

**REPORT**

Centre for  
Mental Health



# Across the wire

Veterans, mental health  
and vulnerability

**Matt Fossey**

## Foreword

by General the Lord Ramsbotham GCB CBE

The all-too-frequent sight of hearses containing Union Jack draped coffins, being driven slowly along the people-lined main street of the village of Wootton Bassett, serves as a poignant reminder of the sacrifice implicit in membership of our armed forces.

In theory we have been at peace since 1945, but only in 1968 has a serviceman or woman not been killed in action somewhere in the world during that period. The majority have been members of the regular forces, but their numbers also include members of the reserves, rightly categorised by the term 'twice a citizen'. Sadly, we also see and hear of young men and women who have suffered terrible disablement, following injuries from which their parents and grandparents would not have survived. These are the outward and visible reminders of the debt that the nation owes to those who literally put their lives on the line on its behalf.

However there are, equally sadly, a large number whose service results in medical conditions that are not so obvious. Throughout history the plight of veterans who find it difficult to return to normal life has been both visible and all-too-often ignored. Many young people broke away from chaotic and dysfunctional lifestyles to join the armed forces, which could be accused of providing an entirely false form of existence, in which servicemen are looked after from morning until night, but then discharged, unprepared for the daily demands of civilian life. They do not want to go back to chaos, where those around them, who have not shared their experience, do not understand the nuances of what they are going through. Drink, anxiety and depression lead too many into the hands of the criminal justice system.

Some face the additional problems of Post-Traumatic Stress Disorder (PTSD), again nothing new, but society has changed since the days following World War I, when the British Legion established clubs in which veterans, whose families and friends did not understand what they had been through, could share experiences with comrades in arms, in other words practising, unwittingly, what is now

called counselling or talking therapy. The nation owes a debt to them all, a debt that has been inadequately honoured for too long.

This is why I so welcome *Across the wire*, the result of some very detailed and dedicated research by the Centre for Mental Health. Its publication is, in fact, extremely timely because, as is mentioned in the text, David Cameron has announced that he, personally, is leading a drive on the nation's honouring of its part of what is called the military covenant, in other words the repayment of its debt to its veterans. Although many people have heard of PTSD, which is by no means only a military phenomenon, they have not heard, or have not thought about, the other mental health problems that need to be catered for. Those responsible for responding to the Prime Minister's call to arms include not only ministries such as the Ministry of Defence, the Department of Health and the Department of Work and Pensions, but local government, housing associations, employers and the voluntary sector.

It is all too easy to blame lack of resources for failure to provide what is needed to solve problems. But, in the case of veterans' affairs, ignorance, apathy and lack of co-ordination have been the principal enemies for too long. This is not to say that there are not many dedicated and concerned individuals and organisations, not least the military charities, who have tried to help individuals for whom they feel that they have a particular responsibility. However that system was backed up by a society that no longer exists, in which family and community ties were more of a constant. Therefore, if the nation's obligations are to be realised, there has to be national understanding and co-ordinated national action. *Across the wire* has a most important role to play in supplying both, which is why I put it in the 'required reading' category and commend it most warmly.



## Executive summary

The mental health of veterans of the armed forces and its link to offending has been a subject of considerable concern in recent years. This paper reviews the available evidence and suggests ways of tackling the issues that emerge.

Various social and psychological factors affect the lives of veterans. These may have been caused by events before people entered military service, during service or soon after discharge. They could be a result of previous family, education or social experiences or be a combination of all.

Some of these elements have been discussed at length in the media, and have stimulated widespread debate, most of which has focused on the risk of post-traumatic stress disorder (PTSD) among veterans of recent or current active service in Iraq and Afghanistan.

Most people who serve in Her Majesty's Forces do not suffer with mental health difficulties even after serving in highly challenging environments. The majority of those who return from high threat locations say that they have had a rounded and fulfilling experience (Greenberg, 2010). The armed forces aim to equip service personnel with training, respect, sense of purpose and belonging as well as life skills for successful transition back to civilian life. However, no system is able to eliminate all risk.

There is a vast, and growing, academic interest in the health and well-being of service personnel and veterans. Particularly notable is the work of the King's Centre for Military Health Research (KCMHR, 2010a; KCMHR, 2010b).

This paper explores what we know from published literature about the mental health of people who have served in the armed forces, about the links between mental health and alcohol use in service personnel, and about veterans in the criminal justice system.

There appears to be a specific group of people whose needs are not met fully either by the armed forces or by society on discharge. This group mainly consists of single young men, with difficulties in adjusting to change, poor social skills and limited basic education, dyslexia and dyscalculia, who leave the services early. Their early discharge is either due to

general unsuitability to forces life, or because of breaches of the military codes of discipline which result in punishment and discharge out of the forces. In some cases breaches of discipline may be a reaction to, not a result of, military life and a product of pre-existing personality. There needs to be further exploration and analysis of this particular group.

It is customary in the armed services, and makes good economic sense, to encourage long service and good behaviour through a system of rewards. Since the degree of support offered to reintegrate back into civilian society is proportionate to length of service, those who have only served for a short period of time are given the least support, yet many of these may need the most help. Robust processes should be implemented to identify the most vulnerable individuals and to ensure that support is provided for their transition to civilian life.

Post Traumatic Stress Disorder (PTSD) is a serious health problem that warrants good quality care for those who experience it and their families. But it is not the most common mental health problem experienced by veterans. Depression, anxiety and alcohol abuse are far more prevalent, especially among young men leaving the services early. Mental health services in the NHS should respond to the needs of veterans and their families.

Stigma and discrimination have a significant impact on all aspects of the lives of people with mental health problems, including serving personnel and veterans. The Ministry of Defence should continue to take measures to tackle the stigma and discrimination associated with mental illness, in line with current high-profile initiatives like Time to Change (2010).

Although alcohol has always played a significant role in military life, the harm caused by heavy and sustained consumption is now well known. Excessive alcohol use may mask existing mental health problems, lead to dependence and is associated with violence and criminal activity. The levels of alcohol consumption in the military are significantly higher than in similarly aged groups within the general public. This requires a cultural shift in the armed forces, with leadership at all levels to promote sensible drinking.

Veterans are reported to comprise approximately 3.5% of the total prison population. But much more work needs to

be undertaken to describe what this figure means in the context of those people's history, their service life, mental health needs and use of alcohol. Importantly, we have no way of comparing this figure to other occupations and how far they could be a risk factor for future criminal behaviour. However, recent data published by the MoD (DASA, 2010a) show that there are about 20% fewer veterans in prison compared with a similarly matched non-veteran population. The Howard League for Penal Reform has established a commission which will report in November 2011 on the needs of veterans in the criminal justice system. A full analysis of the available data is required to identify particularly vulnerable groups. We also need further research to understand the needs of veterans in the criminal justice system.

## Introduction: the 'military covenant'

It has long been established that Britain has a 'duty of care' to its armed forces. This began as an unspoken pact between society and the military, with origins in the Tudor period. The pact was formally codified as a 'covenant' in 2000 by the Ministry of Defence (MoD). It is not a law but is reinforced by custom and convention.

The concept of a military covenant has been reinforced through its use in political debates on military spending. In 2007, five former chiefs of the defence staff criticised the Government (HL Deb, 22 November 2007, c931; BBC, 2007a) following which it announced that veterans would get priority treatment on the National Health Service (NHS) (MoD, 2007).

The use of the term covenant has also found its way into legal proceedings. In a September 2008 claim by six Gurkha soldiers for the right to settle in Britain at the end of their service, in his judgment, Mr Justice Blake recited the military covenant before observing that granting them residence in Britain "*would, in my judgment, be a vindication and an enhancement of this covenant*" (Limbu & Ors, R (on the application of) v Secretary of State for the Home Department & Ors, 2008).

The covenant remains a statement of principle but is not a legally binding duty of care for ex-service personnel.

## Previous government policy

When individuals are discharged from the armed forces (i.e. become veterans) the responsibility for the delivery of health care, including mental health care, no longer lies with the MoD, but with the NHS.

*"Soldiers will be called upon to make personal sacrifices – including the ultimate sacrifice – in the service of the Nation ... In return, British soldiers must always be able to expect fair treatment, to be valued and respected as individuals, and that they (and their families) will be sustained and rewarded by commensurate terms and conditions of service."*  
(Army, 2010a)

Priority treatment for War Disabled Pensioners (WDP) was reviewed by the War Pensions Agency with the NHS in 1997. This culminated in the publication of government guidance to the NHS (HSG(97)31) (DH, 1997), which advised the NHS that priority should be provided to people who receive a war pension for examination or treatment that relates to the condition for which they are receiving the pension, unless there is another case that requires clinical priority. A further NHS bulletin was issued in December 2007 ensuring that relevant health officials were informed of priority treatment for this group (DH, 2007).

In 2006, the Government launched a revised strategy for veterans with three key objectives:

- excellent preparation for a transition to civilian life following service;
- support from the Government and voluntary sector for veterans where needed;
- recognition of the contribution to society by veterans (MoD, 2006).

In 2008, a Ministry of Defence Service Personnel Command Paper (SPCP) further set out the Government's commitments to ensure better support for the armed forces, their families and veterans (MoD, 2008).

## Coalition government policy

The mental health of serving personnel and veterans is becoming even more of a topic of political interest and action. The Coalition Government commissioned Dr Andrew Murrison MP to examine the relationship between the MoD and the NHS. Dr Murrison has

made four key recommendations in his report. These include: the examination of the MoD's current systems of assessment and evaluation for mental health problems; an increase in the numbers of mental health professionals providing outreach work for veterans; the introduction of a Veteran's Information Service (VIS) deployed 12 months after a person leaves the service and the trial of an online early intervention service for serving personnel and veterans. Dr Murrison suggests that funding for these initiatives should be sourced from commitments already made by the previous administration and through the imminent strategic defence review (Murrison, 2010).

Strengthening the military covenant is at the centre of what the new Government wants to achieve for service and ex-service personnel:

*"I want to make sure, as Prime Minister, that all the things that your families and you can quibble about back at home – whether you're getting good schools, whether you're getting proper healthcare, the state of the housing and the flats that some of you have to live in – that we take action on all of these things; and we re-write, and re-publish, that military covenant"*  
(Number 10, 2010).

The Coalition Government has stated that the military covenant is one of its highest priorities and will form the foundation of how the Government treats the armed forces community. The Government is currently considering how best to fulfil the military covenant in terms of resource allocation, policies and legislation, and has indicated that this work will be taken forward through a Strategic Defence and Security Review (SDSR), the drafting of a tri-service covenant and the delivery of any commitments that the Coalition has made (MoD, 2010). These commitments include ensuring that service personnel's rest and recuperation leave is maximised; providing extra support for veterans' mental health needs; and ensuring that injured personnel are treated in dedicated military wards.

## Historical background

Mental health problems associated with armed service have caused concern since before the Napoleonic Wars. Initially understood

as melancholy or nostalgia, the causes were attributed to a broad range of factors such as ill-fitting clothing, pressure waves from cannon firing or changes in altitude. With the introduction of mechanised travel, 'railway spine' was also considered an appropriate label for soldiers suffering from psychological distress (Jones and Wessely 2005).

A range of war neuroses commonly called 'shell shock' and 'gas hysteria' came into prominence during World War I (WWI), where a concerted effort was made to provide the most suitable psychiatric interventions (known as 'forward psychiatry'), ensuring that the trenches were replenished as expediently as possible. Whether the symptoms were related to combat experience was still called into doubt and sufferers were often seen as malingerers. In 1916 the *British Medical Journal* reported that the high level of 'insanity' experienced by British forces was a result of alcoholism or syphilis, an opinion popular with the higher chain of command, but denounced by medical staff engaged in the treatment of the men (Elliot Smith and Pear, 1918).

Political concern about the number of veterans with mental health needs is not new. Shell-shock is first mentioned in House of Commons debates during WWI (HC Deb, 13 July 1916, vol 84 cc533-4) although its recognition as an illness was held in question.

It is estimated that by the end of the Great War there were in excess of 200,000 cases of shell shock among British troops and some 613,047 'disorders of the nerves' among German troops (Holden, 1998).

There was a hiatus in the development of military psychiatry during the inter-war period, but the mental health needs of troops were confronted again during World War II (WWII), when innovation on and off the battlefield helped to shape military psychiatry. While the lack of a body of credible evidence continued to hamper academic developments in this field, psychiatric diagnoses were by far the largest reason for medical discharge among military personnel with over 30% in 1943 and over 40% in 1944. About half of psychiatric discharges comprised of 'anxiety neuroses', the incidence of which rose steadily throughout the duration of the conflict. The second largest cause of discharge was peptic ulcer (13% in 1943) (Ahrenfeldt, 1958), a condition also associated with chronic stress.

Perceived pre-existing weak constitutions and a lack of emotional resilience were also thought to be responsible for trauma vulnerability. During WWII, the unfortunate acronym 'LMF' (lack of moral fibre) was stamped on the medical cards of aircrew who, through reasons of extreme stress or trauma, were unable to perform their duties – a millstone for many in future civilian lives (Jones, 2006). The acronym LMF was only removed from usage in 1960 by RAF Psychiatry.

The period following the Vietnam War saw a growing interest in the psychological impact of extreme stress on US veterans and the local population who were subjected to the horrors of that conflict. The recognition of the fact that people with robust personalities could develop psychological problems as a response to exposure to trauma was important in prompting the development of a diagnostic category for PTSD in the *Diagnostic and Statistical Manual III* (DSM) (APA, 1980). It was therefore recognised that severe trauma such as rape, sexual abuse, exposure to conflict situations or prolonged aggression, could lead to a defined set of psychological symptoms.

Subsequent editions of the DSM have seen the criteria for PTSD modified to include traumatic situations that are not 'outside the field of usual human experiences'; recognising that even normal life events can create PTSD (Mol *et al.*, 2005). The individual's subjective response to the traumatic event and the perceived impact on physical integrity are now seen as important factors. However, the person must experience extreme fear, helplessness or horror during the traumatic event and it must be of an 'exceptionally threatening or catastrophic nature' (NICE, 2005).

Health problems experienced by serving troops and veterans were again brought to public attention following the Gulf conflict of 1990/1991, with the emergence of 'Gulf War Syndrome' (a collection of longstanding and often debilitating physical and psychological symptoms with a significant impact on the sufferers' ability to function). The *Medical Assessment Programme* (MAP) was established in July 1993 to examine UK Gulf veterans who were concerned that their health had been adversely affected by service in this conflict. Coker's (1996) evaluation of 1,000 volunteers who attended the MAP showed that they reported multiple common medical symptoms,

including affective problems (50%), fatigue (42%), joint and muscle aches (40%), cognitive problems (26%), headaches (26%), respiratory complaints (24%), gastrointestinal problems (22%), sleep disturbances (21%), and skin problems (19%). Participants often had multiple symptoms, and most had more than one diagnosis.

## Who joins the armed forces?

Understanding the background of recruits is an important factor when considering how military life may affect later life compared with similar groups of young people who did not join the armed forces.

Information made available by the MoD on recruitment for the armed services relates to the standard demographics of age, gender and ethnicity (DASA, 2010b). No official statistics are provided about the geographical areas from which recruits are taken, although many regiments have historical regional areas of recruitment.

There is a link between areas of high social deprivation and offending behaviour. A study undertaken in Scotland concluded that a significant proportion of offending behaviour, in some areas of high social exclusion, is seen as normal role behaviour, normatively governed and approved within its social context (Houchin, 2005). Whether recruitment into the armed forces has an impact on anticipated criminal behaviour needs to be further researched.

Three key factors are thought to distinguish armed forces recruitment. First, traditional forces recruiting grounds are historically areas of economic and social deprivation, where the armed services offer potential to young people that can often not be achieved locally (*Independent on Sunday*, 2006; *New Statesman*, 2007). Second, when the national economic situation is strong the forces have fewer recruits which limit choice during selection. Conversely, during an economic slump, there are more recruits and more choice, while fewer people are opting to leave the forces. And third, the educational threshold for recruitment into the army is very low. Gee (2007) reports that the standard for numeracy and literacy are the same as those expected of a seven-year-old.

It is important to understand the backgrounds of military recruits. Some of the more negative media stories about mental health problems, imprisonment, alcohol abuse and homelessness among veterans do not take this broader picture into consideration. And it is undoubtedly the case that joining the armed forces is a positive experience for many young people who would otherwise have followed a very different path altogether.

### Who is a veteran?

In some countries (e.g. USA), the title of veteran can only be used by individuals who have completed basic training, served in a theatre of conflict and not been discharged dishonourably. This is different to the UK – with its standing and not conscripted military force – where the Government defines a veteran (Dandeker *et al.*, 2006) as anyone who has drawn a day's pay from the armed forces. A veteran is not defined by the length or nature of service. Nor are they stripped of this status if they are discharged from the forces for a serious or criminal breach of the Army Act 1955.

This broad definition has been adopted by many of the service charities, which offer assistance to anyone who has served in the forces irrespective of the length of service. The Soldiers, Sailors, Airmen and Families Association (SSAFA) has adopted the slogan 'One Day's Service, a Lifetime of Support'. Similarly, the Royal British Legion also offers services to veterans irrespective of their length of service providing they have served at least one week. Thus, anyone who has served in the armed forces is by definition a veteran.

There has been a recent move to use other terms such as 'ex-service personnel', hoping that this will change public perception, so that veteran is seen to include all those who have served in the armed forces including those who have been recently discharged.

### Transition back to civilian life

DASA (2010b) reports that the trained strength of the UK armed forces was 178,380 at 1 July 2010; an increase of 4,520 (2.6%) since 1 July 2010. The outflow of personnel from the UK

regular armed forces was 18,340 in the 12 months to 30 June 2010. This is a decrease of 1,990 (9.8%) when compared with the year to 30 June 2009. The strength of the UK armed forces has decreased substantially since the 1950s, when the size of the regular defence force was over 489,000, more than 2.5 times bigger than the current capacity (MoD, 1952).

People leave the armed services for a whole variety of reasons. The majority of personnel come to the end of their contract of service and opt to move to civilian life. This is usually a successful transition, with the experiences and skills developed during service being valuable assets. Others leave for medical or for administrative reasons. Service personnel may be administratively discharged as a result of a range of factors, including civil conviction, physical fitness, financial mismanagement, persistent poor conduct and failing a random drug test.

Approximately 10% of the service population opt to leave each year. Of this group, about 10% (approximately 2,000) are discharged for medical reasons, among whom a further 10% (i.e. about 200) are identified as having a psychiatric problem. These figures show that psychiatric problems account for just one per cent of people leaving the armed forces annually. The numbers of personnel who are dismissed for severe breaches of discipline is also very low. In 2006-07 (the last year when figures were available centrally) this figure was less than 70, approximately 0.4% of the total number leaving the armed forces that year (DASA, 2008).

### Transition support for service leavers

How people are discharged from the armed forces and the level and degree of support they receive can have a big impact on how they cope in the transition back to civilian life (MoD, 2006). The rules and levels of support offered to service leavers is complex, but as a rule those who have served longest receive a more comprehensive and personalised package of support. A brief exploration of the different types of service leaver helps to identify the most vulnerable groups in terms of transition.

People subject to medical discharge (even while under training) receive a comprehensive range of special services to assist with the transition

back to civilian life. Those discharged for psychiatric reasons are provided with follow up by the defence mental health social work service for up to a year to ensure they receive the appropriate level of care from the NHS.

For all personnel serving more than 16 years, the fullest level of support is available, including assistance with employment support, training, graduated resettlement time (GRT) and housing. Far less support is offered to early service leavers.

The use of a transition incentive is understandable from the perspective of the armed forces. Holding onto personnel for longer periods of time is beneficial and cost effective, in terms of training and experience. However, those leaving the services within four years have been identified as a particularly vulnerable group with a higher incidence of mental health problems (Iversen *et al.*, 2005b).

Research shows that the risk of suicide in army males aged under 24 years who had left the armed forces was approximately two to three times higher than the risk for the same age groups in the general and serving populations (Kapur *et al.*, 2009). Pre-existing mental health problems and social experiences may well be a causal factor for this group.

Transition problems appear to be even more of an issue for service personnel who leave the forces after serving a sentence in the Military Correctional Training Centre (MCTC). KCMHR (2006) report that six months after discharge 50% of those studied were in debt and did not have proper housing, 10% were homeless and just over half had a mental health problem, the commonest being alcohol dependence.

Young service personnel leaving the forces not equipped to deal with civilian life are a significant problem. After discharge the military covenant places a *de facto* duty of care upon the statutory services (e.g. NHS, local government) and forces charities (SSAFA, RBL, Combat Stress) but it is not the function of the MoD to provide these services for veterans.

The service charities provide an enormous amount of support and assistance for service personnel, veterans and their families. Indeed they are indispensable. But many of those discharged early may not regard themselves as veterans, and their unique circumstances may

not be catered for by organisations more used to a different client group.

The type of provision offered by the service charities, and how it is delivered, may have to accommodate the needs of a broader range of ex-service personnel, including those who only serve for a very short period of time, are discharged for serious breaches of military regulations or who are temperamentally unsuitable for military life (Deu *et al.*, 2004).

Since many young recruits are from areas of high social deprivation and have lower academic attainment, it is important that they develop life skills as part of their training. These would include basics of financial management, maintenance of psychological (as well as physical) well-being, responsible alcohol consumption and other social skills.

The army is committed to improving the standard of basic skills and, in line with the Government's Skills for Life agenda, all soldiers are required to reach Level 1 and Level 2 in literacy and numeracy as they progress through their careers. The army's target is that all personnel attain at least Level 1 (GCSE grade D-G or equivalent) literacy and numeracy standards within three years of joining (Army, 2010).

## Veterans' mental health needs

It is an important principle that, when staff leave the armed forces, their health care transfers from the military to the NHS. Understanding need and unmet need is necessary for appropriate service planning and commissioning. Consequently, the NHS has to be aware of the needs of veterans for both mental and physical health care services.

The number of personnel leaving the UK armed forces due to a psychological condition is very low. Between 2001 and 2007, the annual number varied from 155 to 215. This means around 0.1% of regular service personnel are discharged annually for mental health reasons. Of these, only 20-25 are diagnosed with PTSD (NHS Choices, 2010).

There are no current population based studies of veterans' mental health similar to those carried out by the US Veterans Agency post Vietnam.

The MoD regularly calculates the number of personnel who seek help for mental health problems via the Defence Medical Services' Departments of Community Mental Health (DCMH) (DASA, 2010c). Although this information is quite comprehensive, it does not show prevalence, for example because it cannot take into consideration those personnel who have unidentified mental health problems or those who are treated in primary care. The absolute need is thus hidden, at least partly due to stigma, discrimination and ignorance.

The NHS and the Department of Health (DH) do not routinely capture demographic data on patients' military history: individual case histories may contain information, where appropriate, of an individual's service.

The incidence of mental health problems among serving personnel and veterans has, however, been examined in detail by the King's Centre for Military Health Research (e.g. KCMHR, 2006) and the Defence Analytical Service (DASA, 2010c).

Recent UK studies of 9,990 veterans show a prevalence rate of 4% for probable PTSD, 19.7% for symptoms of common mental health problems and 13% of alcohol misuse. Deployment to Afghanistan or Iraq was significantly associated with alcohol abuse for regular troops and with probable PTSD for reservists (Fear *et al.*, 2010).

These figures need to be viewed in the context of the level of mental health problems in the general population. One in four British adults experiences at least one diagnosable mental health problem in any one year, and one in six experiences this at any given time (McManus *et al.*, 2009).

One of the few barometers available to show the current prevalence of mental health needs among the veterans population is the work of Combat Stress, the veterans' mental health charity.

### Post-traumatic stress disorder (PTSD)

PTSD was recently diagnosed in 13% of a group of 3,000 veterans by the UK Medical Assessment Programme (Palmer, 2010). Murray (1999) reported on a number of American studies that suggested the prevalence of PTSD among Gulf

War veterans varied considerably, from 3% to 50%, with most studies in the lower range.

Combat Stress reported, in a presentation given to the Royal College of Psychiatrists (Busuttil, 2010), that in a clinical audit of their data between 2005 and 2009, 75% of their clients (a total of 608 people) had a diagnosis of PTSD, often co-morbid with other mental health needs. The information did not indicate how many of the clients subject to the audit had depression or other anxiety disorders. However, the vast majority of these have not served in recent conflicts. Also there is some debate about the nature of complex PTSD.

Busuttil (2010) also reports that Combat Stress has seen 1,303 new referrals in 2009, an increase of 66% over the past six years. These findings, however, need to be measured against other reports. In an analysis of the first 150 attendees at the UK Medical Assessment Programme, Palmer (2010) found that in only 19.8% was the link between their mental health problem and their military service unambiguous – these figures are due for publication shortly.

While there can be no doubt that those suffering from complex PTSD have many needs, some authorities debate the nomenclature and suggest that personality factors (which have been mostly a result of pre-service experience) are more important determinants of health in such people than their military experiences (Greenberg, 2010).

Combat Stress continues to raise the profile of mental illness among veterans. It is working closely with the DH and MoD on a number of projects including the establishment of more community support through a network of 14 nationwide outreach teams.

### Stigma and discrimination

The stigma of mental ill health, and the discrimination that results from it, is as much of an issue for service personnel and veterans as it is for others with mental health problems. In a US study of Vietnam-era veterans, those with PTSD were 8% less likely to find work than their peers. Working veterans with PTSD earned \$3 less per hour, and those with severe depression \$7 less per hour than their colleagues who were well (Savoca and Rosenheck, 2001 cited in Thornicroft, 2006 p.55).

In another study of US service personnel returning from Iraq and Afghanistan, concern about mental health stigma was disproportionately greatest among those most in need of help from mental health services. Soldiers and marines whose responses were scored as positive for a mental disorder were twice as likely as those whose responses were scored as negative to show concern about being stigmatised and about other barriers to mental health care (Hoge *et al.*, 2004). Iversen *et al.* (2005a) reported, in a study of 315 UK veterans, that among those who had mental health problems, but were not seeking help, the most common reasons were 'I could deal with it myself' (72%) and the perceived stigma and embarrassment of consulting (20%).

## Mental health support for veterans

Service personnel and veterans require a wide range of interventions for their mental health.

Independent guidance has been published by The Royal College of General Practitioners (RCGP), The Royal British Legion and Combat Stress to support GPs in identifying and meeting the health care needs of veterans more effectively (RCGP *et al.*, 2010). This is very helpful in highlighting the issues for GPs, and suggests that GPs record and code veterans in their databases. Although not mandatory, this is an important step in collecting data that can be used to begin to show patterns of need in this group.

The Coalition Government has made an assurance that it will continue to deliver on commitments to improve mental health services for both veterans and serving personnel made in the Service Personnel Command Paper (SPCP: MoD, 2008) and beyond. This includes a roll-out of community mental health pilots. These have been operating in six locations across the UK, the aim being to provide evidence based mental health services in the community for veterans. Each pilot is purposefully different, in order that the most effective ways to engage veterans with local mental health services can be identified (RBL, 2008). This work is subject to external evaluation by the University of Sheffield and the lessons learnt about the best ways to engage

with veterans should be made available for the whole of the NHS.

The SPCP also states that the needs of veterans will be taken into consideration when looking at the continued delivery of the *Improving Access to Psychological Therapies* (IAPT) programme. The IAPT programme established a veterans' mental health special interest group to debate and consider the implications for service delivery for this vulnerable group. Subsequent guidance was issued for commissioners (DH, 2009). Linking IAPT services to existing psychological therapy services offering interventions for complex needs, such as PTSD, would provide a care pathway for veterans who may otherwise have limited access to these services.

Understanding what services need to look like to attract veterans (or 'men' if the main barrier to access is gender) and how to ensure people get access to these services is important. The Mental Health Foundation (2010) recently called for action to ensure that veterans themselves do not see mental health problems as a sign of weakness. Veterans could be the target of local health promotion initiatives and the case is strong for veterans to be involved in the development of these initiatives.

### Support for reservists

Psychiatric services have also been made available for reservists through the *Reservists Mental Health Programme* (RMHP), which supports people who would otherwise use the NHS when they are not on active service. The NHS Choices website reports that between November 2006 and May 2009, the RMHP was contacted by around 300 individuals of whom 92 attended to be assessed. Of these:

- 70% were diagnosed as having a combat-related mental health problem;
- 25% were assessed as not having a mental health disorder;
- 5% were assessed as having a problem not related to their deployment.

These numbers seem very small compared to what would be expected within the reserve force. Insufficient data on reservists (or indeed veterans) seeking help for mental health needs, means that it is not known how many reservists see their GP or attend psychological therapy programmes such as *Improving Access to Psychological Therapies* (IAPT).

## Use of alcohol

*“At the time it never seemed so bad. In fact it was good. Brilliant. Every day with the lads. Drinking and drinking and drinking and having a laugh. It was what we did. We were a bunch of lads and we were part of a team ... lads in football teams and rugby teams muck about and have a laugh ... but [they] only get to meet up a couple of times a week ... My team was a 24/7 team. And we played the ultimate extreme sport where mistakes meant a whole lot more than 2 points dropped ...”* p.1-2

*“In the base we would sit around and play cards and drink. Then it would be time to get kitted up and go on patrol ... we would all pitch up at the UDA club on the Shankhill ... so drunk I was literally dragging my weapon on the ground behind me ... back to base ... debriefed and it was plainly obvious we were smashed ... it was how the army got by on the streets and fields of Ulster.”* p.8-9

Willie’s story (Frankland 2009)

The use of alcohol in the armed forces is steeped in history. Alcohol use has long been associated with saluting military leaders, even as long ago as the Macedonian and Greek cultures (Macurdy 1932). It forms the basis of many regimental ceremonies (Edwards, 1961) and it was only in 1970 that the rum ration was abolished in the Royal Navy, following the *Great Rum Debate* in the House of Commons (HC Deb 28 January 1970 vol 794 cc1660-86). The depressive and analgesic effects of alcohol were undoubtedly very important when battles were fought in close combat, when aggressive inhibition was encouraged and when battlefield medicine was very crude. However advances in technology, especially since WWII, have meant that alcohol use among operational troops has to be tempered, especially as they are operating complex and expensive equipment.

However, alcohol remains very affordable and drinking, often to excess, is socially acceptable and encouraged, particularly among lower ranks. There is a significantly higher consumption of alcohol among service personnel than the general population (Fear *et al.*, 2007). Alcohol continues to play a significant role in military ‘decompression’, where combat troops are given a short period of leave and

psychological support following deployment (Hacker-Hughes *et al.*, 2008).

Certain sub-groups among the serving population have been found to be at more of a risk from excessive alcohol consumption. Service specific data have shown heavy drinking to be a particular problem for the Royal Navy. Henderson *et al.* (2009) showed that 40% of survey respondents met the criteria for heavy drinking, 27% for very heavy drinking; 48% reported binge drinking at least once a week and 15% were classed as problem drinkers. As also identified by Iversen *et al.* (2007) and Fear *et al.* (2007), heavy drinking was associated with younger age, lower rank and poorer overall health. All results were substantially higher than in age-matched civilian samples.

Fear *et al.* (2007) used the Alcohol Use Disorders Identification Test (AUDIT) scale to compare rates of harmful alcohol consumption among serving personnel, age matched to the general population. The researchers found that those in the armed forces consistently drank more harmful amounts of alcohol than their civilian counterparts. Excessive use of alcohol in the armed services tends to ameliorate with age. The study showed that 36% of 16-19 year old males in the armed services drank harmful amounts of alcohol compared with 8% in the general population and for 20-24 year olds this was 32% compared to 14%. Given that younger men leaving the armed forces early are at greater risk of mental health problems, any associations with harmful alcohol consumption need to be investigated urgently.

Very little academic research seems to have been undertaken on the consumption of alcohol in the veteran population. Palmer (2010) reports that of the first 150 attendees at the UK Medical Assessment Programme, more than 80% used alcohol, of whom 30% of those misused alcohol. Of the alcohol misuse group, 22.5% had come into contact with the criminal justice system and 24.1% had experienced relationship problems because of drink. Anecdotal reports and life stories, such as those by Frankland (2009), also seem to suggest that excessive alcohol use is a risk among veterans.

*“He was drunk. Very drunk. All afternoon in the pub drunk and making his way home. [On the bus]. An argument. A fight ... [He] had been so drunk that he thought they had been stealing his shopping and assaulted them.”*

Don’s story (Frankland, 2009 p.64)

Many studies have shown the association between alcohol and violence (Galanter, 1997; Murdoch and Ross, 1990). The Home Office reports that screening of assault patients in accident and emergency departments has shown that between 65% and 80% were intoxicated at the time of the injury and murders committed by relatives and friends are particularly likely to be linked to the consumption of alcohol (Deehan, 1999).

It is not a huge leap to suppose that the cultural and social use of alcohol in the armed forces, and the reported excessive use of alcohol by service personnel, may be a factor in dangerous and irresponsible drinking among some veterans, and its consequences such as domestic violence, homelessness, and exposure to the criminal justice system.

The need to tackle problem drinking within the armed forces has been recognised by the Government and the army. The MoD (2009b) has set out offences associated with alcohol, intoxication and fitness to perform duties, and the army has produced guidance on sensible drinking (Army, 2010b).

## Veterans in the criminal justice system

The current focus of concern about veterans in prison in the UK has stimulated debate and questions in the House of Commons and headlines in the media.

*“Stricken boys turn to crime”* *The Sun*, 25 September 2009

*“MoD failing in duty of care to war veterans, leaving many to face jail terms, peers say”* *The Guardian*, 15 April 2010, p.4

*“Campaign to Save Troops from Prison”* *The Sunday Express*, 11 April 2010, p.37

Historically it was prudent to recruit prisoners to serve in army regiments or the Royal Navy. This was a common occurrence during the American

War of Independence (Ranlet, 1984) and the Napoleonic Campaigns (Myerley, 1996), where prisons were emptied to create new battalions. By enlisting, debtors could also escape liability for their debts (and prison) for amounts up to £30. The forced enlistment of vagrants was also commonplace and men were kidnapped by ‘crimps’, who made a trade of selling their victims to recruiters. Today, having a criminal record does not automatically disbar someone from joining the armed forces (Army, 2010c), although the recruitment is not quite as fervent.

Concern about the number of veterans in prison is not just a UK phenomenon. The US Department of Justice collects information on veterans in prison. It estimates that the number of veterans in US prisons is gradually falling, with roughly 10% of the prison population being described as veterans (about 140,000 people) in 2004, down from 20% in 1986 (US Department of Justice, 2007), and media stories are emerging from other European countries, such as Denmark (Copenhagen Post, 2010), also expressing concern about the number of veterans in prison.

In 2008 the National Association of Probation Officers (NAPO) estimated that there were 8,500 ex-service personnel in prison (i.e. about 10% of the prison population). It refined its estimates in 2009 to account for veterans across the criminal justice system, including probation. These estimates suggested that there were a further 12,000 subject to probation. These data have been contested, however, from a number of sources.

In 2010 the Defence Analytical Service Agency (DASA 2010d) reported that as of 6 November 2009 there were 2,207 veterans in prison, representing 3% of the prison population. This figure is derived from a cross sectional study matching MoD files of service leavers with Ministry of Justice (MoJ) data on the prison population at a snapshot in time. These data have been further revised to account for older veterans who exited the army, Royal Navy and RAF before 1972, 1993 and 1968 respectively. The MoD now estimates that an additional 613 veterans were in prison on 6 November 2009, an uplift to 3.5% (DASA, 2010a).

Although the DASA figures are illuminating, they must be viewed in context, and a number of issues still need to be addressed.

- 1 The population in custody on 16 April 2010 was 84,884, 2.5% more than a year earlier. Of these, 80,591 were male and 4,293 female. In 2008, 134,000 people entered prison in England and Wales, up by 7% from 2007 (Criminal Justice Alliance, 2010). The DASA analysis gives a snapshot on 6 November 2009, when 2,207 inmates were identified as veterans. Although it is not anticipated that this figure would change significantly, further sampling would be needed to determine whether this figure gave a clear picture, especially as the offender population is in permanent flux.
- 2 The figure is a record of a fixed date and does not include reservists. Although the data give a good estimate of the numbers they are not an entirely accurate representation. The reservist forces have a higher incidence of mental health needs (Browne *et al.*, 2007) compared with the regular force, and there may be a number of reservists in prison, who are not accounted for in this data.
- 3 No work has been undertaken on the incidence of other employment groups or professions in prison. We are therefore not able to conclude if veterans are over-represented compared with other groups. This also limits opportunities to compare index offence and demographics with appropriate controls. The MoD does compare veteran numbers against non-veterans in prison, however, and estimates that for males aged 18-54, the proportion of prisoners who come from the general population is 43% greater than the proportion of veterans who are in prison (DASA, 2010a).
- 4 The current (DASA, 2010a) data indicate that on 6 November 2009 only 21 of the male veterans in prison were officers, and 2,036 were from other ranks. The army has a history of recruiting school leavers with poor educational attainment from areas of social deprivation. These socio-economic factors are also linked to high levels of criminal behaviour (Houchin, 2005). The army may have acted as an interlude for those who may have otherwise been involved in criminal activity. Yet it must also be acknowledged that many recruits from disadvantaged backgrounds go on to forge very successful careers in the army and are discharged to lead full and meaningful lives in the community.
- 5 The DASA data do not show the length of service of veterans identified in prison. Further analysis of the DASA data could show the lengths of service and, consequently, whether there are any correlations between length of service and offending history.
- 6 The DASA (2010a) data compare estimates of the numbers of veterans in prison with members of the general population. These estimates also show offence type compared with the general prison population (see Table 1). Overall there are generally higher ratios of the general population in prison (496.3 per 100,000) as opposed to veterans (298.4 per 100,000). However, there is a high proportion of veterans who have been imprisoned for committing violence against

**Table 1. Number in prison per 100,000 for veterans and for the general population, males aged 18-54 years.**

Offence group	Number in prison per 100,000	
	General population <sup>a</sup> (14,620,000)	Veterans <sup>a</sup> (651,235)
Overall <sup>b</sup>	496.3	298.4
Burglary	53.4	13.2
Fraud and forgery	11.6	3.8
Theft and handling	19.9	7.2
Motoring	5.9	2.3
Drug offences	71.7	32.7
Robbery	62.2	23.8
Violence against the person	134.6	100.6
Sexual offences	51.5	63.1

a Veteran population estimates were not available for individual years of age so the age groups 16-24, 25-34, 35-44, 45-54 were used for the calculation of rates in both the veteran and general population

b 'Overall' includes 'offence not recorded' and 'other offences' (Reproduced from DASA, 2010a para. 19)

the person (100.6 per 100,000 veterans) and for sexual offences (63.1 per 100,000). This indicates that proportionally more veterans have committed sexual offences than would be expected in the general population.

- 7 The current DASA data provide information relating to the time lapse between leaving the forces and committing the index offence, but they do not show whether or not these were first offences.

A summary of the DASA data is shown in Table 1.

### The mental health of veterans in prison

Although there is now a slightly clearer picture about the numbers of veterans in prison, there is still no clear information on the mental health of these individuals and insufficient data to support evidence-based policy development. In response to a parliamentary question, the Secretary of State for Defence recently stated that *“Information on the numbers of veterans in prison/probation diagnosed with mental illness linked to their service is not available.”* (HC Deb, 27 July 2010, c1065W).

Collecting this information may prove to be very difficult. More general research and information is, however, available about the mental health needs of prisoners (e.g. Durcan, 2008; Seddon, 2007). Singleton *et al.*, (1998) estimated that 8% of prisoners have a severe mental illness, 66% a personality disorder, 45% a common mental health problem, 45% drug dependency and 30% alcohol dependency.

A brief literature search does not produce any results for specific UK research on the mental health of veterans in prison, although some literature has been published on regimes to assist veterans in custody (Brookes *et al.*, 2010). Some studies have been carried out in the United States, including a comprehensive assessment (including mental health diagnoses) of a sample of 8,236 veterans, 1,676 of whom were in jail (McGuire, 2003). Of those in prison, one in three had a serious mental illness and one in two reported current drug use. The study does not compare this population with a control group, so it is difficult to know whether similar levels of mental illness and substance abuse are also to be found in the rest of the prison population.

### Support for veterans in prison

A number of charities has been established to assist veterans who find themselves in the criminal justice system e.g. Veterans in Prison and the Veterans in Prison Association. The degree and scope of the effectiveness of these organisations may be limited by geography, finance, efficacy of interventions offered and size of the organisations. The MoD, the MoJ and offender and service charities have worked together to develop information resources for criminal justice staff, including police and prison officers. Work is also ongoing across the prison service to collect more accurate data about the service histories of inmates and to develop a more robust prison in-reach system for veterans (Veterans UK, 2008). These developments will provide the established service charities, such as SSAFA, Combat Stress and RBL, with more access to vulnerable ex-servicemen in prison.

In 2009, Nick Wood at HMP Everthorpe, East Yorkshire, developed a veterans’ data collection tool and support system Veterans in Custody Support (VICS). This system is now being adopted by prison establishments across the UK; it is currently active in 91 prisons in England and 2 in Scotland (Wood, 2010).

While data about veterans in the prison population is beginning to emerge, there is a danger that an over-emphasis on identification and provision of services in prison will detract from the serious questions that need to be asked. Do we know if there is any correlation between military service and future offending behaviour? If index offences are linked to alcohol abuse, does this have any association with drinking culture in the forces? Does length of service, or being an early service leaver, matter? Are the mental health needs of veterans any different from other prisoners? Why is there a higher proportion of imprisoned sexual offenders among veterans than the general population?

## Conclusion

A veteran's journey begins on the day that they enlist with the armed forces.

Most people who serve in the armed forces have a fruitful and successful career and contribute positively to their communities on leaving. However a small number are not suited to life in the military and may leave earlier than expected. This may be for breaches of discipline, temperamental unsuitability, or just not fitting into the culture and regime. Of this group a number will be very vulnerable and will require support and assistance in civilian life. This group is not well understood and it is feasible that their egress from the forces means that they disappear from view, only to re-emerge when they come into contact with criminal justice or mental health services.

Not enough information is known about demographics of recruitment and what the armed forces might have done to improve the life chances of young people who may have otherwise not had the opportunities, skills and training afforded by joining up. This information would help to develop a more rounded picture of the contributions made by the armed forces.

One in four British adults experiences at least one diagnosable mental health problem in any one year, and one in six experiences this at any given time (McManus *et al.*, eds., 2009). Veterans will also have mental health problems. As in the general population, depression, anxiety and alcohol abuse are the most common.

For some veterans and their families, mental health problems as a result of service experiences, such as PTSD, are traumatic and debilitating. There are a number of evidence-based interventions that are recommended in the treatment of PTSD and these should be made available in a timely and accessible fashion. The current research does not indicate whether these interventions are best delivered in specialist veterans' mental health facilities, or in the mainstream NHS.

Very few people are medically discharged from the forces because of mental health problems. It is reported that presentation with combat related mental health problems can be as long as 14 years post discharge (Busuttill, 2010). There is, however, evidence to suggest that ex-

service personnel are no more or less likely to seek help than people who have never served. Stigma is important (Time to Change, 2010), but this is as much a societal issue as it is a military one (Greenberg, 2010).

Alcohol plays a significant role in military life. Over recent decades there has been a cultural change in the use of alcohol, but the average service person still consumes far more alcohol than their civilian equivalent. Not only is this physically damaging but, for some, increased alcohol tolerance, problem drinking and dependency may spill over into civilian life following discharge.

Recent studies have shown that no more than 4% of the prison population has served in the armed forces, but with the information available it is very difficult to know whether military service had any bearing on their offence. Indeed, having been in the armed forces might have been incidental. However, once a prisoner is identified as a veteran, the options available for support and rehabilitation are much greater than those on offer to a non-veteran prisoner.

Without further research, no conclusions can be drawn as to whether the mental health problems faced by veterans are any different from those of other prisoners.

To effectively deliver a military covenant that discharges the country's debts to those who have given their intention to lay down their life, identification and recognition of those who are the least resilient needs to be more robust, even when these factors are pre-existing and a product of life prior to joining the services.

This work needs to start early, at the point of recruitment, and to continue through the period of service. The question of what determines vulnerability needs to be explored in more detail, but the evidence available suggests that the greatest risks are faced by personnel who leave the services early, those who misuse alcohol and those with mental health problems.

The MoD has made efforts to identify the most vulnerable early service leavers and offer them more support and assistance on discharge, and guidance notes are available for resettlement staff (MoD 2009a). Further assistance using a system of light touch mentoring has proved to be ineffective (Braidwood and Williams, 2009), mainly due to poor take-up, and a conclusion that existing means of assistance and welfare

support, such as Jobcentre Plus, social services etc., were adequate.

Poor take-up of services could be partly due to maturity, stigma or ignorance, especially if mental health problems had not been identified at the time of discharge. Gender is also an important element in service take-up. Men generally are less likely than women to seek support for their health (Galdas *et al.*, 2005; Tudiver and Talbot, 1999) and this may be more relevant than the fact that they are soldiers or veterans.

## Recommendations

**Recommendation 1:** The MoD should provide more detailed information about the demographics of recruitment. This will enable a greater understanding of the impact of joining the armed forces both on an individual and a population level. Greater transparency in reporting these data would help to inform media debate about both serving personnel and veterans.

**Recommendation 2:** Further research should be commissioned by the Government to identify the risk factors for mental ill health among early service leavers and to determine what can be done further to assist successful transition back into civilian life. More needs to be done to identify this group prior to joining up, through access to medical and social services records (without charge) and during basic training, which could then be seen as an extension of the period of selection.

**Recommendation 3:** The Government should commission economic research to determine the broad societal costs of early service leaving, and what could be done to ameliorate against some of the most expensive aspects of this phenomenon.

**Recommendation 4:** The existing support offered by the service charities should be reviewed to promote a seamless management of provision 'across the wire' i.e. services for forces personnel provided *in situ* through to services for veterans in the community.

**Recommendation 5:** Accurate demographic data on veterans should be collected routinely by statutory services, particularly primary care, housing, social care and criminal justice.

This will help to inform evidence-based commissioning, and ensure that valuable data are available to inform research and policy in this area.

**Recommendation 6:** Mental health and primary care services in the NHS must be able to meet the needs of veterans. This includes the continued development and roll-out of the Government's IAPT programme. Psychological therapy services must be responsive to the needs of veterans and have the mechanisms and care pathways in place to refer to specialist mental health trauma services when necessary, including those offered by the private and voluntary sectors. The forthcoming mental health strategy for England will be an important opportunity to make progress in this area.

**Recommendation 7:** Mental health treatment for veterans must be evidence-based. Providers need to be regulated to ensure that the most vulnerable veterans with mental health needs are not subject to non-validated or unproven interventions. Guidance from the National Institute for Health and Clinical Excellence is vital to underpin this, supported by assertive inspection by the Care Quality Commission.

**Recommendation 8:** The MoD must challenge the stigma which prevents personnel with mental health needs from seeking support. Tackling mental health stigma and discrimination should also be integral to the services offered by the military charities. Service charities need to know how best to work with the most vulnerable veterans with mental health needs. Action to tackle stigma and discrimination in society as a whole should also continue following the work begun by Time to Change.

**Recommendation 9:** Further research should be commissioned by the MoD to examine the impact of the military culture of alcohol consumption on the drinking habits of veterans. There also remains a need for the promotion of sensible drinking within the armed forces.

**Recommendation 10:** A full analysis of the available DASA data should be undertaken to identify particularly vulnerable groups of veterans who may come into contact with the criminal justice system. The relationships between alcohol abuse, mental health, offending behaviour and military service need to be examined in detail to enable evidence-based policy making in this area.

## Abbreviations

APA	American Psychiatric Association
DASA	Defence Analytical Service Agency
DCMH	Department of Community Mental Health
DH	Department of Health
DSFM	Defence School of Finance and Management
DSM	Diagnostic and Statistical Manual of Mental Disorder
GRT	Graduated Resettlement Time
HC	House of Commons
HL	House of Lords
HMF	Her Majesty's Forces
IAPT	Improving Access to Psychological Therapies
KCMHR	King's Centre for Military Health Research
LMF	Lack of Moral Fibre
MAP	Medical Assessment Programme
MCTC	Military Correctional Training Centre
NHS	National Health Service
NICE	National Institute of Health and Clinical Excellence
MoD	Ministry of Defence
Moj	Ministry of Justice
NAPO	National Association of Probation Officers
PTSD	Post Traumatic Stress Disorder
RAF	Royal Air Force
RBL	Royal British Legion
RCGP	Royal College of General Practitioners
RCPsych	Royal College of Psychiatrists
RMHP	Reservists Mental Health Programme
RN	Royal Navy
SDSR	Strategic Defence and Security Review
SoS	Secretary of State
SPCP	Service Personnel Command Paper
SPVA	Service Personnel and Veterans Agency
SSAFA	Soldiers, Sailors, Airmen and Families Association
VICS	Veterans in Custody Support
VIPA	Veterans in Prison Association
WDP	War Disabled Pensioners
WWI	First World War
WWII	Second World War

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## Across the wire

### Veterans, mental health and vulnerability

Matt Fossey

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Centre for  
Mental Health



*Realising a better future*

Centre for Mental Health  
134-138 Borough High Street, London SE1 1LB

T 020 7827 8300

F 020 7827 8369

[www.centreformentalhealth.org.uk](http://www.centreformentalhealth.org.uk)

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