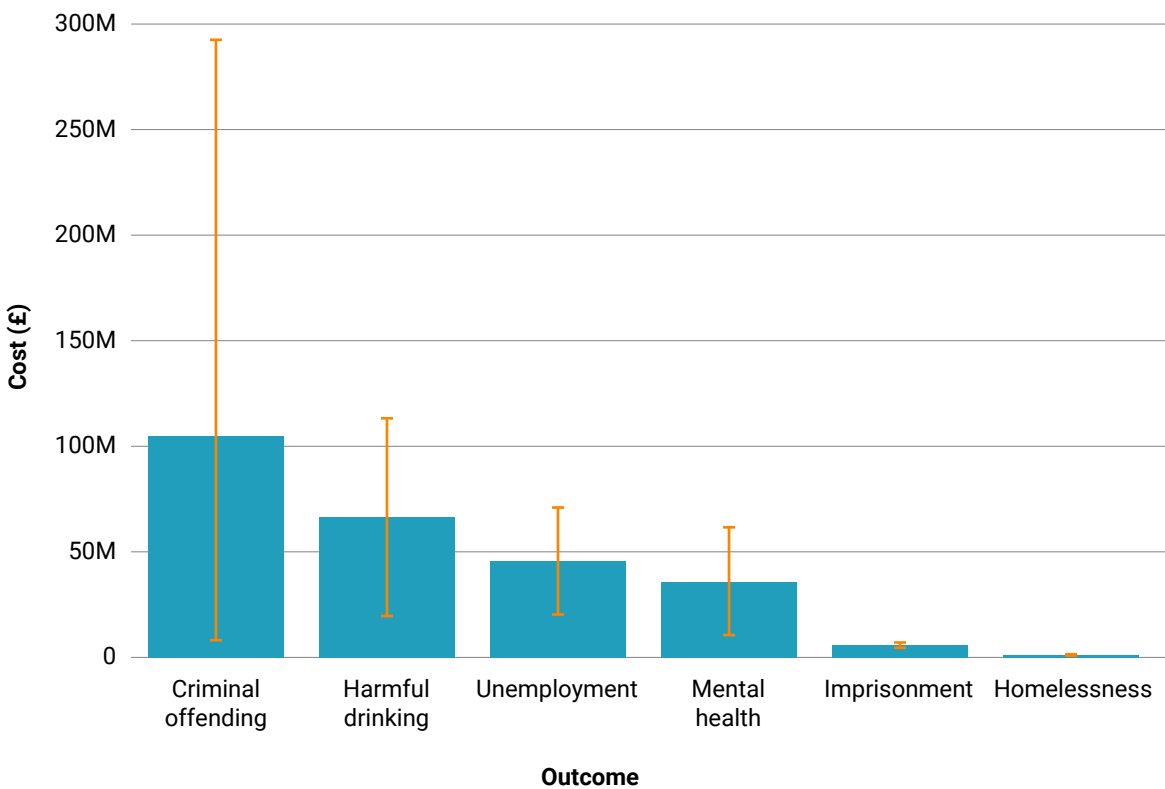
Note: The error bars represent the 95% credible interval.

As shown in Figure 4.2, criminal offending and harmful drinking are the most significant drivers of the overall cost of poor transition, representing 40% and 26% of the cost, respectively.[89] In contrast, the costs associated with homelessness and imprisonment are the lowest in the model.

Table 4.1 highlights the difference between the most prevalent and most expensive outcomes. While mental health challenges are by far the most prevalent outcome, with 16,510 Service leavers who left between 2021 and

2025 expected to experience a mental health condition in 2025, criminal offending has the highest estimated cost due to the high cost of criminal offending.

As discussed in Chapter 3, the research team also estimated the costs relating to PTSD and drug dependency, though these are not included in the total estimated cost of poor transitions due to concerns over double-counting, given their overlap with mental health and criminal offending, respectively. The estimated cost of poor transitions related to PTSD in 2025

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89   The costs relating to criminal offending and harmful drinking also have the greatest uncertainty, suggesting that these costs could be substantially different from those shown depending on Service leavers experiences of these outcomes (e.g. the types of offences they commit, the extent to which harmful drinking impacts their lives or the treatment they receive). While there is potentially some overlap between criminal offending (primarily people committing crimes because they are intoxicated), these costs draw on different sources, as detailed in Chapter 3.

was £27.277m, with 6,200 Service leavers affected.[90] Poor transitions involving drug dependency in the same year were estimated to cost £12.666m, with 470 Service leavers experiencing drug dependency.[91]

Table 4.1. The estimated cost and number of Service leavers experiencing each outcome in 2025

Outcome	Overall estimated cost to the government and the third sector (£m)	Estimated number of Service Leavers experiencing the outcome in 2025
Criminal offending	104.262	3,600
Harmful drinking	66.493	5,130
Unemployment	45.741	2,000
Mental health	35.855	16,510
Imprisonment	5.350	100
Homelessness	0.652	90

Note: It is not possible to estimate the total number of individuals who experience poor transition by adding the numbers of individuals who experience any outcome, because there are substantial overlaps in the prevalence of outcomes.

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90   95% credible interval: £2m to £75m.

91   95% credible interval: £4m to £22m.

Chapter 5.   **Sensitivity analysis**

While many of the assumptions and limitations in this report are due to limited data availability and are thus beyond our ability to test, we conducted a sensitivity analysis to understand how the results were affected when we tested three assumptions: the number of Service leavers, the choice of distribution for sampling cost and the assumption that costs are unlikely to change for imprisonment and homelessness.

5.1. Number of Service leavers

As Table 5.1 shows, the cost of poor transition depends on the number of Service leavers. If more people leave the Armed Forces and the proportion experiencing adverse outcomes remains constant, the total cost of poor transition increases. This finding highlights the need to update the estimates of poor transition costs as new data on the number of Service leavers becomes available.

Table 5.1. Sensitivity analysis: number of Service leavers

Year	Estimate type	Lower estimate of Service leavers	Mean estimate of Service leavers	Upper estimate of Service leavers
2025	Estimate cost (mean) (£m)	258.34	258.35	258.36
	95% credible interval (£m)	62.6–546.17	62.6–546.19	62.6–546.26
	Number of Service leavers	11,500	13,900	18,100
2026	Estimate cost (mean) (£m)	255.13	265.47	284.01
	95% credible interval (£m)	61.83–539.41	64.36–561.13	68.88–600.31
	Number of Service leavers	11,300	13,900	18,200
2027	Estimate cost (mean) (£m)	240.45	262.22	299.60
	95% credible interval (£m)	58.26–508.38	63.57–554.23	72.65–633.18
	Number of Service leavers	11,100	13,700	18,100

Year	Estimate type	Lower estimate of Service leavers	Mean estimate of Service leavers	Upper estimate of Service leavers
2028	Estimate cost (mean) (£m)	216.98	250.35	306.79
	95% credible interval (£m)	52.54–458.73	60.74–529.13	74.42–648.33
	Number of Service leavers	11,000	13,600	17,800
2029	Estimate cost (mean) (£m)	196.19	241.26	316.08
	95% credible interval (£m)	47.48–414.92	58.52–510.01	76.67–668.05
	Number of Service leavers	10,800	13,400	17,500
2030	Estimate cost (mean) (£m)	192.98	239.28	313.36
	95% credible interval (£m)	46.71–407.98	58.02–505.68	76.02–662.27
	Number of Service leavers	10,700	13,300	17,400

5.2. Choice of distribution

To understand the effect of modelling choices on the results, we reran the analysis using a normal distribution, a triangular distribution and a beta PERT distribution with different scale distributions. Table 5.2 shows the mean estimates and confidence intervals for each distribution. The triangular distribution yields the highest mean estimates and the widest intervals, while the normal distribution yields lower estimates with negative confidence intervals. When varying the scale parameter of the PERT distribution, lower scales yield higher estimates and wider confidence intervals, indicating that the choice of distribution substantially affects both the central estimates and the uncertainty. However, selecting a PERT distribution with scale=4 (the default) provides a balanced approach, suggesting it is suitable for the analysis. Policymakers should interpret all results with caution, as this analysis shows that results are sensitive to the distributional choices for the cost of each outcome.

Table 5.2. Sensitivity analysis: distribution and scale parameter choice

Year	Distribution	PERT distribution (scale = 4)	Triangular distribution	Normal distribution	PERT distribution (scale = 1)	PERT distribution (scale = 2)	PERT distribution (scale = 6)	PERT distribution (scale = 9)
2025	Mean estimate (£m)	258.35	336.13	180.6	336.14	297.28	238.92	222.99
	95% credible interval (£m)	62.62–546.2	65.4–700.64	-208.83–570.13	41.31–718.94	49.1–647.32	72.73–483.39	83.72–424.69
2026	Mean estimate (£m)	265.46	345.36	185.51	345.41	305.42	245.49	229.14
	95% credible interval (£m)	64.36–561.17	67.25–719.81	-214.67–585.62	42.52–738.7	50.47–664.94	74.79–496.6	86.07–436.39
2027	Mean estimate (£m)	262.21	341.13	183.27	341.13	301.61	242.45	226.34
	95% credible interval (£m)	63.61–554.23	66.43–710.95	-211.95–578.51	42.02–729.55	49.85–656.63	73.86–490.38	85.02–431.06
2028	Mean estimate (£m)	250.36	325.73	175.04	325.7	288.01	231.52	216.13
	95% credible interval (£m)	60.74–529.18	63.48–678.71	-202.15–552.35	40.12–696.49	47.62–627.02	70.55–468.28	81.2–411.57
2029	Mean estimate (£m)	241.25	313.81	168.63	313.84	277.54	223.1	208.25
	95% credible interval (£m)	58.51–510.01	61.13–653.88	-194.95–532.17	38.64–671.17	45.88–604.27	67.98–451.24	78.24–396.57
2030	Mean estimate (£m)	239.3	311.32	167.33	311.31	275.3	221.3	206.57
	95% credible interval (£m)	58.03–505.81	60.64–648.66	-193.24–528.02	38.3–665.69	45.5–599.3	67.41–447.66	77.59–393.42

5.3. Changing costs for imprisonment and homelessness

As Table 5.3 shows, aligning the costs of homelessness and imprisonment with historic increases slightly increases the expected cost of a poor transition. However, because of the low proportion of Service leavers expected to experience homelessness (0.16%) and imprisonment (0.17%), the increasing costs associated with these outcomes do not substantially change the expected costs of poor transition.

Table 5.3. Sensitivity analysis: increasing costs of imprisonment and homelessness

Year	Estimate type	Main estimate	Adjusted estimate with cost increases
2025	Mean estimate (£m)	258.35	258.35
	95% credible interval (£m)	62.62−546.2	62.6−546.14
2026	Mean estimate (£m)	265.46	265.48
	95% credible interval (£m)	64.36−561.17	64.37−561.17
2027	Mean estimate (£m)	262.21	262.32
	95% credible interval (£m)	63.61−554.23	63.67−554.46
2028	Mean estimate (£m)	250.36	250.67
	95% credible interval (£m)	60.74−529.18	60.97−529.63
2029	Mean estimate (£m)	241.25	241.89
	95% credible interval (£m)	58.51−510.01	59.01−510.78
2030	Mean estimate (£m)	239.3	240.4
	95% credible interval (£m)	58.03−505.81	58.87−507.29

Chapter 6. **Conclusion**

6.1. Mitigating the costs of poor transitions to the government and the third sector

This report highlights the significant costs associated with Service leavers experiencing adverse outcomes in the four years after leaving the Armed Forces. These costs are estimated to range from £63m to £546m in 2025, with a mean estimate of £258m. Although these costs are primarily driven by a minority of Service leavers facing poor transition outcomes, they underscore the potential financial savings achievable through targeted support or interventions to reduce the prevalence of such outcomes. Notably, over half of these costs stem from criminal offending and harmful drinking, which affect approximately 6% and 9% of Service leavers, respectively. These figures suggest that addressing these issues could yield substantial savings, though the outcomes are also the least certain. Recent years have seen substantial progress in developing and evaluating interventions within the Armed Forces community that could mitigate these adverse outcomes.[92] However, many interventions and programmes oriented at improving transition outcomes remain unevaluated. The sector, therefore, must continue to prioritise robust impact and

economic evaluations to understand which interventions could best help mitigate the costs of poor transition.

In addition to addressing high-cost outcomes, the research highlighted three areas where poor outcomes are more prevalent among veterans than civilians: mental health issues, PTSD and harmful drinking.[93] These disparities are unsurprising given veterans' increased combat exposure and the drinking culture within the Armed Forces. However, they represent areas where veterans may face significant disadvantages and where tailored interventions may be most needed. Encouragingly, there is substantial research on interventions within the Armed Forces community that could mitigate these adverse outcomes.[94]

It is important to note that, in estimating the costs of poor transition out to 2030, the model assumes that the transition context remains relatively constant. However, several anticipated trends and developments in Defence, as well as in the wider UK societal context, may increase costs and require attention and/or targeted intervention. For example, anticipated increases in Defence investment and strengthening of UK military readiness, as called for by the 2025 Strategic Defence Review, may increase the number of Armed Forces personnel and, eventually,

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92   See, for example, Centre for Evidence for the Armed Forces Community (2025a); Centre for Evidence for the Armed Forces Community (2025b); Centre for Evidence for the Armed Forces Community (2025c); Goodson et al. (2025); Battles et al. (2025); Bridges-Curry et al. (2025); Provan et al. (2024); Williams et al. (2025); Cardiff University (2022).

93   Harmful drinking is both a high-cost and high-prevalence outcome.

94   See, for example, Centre for Evidence for the Armed Forces Community (2025a); Centre for Evidence for the Armed Forces Community (2025b); Centre for Evidence for the Armed Forces Community (2025c); Goodson et al. (2025); Battles et al. (2025); Bridges-Curry et al. (2025); Provan et al. (2024); Williams et al. (2025); Cardiff University (2022).

Service leavers in the UK. As discussed in Section 5.1, this would correspondingly amplify the costs of poor transition to government and the third sector. Similarly, changing labour market trends may, in the future, feature greater or lower risks of Service leavers experiencing unemployment, with corresponding impacts on unemployment-related costs. Lastly, the costs of poor transition may decrease in the future as interventions to prevent and mitigate poor transition outcomes mature.

6.2. Improving understanding of the true costs of poor transition

We should recognise that the true costs of poor transition remain highly uncertain for several reasons. While the report focused on estimating costs incurred in the first four years after transition, the prevalence data primarily reflect outcomes among working-age veterans or the broader veteran cohort, with two key implications:

- First, the true cost of poor transitions is likely much higher, as adverse outcomes often persist for many years. For example, Murphy and Busuttil found that veterans seeking treatment for mental health conditions typically did so 11 years after leaving Service.[95]

- Second, it is challenging to distinguish between costs attributable to the experience of leaving the Armed Forces and costs incurred due to poor outcomes resulting from other dynamics (e.g. ageing), as there is limited evidence on when adverse outcomes occur. It remains unclear whether poor transitions manifest immediately after leaving Service

or emerge years later, highlighting a significant research gap.

Substantial gaps in data on the prevalence of poor outcomes among Service leavers and the broader veteran community also add to the uncertainty around the costs of poor transition:

- Data on **drug dependency** is outdated, with the most recent estimates from 2007. While existing evidence suggests similar levels of drug dependency between veterans and civilians, further research is needed to examine the prevalence and types of drug dependency, and whether Service experience influences these levels.

- Similarly, data on **debt and financial insecurity** are sparse, and the most reliable information dates back to 2007. Given changes in the UK's economic context, additional research should investigate financial insecurity and problematic debt among Service leavers, including potential causes such as poor financial literacy, inadequate transition preparation, or reduced household income due to partner employment challenges.

- The study also highlighted gaps in knowledge around **family breakdown** (particularly the timing of increased levels of family breakdown among working-age veterans implied by the England and Wales Census), harmful gambling and physical health.

The model currently treats adverse outcomes as independent. While this simplification was necessary given the available data, in practice, there are often complex relationships between outcomes. Experiencing one negative outcome may exacerbate or cause other adverse outcomes (e.g. poor mental health leading to unemployment), or adverse outcomes may

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95 Murphy & Busuttil (2017).

share common causes (e.g. physical health exacerbating unemployment and poor mental health). Future research should explore the relationships and causes of poor outcomes to improve understanding of how potential interventions could reduce their prevalence among Service leavers.

Future research could also consider extending estimates of poor transition costs to include costs to businesses, e.g. due to lost productivity and absenteeism, to illustrate the broader economic impacts of poor transition outcomes among Service leavers. It should also be recognised that the estimates presented here reflect only the costs of poor transition among Service leavers – the government and the third sector likely bear broader costs due to the challenges Service leavers' families may face as they transition from the military to civilian life. Future research could also adapt the model to consider the potential impact of interventions that reduce the prevalence of outcomes, or, with sufficient additional data, the time during which Service leavers experience adverse outcomes.

Beyond the quantified outcomes, it is also important to recognise that there are less tangible, yet unquantified, costs associated with poor transition. For example, while

evidence suggests similar employment rates between working-age veterans and civilians, around 40% of veterans may be experiencing underemployment as their jobs do not align with their skills, experience or expected level of seniority.[96] This indicates that employment rates alone may not reflect successful or fulfilling transitions, and there may be wider economic costs stemming from underemployment among the former-serving community.

Finally, while this report quantified the costs of poor transitions, it is important to reiterate that most Service leavers successfully transition to civilian life and face no challenges. Moreover, the costs associated with poor transition are not strictly attributable to military Service. Some challenges faced by veterans may stem from pre-Service experiences or personal circumstances, e.g. adverse childhood experiences often increase the risk of mental ill health among veterans.[97] It is therefore crucial to recognise that many veterans experience positive transitions and derive substantial value from their Service.[98] Future research should continue to explore the benefits of Service and the contributions veterans make to society, avoiding an overemphasis on the minority who face adverse outcomes.

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96   Fisher et al (2021); Flynn & Ball (2020).

97   See Sharp et al (2024), for example.

98   See, for example, the ongoing Centre for Evidence for the Armed Forces OUTCOMES study (Centre for Evidence for the Armed Forces Community 2025d).

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