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Galahad SMS Ltd
Substance Misuse Solutions

Final Report, March 2021

"Fall Out": Substance misuse and service leavers: a qualitative investigation into the impact of a Compulsory Drug Test (CDT) discharge.

COMMUNITY FUND

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We would also like to extend our sincere thanks to the many ex-military personnel who participated in the research and for their openness, honesty and candour. Re-living these significant life events was an emotional and difficult experience for some of the participants and we hope that we have been able to summarise their contributions accurately.

We are grateful too for the individuals, organisations and experts in their field who gave up their time to talk us.

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Foreword

Sometimes we produce a report that far exceeds its initial aim. 'Fall Out' is one of them.

On the face of it, the Armed Forces have a straightforward 'one strike and you're out' approach to drug use which meets their needs and leaves those serving in no doubt about the consequences of being caught drug taking. As this research identifies, the situation is considerably more complicated.

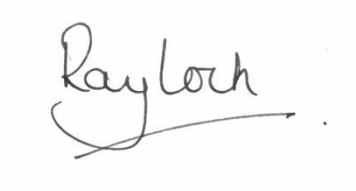
Let us first proceed from two statements of evidence. First, many people join the Armed Forces, serve with honour, and leave with their lives having been positively transformed in a way that simply does not take place in any other part of society. Second, the use of recreational and harder drugs in Britain has become increasingly widespread, spanning age, geography and socioeconomic status. This is sad, but undeniable.

With these facts in mind, the debate then revolves around the responsibility the Armed Forces have towards those who transgress. By recruiting people with pre-service vulnerabilities, the Armed Forces, and particularly the British Army, are taking on a moral duty to ensure such vulnerabilities are managed and overcome. The offer of an escape from a life of deprivation is a key attraction in recruitment that spans centuries. It is therefore reasonable in a modern society to expect the Armed Forces to prevent in-service triggers, and to provide better access to appropriate care. If discharge is inevitable, then it must be accompanied by far greater support than even the newly published Defence Holistic Transition Policy describes.

One surprising feature of 'Fall Out' is the relationship between drugs and alcohol. That some of the subjects of this study described their "disappointment" at the perceived disparity of treatment of those offending through alcohol compared to drugs misuse is a reflection of an attitudinal shift. We know that the Ministry of Defence is trying to reduce its people's alcohol consumption, but it lags far behind the civilian world. Indeed, evidence continually shows high, to the point of harmful, alcohol consumption rates for both serving and ex-serving personnel. Military service has for some time provided an inoculation against drug use (which is why its zero-tolerance policy has allowed young soldiers on leave at home to, literally, "just say no") but an accelerator of alcohol misuse. If both are indeed escapes from a nightmare reality, should soldiers fresh out of Sixth Form College perhaps not be treated at least as sympathetically over one form of substance abuse as another?

During my time in the Royal Air Force, the arrival of the CDT team was greeted as an annoyance; but no-one was immune, and as Station Commander I enjoyed no special treatment, joining the queue at the gymnasium urinals with everyone else. There is no suggestion that the way in which the Armed Forces conduct drug testing needs changing. But there is evidence that the way in which those who fail it are supported afterwards should be improved, and there is more to be done for those joining the Services with vulnerabilities. Finally, and unexpectedly, as society accepts and possibly legalizes the use of 'soft' drugs, how do the Armed Forces manage young recruits for whom alcohol is perceived to be both a greater threat to their wellbeing, and at the same time a legal drug upon which so much of the ethos of Armed Forces is found?

This report deserves consideration at the highest level within the Armed Forces, and by those who offer services to people in need. At Forces in Mind Trust, we will do everything we can to make sure 'Fall Out' is read in such offices. I would urge readers to play their part in turning consideration into action.



Air Vice-Marshal Ray Lock CBE

Chief Executive, Forces in Mind Trust

Executive Summary

The primary aim of the *Fall Out* project is to learn more about a specific cohort of Early Service Leavers (ESLs) — those dismissed from the Armed Forces as a result of a positive Compulsory Drug Test (CDT). Although the exact numbers of CDT failures are not routinely published, data available through Freedom of Information (FoI) requests (MoD FoI Requests, Various) and research papers (Bird, 2007) suggest that between 600 and 770 serving personnel return a positive CDT result each year.

The *Fall Out* study, through qualitative enquiry, maps participant journeys in, through and out of military service and explores their discharge and transition experiences. It provides clear recommendations for the development and delivery of policy and processes to assist CDT leavers in making a successful transition to civilian life.

Methods & Sample

- We undertook a comprehensive review of the UK and International literature and identified over 130 academic publications and policy reports. A synthesis of this literature helped to inform our research plan and contextualise research findings.
- The primary research was conducted through two methods: in-depth qualitative interviews with service leavers discharged from the military for failing CDT, and subject-matter experts (SMEs) who are involved in policy, clinical practice and service delivery.
- ESLs were recruited for the study through social (Facebook, Twitter, Instagram) and print (the Sun) media posts and advertising as well as through referrals via existing networks. Participants were offered retail vouchers (£30 per interview) as an incentive. Eighteen ex-service personnel from across England, Wales and Scotland were interviewed during the first phase of the study; sixteen of these took part in a second follow-up interview. The demographic characteristics of the sample are set out in Table 1.

Table 1 Demographic characteristics of *Fall Out* sample.

	Sample (n=18)
Gender (M/F)	100% / 0%
Ethnicity (White/BAME)	94% / 6% (*n*=1)
Age (mean/median: range)	29yrs / 28yrs: 18-44yrs
Service (British Army/Royal Navy/Royal Air Force)	83% / 6% (*n*=1) / 11%
Rank on Discharge (OR2 / OR3 /OR4)[1]	61% / 33% / 6% (*n*=1)

Findings

Pre-service experiences

- Many of the sample had experienced challenging pre-service circumstances and vulnerabilities (including mental health diagnoses, adverse childhood experiences, limited

[1] Other Ranks (OR) is the Nato Grade Coding system used to classify ranks across the Armed Forces of member countries. OR refers to military personnel who are not Commissioned Officers. For example, in the British Army OR2 refers to Private (or equivalent); OR3 to Lance Corporal; OR4 to Corporal. Comparable ranks across the Tri-Service are available at: https://www.gov.uk/government/publications/tri-service-pension-codes-april-2019/key-to-rank-codes-april-2019

economic opportunity). For the majority, escaping these environments was a significant motivation for joining the military.
- Others talked of military service as a way to access training and development opportunities.
- Two-thirds (66%) had early experiences of drug use prior to enrolling in the Armed Forces, while more still were regularly exposed to drugs via their family and peer social groups.
- Most perceived taking drugs as a normal part of contemporary adolescence.
- All were highly motivated to 'get clean' and many talked of military service as an opportunity to distance themselves from substance misuse.
- All participants reported at least some alcohol use before entering service, but few described hazardous levels of drinking.

In-service experiences

Positive aspects of service

- Despite the way in which participants' military careers had been curtailed, all spoke positively about aspects of their in-service careers:
    - Most talked of the special bonds of friendship formed while in-service, fostered by shared experiences and a strong sense of belonging.
    - Many appreciated that the Armed Forces had provided them with opportunities for personal growth and professional development.

Negative aspects of service

- Within the accounts of military lived experiences, there were also descriptions of challenging circumstances and scenarios with which some had struggled to cope:
    - Approximately half experienced periods of disillusionment with their military lives which, according to their own accounts, triggered personal and professional 'downward spirals' and substance misuse. Factors influencing these negative trajectories included perceived poor treatment, bullying, boredom, lack of operational experience and struggling to fit in.
    - There were also accounts of in-service mental health difficulties including depression, anxiety, suicidal thoughts and symptoms of PTSD. Few accessed help for these issues and when they did, most described pastoral rather than clinical or other professional support.
    - There was little evidence of a clear protocol for referral onto evidence-based pathways for treatment and support.
    - The perception that mental health was stigmatised in military life, and feelings that they were unworthy of support were noted as common barriers to help-seeking among the sample.
- Clear opportunities exist for the Armed Forces to develop its commitment to the promotion of peak mental fitness while avoiding processes and practices that potentially harm mental health

In-service substance misuse

- Very little is known about the scale of drug use and drug reliance in the UK Armed Forces.
- Participants in this study described variable patters of drug misuse, from a one-time only occurrence to more regular and sustained use. According to participant accounts, drug use among service personnel was largely confined to certain cliques and mainly occurred away from camp during weekend and leave periods.

- Some participants had initially been surprised to find out that some serving personnel took drugs and that, among certain cliques, it was viewed as acceptable. These perceptions of drug use being more embedded and culturally endorsed than recruits expected are important as evidence from the literature suggests that a *perception* that substance misuse is allowed or endorsed is associated with higher rates of actual substance use (Fear et al., 2007)
- Cocaine was the most commonly reported drug used by serving personnel. It was also the drug responsible for the majority of the participants' CDT failures. The common perception was that cocaine was metabolised quickly and, if timed and used 'tactically' at the start of leave periods, for example, the risk of CDT detection was less than that for other drugs. Few of the sample thought taking drugs while in-service was risk free, but judging by their accounts, and evidence from the literature, risk-taking and sensation-seeking may be disproportionately high among young service personnel.
- Alcohol was perceived to be an integral and sanctioned part of service life. Most reported a significant increase in alcohol consumption after joining the military and a greater propensity to binge drink. Many felt that an ability to cope and engage with military drinking culture was an important component of social and professional acceptance.
- Evidence from this study suggests that the military alcohol-endorsing culture may inadvertently encourage other forms of intoxication; many talked of the pivotal role alcohol played in drug-taking behaviours.
- The prevalence of drug use among peer and family groups was reported as a significant driver for participants' own substance misuse.
- A minority of the sample pointed to more complex reasons for substance misuse that were grounded in adverse childhood experiences, personal loss and poor mental health.
- A minority (n=3) of those interviewed said that they had used drugs intentionally to secure an early release from the Armed Forces.

Compulsory Drug Testing (CDT)

- Few argued with the Forces 'right' to dismiss them for taking drugs, but many felt aggrieved by a perceived disparity in the disciplinary treatment of service personnel found to have committed infractions while drunk compared with those caught by CDT. Some called for a more rehabilitative and holistic approach to drug users in the Armed Forces.
- All the participants were fully aware of Armed Forces' zero tolerance policy on drug use. Prior to their positive CDT, however, most considered the risk of being caught to be minimal. Few had seriously considered the potential short- and long-term consequences of a CDT discharge.
- The research uncovered marked inconsistencies in the treatment of individuals once they had failed a CDT, although among those discharged since 2018 (*n*=6) most reported a more standardised experience. For most, the period immediately following the CDT was characterised by anxiety and uncertainty.
- There were some reports of harsh and humiliating treatment in the aftermath of a positive CDT. These included ostracization, verbal dressing downs, separation from peers and being called out/shamed in front of colleagues. This treatment reportedly had lasting impacts on some individuals and compounded existing feelings of vulnerability, isolation and shame.
- While awaiting discharge, some had engaged in self-destructive behaviours and continued substance use. Interviewees talked of high levels of shame over drug test failures and being discharged from the Armed Forces – feelings that were often long lasting.
- Very few of the participants received psychological, social, or transition support post CDT, all of which are arguably pivotal to the likelihood of a successful transition.
- None of the participants recalled receiving support for drug use or mental health difficulties in the immediate aftermath of a failed drug test.

- Only a few participants reported using time constructively pre-discharge to prepare for transition. Those who did so reported supportive and informed CoC and/or empathetic and supportive peers. They recognised the positive contribution that these sources of support had made to their post-military life chances.

Transition

- Historically, ESLs have been entitled to very limited transition support. In recognition of mounting evidence that ESLs are disproportionally disadvantaged and are at an elevated risk of unemployment, homelessness, unemployment and mental health issues, this situation is increasingly being addressed. From 2015, all ESLs, including those dismissed as a result of a CDT, were eligible for the CTP Future Horizons Programme.[2]
- Of the sample, half were eligible for the CTP programme, but only two recalled being offered it. Both declined.
- More than half of the participants said that they had found it relatively easy to find a job after discharge, but there were many reports of temporary and unsatisfying work. A number of veterans were able to circumvent formal job applications — finding work through family businesses or those run by friends.
- Some also struggled to adapt to civilian working cultures and practices. This was particularly evident among those who had joined the Armed Forces at an early age and had little experience of adulthood outside of the military.
- The majority of respondents in the *Fall Out* study reported being able to move back with family (and particularly parents) following their CDT discharge, although some had not been forthcoming with the reason for their dismissal. There were, however, accounts of more difficult and chaotic transition journeys that included periods of homelessness and breakdown of family relationships.
- The majority of participants continued using drugs and alcohol after leaving the Armed Forces. At the time of interview, two reported receiving professional help for drug or alcohol dependency and one described himself as being in recovery. More described ongoing patterns of cocaine, cannabis and potentially hazardous alcohol use for which they were not seeking support.
- Four participants said that they had a current diagnosis of a mental health issue; others still had formal mental health assessments pending. Two-thirds perceived a decline in their mental health following a CDT failure and discharge.
- Respondents recounted various pathways of support through GPs and veterans' services but accessing the most appropriate support was not always straightforward. Barriers to accessing this support included the stigma attached to seeking help for mental health issues, and lack of awareness of the help available to them and their eligibility for it. A couple of participants also reported feeling unworthy of help from veterans' services because of the manner in which they had been discharged.

Subject Matter Experts

- Subject Matter Experts (SMEs) described veteran-clients as often experiencing multiple problems at the same time.
- Some clients misused substances as a way of coping. Inevitably, substance misuse often compounded problems, putting additional barriers in the way of transition and life beyond the military – a process that is already fraught with complexity and challenge.

[2] CTP Future Horizons is an initiative designed to help service leavers find suitable civilian employment. For further details see: https://www.ctp.org.uk/futurehorizons

- SME's also talked of links between veteran-client drug use, CDT discharge and pre-existing vulnerabilities.
- SMEs, echoing comments made by research participants, also recognised that escaping challenging home environments and Adverse Childhood Experiences (ACEs)[3] was a motivation for some to join the military. Returning to these environments post-discharge, however, could potentially exacerbate their existing vulnerabilities.
- Key informants highlighted a need for holistic support following a CDT discharge to not only address substance misuse, but also underlying problems with mental health, housing issues, debt, gambling, etc.
- The need for holistic support to assist veterans with the multiplicity of issues surrounding and/or underlying substance misuse further underscored the need for coordination amongst service providers, including veterans' charities, the NHS, local authorities, and other agencies where relevant.
- SMEs argued for the military to adopt a more nuanced approach to the understanding and management of drug misuse, to recognise differing drug-use behaviours and enable the most appropriate support.

Recommendations

Developing a culture of peak mental fitness

- Evidence from *Fall Out* indicates that the Armed Forces may attract many **recruits with pre-service vulnerabilities** (some linked to exposure to childhood trauma) who join the Services hoping for a turning point in their lives. While there is some evidence that certain aspects of the Armed Forces' context and culture (e.g. unit bonding, a sense of belonging, promoting problem solving skills and opportunities) provide an environment which is *protective* of those with such pre-service problems (Sciaraffa et al, 2018), there is also some indication in studies that exposure to other aspects of military life (e.g. alcohol-endorsing culture, potential bullying (Takizawa, 2015), anti-help seeking cultural norms, and, in this instance, the process of post-CDT discharge) can worsen mental health and undermine peak mental health fitness and an individual's ability to thrive.
- Evidence from *Fall Out* suggests that there may be scope, organisationally, for the Armed Forces to further its active commitment to developing a whole **organisational culture** (from leadership down) that promotes peak mental fitness and that minimises **processes and practices** that do unnecessary harm to good mental health.

RECOMMENDATION: The Armed Forces should take a more proactive approach to monitoring and identifying when a service person's mental health might be deteriorating, and to provide early support (such as informal conversations on wellbeing; access to talking therapies or counselling, brief assessment, etc.).

RECOMMENDATION: The Chain of Command (CoC) should build on current mental health promotion efforts that proactively seek to monitor those with pre-service mental health vulnerabilities (such as substance misuse, hardship, neglect, abandonment, abuse, etc.).

RECOMMENDATION: The Armed Forces should consistently mobilise protective occupational factors and experiences (such as unit bonding, occupational opportunities, physical fitness regimes and problem-solving skills) which appear associated with optimal physical, mental and professional performance.

[3] While precise definitions of Adverse Childhood Experiences (ACEs) vary, the term often references the following experiences: verbal abuse; physical abuse; sexual abuse; physical neglect; emotional neglect; parental separation; household mental illness; household domestic violence; household substance abuse; incarceration of household member.

RECOMMENDATION: The CoC should actively seek to minimise avoidable occupational harms (such as bullying, ostracization, excessive drinking, boredom) likely to further exacerbate developmental trauma and military performance.

RECOMMENDATION: The Armed Forces should provide trauma and mental health awareness training for personnel managers. Education at this level should also include Making Every Contact Count (MECC)[4] training to ensure that the resilience and mental fitness of serving personnel are optimised.

RECOMMENDATION: The Armed Forces should provide additional training for staff with 'pastoral' roles (Welfare Officers, Padres, etc.), often the first point of contact for personnel with mental health concerns, to ensure they are able to recognise situations where clinical interventions are required.

Inconsistent and damaging discharge processes

- The *Fall Out* study elicited widely differing accounts of service personnel's treatment in the aftermath of a positive CDT. Some reported harsh and/or humiliating treatment, protracted periods of uncertainty prior to discharge, and little by way of health and/or transition support. In some cases, these experiences exacerbated anxiety and mental health difficulties.

RECOMMENDATION: Greater efforts should be made to ensure clarity, consistency and transparency in the application of JSP 835 guidance on the management of CDT failures at a Tri-Service level.

RECOMMENDATION: *Fall Out* evidences the need for a process review and training on the administration of the guidance to ensure that all staff involved understand the potential impact of overly punitive treatment on mental health and successful transitions. Training should emphasise the importance of the following:

- **Timeliness of communications –** individuals should be kept fully informed at all times of case progress
- **Respectful treatment** – regardless of CDT result
- **Consideration –** care and support of a potentially vulnerable cohort likely to struggle post-service
- **Raise awareness of links –** between demeaning, belittling, unsupportive, isolating treatment, and poor mental health and transition outcomes.
- **The positive role of supportive peers/CoC –** can help CDT dischargees to be practically and emotionally prepared for the challenges of transition.

Mental health and substance misuse assessment and support

- The *Fall Out* study makes a compelling case for screening individuals who fail CDT for indications of problematic substance misuse and mental health issues.

RECOMMENDATION: All service personnel testing positive for drugs should be routinely screened for substance misuse and mental health difficulties.

Where resources are available, these assessment tools should, ideally, be administered by impartial, qualified professionals.

[4] Making Every Contact Count (MECC) is an evidence-based, behavioural change approach to improving health and wellbeing through better client/practitioner engagement and conversations. See, for example, Nation Institute for Clinical Excellence (NICE) https://stpsupport.nice.org.uk/mecc/index.html

RECOMMENDATION: The Ministry of Defence and NHS providers across the UK should work together to develop a joint protocol for managing those who test positive for drug use.

This protocol should be mindful of the following approaches and considerations:

- **Extra Time.** Additional consideration should be given to those who joined the military at a young age (pre 18 years old). Evidence from this and other studies suggest that this cohort is the least prepared to negotiate some of the practicalities of civilian life (paying bills, apply for housing, etc.). Premature and unexpected discharge (through positive CDT) often deny these ESLs sufficient time to acquire these essential life skills.
- **Contextualising substance misuse.** Consideration should be given to a system for assessing the extent to which an individual's drug use may be linked to youth and/or immaturity rather than more entrenched substance reliance/addiction.
- **Avoiding Learned Helplessness**. Every effort should be made, even after a decision to discharge, to minimise exposure to additional harmful processes at a critical point of transition to civilian life (e.g. minimising shaming and bleakness about future prospects).
- **Support.** Consideration should be given to a model which provides practical mental health and resettlement support that spans the Armed Forces to civilian transition. This should be non-judgmental, proactive, outreaching, relationship-based (due to ESLs decreased likelihood of engagement), co-produced by ESLs with lived experience (of military service and transition), and evaluated for cost-effectiveness.
- **Screening.** Routine assessment screening for substance use should be conducted in primary care and other settings to mobilise prevention efforts for those with emergent problems. Alcohol and Drug disorder disclosures should signal clinicians to carefully query patients regarding childhood adversity, and, conversely, indications or revelations of childhood adversity exposure should also prompt alcohol and drug screening.

Early detection and intervention

- Management staff should be educated to develop alertness to early risk factors this study has identified in the research and from the literature review. For example, spotting those with avoidant-coping styles, with gambling or other impulse-control issues. Service personnel are more likely to engage in harmful substance misuse if their sense of military belonging deteriorates or is compromised, if they become socially isolated, or when their protective family or Unit relationships break down. These early detection and intervention efforts should also address related mental health problems that manifest as self-medication with drugs and alcohol.
- The Forces already have excellent responses to, and treatment of trauma, in serving personnel. We are suggesting that this expertise be harnessed and applied to the proactive care for those at risk of substance misuse.

RECOMMENDATION: The Armed Forces should embed an evidence-based early intervention approach to de-escalating the risk of substance misuse difficulties emerging.

RECOMMENDATION: The Armed Forces should develop awareness training for the CoC to identify the triggers for 'reactive' drug misuse among serving personnel.

- The Armed Forces should explore ways in which data on Adverse Childhood Experiences and pre-service vulnerabilities might be collated (at recruitment stage) to improve the management of and outcomes for these individuals/cohorts.
- Practices that can re-awaken or and exacerbate past trauma (e.g. treating individuals with disrespect and unfairness/ making them feel powerless and insignificant) should be addressed.

RECOMMENDATION: Better data are required to establish baseline measures of drug and alcohol use within UK military contexts.

Data collection should be carried out by independent and credible research institutions/suppliers with a proven track record of military research to assure data quality and instil confidence among participants (guaranteeing anonymity, understanding the cultural landscape, etc.). Baseline data could then be used to:

- Counter misconceptions of substance misuse within the Armed Forces (i.e. the *perception* that substance misuse is allowed or endorsed is associated with higher rates of *actual* substance use (Fear et al., 2007)).
- Use to inform substance-misuse education programmes.
- Inform behavioural change initiatives aimed at reducing the prevalence of drug and alcohol use within UK Armed Forces.

In the US, the *Health-Related Behaviors Survey*[5] comprehensively assesses health behaviours (including drug alcohol and substance misuse), overall wellbeing of US service personnel, and how these factors potentially impact on readiness. Aspects of this may serve as one useful model from which to develop UK specific tools.

Deterring drug and alcohol misuse

- Evidence from this study suggests that the military drinking culture may inadvertently be encouraging other forms of intoxication.

  RECOMMENDATION: Building on existing guidance and directives, organisational action to both address alcohol-endorsing cultures and reduce excessive drinking levels should continue to be priorities for the UK Armed Forces.

- Evidence from this study suggests that key deterrence messages are being ignored or subsumed by stronger cultural norms. The necessity of change within a post-pandemic environment could now present a timely opportunity to review substance-misuse education delivery.

  RECOMMENDATION: The Armed Forces should review its current substance misuse programme with a view to developing a coherent, Tri-Service approach. An update model for the education might usefully consider online, interactive and inclusive e-learning programmes, tailored to individuals' level and learning style, with follow-up information and support as required. In addition, evaluation tools should be built into any new service provision to enable the measurement of outcomes.

Signposting & tailoring support

- Evidence from *Fall Out* highlights a need to better signposting and tailored support. With so many organisations offering both general and targeted support to veterans, some participants had found it difficult to identify and link with the service most appropriate to their specific needs. Furthermore, some admitted being unsure whether they, as CDT discharges, were eligible to seek help from particular veterans' support organisations.

[5] For more details see https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Survey-of-Health-Related-Behaviors/2018-Health-Related-Behaviors-Survey

RECOMMENDATION: The Armed Forces should carefully assess the social circumstances of each CDT-positive individual to determine potential vulnerabilities (e.g. substance misuse, physical/mental health, gambling/debt, etc.) and identify the most appropriate support agencies. This assessment could use the extant HARDFACTS[6] framework and would provide standardised tools for the management and measurement of transition.

- *Fall Out* highlighted low levels of engagement with the Future Horizons Programme despite the fact that is has been demonstrated to improve employment outcomes and was (for half the sample) one of the few transition support services that was available them as CDT discharges.

  RECOMMENDATION: All service personnel discharged through CDT should be referred to Future Horizons for advice and support. Evidence from *Fall Out* indicates a need to review the referral process to identify barriers to engagement and to encourage greater levels of uptake with the programme.

- Evidence from *Fall Out* suggests that some CDT discharges struggled to adjust to the world of civilian employment after transition.

  RECOMMENDATION: The Armed Forces should ensure that transition support includes training that sufficiently prepares ESLs for work in civilian contexts. This training is particularly critical for those who joined at an early age/as school-leavers and those (such as CDT discharges) who have limited time to prepare for transition.

Advancing the state of the art

- As the first UK-focused study exploring this cohort of ESLs, the research has highlighted some potentially fruitful areas of further enquiry. Some of our recommendations for future research are outlined below.

  RECOMMENDATION: Further UK research is needed on the outcomes of UK ESL subgroups and other high-risk leavers (e.g. those leaving due to misconduct/substance misuse). This study represents a significant starting point, but access to this hard-to-reach group has proved challenging – participants were recruited 'in the community' after discharge from the Armed Forces. Closer collaboration with the MoD to facilitate access to ESL cohorts before discharge may well prove beneficial in terms of securing a larger sample size and further insight.

  RECOMMENDATION: An economic evaluation should be completed of the costs to the Armed Forces associated with ESL and substance-misuse or conduct-related discharges, in order to track outcomes, assess the economic benefits of more intensive intervention, and establish where and how costs might be reduced within an appropriate and feasible time frame.

  RECOMMENDATION: The millennium birth cohort was 17 years of age at the last data sweep. This data could usefully be explored to better understand the pre-service profiles of those joining the Armed Forces. The Millennium Cohort Study[7] would provide useful background data on childhood mental health status, educational and socio-economic circumstances,

[6] The HARDFACTS framework is used in the Defence Transition Referral Protocol (DTRP) which seeks to identify physical, psychological, welfare and transition needs. The HARDFACTS assessment criteria are: **H**ealth; **A**ccommodation & **R**elocation; **D**rugs, Alcohol & Stress; **F**inance & Benefits; **A**ttitude, Thinking & Behaviour; **C**hildren & Family; **T**raining, Education & Employment; and **S**upporting Agencies.

[7] The Millennium Cohort Study is co-ordinated by the Centre for Longitudinal Studies (CLS) at University College London (UCL). It follows the lives of c.19,000 young people born in the UK between 2000 and 2002. For more information, see: https://cls.ucl.ac.uk/cls-studies/millennium-cohort-study/

parental mental health difficulties, parental substance misuse, and other useful issues. This research could potentially help refine decisions to optimise the support and management of those recruits with existing vulnerabilities.

RECOMMENDATION: More high-quality research and evaluation is required on 'across the transition' care coordination approaches. In the US, for example, a proactive texting follow-up support system has early stage evidence of efficacy and is currently being trialled further. (Peterson et al, 2018). In the UK, Contact[8] is a group of charities and academics that work with the NHS and the MoD with the aim of improving access to support for health and wellbeing for the military community. It is currently working on collaborative transition care pathways including common assessment systems, casework management and quality accreditation criteria. We would emphasise the importance of ensuring that the research, development and application of care coordination approaches are inclusive of those discharged as a result of drug misuse.

Conclusion

The *Fall Out* study is the first research of its kind in the UK to focus on the in-service and transition experiences of a cohort of ESLs discharged for failing a CDT. The participant narratives highlight often complex individual journeys into, through and then transitioning out of, the Armed Forces. While each individual journey is unique, there are experiential commonalities that point to genuine opportunities to improve the potential outcomes for this specific cohort of ESLs, many of whom entered the Armed Forces hoping for a better life.

That the Forces have the right to discharge personnel who are in violation of policy is not in question; none of the participants would contest this fact either, although many in the study felt themselves to have been highly proficient in their military roles and felt that they were deserving of a second chance. The issue is how the discharge process is managed to minimise further harms and ensure that it does not exacerbate underlying problems.

[8] Further information on Contact, including details of its partner organisations, is available at: https://www.contactarmedforces.co.uk

1 Introduction

Approximately 15,000 personnel leave the British Armed Forces every year. In recent years the majority of those leaving the Armed Forces did so voluntarily, exiting before the end of their agreed engagement or commission period (Voluntary Outflow). In 2019, for example, Voluntary Outflow accounted for three-fifths (60.9%) of trained and trade trained personnel leaving the Armed Forces. One-quarter left the Armed Forces for 'other' reasons – including medical or compassionate grounds, for misconduct, due to dismissal, or because of death during service. One in seven (13.7%) left having reached the end of their commission or engagement period (MoD, 2019).

The data on outflow include Early Service Leavers (ESLs). Although definitions of this cohort differ between countries and studies, a generally accepted and current UK definition is that ESLs are personnel who are discharged from the military:

- Compulsorily from the trained or untrained strength;
- Or at their own request from the trained or untrained strength before completing the minimum term of their contract (between 3 and 4.5 years depending on Service branch) (Buckman, 2013; Godier et al., 2018).

While official statistics do not routinely provide a detailed breakdown of this specific cohort of leavers, some previous research has suggested that ESLs may account for as much as half (50.5%) of the outflow from the Armed Forces (FiMT, 2013).

Previous studies have shown that ESLs are disproportionately disadvantaged and are at higher risk of unemployment (Ashcroft, 2014; Godier et al, 2018), homelessness (Elbogen, 2018), substance misuse (Woodhead, 2011) and mental health issues (Buckman et al, 2013; Iverson et al, 2007). Historically, ESLs in the UK have had very limited access to transition support. In recognition of emerging research pointing to the greater vulnerability of this group, however, new directives and guidance have been developed to better meet the needs of this group. JSP 534 Tri-Service Resettlement and Employment Support Manual (MoD, 2015), for example, on the recommendations of a report funded by the Forces in Mind Trust (FiMT) (Fossey & Hughes, 2013), for the first time provided ESLs with access to Career Transition Partnership Future Horizons (CTP Future Horizons) support with their resettlement back into the community. The recently published JSP100, Defence Holistic Transition Policy (MoD, 2019b) has further widened access to transition support to all service personnel, 'irrespective of reason for discharge', and seeks to ensure all service leavers are referred to appropriate support services.

As noted above, included in the definition of ESLs are those who are discharged compulsorily. Among this group are a subgroup of ESLs who are discharged for returning a positive result on the Compulsory Drug Testing (CDT) programme. MoD guidance on policy and procedures in relation to substance misuse are provided by JSP 835 (MoD, 2013), which states that:

> *Substance misuse is incompatible with the demands of service life and poses a significant threat to operational effectiveness.…The aim of the CDT programme is to provide an effective deterrent capability, in the most cost-effective manner, in support of the Armed Forces' wider measures to prevent drug misuse within the Services.*

Although the exact numbers of CDT failures are not routinely published, data available through Freedom of Information (FoI) requests (MoD FoI Requests, Various) and research papers (Bird, 2007)

suggest that between 600 and 770 serving personnel (across all three Services) return a positive CDT result each year.[9] In line with current guidance it is likely that most would be dismissed as a result.

Although several international studies have focused on substance misuse among serving personnel and among veterans, no UK study has investigated the impact of a CDT discharge on subsequent substance misuse, mental health and readjustment to civilian life. The paucity of data on drug misuse among UK military personnel has been highlighted in previous studies, including work commissioned by FiMT (Samele, 2013). This review of the evidence found "no research, per se, on drug use in UK military personnel" and documented "drug misuse and comorbid mental illness in UK serving and Ex-service personnel" as a "research gap". Other work in this field has also pointed to the need "to explore the experiences of ESLs in relation to military life, and their attitudes and expectations regarding transition and future prospects." (Godier et al, 2018). This research also noted that those discharged for disciplinary reasons (such as a positive CDT) have not been studied.

It is against this backdrop that we present this ***Full Report*** outlining the findings of the research project supported and funded by FiMT entitled: *Fall Out: Substance misuse and service leavers: a qualitative investigation into the impact of a Compulsory Drug Test (CDT) discharge (Fall Out).* It is the first UK-based study of its kind focusing on a specific cohort of ESLs; those dismissed from the Armed Forces as a result of a positive drug test. A stand-alone ***Briefing Report*** has also been prepared which synthesises key findings and recommendations from the research. The *Fall Out* study, through qualitative enquiry, seeks to investigate the discharge and transition experience of a cohort of ex-Forces personnel who were discharged as a result of a positive Compulsory Drug Test (CDT) result. Among other issues, the study explores pathways into and out of substance misuse and the impact of a CDT discharge. It provides clear recommendations for the development and delivery of policy and processes to assist CDT leavers make a successful transition to civilian life.

Post fieldwork, and during the preparation of this report, the MoD published the JSP100 Defence Holistic Transition Policy (MoD, 2019b). We very much welcome the guidance that it provides to Front Line Commands in delivering consistent support to service persons, facilitating smooth transition to civilian life, including those who may have left service suddenly or involuntarily. The Policy places necessary emphasis on issues that we have highlighted in this research and pre-emptively addresses some of the recommendations we have made. We hope that by having shared some our preliminary findings in mid-2019 with Defence Authority for People, we have been able to provide a significant and meaningful contribution to this policy area. We also note that JSP100 is iterative and "will seek to identify gaps and duplication of effort to improve support provision" to service persons. It is our sincere hope that this report will add to the evidence base and will help inform future thinking and policy iterations for the benefit of all service persons, veterans and their families.

We should also note that since the completion of the report and its submission for review, an updated version of JSP 534, *The Tri Service Resettlement and Employment Support Manual* (Issue 19) (MOD, 2020) has been published. Issue 19 marks some significant changes in policy in relation to service leavers' entitlements. Of particular relevance to the *Fall Out* study are amendments made to paragraph 110 and paragraphs 202 through to 210. In summary, these amends state that personnel

[9] See the following MoD responses to FOI requests:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/555925/RED_FOI2016_08187.pdf;
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/527275/HOCS_FOI_2016___Information_of_Army_personnel_drugs_test_abuse_from_2014_to_2016.pdf;
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/758255/06201.pdf
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/555925/RED_FOI2016_08187.pdf In 2017, 770 individuals from across the three services, approximately 0.6% of Full-time Trained Strength (RN/RM & RAF) and Full-time Trade Trained Strength (Army), returned positive CDT results.

leaving the services compulsorily (which includes those discharged as a result of a CDT) are afforded the same resettlement provision as 'normal' service leavers. Resettlement support is now based on length of service and no longer penalises those leaving the service as a result of disciplinary discharge. This has significant ramifications for those dismissed as a result of CDT. We welcome these amends to JSP 534.

This study was conducted by Galahad SMS Limited in partnership with the Veterans & Families Institute for Military Social Research at Anglia Ruskin University (ARU). Ethical approval for this research was granted by the Department Research Ethics Panel in the Faculty of Health, Education, Medicine and Social Care at ARU.

1.1 Structure of the report

For the purposes of the report, findings are mapped against participants' journeys and timelines. Throughout the report the analysis considers ways in which pre- and in-service attitudes, experiences and behaviours impact on the transition pathways for this cohort.

The fieldwork has uncovered a rich seam of experiential narrative. While there are many unique scenarios and experiences within each participant case study, commonalities are extant across the sample which give us confidence in the validity of the data despite the relatively small sample size. The structure of the report is as follows:

- Chapter 2. Provides a brief summary of the research methods including details of recruitment sample.
- Chapter 3. Gives a contextual snapshot of the cohorts' pre-military lives, focusing on motivations for joining the Armed Forces and pre-service substance misuse, attitudes and behaviours.
- Chapter 4. Follows the participants' in-service journeys and seeks to explore participants' positive military experiences, but also perceived personal challenges, with a view to illuminate and contextualise in-service substance misuse.
- Chapter 5. Explores in-service substance misuse and includes substance-misuse attitudes and behaviours and participants' perspectives on the drivers of misuse.
- Chapter 6. Focuses on Compulsory Drug Testing and the participants' post-test experiences up to the point of discharge. It explores respondents' perceptions of the CDT/discharge process and the immediate health and social impacts of returning a positive CDT test.
- Chapter 7. Provides discussion and analysis of respondents' experiences of transition, focusing on the social, economic, environmental and health impacts of the CDT discharge.
- Chapter 8. Presents and analyses the accounts of the subject matter experts providing alternative perspectives of those leading and/or working in veteran-focused health and social care.
- Chapter 9. Presents some summary conclusions.
- Chapter 10. Consolidates the recommendations for policy and practice based on evidence from the qualitative research and literature review.

2 Methods, Sample & Study Limitations

2.1 Literature review

A systematic search was completed of the following electronic databases for literature published between 2000 and August 2019: Embase, Medline, PsycINFO, ProQuest and PubMed. Search results were limited to papers published in English and included both UK and international studies. Search terms included military, Armed Services, Armed Forces, Early Service Leavers, substance misuse, drug misuse, alcohol misuse, mental illness, separation, discharge, transition, support, acceptability. Search terms used were identical for all databases.

In total, 130 relevant academic articles and resources were identified. Almost all were peer reviewed articles. In addition to searching bibliographic databases, reference lists of all relevant papers and reviews were searched. The majority of studies investigating subgroups of those leaving the Armed Forces on an involuntary basis have been completed in the US. Care was taken, when analysing US findings to take into account different military cultures in the UK and different service and welfare contexts. In drawing conclusions, differences between military cohorts during several conflicts have also been taken into account.

2.2 Qualitative Research with ESLs

Qualitative research with ESLs was the primary methodology employed in the *Fall Out* study, providing a way of contextualising, describing and exploring the social worlds of a cohort of ESLs dismissed from the Armed Forces as a result of a positive CDT result. This component of the research project was undertaken over a six-month period (December 2018 to May 2019) and comprised face-to-face and telephone in-depth interviews over two waves. The interviews were semi-structured and conducted using an interview schedule approved by the ARU ethics panel. Semi-structured interviews enable specific questions to be asked whilst also giving space for interviewees to raise their own thoughts "rather than being restricted by researchers' preconceived notions about what is important" (Berry, 2002:681). The use of a semi-structured style also allowed us to gain the maximum benefit from the participants as "semi-structured interviews allow respondents the chance to be the experts and to inform the research" (Leech 2002:668).

All the interviews were recorded and transcribed verbatim. After transcription, the interviews were thematically analysed using hand coding by the first author and these were checked by other authors to establish inter-coder reliability. A rarefied version of Braun and Clarke's (2006) method guidelines for quality thematic analysis were used a bespoke question set to guide the process and ensure through analysis was undertaken. All interviews were recorded and transcribed verbatim.

Interviews were conducted in two waves. Repeat interviews offered a range of benefits over single interviews for the *Fall Out* study. These benefits included: keeping interviews to a manageable length, thus reducing participant fatigue; allowing time between interviews for the research subjects and interviewers to reflect; opportunities to validate and explore issues raised in the initial interviews; and more time to build trust and confidence between researchers and research subjects (for further discussion see Grinyer & Thomas, 2018). Other studies have further suggested that repeat interviewing maybe particularly applicable to research involving sensitive subject areas and potentially vulnerable participants (Vincent, 2012).

Fall Out's first wave interviews sought to gather background information and context and to explore specific aspects of:

- Pre-military lives - notably motivations to join the military and pre-service substance misuse behaviours and attitudes.
- In-service life - focusing on military careers and lived experiences, substance misuse, CDT, discharge experiences, and access to support.

The second wave focused on transition and the impact of discharge on health, well-being, employment and social relationships.

2.3 Recruitment

Fall Out adopted a multi-pronged, flexible and adaptive approach to the recruitment of this hard-to-reach sample. The recruitment strategy was purposive (Bryman, 2012), non-random and involved multiple channels comprising:

- Print media – one full-colour, credit-card-sized advert was run in *the Sun* in Early December 2018
- Snowballing – through participants, key informants and professional networks (including Twitter followers)
- Social media – primarily through Facebook, but also Instagram and Twitter. Posts (original and forwarded media articles) were used to generate interest and raise awareness of the project. These were further boosted using Facebook Advertising tools to extend reach to specific demographic groups with matched relevant interests (e.g. Royal Air Force, British Armed Forces, The Royal British Legion, Veterans, Royal Marines, Armed forces, Royal Navy, Military Families or British Army, Employers: HM Armed Forces, etc.)

Facebook proved to be the most successful channel for sample recruitment for this study. Its efficacy as a cost-effective way to access and retain young, hard-to-reach groups (Whitaker et al., 2017), including military veterans (Pedersen et al., 2015) is evidenced elsewhere. The *Fall Out* research team had over 75 unique interactions with potential participants; exchanging more than 350 texts, Direct Messages, emails and phone conversations. Through these exchanges the team was able to compile a database of 52 ex-service personnel discharged for CDT who expressed an initial interest in participation. Thirty-seven of these supplied contact details to which participant information sheets and consent forms were sent (34 electronically, 3 by post); 23 of which were signed and returned. Twenty-three wave one interviews were scheduled; five participants subsequently withdrew. In total the research conducted 18 Wave One interviews and 16 follow-up Wave Two interviews. Interviews for Wave one lasted approximately 1 hour; Wave Two interviews between 30 to 40 minutes.

Figure 1. *Fall Out* recruitment post, Facebook

To maximise participation, and in-line with standard research practice, respondents were incentivised with £30 per interview which was paid in the form of 'value-in-kind' retail vouchers (e.g. Argos, Amazon, iTunes, etc.). Although the use of incentives in human research is contentious, most studies demonstrate that use of payments is generally non-problematic and unlikely to influence results except in certain circumstances which, in this case, do not apply (Grant & Sugerman, 2004). Grady (2001) also concluded that the 'distortion' effect of incentives on data is countered if participants are fully informed about the research and the benefits or risks of participation. In accordance with the ethical governance of this study, there was a mandatory requirement for all participants involved in the research to read a comprehensive participant information sheet, sign and return an accompanying form to ensure fully-informed consent. This process was managed through Adobe Sign.

Figure 2. *Fall Out* recruitment ad, the Sun

2.4 Profile of interview participants

The demographic characteristics of the sample are set out below in Table 1. The majority, three-quarters, had been discharged in the 5-year period prior to the study; the remainder had left the Armed Forces more than 10 years previously. All but one individual had achieved the rank of OR2 or OR3 rank at the time of their discharge. All 18 participants were male, with 17 self-identifying as White British and 1 as Black British. Respondents originated from across England, Scotland and Wales; with representation from London, the Home Counties, South East, North East, North West and the Midlands.

The age range of participants was between 18 and 44 years; one-third were under 25 years-old, two-thirds under 30 years-old.

Table 2 Demographic characteristics, substance misuse histories and mental health of *Fall Out* sample.

	Sample (n=18)
Gender (M/F)	100% / 0%
Ethnicity (White/BAME)	94% / 6% (*n*=1)
Age (mean/median: range)	29yrs / 28yrs: 18-44yrs
Service Branch (BA/RN/RAF)	83% / 6% (*n*=1) / 11%
Time since leaving service (mean/median: range)	6.7yrs / 4.5yrs: 0.5-23yrs
Rank on Discharge (OR2 / OR3 /OR4)	61% / 33% / 6% (*n*=1)
Substance detected CDT (Cocaine/Cannabis/Body Enhancers/Ecstasy)	56% / 28% / 11% / 6% (*n*=1)
Pre-service Drug Use (Y/N)	66% / 33%
Pre-service Alcohol Use (Y/N)	94% / 6% (*n*=1)
Diagnoses of Mental Health Condition (Y/N/Undeclared)	22% / 56% / 22%

More than half of the sample (56%) tested positive for cocaine (primarily) on the CDT that had led to their discharge; other drugs implicated in this context, but reported to a lesser degree, were cannabis (28%), performance enhancers (11% - including steroids and non-approved supplements) and ecstasy (6%). There were also some reports of CDTs returning positive results for more than one banned substance. **Three of the respondents also claimed to have deliberately failed the CDT to**

facilitate an early discharge from the Armed Forces. These same three respondents all reported a disaffection with their personal and/or professional circumstances in the period leading up to their career-terminating CDT and cited this as a contributing factor to their decision to take the drugs implicated.

Two-thirds of participants in the *Fall Out* study had, to varying degrees, experience of drug use prior to joining the military. All but one of the participants reported at least some alcohol use pre-service. Four participants (1 in 5 approximately) had current (post-service) and/or previous (pre-/in-service) clinical diagnoses of mental health conditions.[10]

2.5 Consultation with subject matter experts

In addition to the interviews conducted with ESLs discharged as a result of a positive CDT, phone discussions were also held with subject matter experts (SMEs; n =6) regarding compulsory drugs tests and substance misuse by virtue of their roles within organisations offering support, advice and treatment to veterans. The SMEs represented a number of organisations from policy, statutory and third sector provision. The SMEs were purposively sampled from the extensive contact base of the authors. Although their views are not entirely representative, their breadth of experience and subsequent insights into the management of CDT in the military and the treatment of CDT veterans has been invaluable.

2.6 Analysis and reporting

All interviews were digitally recorded with the fully-informed consent of the participants and were transcribed verbatim. Researchers adopted a thematic analytical approach to the data, systematically working through texts to uncover, interpret and report meanings within the transcripts. This process was aided by the use of NVivo qualitative analysis software.

An interim report was prepared and submitted to the funder in July 2019, findings of which are incorporated in the body of this report.

It should be noted that the following report includes verbatim quotations from participants; some of these contain strong language, opinions and references to situations that might cause offence.

2.7 Ethics

Ethical approval for this research was granted by the Department Research Ethics Panel in the Faculty of Health, Education, Medicine and Social Care at Anglia Ruskin University.

2.8 Study limitations

As a qualitative study, this research does not claim to be representative of all those discharged from the military as a result of a positive CDT, nor was it designed with that aim in mind. It should also be noted that the complexity of accessing and maintaining engagement with this hard-to-reach group may have introduced some sample bias – we were unable, for example, to recruit participants who were currently homeless or detained within the Criminal Justice System. We were also unable to

[10] While these figures are broadly in line with those from the general population(in which 1 in 4 experience mental health issues each year - see, for example, statistics from MHFA England https://mhfaengland.org/mhfa-centre/research-and-evaluation/mental-health-statistics/) it is important to note that not all of the sample chose to respond to questions seeking information pertaining to their mental health.

recruit any female participants for the study. No publicly available data exist on the gender composition of military CDT failures, so it is unclear the extent to which female service personnel are affected by CDT discharge. Interviews with participants uncovered no anecdotal evidence of drug use by female service personnel.

We also must consider the possibility that some respondents may have chosen to participate as a way of airing grievances or perceived poor treatment. According to most respondents, however, their primary motivation for participating in the research was the hope that their input might inform the improvement of policy and practice. One or two were, at least initially, motivated by the incentives.

The data collected for this study were elicited through semi-structured interviews with research participants. No screening tools for mental health or substance misuse (e.g. Alcohol Use Disorders Identification Test [AUDIT], Drug Abuse Screening Test [DAST]) were administered to the participants to assess them formally or validate their self-reports of substance misuse and mental health.

Given the characteristics of the sample and themes extant in the participant narratives, we should also highlight the potential for recall bias. Most participants found receiving the news of their CDT failure a difficult and emotional experience; by their own admission, some struggled to recount specific details of the event when questioned. For those who had been in civilian life for some time (one-quarter of respondents had left the Armed Forces more than 5 years prior to the study), recalling the minutiae of the discharge experience was not always straightforward.

3 Pre-service experiences

This chapter, through an analysis of the accounts of ESLs discharged as a result of a positive CDT, provides a contextual snapshot of aspects of the cohorts' pre-service experiences. In this chapter we seek to understand participants' motivations for joining the Armed Forces; we explore the sociocultural and environmental factors that influenced these decisions including, where applicable, references to potential adverse childhood experiences. This chapter also explores respondents' pre-service substance-misuse histories, focusing on attitudes, behaviours and drivers of early drug and alcohol misuse.

3.1 Motivations for joining the Armed Forces, challenging environments and vulnerabilities

Across the sample of ESLs discharged as a result of a positive drug test in this study, **many had experienced challenging pre-service circumstances and vulnerabilities**. For most, these included home environments in which parental and/or peer drug use was common, and economic environments that offered few employment opportunities. A minority also reported pre-service diagnoses of mental health conditions, learning difficulties and adverse childhood experiences that included: bullying, physical violence and sexual abuse.

For the majority, escaping social and environmental pressures emerged as a significant motivation to join the military. Respondents recognised the benefits of distancing themselves from negative influences, including friends and some family members, as well as extricating themselves from environments that offered few opportunities for self-improvement. Among the negative influences mentioned in this context, were friends and families with substance misuse issues. A few respondents also talked of escaping abusive familial relationships:

> *… a part of me wanted to get away from the current shit lifestyle I was in, and I thought I could sort my shit out and get away from it all.*

Others talked of military service as a way of **personal reinvention**; life in the Armed Forces, they hoped, would allow a fresh start. Furthermore, some also feared that 'staying put' in these challenging environments would put them at risk of becoming embroiled in the criminal justice system:

> *A hell of a lot to deal with. To be fair I did see the Army as a very easy scapegoat to be whoever the fuck I wanted to be, and no one knew who I am.*

> *I wanted to join the Army to get away from my lifestyle, because I was in danger of becoming a walking hand grenade. It was either I would end up in jail or join the Army.*

The majority of respondents recognised clearly that the Armed Forces provided **opportunities to access training and personal development** perhaps not otherwise readily available to them. Again, this was often framed in terms of the need to escape from limiting and challenging home and/or social environments. For some, being in the Armed Forces was all that they had ever wanted to do – an early and strongly held aspiration that, for some, was influenced by family histories of service.

Overall, the view that joining the Armed Forces is seen both as an opportunity and as a means of escape echoes findings from other studies, many of which also report that **ESLs are more likely to come from deprived socioeconomic backgrounds and to have had exposure to more pre-service adverse childhood experiences** such as socioeconomic difficulty, multiple family-based and

developmentally traumatising adversities (Bergman et al., 2019b; Woodhead et al., 2011; Blosnich et al., 2014; Montgomery et al., 2013). While participants in the *Fall Out* study were not questioned directly about their exposure to pre-service adverse experiences, details were readily volunteered in the context of their CDT failures and journeys into, through and out of military service. Most accepted responsibility for taking drugs in-service in contravention of the military's substance misuse policy, but many felt that pre-service histories, to varying degrees, may have influenced their decisions to take drugs. Evidence from both the *Fall Out* study and the academic literature has **ramifications for the recruitment[11], management, health and transition of service personnel**. Both sources of evidence point to the need to assess and address pre-service experiences as they are associated with higher likelihood of poorer mental health, raised stress levels, and maladaptive coping strategies (Pomerleau, 1987; Dembo et al., 1992; Kendler et al., 2000).

3.2 Early experiences of substance misuse

3.2.1 Drug use

The majority (two-thirds/66%) **of the *Fall Out* sample had early experiences of drug use prior to enrolling in the Forces**, although there was some marked variation in the patterns of consumption described. Drug-taking behaviours varied from low frequency 'experimentation' with cannabis to regular and potentially more problematic misuse of Class A drugs, Novel Proactive Substances (NPS) and performance enhancers. The list of drugs used included: powdered and crack cocaine; LSD; amphetamine; ketamine; MCAT; ecstasy; steroids and pro-hormone.

For most, drug-taking behaviours were framed as a 'rite of passage', an intrinsic part of contemporary adolescence – it was simply what the respondents felt their generation did. A few isolated cases reported more regular, systematic and potentially problematic patterns of substance misuse. Among these participants there were accounts of periods of daily Cannabis and Class A use and references to early experimentation with a wide variety of drugs. For example, one respondent offered the following:

> *From about 13, I was well into it … was quite bad really… I started smoking cigarettes at 11, cannabis at 12 and probably got stuck in to class 'A's at 13. At that time, it was mainly cocaine or MCAT. It progressed to MDMA, Ecstasy. [I] experimented with crack; I never really got stuck into that, thank Christ! We could have been having a very different conversation if I had. MCAT, that's the thing that really took a hold of me. I would put it up there as being as bad as heroin, to be honest, for what it can do to people. Absolutely. It's turned me into a vile, vile person.*

These early patterns of substance misuse, however, are significant in that longitudinal studies have linked such early experimentation with the early onset of conduct problems and an associated six-fold higher chance of adult substance reliance (Svingen et al, 2016; Fergusson et al, 2005).

Drug use was generally perceived to be part and parcel of a night out and normalised behaviour in certain social settings. Drug-use among this study's cohort of ESLs, however, was more prevalent than that of drug-use among general populations. According to the most recent Crime Survey for England and Wales (CSEW), for example, one-third of adults (aged 16 to 59 years) have taken drugs at some stage during their lifetimes, with 20% or 1 in 5 adults (aged 16 to 24 years) having taken drugs in the previous 12 months (Home Office, 2019).

[11] At no point does this study advocate recruitment in itself as a means of rejecting those applying to the Armed Forces with ACEs, rather it suggests that greater awareness of ACEs may help guide, support and manage those affected by them.

In addition to the social and environmental factors outlined above, conversations with participants explored other drivers of pre-military substance misuse. For the most part, these involved notions of conformity, fitting in and peer pressure, but also a recognition that taking recreational drugs was about feeling good, albeit temporarily:

> *I thoroughly enjoyed it. I enjoyed the feeling, I enjoyed the buzz, I enjoyed the vibes. At the time anyway. And then the next morning, it would be 'what have I done that for again?', and then I would go out the next night, it would be there, and I would think: 'oh, go on then.'*

Mixing in social circles in which drug use was prevalent provided some individuals with a positive affirmation that their patterns of substance misuse were shared and normalised. The pressure to conform to contemporary ideals of masculine body image was a specific driver for some of those respondents reporting use of performance-enhancing substances. While there were some reports of participants using drugs pre-service to help manage physical or mental pain (e.g. anger management, bereavement, family dysfunction) this was expressed only in a minority of cases in pre-military contexts.

While there was a high prevalence of drug use and exposure to drug use among the sample, and, as suggested by previous research among recruits, in some branches of the British Forces,[12] evidence from academic studies suggests that this may be explained in part by Armed Forces' recruitment processes and the demographic from which candidates are drawn. A number of **studies suggest that the Armed Forces' recruitment process may specifically favour those with traits associated with greater likelihood of substance misuse**, including sensation-seeking, fearlessness, attraction to adrenalin-high situations and impulsivity (see Brodsky et al., 2001; Iversen et al., 2007; Freeman & Woodruff, 2011; Anestis et al., 2019). Previous Galahad research (Galahad, 2005) on soldiers and sensation seeking may also go some way to shedding further light on this. It found an overlap in the psychological profiles of sensation seekers (risk-takers), drug users, and soldiers. Such personality traits or coping skills are often associated with survival of childhood adversity and childhood conduct problems (Fergusson et al., 2005). Evidence from the literature was supported by comments from the participants in the *Fall Out* study, including the following:

> *The typical people who join the Army are from that background! [Drug using]. We are risk-takers. We like to get messed up and it is part of the culture in the Army, the drinking culture. The drinking culture and doing cocaine and that, they are the same culture. Some people draw a line, some people don't.*

With only two exceptions, participants also reported **regular exposure to drugs prior to joining the military**; this was also the case among those who did not partake in drug-taking themselves before entering the Armed Forces. Drug use among peers was reported to be commonplace in the participants' social environments before enlistment. In addition, more than one-half of this cohort referred to drug use among parents, siblings and members of their wider families. In some cases, families' involvement in illegal drug use also included distribution and dealing:

> *To be honest, the area that I grew up in, it was everywhere, and it still is now and it's harder not to find it than to find it really! So, it's something I've always been aware of. And my Dad's brother was a dealer at one point as well, so I had knowledge of it anyway.*

Parental substance misuse is particularly significant as a finding among this cohort since it is a well-acknowledged adverse childhood experience. It has also been correlated with other clustering

[12] Previous research has suggested that prevalence of pre-service drug use, at least among British Army recruits, may be as high as 70%. See: MCM Research 1998: *Drug Misuse in the British Army*. Restricted report for PS2(A). Also: Galahad SMS Ltd. (2007) Prevention of Drug Misuse in the Army, Phase II Report. Available from the House of Parliament Deposited Papers at: http://www.parliament.uk/deposits/depositedpapers/2008/DEP2008-2974.pdf

adverse childhood experiences such as neglect, abuse and parental mental health difficulties (Barnard & McKeganey, 2002). The accumulation and persistence of such risk factors, over childhood, is seen as being damaging to the developing immune system and associated with a higher chance of a range of poorer lifetime health (physical and mental health), educational and social outcomes (Felitti, 2009). This may, at least in part, explain the higher vulnerability levels documented for ESLs (Bergman et al., 2016; 2019a; 2019b). Exposure to such developmental trauma can lead children and young people to develop a range of coping skills to survive chaotic family environments. For example: reliance on substances to dampen and numb responses, and a normalisation of fear and of high-octane lifestyles (Dembo et al., 1992; Douglas et al., 2010). A recent US study of those separating from the Armed Forces for 'other than honourable' reasons (Elbogen et al., 2018), also found among the ESL cohort a higher incidence of parental drug use and poor parental mental health. This study also noted a higher incidence of those in the Armed Forces with such family experiences becoming reliant themselves on substances.

There was a recognition, among some of the participants, that their pre-military substance misuse had resulted in negative consequences; predominantly, these were articulated in terms of breakdowns in family relations:

> *Family life, yeah. My relationship with my mother definitely, a lot more strained, for a couple of years. I think she saw what was happening but couldn't understand why. It was more a friction of her not wanting me to do the things I was doing and me just doing them anyway.*

> *Oh yes, it caused hell at one point. The trouble I was getting in to. My mum and dad lost the house and everything through us…through me being a little bastard to be fair. That's when I decided I needed to sort my head out. So, I joined the forces to stop all that.*

Despite the fact that most of the participants in the *Fall Out* study had some experience of drug-use before going into the Armed Forces, **all were highly motivated to 'get clean'**, recognising this as a mandatory requirement for a military career. **Many talked of military service as an opportunity to distance themselves from substance misuse**. For some, particularly those joining the military as a way of self-improvement or escape, beginning a career in the Armed Forces was just the incentive they needed for drug cessation:

> *I had done my time with all the drugs. This was a new chapter for me to focus on.*

Several participants, however, struggled to quit and remain drug free prior to joining the services. In some cases, social and environmental factors — mostly centring on peers and negative influences — placed significant barriers to positive behavioural change. Others, however, harnessed these challenging circumstances to further affirm their decisions and their aspirations for a better life:

> *Yeah, it was the hardest thing I've ever done in my life…the motivation behind it is what kept me going and staying away from that kind of things. I can't say it was easy, because it wasn't easy… I kind of kept away from a lot of people that I wouldn't have done before. I tried to tie myself with people who I thought I should tie myself with.*

3.2.2 Alcohol

All participants reported at least some alcohol use before entering military service. As with drug use, most perceived this to be part of normal adolescence among their peer groups. Few, however, saw themselves as having hazardous patterns of consumption prior to joining the military. It is important to note the links that participants made between their alcohol consumption and drug-taking behaviours; many considered the two activities to be synonymous in all contexts – before joining, as well as during and post service. While some were introduced to drinking from an early

age, most said that they had a very limited tolerance of alcohol before signing up. Most also stressed that their alcohol intake increased markedly after joining the Services.

3.3 Key Points

⇒ Many of the sample had experienced challenging pre-service circumstances and vulnerabilities (including mental health diagnoses, adverse childhood experiences, limited economic opportunity). For the majority, escaping these environments was a significant motivation for joining the military.

⇒ Others talked of military service as a way to access training and development opportunities.

⇒ Two-thirds (66%) had early experiences of drug use prior to enrolling in the Armed Forces, more still were regularly exposed to drugs via their family and peer social groups.

⇒ Most perceived taking drugs as a normal part of contemporary adolescence.

⇒ All were highly motivated to 'get clean' and many talked of military service as an opportunity to distance themselves from substance misuse.

⇒ All participants reported at least some alcohol use before entering service, but few described hazardous levels of drinking

4 In-service experiences

The previous chapter explored participants' pre-service experiences and highlighted the challenging circumstances they often faced, their vulnerabilities and substance misuse patterns. Despite and perhaps because of these factors, participants were highly motivated to join the Armed Forces – to fulfil ambitions, escape their circumstances and embrace opportunities for personal and professional growth.

In this chapter we seek to understand participants' perceptions of their service experiences focusing on the opportunities and challenges extant in their military careers including training, life on camp, social and professional relationships and the perceived impact these factors had on substance misuse and health.

Despite the manner in which the participants' military careers had been curtailed – abruptly and in most cases unexpectedly – all spoke positively about certain aspects of their in-service experiences. Participants (from the British Army) described themselves, to a large extent, as true soldiers, '*green through and through*' and/or having 'loved' military life. Across all the Services, many of the participants mentioned enjoying training; deployment; friendships; sports; travel; going on exercise, and having experienced a strong sense of belonging. Indeed, discussing their time in the Armed Forces was for some a very emotive exercise, particularly for those who expressed regret and embarrassment for having been dismissed as a result of a positive CDT. The majority of respondents also considered themselves to have been good at their jobs – some even said that they were highly regarded by their Chain of Command, even that they had 'excelled' while in service. **Within the accounts of military lived experiences, however, there were descriptions of challenging circumstances and scenarios with which some had struggled to cope**. From participant accounts it was clear that some of these challenges had negatively impacted on motivations to remain drug-free. As noted previously, **three participants deliberately took drugs as a way of getting out of the military; these decisions**, **to varying degrees**, appeared to be **motivated by experiences and perceptions of poor treatment**.

4.1 Friendship bonds

Respondents in the *Fall Out* study spoke at length about the sense of camaraderie they experienced while in the Armed Forces. Most talked of **lasting and special bonds of friendship** created during their time in the Armed Forces, fuelled by shared experiences and a tangible sense of belonging. **Participants rated these friendships as one of the most positive aspects of their military careers** and recognised that these strong social connections had been hard, sometimes impossible, to replicate in 'Civvy Street'.

Evidence from the literature further suggests that these social bonds may be of particular importance to those from challenging backgrounds. **For those affected by both adverse childhood experiences and chaotic family life, a positive sense of community, attachment and belonging may well act as a protective shield against the worst effects of historic trauma and of chaotic family relationship**s (Sciaraffa et al., 2018; Aldwin et al., 1994). A U.S. study of a large-scale military sample suggested that the "highly structured and intense doctrination of military training" and the occupational environment may give those with psychopathic personality traits (not uncommon in high-risk occupations) a potentially protective advantage (Anestis et al., 2019). However, more studies are currently required to clarify which occupational factors in the Armed Forces provide the most benefit, how and for whom.

4.2 Opportunities

Those interviewed as part of the *Fall Out* study recognised the value of career and recreational opportunities that the military had afforded them. Career highlights were mostly felt to be activities that took them away from the camp setting. These included tours, exercises, sports as well as other social aspects, bonds and connections.

Many felt the most fulfilled when they were doing the job for which they had been trained – described by some as 'proper soldiering'. For those who had experience of tours, these also featured in respondents' lists of career high points, despite the obvious challenges:

> *My experience of tours, good and bad I suppose. TELIC4 was the highlight of my military career…. that was when the Mahdi Army decided to kick off. It was doing a job, which was fantastic, but… it sounds wrong, I did enjoy it. We were right in the thick of it and it was brilliant. Sounds horrendous, but it was brilliant.*

Despite an untimely and perhaps undistinguished end to their military careers, participants of *Fall Out* talked eloquently of the impact their military careers had on their personal development and growth. It was clear that **the Armed Forces provided an environment in which many felt they had been able to thrive.** Respondents reported that the military had, through experiences, friendships and the attainment of skills, impacted positively on their life skills and self-esteem. The following quotes are fairly typical of the sentiments expressed by the majority of respondents in this context:

> *It grew me as a person obviously…it has shaped me as a person. It taught me a lot about myself, a lot about the world. And I can't really fault it for that.*

> *I found things out about myself too –what I could achieve if I put my mind to it. I didn't do anything at school, dropped out, got expelled, so I never did any education. [the Services] really pushed me to the limits and it gave me loads of confidence. Even what I do now…the values I've got and the achievements I got…doing what I could, basically brought me on as a person.*

Evidence from the literature (in addition to those factors outline above in 4.1) indicates that **access to career and recreational opportunity can also be a protective factor, particularly for those with exposure to early adverse experiences** (Aldwin et al., 1994; Anestis et al., 2019).

4.3 Expectation versus reality

Life in the military, however, was not all positive. For many there was a strong disconnect between high expectations on joining the service and the realities of life on a unit. It was clear from the discussions with participants that there was a potential downside to being highly motivated to serve; among this cohort there was a risk that the negative impacts of unrealised expectations and disillusionment were particularly damaging. **Nearly half of the participants talked about becoming disillusioned with life in the Forces at some point**, **about expectations not being met and this being a trigger for 'downward spirals' and substance misuse.** For some, these disparities between expectations and the lived experiences were exacerbated by what were perceived to be the false promises made to them by recruiters and 'glossy' advertisements.

These **downward trajectories described by participants often began with an incident of perceived unfair or humiliating treatment, career mismanagement, bullying or rejection**. There were also reports of other risk factors in this context which included **the boredom of life in camp** as well as issues centring on post- and non-deployment. Going on tour, operations and seeing action, for example, were strong drivers for individuals to join the military. While one third of the *Fall Out*

sample had realised this ambition, the majority had not. For these individuals, this **lack of operational experience** was a significant source of disappointment which ultimately had affected their experience of and satisfaction with military service. Even among those who did manage to go on tour, some reported being (apologetically) disillusioned with the experience when it transpired that the realities of tours did not align with their expectations. The following quote reflects sentiments expressed by a number of contributors:

> *I was in the Army since I was 16, straight out of school. Then all the training, and like I sort of joined thinking I was going to be war fighting…training to go to Afghanistan…And then we go to Afghanistan and nothing really happened out there, and I struggled with the fact that I was meant to go out there and do something, and you know make a difference or whatever it is, and I wanted to do what I was trained to do. I wanted to fight in a war. I know that sounds quite selfish because I never want to wish anything like that on anyone.*

For those in the sample who had experienced tours, periods following deployment were reported as particularly challenging. In some cases, participants talked of supplementing sanctioned decompression and readjustment with substance misuse:

> *So, when we come back [from Afghan], I must have just rubbed some people up the wrong way and I was put in the stores, that's when everything started going wrong…I'd not touched drugs before I joined the Army, I never sort of dabbled at all, but from that point that was when my life started going down the drain.*

Others talked of the negative impacts of being separated from closely knit, on-tour companies post deployment:

> *When we got back from Afghan… we were going out drinking and I started I guess to disassociate myself from the rest of the regiment, and I kept to myself, whereas everyone I had served with had just been taken away and the only time I saw them was PT. That sort of affected me as a young lad because I don't make friends easily.*

As noted above, participants reported high levels of career satisfaction when they were doing what they were trained to do – being pushed, training hard and 'proper soldiering'. Some respondents commented on the differences between training and life on the unit. Many had spoken positively of their experience of training, getting in shape, being 'run ragged' and the rigid structure that accompanied this period of their military lives. On camp, however, the consensus was that life was a little freer; many spoke of **boredom, lack of structure, poor facilities and not being able to do the job they had 'signed up for'**. All of these sentiments negatively impacted on service personnel's motivation to perform to the best of their ability, realise their potentials, toe the line and ultimately stay focused and out of trouble:

> *I love that military side of things, but I wasn't great at living in camp. That was where my… That is where I used to go off the rails.*

4.3.1 RECOMMENDATION: The Armed Forces should include more effective messaging at the recruitment stage to help manage recruits' expectations. For example, making recruits aware that while the role may involve periods of high intensity and challenge, like many other jobs, it inevitably includes periods of downtime. The communication of such messages is particularly important to those recruits with predilection for risk-taking and/or sensation-seeking.

As noted previously (see Section 3.2.1), academic studies have suggested that the service recruitment process may well favour individuals with these personality traits (see Brodsky et al., 2001; Iversen et al., 2007; Freeman & Woodruff, 2011; Anestis et al., 2019). Evidence from *Fall Out*

suggests that the ways in which time on base is structured could be improved to help keep service personnel (and sensation-seekers in particular) better motivated, engaged and disciplined.

4.4 Belonging & fitting in

As noted previously, the camaraderie and the friendships respondents made in service were generally perceived to be an extremely positive aspect of life in the military, but for the minority who struggled to fit in or be accepted by their peers and/or CoC, social and professional interactions were more complex and difficult to negotiate: *'if you're not a cliquey person or popular person, you didn't really fit in*'. Fitting into cliques and traversing the social complexities of living and fighting together is an essential condition of military life (Kirke, 2009).

Career progression and professional development were also perceived by participants of the *Fall Out* study to be far from transparent or meritocratic; the majority of participants described how, in their perception, promotion and opportunities were dished out more to those who could 'play the game' or fit in rather than those who were good at their jobs. For some this was a cause of considerable frustration:

> *Well, [pause] there was a bit of a hostile atmosphere in [UNIT NAME] at times. It was quite an every-man-for-himself sort of place. It was very much a brown-nosing [culture]. It wasn't about your ability to soldier, your mental capacity. It was about who's dick you could suck the hardest.*

4.5 Bullying

In extreme circumstances, respondents' experiences of not 'fitting in' in their units included incidents of bullying that, according to the contributors, were prompted by poor professional performance and/or other personal challenges they faced at the time. One respondent, for example, said he was bullied because of his learning difficulties another because he struggled with anxiety:

> *They watched me in trouble and instead of moving me, they just took the piss. They bullied me, belittling me on parade and people breaking in my room and rubbing shit on the wall and pissing on the bed.*

In longitudinal studies, **childhood exposure to bullying has been noted as a major risk factor for a range of damaging and costly outcomes** – including higher risk of poor adult mental health and poorer employment outcomes (Takizawa et al., 2015). It is therefore important to note that a number of respondents also reported being bullied prior to joining the military. For these individuals, breaking free from bullying was cited as an important motivation to go into the Armed Forces. For some, military service had been empowering and protective:

> *I was bullied at school and I didn't really have any friends. And If I didn't join the Army, I'm convinced I would have been completely alone, living on my own with no interaction with anybody. But the Army gave me that confidence.*

Not all, however, reported such positive impact; treatment in camp for some simply perpetuated a cycle of mistreatment from which they had hoped to escape.

4.6 Mental Health

Studies of overall mental health prevalence rates in the UK Armed Forces reveal broadly similar rates of illness to those found in civilian populations (KCHMR, 2014). Common mental health problems (e.g. depression and anxiety) are the most frequently identified among veteran populations,

followed by PTSD. Alcohol misuse is noted as by far the greatest problem affecting those in the Armed Forces.

Despite this overall finding, some subgroups within the Armed Forces experience poorer mental health than others, including higher risk of self-harm, suicidal thoughts and potentially of suicide (Woodhead et al, 2011; Bergman et al., 2019a). These subgroups comprise: ESLs (Iversen et al., 2005; Bergman et al., 2016), those exposed to combat (KCHMR, 2014) and those with pre-service vulnerabilities potentially related to adverse childhood experiences.

A number of veterans in the *Fall Out* study talked about experiences of mental health difficulties while in service. Some talked of **PTSD symptoms, others of suicidal ideation, others still of depression and of significant anxiety**. While these were not always diagnosed or self-identified during their time in service, subsequent crises, medical interventions or retrospective reflections had led a number to conclude that they had been struggling with poor mental health at times during their military careers.

4.6.1 Seeking help

Participants did not always access help for these issues and when they did, most described interventions that were pastoral rather than clinical. When individuals raised mental health issues with superiors or with medical centres, this often resulted in referrals to a Padre or Welfare Officer rather than to specialist medical or mental health professionals. This is perhaps to be expected given that these informal channels are often the first line of support for those reporting issues with mental health, with more formal/clinical support potentially being made available if the informal support stage proves insufficient. While interactions with pastoral carers were broadly welcomed by interviewees, some felt that access to dedicated mental health support may have improved outcomes. For participants of *Fall Out,* **there was little evidence of a clear protocol and subsequent referral onto broader evidence-based pathways for treatment and support** – even when individuals were in distress and revealed high-risk behaviours in terms of their mental health. This may indicate a need to improve the training of Welfare Officers and Padres if, as evidence from this study indicates, they are often the first point of contact for those who present with mental health issues in service. Furthermore, personnel's access to clinical support can be dependent on Welfare Officers/Padres having the skills and training to recognise when and how to make appropriate referrals.

> *I'd only ever speak to the Welfare Officer... I just told him everything. And he was like: 'Wow fucking Hell, you've been through a fucking lot!' And I told him: 'Yeah, it's just one thing after another now and I've got to do something about it'. I'd tried committing suicide twice.*

Participants in the *Fall Out* study identified a number of **barriers to seeking support for mental health challenges**. Some said they felt unable to talk about problems and/or mental-health issues. Others talked of mental health being stigmatised in military life:

> *I would think about mental health and all and think, you know, am I depressed? And you know I was at that age back then where I was thinking, I'm in the Army, I didn't see any action in Afghan, if I go to the fucking Padre and tell him I've got mental health issues, I'm going to be a laughing stock, people are just going to tell me to grow up or man up. You know there was still an awareness about the stigma, but the stigma still existed and that was still the issue because I thought even if I talk to any sort of military charity they're just going to turn their nose up at me and say 'Tarra mate'!*

A number described **feeling unworthy of receiving help**. They explained that the Armed Services' environment included personnel who had experienced significant physical or mental trauma. When they compared their situation to these colleagues, some said they felt less justified in seeking help with what they considered to be 'minor' mental health issues and, perhaps, less deserving of support.

While most academic studies have found similar help-seeking patterns among military personnel compared to the general population (Hom et al., 2017; Iversen et al., 2010), **ESLs have been identified as less likely to seek help**. A significant body of literature also highlights a **cultural reluctance** (often referred to as a 'suck it up' mentality) on the part of many veterans to seek help for deteriorating mental health (Green et al., 2010; Koenig et al., 2004; et al., 2018). Other studies show that veterans (like civilians) take around a decade to seek help (Wang et al., 2007; Murphy et al., 2015).[13] Such delays are concerning as there is good documentation that early evidence-based interventions have the best chance of improving recovery and quality of life – particularly for adolescents and young adults (Patel et al., 2007; Patton et al., 2004). Closing this gap between the proportion presenting with mental illness and those seeking treatment is seen as a priority to reduce the burden of mental illness at an individual, occupational and societal level.

Consistent with some of the factors identified in the *Fall Out* study, academic literature notes that the most common reasons to avoid seeking help include: individuals not realising that they are unwell (Cheney et al., 2018), stigma (Freeman & Woodruff, 2011), worries about the impact of mental illness on career advancement (Fertout et al., 2015), dislike of formal services (Cheney et al., 2018), a preference for self-reliance (Stevelink et al., 2019), difficulty navigating towards help (Samele, 2013) and an 'avoidant coping style' which has been associated with use of substances to manage psychological distress (Devonish et al., 2017).

Overall, among the sample in the *Fall Out* study who described having experienced some degree of mental health problems while serving, **interviewees described a somewhat ad hoc in-service process that did little to instil hope of recovery.** A lack of alertness to and curiosity about the significance of their behavioural problems was also reported in this context. This resulted in some feeling that their needs had not been systematically investigated nor fully met. **Padres and Welfare Officers appeared to be an engaging and important part of the process of support for those in the Armed Forces** according to those describing their in-service care, **but these descriptions also pointed to a lack of integration with wider evidence-based treatment pathways and support.**

4.7 Developing a culture of peak mental fitness

Evidence from *Fall Out* suggests that there may be scope, organisationally, for the Armed Forces to further its active commitment to developing a whole organisational culture (from the leadership down) that promotes peak mental fitness and that minimises practices and processes that do unnecessary harm to good mental health.

The Armed Forces have the potential to mobilise protective occupational factors and experiences (such as unit bonding, occupational opportunities, physical fitness regimes and problem-solving skills) which appear associated with optimal physical, mental and professional performance.

The *Fall Out* study suggests that the Armed Forces may attract many recruits with pre-service vulnerabilities (some linked to exposure to historical trauma) who join the military hoping for a

[13] Some research evidence, however, suggest that veterans from recent deployments (Afghanistan) are seeking help more quickly (2 years) when compared with those from older operations (Norther Ireland, 13 years to seek help) (Murphy et al., 2015)

turning point in their lives and to escape deprived environments. The effective management of this cohort, however, is fraught with complexity, as evidenced by existing research literature and these participants' accounts.

4.7.1 RECOMMENDATION: The Armed Forces should take a more proactive approach to monitoring and identifying when a service person's mental health might be deteriorating, and to provide early support (such as informal conversations on wellbeing; access to talking therapies or counselling, brief assessment, etc.).

4.7.2 RECOMMENDATION: The Chain of Command (CoC) should build on current mental health promotion efforts that proactively seek to monitor those with pre-service mental health vulnerabilities (such as substance misuse, hardship, neglect, abandonment, abuse, etc.).

4.7.3 RECOMMENDATION: The Armed Forces should consistently mobilise protective occupational factors and experiences (such as unit bonding, occupational opportunities, physical fitness regimes and problem-solving skills) which appear associated with optimal physical, mental and professional performance.

4.7.4 RECOMMENDATION: The CoC should actively seek to minimise avoidable occupational harms (such as bullying, ostracization, excessive drinking, boredom) likely to further exacerbate developmental trauma and military performance.

4.7.5 RECOMMENDATION: The Armed Forces should provide trauma and mental health awareness training for personnel managers an. Education at this level should also include Making Every Contact Count (MECC)[14] training to ensure that the resilience and mental fitness of serving personnel are optimised.

4.7.6 RECOMMENDATION: The Armed Forces should provide additional training for staff with 'pastoral' roles (Welfare Officers, Padres, etc.), often the first point of contact for personnel with mental health concerns, to ensure they are able to recognise situations where clinical interventions are required.

4.8 Key Points

⇒ Despite the way in which participants' military careers had been curtailed, all spoke positively about aspects of their in-service careers.

⇒ Most talked of the special bonds of friendship formed while in-service, fostered by shared experiences and a strong sense of belonging. Many appreciated that the Armed Forces had provided them with opportunities for personal growth and professional development.

⇒ Within the accounts of military lived experiences, there were also descriptions of challenging circumstances and scenarios with which some had struggled to cope.

[14] Making Every Contact Count (MECC) is an evidence-based, behavioural change approach to improving health and wellbeing through better client/practitioner engagement and conversations. See, for example, Nation Institute for Clinical Excellence (NICE) https://stpsupport.nice.org.uk/mecc/index.html

⇒ Approximately half experienced periods of disillusionment with their military lives which, according to their own accounts, triggered personal and professional 'downward spirals' and substance misuse. Factors influencing these negative trajectories included perceived poor treatment, bullying, boredom, lack of operational experience and struggling to fit in.

⇒ There were also accounts of in-service mental health difficulties including depression, anxiety, suicidal thoughts and symptoms of PTSD. Few accessed help for these issues and when they did, most described pastoral rather than clinical or other professional support.

⇒ There was little evidence of a clear protocol for referral onto evidence-based pathways for treatment and support.

⇒ The perception that mental health was stigmatised in military life, and feelings that they were unworthy of support were noted as common barriers to help-seeking among the sample.

⇒ Clear opportunities exist for the Armed Forces to develop its commitment to the promotion of peak mental fitness while avoiding processes and practices that potentially harm mental health.

5 In-service substance misuse

In this section we seek to explore participants' experiences of, and attitudes to, in-service substance misuse, including perceived drivers of misuse. The section also describes respondents' perceptions and experiences of compulsory drug testing. Through participant accounts, it explores experiences of the disciplinary process from testing to discharge.

5.1 Drugs

There is very little known about the scale of drug use and drug reliance in the Armed Forces in the UK. Knowledge in the US is slightly better due to regularly completed *Health-Related Behavior Surveys*[15]. In research studies, factors associated with greater likelihood of alcohol and drug misuse during military service include:

- Greater cultural approval for substance use – particularly alcohol use in the Armed Forces (Devonish et al., 2017)
- Male gender (Devonish et al., 2017)
- Being younger than 25 years (Devonish et al., 2017)
- Being single (Seal et al., 2011)
- Parental substance use – for example, childhood perceptions of parental norms, and perceptions of peer and friends' norms are associated with higher levels of alcohol and marijuana use (Devonish et al., 2017)
- Avoidant coping styles (which involve a tendency to avoid dealing with psychological distress head on and avoiding or numbing feelings through other coping strategies such as alcohol and drugs) (Devonish et al., 2017)
- PTSD symptoms (Devonish et al., 2017)
- Depression (Bray et al., 2009; Heltemes et al., 2011)

In the *Fall Out* study, **participants described variable patterns of drug misuse during military service**. For some, drug-taking was described as a one-time only, haphazard event that ultimately led to their dismissal. At the other end of the spectrum, others spoke of more regular consumption while in the Armed Forces. Drug use was portrayed as being concentrated among 'cliques', particularly those who were less engaged or disaffected with aspects of military life, including personnel who had already given notice of their intention to leave the Armed Forces.

5.1.1 Attitudes & Behaviours

While many respondents described pre-service drug use histories, most said they were fully committed to staying clean at the outset of military careers. Indeed, for some, their motivation for joining the military in the first place was to distance themselves from environments and social contexts in which drug-taking was common practice. Many described maintaining abstinence from drug use initially before eventually reverting to use.

For the most part, participants described a gradual re-introduction to drug-taking, which was often re-started when tempted to 'dabble' on a night out, leading to increasingly frequent patterns of

[15] For more details see https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Survey-of-Health-Related-Behaviors/2018-Health-Related-Behaviors-Survey

consumption. Some talked of the realisation that they could or might be able to get away with taking drugs while in the military.

> *I remember getting four weeks off at Christmas and coming back at the first weekend having a spliff. Just for old times' sake more than anything. In my head, [it] then became: 'oh, I can get away with this'.*

> *There's always a caution there but we took massive risks, which didn't seem like massive risks at the time. We'd been doing it for so many weeks, you almost don't believe that you're going to get caught.*

The reference to risk-taking in the comment from participants is important. Evidence from the literature suggests that while individuals with pre-service vulnerabilities may possess many of the qualities needed for effective functioning during military activity (e.g. sensation-seeking, fearlessness, reduced empathy) (Iverson et al, 2007; Brodsky et al, 2001; Anestis, 2019), there are correlations between these personality traits and the less desirable risk-taking behaviours, including substance misuse (Galahad, 2005).

Furthermore, this propensity for risk-taking and sensation-seeking is disproportionately high during adolescent and young adult years when functional and structural changes in the brain significantly exacerbate these behaviours (Steinberg, 2012). It may also explain why many adults tend naturally to 'mature out' of *recreational* drug taking as they move beyond the age of 25 years (Ham & Hope, 2003). Participants made frequent references to their age or immaturity when discussing their decisions to take drugs in-service and how that had influenced their assessment (if any) of the risks accompanying these behaviours.

While most did not consider drug taking in the military to be particularly overt, there was a consensus that it did take place. Participants in the *Fall Out* study described in-service cliques within which drug use occurred and was broadly accepted. Members of these cliques were aware of those service colleagues who 'turned a blind eye' to drug use, and those who did not, as well as those who were users themselves and 'got stuck in'. While drug use in the military was not necessarily seen as a 'well-kept' secret, most who chose to use drugs while in service were aware of people with whom they could take drugs and/or felt 'safe' discussing their drug-taking behaviours and experiences (i.e. what they took, when, where and with whom).

It is important to note that **only a minority of those in the current study talked of drug taking 'behind the wire'.** More often it was something that participants did while on leave or during weekends away. Some, however, said off-camp drug use gave them a somewhat false sense of security, serving to normalise drug taking, influencing and affecting their judgement and broader life decisions and sometimes leading to more compulsive use:

> *I allowed myself to think it was acceptable to do drugs when I was away from camp, because I could get away with it, and then that morphed into having no control over saying no.*

Uncovering the extent of drug use among personnel of certain units came as a shock to some participants who had expected the MoD's well-publicised zero-tolerance policy to have had a greater impact on the drug-taking behaviours of serving personnel. To those who hoped that life in the Armed Forces would serve as a self-imposed rehabilitation experience, this seemed an unwelcome state of affairs which undermined their own determination to make a fresh start. These perceptions of drug use being more embedded and culturally endorsed than recruits expected are important as evidence from the literature suggests that **a *perception* that substance misuse is allowed or endorsed is associated with higher rates of actual substance use** (Fear et al., 2007).

Among those participating in this research**, the most commonly reported drug used during service was cocaine**. It was also the most common drug cited as a reason for failing the CDT test among this cohort, with half of the sample attributing test failures to cocaine use. Interviewees explained that they had specifically opted to use cocaine due to their belief that it was less detectable and therefore a relatively 'safe' option. Many thought that cocaine was metabolised relatively quickly and would be unlikely to be picked up by CDT. This 'tactical' cocaine use, at the start of leave periods, or even at the start of long weekends, was believed to reduce the risk of detection. As noted above, however, participants recognised that taking drugs carried some degree of risk. It is also important to restress that young service personnel are risk-takers by their very nature:

> *I never even thought about it. I got CDT'd once in training, that was it. Twice in my entire career. It never occurred to me. There was always that assurance that it is out of your system after three days.*

A variety of other drugs were also mentioned in the context of Armed Forces substance misuse including (but not limited to) cannabis; amphetamines; Ketamine; MDMA/Ecstasy; Mephedrone (MCAT) [and other New Psychoactive Substances (NPS)]; steroids and pro-hormones. Use of these substances, however, was perceived to be far more infrequent.

5.2 Alcohol

The consensus among participants in the *Fall Out* study was that alcohol use was an integral and, in some respects, sanctioned part of military life. While the majority of this sample reported alcohol use prior to joining the service, most also felt that their patterns of alcohol consumption changed dramatically after signing up – findings which reflect patterns noted in other studies of individuals' use of substances as they transition into the Armed Forces (Golub et al., 2014). Participants not only reported increases in their alcohol intake, but also a greater propensity to binge drink after having entered the military:

> *Fuckin hell! Jesus Christ! The army and alcohol go hand in hand. If you're not working, you're drinking.*

Being able to cope with the military drinking culture and actively participate in it was felt to be an important part of social and professional acceptance. Respondents pointed to the fact that, far from being frowned upon, excessive alcohol use in service was commonplace. The feeling was that as long as personnel were able to stay out of trouble, still report for duty and function, they were unlikely to be reprimanded or disciplined for episodes of heavy drinking:

> *Whereas when I got into the military, it seemed like it was based in the culture, which it was. Just going out and getting drunk every weekend and sometimes during the week. The ruling is that as long as you can stand up straight then no one really cares. As far as the Army is concerned, as long as you can [turn up] do the job, you could be an alcoholic…*

Dependent on the unit, some participants also recognised that, with regards to alcohol, they were given a relatively free rein. This appeared to be particularly the case when on postings overseas. Indeed, being posted abroad was a high-risk substance-misuse flashpoint for some respondents. For these individuals it was a licence to 'misbehave', a liminal zone in which the normal rules no longer applied. Some even referred to postings abroad as '*borderline holidays*'.

A number of these findings are echoed elsewhere. Jones and Fear (2011), for example, identified a long-standing organisational tradition of alcohol use in the Armed Forces with alcohol being used to facilitate social, unit and team bonding and cohesion, as a relaxant and means of comfort at time of stress and as an informal means of operational debrief.

Many other studies have also pointed to high levels both of harmful drinking and of associated alcohol-related problems within UK Armed Forces populations (Jacobson et al., 2008; Rona et al., 2008). Greater approval for drinking has been linked to higher levels of use, whilst reduced approval has been associated with decreased alcohol consumption (Devonish et al., 2017; Delucchi et al., 2008). Although attempts have been made over the last decade to provide more awareness about harmful drinking, and to restrict the availability of alcohol (particularly during active duty), achieving **sustained shifts in this culture has been challenging when military patterns have been so historically entrenched** (Jones & Fear, 2011).

Evidence from the accounts of the participants in the *Fall Out* study suggests that **the military alcohol-endorsing culture may also inadvertently encourage or lead to other forms of intoxication.** For many in this study, getting drunk on alcohol was not ethically superior or more professionally responsible to getting 'wasted' or 'high' on drugs.

Many talked of the pivotal role played by alcohol in drug-taking behaviours. For some, particularly those with low tolerance for alcohol, drugs (cocaine and amphetamines in particular) helped them maintain stamina and 'stay the course' in what were often competitive drinking scenarios. Others closely associated heavy drinking with drug-taking and reported frequently combining drink and drugs on 'big nights out'. Many too talked of the *perceived* disinhibiting effects of alcohol and often made decisions about using drugs when drinking heavily:

> *If I never touched a drop of alcohol, I would never have touched a drug. That's what leads on to it. If you were sober and someone says to you: 'here's a line' or 'do you want a bit of this?', nine times out of ten, if you were sober, you would say: 'no, you're alright mate'. Get a few pints down your neck, you go: 'sure'. It stops you thinking properly, doesn't it?*

5.3 Drivers of substance misuse

There has been little focus in previous studies on risk and protective factors specifically affecting likelihood of drug misuse in the Armed Forces. What evidence does exist identifies the following factors as being associated with a higher likelihood of drug use in the Armed Forces:

- Being younger (Golub et al., 2014)
- Being unmarried (including divorced and separated) (Lo et al., 2012)
- Mental health clinic visits – reflecting associations between drug use and poorer mental health (Golub et al., 2014)

Findings from the *Fall Out* study add to this evidence base; for example, interviewees identified several challenges associated with military life which they felt influenced their own substance misuse. Some of these challenges were grounded in feelings of disillusionment with Armed Forces life, and were influenced by factors such as boredom; perceived poor treatment; lack of purposeful activity; lack of career progression/professional recognition; bullying; difficulties fitting into the unit; post-deployment issues, and 'toxic' peers who were openly negative about their military experiences.

Many participants in the *Fall Out* study identified an institutional culture within the military of using substances, mainly with reference to alcohol. Participants talked of the ways in which alcohol was used as a form of relaxation, a way to promote social bonding and that getting 'messed up' was part and parcel of their in-service lived experience. Participants identified this culture as a potential driver for drug use. There were those who were, however, keen to stress the ubiquity of drug taking and alcohol use among their wider peer group and society as a whole – it was described as a normal and, for the most part, enjoyable part of young adult experience.

> *I think it is the same reason that any young lad, from a walk of life in Civvy Street are [using drugs]. Young lads like to go out, drink, do drugs, get into fights and shag birds. I think it is the same no matter which sector of society you are looking at… People enjoy doing drugs, for the most part.*

There was some recognition, however, that this situation made it harder to adhere to service rules regarding drugs. Participants talked of finding themselves in social situations that exposed them to drugs. While some recognised their own culpability in these contexts – 'owning' their decisions to take drugs – others felt that socialising with substance-using peers had negatively influenced their attitudes and drug-using behaviours.

Others still pointed to complex reasons for substance misuse that were grounded in adverse childhood experiences, personal loss and poor mental health:

> *My past started to, not come back up on my life, but the abuse side started playing on me too much and I started getting really wound up…we got treated like children… and everyone was being quite touchy and quite angry and pissed off all the time.*

> *I had lost a close family member as I started my basic training. Then I lost another close family member once in; I think that those things probably triggered it. Thinking: '[You] don't want to be down here being treated like a dickhead', do you? And: I'm not getting anywhere.*

Existing studies have also noted that exposure to trauma clusters during childhood was associated with a higher chance of developing substance-misuse problems (Danielson et al., 2009; Rosen & Martin, 1998). Evans and colleagues, for example, noted that having more than three adverse childhood experiences (ACEs) was linked to a higher probability of alcohol and drug use among veterans, compared with a matched civilian cohort (Evans et al., 2018b).

Having mental health symptoms prior to deployment has also been associated in the literature with problematic alcohol use while in the Armed Forces (Jacobsen et al., 2008; Kelley et al., 2013). Taking an overview of the *Fall Out* cohort, few reported mental health difficulties whilst in service. This may be because the structure of the Armed Forces conferred some degree of protection against the escalation of difficulties. However, on separation from the Armed Forces, many did then experience escalating problems and a growing realisation that these might have been linked to pre- or in-service onset of poor mental health.

There is a sizeable body of literature reporting associations between substance reliance and mental health difficulties – particularly PTSD and depression (Brady et al., 2004; Cucciare et al., 2015; Highfill-McRoy et al., 2010; Kelley et al., 2015). Seal et al (2011), for example, found that three quarters of those with both alcohol and drug dependence had PTSD; 63% of those with either alcohol or drug reliance also met the criteria for PTSD, suggesting a high rate of comorbidity. Indeed, Seal identified the reduction of PTSD symptoms as an important step in the reduction of reliance on substances. Cucciare et al (2015) found that lifetime use of cocaine was associated with a greater likelihood of veterans experiencing PTSD. Other studies noted links between PTSD and harmful alcohol use; a systematic review of the co-existence of alcohol dependency and PTSD noted that between 10% and 60% of those with PTSD presented with alcohol misuse (Debell et al., 2014).

Highfill-McRoy et al (2010) found evidence of a tendency for veterans with PTSD to self-medicate using substances. This hypothesis is well rehearsed in military studies and elsewhere (Brady et al., 2004; Kelley et al., 2015).

In terms of protective factors against drug and alcohol use in the Armed Forces, there is evidence from the literature that marriage, or a long-term relationship, may be protective in relation both to alcohol and cannabis use, and may reduce binge-drinking as well as the risk of mental illness

(Duncan et al., 2006; Kelley et al., 2015; Hoopsick et al., 2019). Hoopsick et al's study also found that greater unit support during deployment was linked to a decreased risk of drug use after deployment. This led to a recommendation for interventions that facilitate stronger interpersonal relationships during deployment.

5.4 Impact of in-service substance misuse

Participants were asked to consider the extent to which their in-service substance misuse had impacted on their military experiences. Some respondents talked of impact in relation to their ability to do the job, but also the ways in which substance misuse affected their motivation and ability to progress.

Some felt that the negative influence of disgruntled peers (those disaffected with their service experiences) had impacted on their career opportunities and also on their relationships with other serving personnel; some talked of being 'blanked' or disowned by more engaged colleagues with whom they had trained and with whom they had initially formed strong connections:

> *… quickly I was starting to be associated with the drinkers –. The negative people; the ones that hated the Army. I didn't hate the Army, but I said I did. "Oh, the Army is shit, I can't wait to get out". I could have got away from that. In the end the good lads, the really good lads, […] the ones that stayed being good lads, who I had known in training, just didn't want to know me. I had some good pals in training but very quickly we went our separate ways.*

The majority, however, did not perceive their substance misuse to have had a significant impact on their work. **One participant even suggested that not drinking could actually hinder one's career progression given that alcohol was such an inherent part of military culture**. Those who did not participate risked inadvertently creating the perception that they were not 'team players', anti-social or did not fit in.

5.5 Addressing drinking culture

Those interviewed for the *Fall Out* study described close associations between their military alcohol use and their decisions to use drugs. Evidence from this study suggests that the military drinking culture may inadvertently be encouraging other forms of intoxication.

As noted above, the Military has traditionally had high alcohol-endorsing norms. Studies have shown that this leads to higher levels of alcohol use among military cohorts (Fear et al, 2007). Attempts have been made to address these norms, but it has been challenging to shift whole-system culture (Jones & Fear, 2011).

5.5.1 RECOMMENDATION: Building on existing guidance and directives, organisational action to both address alcohol endorsing cultures and reduce excessive drinking levels, should continue to be priorities for the UK Armed Forces.

5.6 Early detection and intervention

Evidence from *Fall Out* points to opportunities for early intervention to counter drug misuse within the Armed Forces. Management staff could be educated to develop alertness to early risk factors identified in the research and literature review. For example, spotting those with avoidant-coping styles, with gambling or with other impulse-control issues. From this study, service personnel appear more likely to engage in harmful substance misuse if their sense of military belonging deteriorates or

is compromised, if they become socially isolated, or if their protective family or Unit relationships break down. These early detection and intervention efforts should also address related mental health problems that manifest as self-medication with drugs and alcohol. The use of interventions by the CoC, and a stepped approach to accessible NICE-recommended[16] substance misuse and mental health support might, in the long run, prevent costly loss of trained strength.

The Armed Forces already have excellent responses to and treatment of trauma in serving personnel. We are suggesting that this expertise be harnessed and applied to the proactive care for those at risk of substance misuse in an effort to: stem the outflow of trained strength through CDT discharge; and reduce the negative impacts that CDT discharge can have on successful transitions to civilian life. Training for the CoC should include awareness and identification of 'red flags' for potential drug and alcohol misuse, particularly in the under 25 age group. These can include, for example:

- Physical changes or deterioration
- Aggressive or emotional outbursts
- Isolation from peers
- Death/divorce or separation in the family
- Disciplinary offences
- Requests for leave or transfer
- Career frustrations such as denied promotion, courses, etc.
- Incidents of public shaming or humiliation (e.g. 'dressing down')
- Gambling or debt problems
- Excessive alcohol use

5.6.1 RECOMMENDATION: The Armed Forces should embed an evidence-based early intervention approach to de-escalating risk of substance misuse difficulties emerging.

5.6.2 RECOMMENDATION: The Armed Forces should develop awareness training for the CoC to identify the triggers for 'reactive' drug misuse among serving personnel.

- The Armed Forces should explore ways in which data on Adverse Childhood Experiences and pre-service vulnerabilities might be collated (at recruitment stage) to improve the management of and outcomes for these individuals/cohorts.
- Practices that can re-awaken or and exacerbate past trauma (e.g. treating individuals with disrespect and unfairness/ making them feel powerless and insignificant) should be addressed.

5.6.3 RECOMMENDATION: Better data are required to establish baseline measures of drug and alcohol use within UK military contexts.

- Data collection should be carried out by independent and credible research institutions/suppliers with a proven track record of military research to assure data quality and instil confidence among participants (guaranteeing anonymity, understanding the cultural landscape, etc.) Baseline data could then be used to:

[16] NICE – the National Institute of Clinical Excellence provides evidence-based guidelines for health and social care professionals in England. See www.nice.org.uk for further information.

  - Counter misconceptions of substance misuse within the Armed Forces - the *perception* that substance misuse is allowed or endorsed is associated with higher rates of *actual* substance use (Fear et al., 2007).
  - Inform substance-misuse education programmes.
  - Inform behavioural change initiatives aimed at reducing the prevalence of drug and alcohol use within UK Armed Forces.
- In the US, the *Health-Related Behaviors Survey*[17] comprehensively assesses health behaviours (including drug alcohol and substance misuse), overall wellbeing of US service personnel and how these factors potentially impact on readiness. Aspects of this may serve as one useful model from which to develop UK specific tools.

5.7 Deterring drug and alcohol misuse

Galahad, the company originally contracted to supply substance-misuse education to the Armed Forces, developed a model which employed ex-service personnel to deliver its education programmes. These programmes combined accurate and engaging science and health information with credible presenters familiar with military culture and vernacular and were delivered at unit level, often to audiences of up to 700 service personnel at a time. Current education provision for the British Army continues to be based on this model. Given the evidence from this study that key messages are being lost or ignored (e.g. few expected to fail a CDT; all were aware of the zero-tolerance policy, but were prepared to risk taking drugs; strong association of alcohol with drug-taking behaviours, etc.) and the need to adapt to a post-pandemic environment, it could now be a timely opportunity to review substance misuse education delivery.

5.7.1 RECOMMENDATION: The Armed Forces should review its current substance misuse programme with a view to developing a coherent, Tri-Service approach. An update model for the education might usefully consider online, interactive and inclusive e-learning programmes, tailored to individuals' level and learning style, with follow-up information and support as required. In addition, evaluation tools should be built into any new service provision to enable the measurement of outcomes.

Education, however, should be only one part of a strategy to deter drug and alcohol misuse. If the cultural pressure to do something is strong enough, no amount of information on harm will stop it. Unless the cultural environment changes, the alcohol use will remain the same. The UK Armed Forces have, like many other forces around the world, a '*culture of intoxication'* (Fox, 2010). As long as this is an institutional norm, it is to be expected that the intoxicants (chosen substance) may change based on the generation and their norms of use, but the culture will persist. The *Fall Out* study has shown that the newer generation use and think of drugs in a way their parents or grandparents used and thought of alcohol. The CDT policy is caught in the cultural lag. This does not imply, of course, that recreational drug use be normalised in the Armed Forces, but that the responses to such use might benefit from an overhaul.

[17] For more details see https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Survey-of-Health-Related-Behaviors/2018-Health-Related-Behaviors-Survey

5.8 Key Points

⇒ Very little is known about the scale of drug use and drug reliance in the UK Armed Forces.

⇒ Participants in this study described variable patterns of drug misuse, from a one-time only occurrence to more regular and sustained use. According to participant accounts, drug use among service personnel was largely confined to certain cliques and mainly occurred away from the base during weekend and leave periods.

⇒ Some participants had initially been surprised to find out that some serving personnel took drugs and that, among certain cliques, it was viewed as acceptable. These perceptions of drug use being more embedded and culturally endorsed than recruits expected are important as evidence from the literature suggests that a *perception* that substance misuse is allowed or endorsed is associated with higher rates of *actual* substance use (Fear et al., 2007)

⇒ Cocaine was the most commonly reported drug used by serving personnel. It was also the drug responsible for the majority of the participants' CDT failures. The common perception was that cocaine was metabolised quickly and, if timed and used 'tactically' at the start of leave periods, for example, the risk of CDT detection was less than that for other drugs. Few of the sample thought taking drugs while in-service was risk free, but judging by their accounts, and evidence from the literature, risk-taking and sensation-seeking may be disproportionately high among young service personnel.

⇒ Alcohol was perceived to be an integral and sanctioned part of service life. Most reported a significant increase in alcohol consumption after joining the military and a greater propensity to binge drink. Many felt that an ability to cope and engage with military drinking culture was an important component of social and professional acceptance.

⇒ Evidence from this study suggests that the military alcohol-endorsing culture may inadvertently encourage other forms of intoxication; many talked of the pivotal role alcohol played in drug-taking behaviours.

⇒ The prevalence of drug use among peer and family groups was reported as a significant driver for participants' own substance misuse.

⇒ A minority of the sample pointed to more complex reasons for substance misuse that were grounded in adverse childhood experiences, personal loss and poor mental health.

6 CDT & discharge experiences

In this section we seek to explore participants' perceptions and experiences of compulsory drug testing (CDT). Through the accounts of the respondents, we focus on drug-taking behaviours prior to their positive tests, but also on subsequent events and their experiences of the disciplinary process ultimately leading to their discharge.

6.1 Zero tolerance

The Armed Forces' zero tolerance of drug use was a subject of much discussion among the research participants. Few argued with the Forces 'right' to dismiss them for transgressing the rules on drug use, but many felt aggrieved at the **perceived unfairness and hypocrisy inherent in the differential treatment of service personnel** found to have committed crimes and policy infractions while drunk on duty compared with, for example, those found to have traces of drugs in their urine from off-duty use. As noted above, many talked of the prevalent role of alcohol in military culture and there was a perception that it was very much a sanctioned and institutionalised form of substance misuse governed by poorly defined 'rules' (either implicit or explicit).

Furthermore, given the frequent reports from the participants that their recreational drug use was often accompanied by heavy drinking, **it could be argued that an alcohol-endorsing culture may inadvertently encourage other forms of intoxication.**

The following respondent, for example, echoed many others in his opinion of the zero-tolerance policy **and plea for the military to adopt a more rehabilitative and holistic approach to dealing with drug users in service**:

> *It just seems like a waste of day to be perfectly honest. If you're not getting people for alcoholism, then what is the point spending all that time trying to track down people for narcotics and things like that… and beating them out without any help. There is a direct correlation between people taking these recreational drugs and alcohol and things like depression and anxiety and other mental issues. Rather than giving people the support they need, they're just kicking them to the curb, more as a way to save money rather than to actually help people.*

This interviewee's response mirrors a call from other research studies for a more evidence-based approach in the Armed Forces to substance-misuse management and greater use of proven therapeutic approaches and campaigns. These include early detection, support and/or evidence-based interventions to help de-escalate problems, rather than awaiting more severe, damaging and costly issues developing in the future (Derefinko et al. 2018; Glover et al., 2018).

6.2 Participant's perceptions of CDT

There was some agreement that CDT did serve as a deterrent to serving personnel. That said, the majority of the sample discussed ways to 'beat the system', including evasion tactics such as making oneself scarce when CDT arrived on camp. There were also a number of similar reports of strategies they or colleagues had employed (often said to be 'common knowledge) to cheat the CDT. These strategies included: drinking large quantities of fluid prior to the test (cranberry juice was mentioned frequently in this context), and various methods to dilute the urine sample. Given that most of the sample had used drugs in a pre-meditated way and all had returned a positive drug test, the effectiveness of these strategies may be questionable – a point that some of the participants clearly acknowledged.

Respondents also mentioned that the timings of CDT, to a certain extent, were predictable. There was, for example, an expectation that CDT would show up on camp following extended leave periods. Out of the ordinary directions posted on routine or Part One Orders[18] – being ordered to report in PT kit at certain times or locations, for example – were also said to be indicative of the potential arrival of CDT.

For all the bravado, tips and tricks, however, many of those who had used drugs still described the arrival of CDT on camp as anxiety-inducing. Standing in line to produce a sample was, for these individuals, a serious reality check:

> *I'd be going crazy running with cling film around my body and drinking litres of water trying to sweat it out in the steam room! I would panic.*

Others simply did not think that they would ever get caught or at least felt they were prepared to take the risk. Some risk was perceived to be mitigated by the 'tactical' use of drugs (cocaine in particular); it was a common belief that certain drugs would be undetectable by a CDT after a period of a few days. **Before they failed a CDT, for many, the risk of getting caught was deemed to be minimal. Few had seriously considered the potential consequences of their actions**. As noted previously, academic studies have identified such risk-taking and lack of consequential thinking as common during adolescence and young adulthood – correlated with functional and structural changes taking place in the brain at this life stage (Steinberg, 2012). Risk-taking behaviours have also been noted to be common personality traits among those in the Armed Forces (Brodsky et al., 2001; Freeman et al*.,* 2011).

6.3 CDT to obtain a discharge

Missed opportunities for interventions were particularly evident among a sub sample of *Fall Out* participants. **A minority** (*n*=3) **of those interviewed said they had used drugs intentionally to expedite an accelerated discharge from the Armed Forces**. While the ways in which they went about this exercise differed, all shared a common disaffection with their circumstances at the time of the test. It is particularly unfortunate, for these individuals, that their levels of dissatisfaction with professional and/or personal lives had reached such a point that deliberately failing a CDT was perceived to be the only course of action left available to them. It is also regrettable, perhaps, that they had been unable (or unwilling) to access support that may have helped them better negotiate their particular life challenges. The comments below illustrate the range of personal and professional issues which these participants had struggled to resolve that had ultimately led to their failed drugs test. Common across these accounts were descriptions of social separation, either through isolation and/or a loss of comradeship, that appeared to represent a tipping point.

> *In a way [I did deliberately fail the CDT]. Yeah, to be honest, it was a mental health sort of thing…I've gone through some serious sort of struggles. There were definitely problems. When I was [assigned a new position] that's when I started gambling and I started going out more and I was like 'fuck it'. I was like going out with my mates back home, and I fell in with the wrong crowd, because I never had friends, but like the Army was sucking my soul away, like I was so depressed I was looking for any way out…I wasn't like right, I'm going to fail a drug test, but I was like 'fuck it'. I'll smoke and do whatever I want and if they catch me, well what's the worst that's going to happen?*

> *[A colleague] who was quite good to me, got a posting to [another regiment] … so I just said, 'stuff this', and just went ahead and did it… I knew the CDT was on that day. One of the lads had*

[18] Orders issued regularly at unit/fighting arm/squadron level detailing tasks, duties, schedules, meetings, policies, etc.

some and I just said 'gimme some of that' and went and had the CDT. I just couldn't hack it anymore.

Every soldier knows full well, you have a Monday off and a long weekend, nine times out of ten you will probably have a CDT. I was on it all weekend. I'm talking, Friday, Saturday and Sunday, and through to the early hours of Monday morning…I was going through a lot, but I think it was the Tuesday. I was on it all weekend; I didn't give a flying fuck. I was hoping for a CDT. All my mates I had in [LOCATION], all the Corporals, all my friends, were in a different country. I didn't have anyone to converse with; I didn't have anyone, so I didn't give a flying fuck.

6.4 Substance misuse prior to CDT

Among the sample, as one might imagine, there were very differing experiences of drug use and behaviours in the period leading up to CDT. There were, however, some commonalities between accounts of these events. Many described returning from tours, operations or leave periods and using this downtime to catch up with, or in some case have 'blow outs' with mates – both civilian and military – facilitated to a certain extent by the additional funds they had saved/been paid for overseas duties. There were a number of examples too, of personnel being arrested for other infractions which led to them being charged for drug possession.

While not mentioned explicitly by respondents, these common narratives may suggest **associations between drug use and a need to decompress, relax and/or reconnect with civilian 'normality'; to re-establish bonds and routines after extended periods of absence**. Also, there was some indication that serving personnel needed this post-deployment time to recalibrate and adjust before returning to the comparative mundanity of camp life.

Some had failed a CDT before going on tour; punctuating an intense period of pre-deployment training with a 'last hoorah'. Whether this was indicative of a need to spend time with friends and/or family members before deployment or whether it was overconfidence – believing that they would not be tested - was unclear. Missing out on tours, a reason many had given for joining the services in the first place, was, for some, a source of considerable regret.

Others talked of **mental health issues and cumulative personal challenges from which they sought to escape through self-medication and substance misuse**. The following quote, from one such participant, again exposes a missed opportunity for appropriate intervention.

The weeks leading up to my CDT I was quite depressed; I was seeing the Chaplain… when I came home and that's when I took the cocaine. I was burying myself and just wanted to be numb and forget everything.

6.5 CDT process

Although there was much similarity in respondents' descriptions of the CDT process itself, the research uncovered **marked differences and inconsistencies in the treatment of individuals having failed the test**. It should be stressed, however, that those who had been discharged most recently reported a more standardised experience.

For most, the period immediately following the CDT was, to varying degrees, characterised by anxiety. For some, the reality finally hit home that their decision to take drugs had potentially jeopardised their military career aspirations, threatened relationships with colleagues and family, and ultimately impacted longer-term life chances:

> *I felt like my world had just collapsed. I didn't know what I was supposed to tell my parents. I'd just had a new baby son. My son was six months old. I was like: 'what have I done?' I knew that I wasn't going to get the tour, which was all that I wanted to do.*

Most respondents reported internalising and/or underplaying their anxieties in the aftermath of their CDT. In hindsight, many recognised that this reflected emotional immaturity and an inability to seek support. The following extract is just one illustration of the emotional turmoil that many reported at this juncture:

> *I was a kid and I'm only now realising, sort of figuring out, how to handle my emotions, and what I really feel, so at the time I was scared and frightened and really anxious and worried -- am I going to get caught? But to my mates back home I'd be like 'fuck it, what the fuck, if I get kicked out, I get kicked out'. But I wasn't opening up to anyone about my worries at the time.*

6.6 Receiving notification of CDT result

The narratives of *Fall Out* respondents also illustrated **differing experiences of being notified about positive CDT results**. These included: being recalled from leave periods for an unspecified reason (both while on scheduled and compassionate leave); being 'called out' on camp or during roll call and being summoned to the offices of senior staff; and one respondent was informed of his CDT failure while on post-tour decompression.

For the most part, participants admitted that news of a failed CDT came as quite a shock. Many talked of a protracted period of time between taking the test and being informed of the result. Most wrongly assumed that CDT had failed to detect their drug use:

> *Well, I got tested and then nothing was said for about 2 to 3 weeks. After that, just up to that point, I thought: 'Well obviously no one got caught'. Nothing was said so I thought that was the end of the subject. And then all of a sudden, I got called back on parade. Our Sergeant Major at the time started telling us: "Whoever I call out now, go up to the CO's office". Started reeling off names and all of a sudden, he said my name.*

> *From my understanding it takes 2-3 weeks for results to come back, and I didn't hear anything, so I thought it was fine. Then I started getting these weird phone calls. They don't let you know that you've failed over the phone. They sort of try and trick you into going there [back to camp].*

Participants all gave accounts about how they were informed about the CDT failures by their COs or CO's designated representatives, although their experiences and the level of detail they were able to provide varied considerably across the sample. **Many said they had found the information hard to process at the time** and this was a reason given by some for struggling to provide thorough accounts of the event:

> *I can't remember too much into detail now. And there were so many different thoughts and feelings going through my head at the time and things going on. My mind was just all over the shop really.*

JSP 835 notes that the initial interview in which personnel are informed of the CDT result "is likely to have a profound effect on the individual" (MoD, 2013) and this was certainly borne out in the accounts of respondents. The following quotes illustrate levels of confusion, stress or anxiety that impaired decision-making at a potentially life-changing juncture. Again, the following extracts from conversations with participants point to a level of immaturity and an inability to deal with the emotional and practical consequences of their actions:

> *I got a message to go down to my HQ and go see the CO and I was like, I didn't want to make it seem like I was being disrespectful and like, fuck all of it, so I just went there, signed the paperwork, said yeah, did coke etc, yeah I did do it. I was then marched to my room, made to pack all my bags, and my mind wasn't really right, and I was quite pissed off.*
>
> *They informed me that I had failed the CDT and they gave me three options: denial, request a retest, admit it's in there, or challenge how it got in there. I can't remember what I said, but it was total bullshit. I was like, no no no no!! And then I thought I've got to deny this. I realised that no, I have done it, I have been caught, so what am I doing? No point fighting, I have to admit what I've done.*

From the more detailed accounts given, there was evidence (particularly from those discharged most recently) that COs had acted in accordance with JSP 835 guidance including: informing personnel that they had failed the CDT, with which substance(s), the levels detected, and presenting personnel with the option to admit, deny or challenge the result – including the processes associated with each of these choices.

In the study sample, there were examples of individuals who had admitted, or denied and/or challenged the results. One had initially been retained after admitting drug use, only to fail a CDT at a later date; while another had unsuccessfully challenged a positive CDT for steroids, claiming it was a 'false positive' that he believed to have been a result of taking 'contaminated' supplements. A number had also admitted to drug use, expressed their desire to remain in the military, and had presented their cases accordingly. None of these individuals, however, managed to remain in service.

Accounts of interactions with COs in these initial interviews varied. Some respondents recalled COs being calm, understanding and broadly supportive. In some cases, participants said that their CO had been keen to retain them, but their power to make such decisions had been compromised as a result of policy changes[19] or due to precedents set by their or other units:

> *I did the test and three weeks later it was all over the news about how the policies had changed. I thought, oh it's Karma talking to me on leave! Like, oh for fuck's sake!! (laugh) I knew that they were going to go full barrels with it.*
>
> *I didn't question the CO because he was doing just what he has been directed to. Even my [named members of COC] were all there and were trying to fight for me to stay in because they said: 'honestly, we don't believe you have done anything bad. And we don't believe you are an issue. The only issue we are going to have is that they got rid of a Warrant Officer for exactly the same thing in another regiment. Even though the CO might fight to keep you in, it is very unlikely because the higher-ups are going to want to get rid of you. You can't be keeping [rank] and get rid of a Sergeant Major for the exact same thing'*

Among the experiences detailed by the respondents, however, there were examples of more severe 'dressing downs' from the COC in which participants' honesty and integrity were explicitly called into question:

> *The Sergeant marched me to the OC's office at 10'o'clock. He called me liar and a disgrace and that I wasn't to be trusted in the British Army…he didn't even look at me when he said it.*

[19] Prior to the commencement of fieldwork, Gavin Williamson announced that army would no longer readmit troops previously sacked for taking banned substances. See, for example, Army to introduce zero-tolerance drugs policy - Gavin Williamson, *BBC*. 03.11.2108

This type of verbal 'dressing down', experienced by the above participant and others in the study, reportedly had a profound and lasting impact on these individuals at a point where they felt particularly vulnerable, ashamed and faced protracted periods of uncertainty.

6.7 Post-CDT test discharge experience

The research interviews revealed a wide range of practices regarding treatment following CDT positive results. The time between receiving the results of the CDT test, and being discharged, varied considerably. Some were sent home to await discharge (of periods up to six months), others remained on camp. Information flow during these periods was generally poor; many were not kept informed of timetables and described being kept 'in limbo' for months. Hardly any interviewees reported access to psychological, medical or social support during this time. **Very few described being given training or being directed to services designed to aid transition**. There were also accounts of **separation from peers, imposition of menial duties and ostracization**. Those interviewed experienced **uncertainty, anxiety, and isolation, all of which impacted on their mental health and on the effectiveness of later transitions**.

6.7.1 In limbo

The range of time between the CDT result and discharge spanned one week to eight months. The majority of those interviewed described a lengthy period of uncertainty, inaction and of being 'in limbo' while they awaited a decision on dismissal or a date of discharge. Respondents talked of becoming increasingly disgruntled and disillusioned during this waiting period. Even those who had initially been highly determined to explore ways in which they might be able to remain in the Armed Forces, subsequently lost motivation to do so.

Some engaged in self-destructive behaviour and continued substance misuse during this 'in limbo' period. There was a perception among some that having jeopardised their military futures, they had little left to lose. Others described tangible frustration at being kept in the dark as to the outcomes of their positive CDT result:

> *I was in limbo for about two months. I just stopped caring at that point. I requested to discharge, I said: 'if you are going to boot me out, then boot me out'. They CDT'd me the following week; I had been smoking cannabis that week, I thought: 'fuck it, I just want out'. I was absolutely done with it.*

There were a few accounts of using this waiting period constructively and tactically to plan transition. These individuals were, however, very much the exception rather than the norm. **A common thread in these accounts were reports of supportive and informed CoC and/or the presence of empathetic and helpful peers. Those experiencing these forms of support appeared better prepared, practically and emotionally for the challenges of transition**. All recognised the positive contribution that these individuals had made to their post military life chances:

> *I was pretty much solely focused on getting myself organised for Civvy Street. I had the luxury of doing that, whereas other people generally don't. A lot of people don't have the support of their Chain of Command like I did. It is just a case of you've got five days and you're gone, whereas because of the situation I was in, I managed to prolong it quite a lot. I was preparing for civilian life, so I had jobs already lined up, I had work planned out, and I had things in place. And that was only because I had the support of people around me rather than just being kicked out…It was kind of a play by me and my superiors to stay in and get everything done before I was thrown out on my arse, basically.*

6.7.2 Separation & isolation

Most participants reported being physically separated from close colleagues or friendship groups – either removed from the lines or sent home – during protracted periods between returning a positive CDT and their discharge. Studies note that these unit bonds and friendship groups are important protective factors, particularly in terms of reducing trauma symptoms and supporting positive mental health (Jones et al., 2012; Greenberg et al., 2003). **Given that all participants cited friendship bonds and social lives** as **the most positive aspects of military life, this punitive separation had a profound impact:**

> *I got moved out of my room, away from all my mates, to where all the shitbags go. Moved in with all the other people who failed their CDT…a separate building, for those who had failed and those who were injured.*

> *I know I got isolated; I couldn't knock about with anyone. And we had to get escorted down the cookhouse as well.*

Those who had been sent home to await a final clarification on the disciplinary action to be taken as a result of their positive CDT appeared to be particularly susceptible to feelings of isolation, having been removed from their professional social networks.

6.7.3 Changes in duties and ostracization

After CDT, many of those remaining on camp were allocated menial tasks or restricted duties. **While many of the respondents recognised, in retrospect, that these steps were taken to ensure compliance with health and safety and/or disciplinary protocols, they had a significant impact on their sense of wellbeing and self-worth.** Participants talked of having to report at regular intervals to the Guard House, or to their superiors, where they would be given jobs such as cleaning up the camp, sweeping leaves, polishing brass, laminating documents, etc. Some participants felt demeaned by this change in duties, others said that it exacerbated feelings of shame and regret. Losing the respect of their former colleagues was a particularly harsh lesson for some:

> *We had to report to the guard house at particular times, and then given a brush and told to clean up the camp. These are guys that respected me before what happened. I was taken really from a very positive career, having fallen into a negativity trap, to having the rug pulled from under my feet.*

While some respondents managed to maintain non-judgemental relationships with peers following CDT, there were also reports from others of feeling ostracised and, in some cases, humiliated as a result of the treatment they received at the end of their military careers. For example, there were reports of respondents being publicly called out in front of their peers by the COC:

> *Our Company Major... Our company was on parade Sunday mornings and then he would come up and belittle us in a way. 'Those people over there who got caught, they should not be around you. They should not be trusted with weapons.' In my head, I was still the same soldier as I always was. For him to belittle us like that with everyone else there, in front of the Company was a bit of a dig, I think. The Officers, they kind of look down on you anyway.*

One respondent, who had struggled his entire career to fit in, found the demeaning treatment hard to bear:

> *It was horrible; it was the worst couple of months of my life…You have to go through the discharge process then and, at the time, I was still living in the block in the same place, still*

> *working in the same job and everyone was taking the piss about my anxiety. I was there waiting to be kicked out on a drug offence that everyone hated, and people telling me to grow up and I wasn't going to get a job and I was shit scared…so it was all like fear-mongering to a kid at that age…*

What was clear from discussions was that respondents' **experiences during this pre-discharge period were improved significantly when they were supported by peers and those up the COC**. A few reported offers of practical help and support as well as a degree of empathy from colleagues. One senior NCO had offered to provide a character reference to one of the respondents. Another participant had been given some time by his CO to prepare job applications in advance of his discharge.

6.8 Discharge

After long periods in limbo, the time between eventual notification of discharge and leaving the services was then relatively brief. Most respondents reported being dismissed from service within a matter of days, or even hours, of receiving the official decision on their discharge:

> *I was sitting on the settee one night. The phone went and I was told that I would be picked up at zero seven hundred hours, again. Brought to camp and going in front of the Commanding Officer of the regiment…he read out my name, rank and all that. He said you are discharged today, [DATE]. That was it. I was told to go to my room, pack my stuff…I had to ask my mates to come and pick me up, and was walked to the gates as a civilian.*

> *I handed all my kit in, and then some forms I had to get people to sign them, and literally it was a case of, see you later! Walked me out the gate and that was it.*

As indicated above, before discharge many participants described having to return military issued kit and collect signatures of receipt. A number found this exercise a punitive and unpleasant experience, often involving sequential 'dressing downs' as items were returned:

> *I had to go around and give all my kit back and get all the signatures from different members of staff. As you can imagine, every single time, I was a young kid, I had to go get a signature off a 30-40 year old man who has devoted his life to the Army, I would get the lecture: you fucked your life up, and all this shit. They were telling me, what are you going to do with your life? and just making me feel terrible about it.*

> *I had to go around and get signatures and every single person you had to get a signature off they always had a lecture, like that was it, your life's over.*

Many of these comments centred on the lack of hope and prospects that these young men might face following their drug-related discharge. This is concerning given that separation from the Armed Forces (Kapur et al., 2009; Shen et al., 2016), early leaver status and co-existing mental health and substance misuse reliance are all noted as increasing the risk of suicide (particularly noted for younger soldiers) (Woodhead et al., 2011; Bergman et al., 2019a; Brignone et al., 2017).

6.9 Inconsistent and damaging discharge processes

According to the accounts of participants in *Fall Out* there were **marked inconsistencies in the ways administrative procedures were applied following a positive CDT result**. Evidence from this research also highlighted examples of harsh and humiliating treatment that, according to some, exacerbated mental health issues and increased levels of stress and anxiety. In extreme cases, poor treatment post CDT resulted in patterns of **self-destructive behaviour**. In most cases, the discharge

process left this potentially **vulnerable group ill-prepared for the challenges of transition** and largely unsupported.

There needs to be greater awareness that the CDT discharge process can be a trigger for mental health issues, PTSD and further substance misuse. Many respondents reported that the discharge process was the start of years of mental health problems:

> *I'd tried committing suicide twice... I was fucked in the head, and I won't lie to you, I'm not properly there yet, but I'm a thousand times better than I was. My mental health over the past 6-8 months has been something that I feel that I'm fortunate to be actually still living and breathing. I did want to go. Honestly. And I've still got a long way to go. All I want to do is move in the right direction.*

While JSP 835 (MoD, 2013) provides clear guidance on the management of CDT failures, evidence from the participants' accounts indicate marked variation in how this guidance was applied. Factors that accounted for these variations included differing interpretations of the guidance at both Service and Unit/Squadron/Fighting Arm level, and year of discharge – those discharged most recently reported a more consistent experience of the CDT disciplinary process.

6.9.1 RECOMMENDATION: Greater efforts should be made to ensure clarity, consistency and transparency in the application of JSP 835 guidance on the management of CDT failures at a Tri-Service level.

6.9.2 RECOMMENDATION: *Fall Out* evidences the need for a process review and training on the administration of the guidance to ensure that all staff involved understand the potential impact of overly punitive treatment on mental health and successful transitions. Training should emphasise the importance of the following:

- **Timeliness of communications** – individuals should be kept fully informed at all times of case progress.
- **Respectful treatment** – regardless of CDT result.
- **Consideration** – care and support of a potentially vulnerable cohort likely to struggle post-service.
- **Raise awareness of links** – between demeaning, belittling, unsupportive, isolating treatment, and poor mental health and transition outcomes.
- **The positive role of supportive peers/CoC** – can help CDT dischargees to be practically and emotionally prepared for the challenges of transition.

6.10 Support and advice

Clearly evident from the *Fall Out* research interviews was the paucity of support available to this cohort of service leavers after CDT. Participants reported receiving little help with health, psychosocial, substance misuse or resettlement issues.

6.10.1 Mental health and substance misuse support

There is already a sizeable body of literature identifying associations between alcohol and drug use and poor mental health among veterans – particularly PTSD and depression (Brady et al., 2004; Cucciare et al., 2014; Highfill-McRoy et al., 2010). This suggests that for many who have tested positive for drugs, there is a strong likelihood that they are facing a triple challenge of substance reliance, mental health difficulties and sudden loss of career for which they were ill-prepared. Those

with a history of multiple clustering adverse childhood experiences (Carroll et al., 2017) and ESLs (Woodhead et al., 2011) are at increased risk of poor mental health. For all of these reasons, those testing positive for drug use would appear to represent a particularly high-risk group as they negotiate transition back to civilian life. A US PhD dissertation which explores the evidence and experiences of those who leave the military via a non-honourable discharge for drug use (Phillips, 2018), identifies that those who leave the military in this manner experience a 'dual challenge' in the transition back into civilian life – coping with the separation itself, but also managing the symptoms of their substance use disorders. In Phillips' view, this double challenge further compromises the chances of successful transition from military life. UK studies also note that ESLs are less likely than other veterans to seek help for mental health problems, potentially increasing the likelihood these problems remain (Woodhead et al., 2011; Godier et al., 2018).

It is unfortunate that not one of the respondents in the *Fall Out* study reported any routine discussion with medical staff or other specialists about their drug use. **None of the interviewees recalled being formally screened for potentially problematic substance misuse** (e.g. via AUDIT, DAST, etc.) **or for mental health difficulties on testing positive** (despite close associations in studies between in-service drug use and poor mental health). No assessments were described as taking place to determine whether those who had returned a positive CDT had any immediate concerns regarding substance misuse, addiction or mental health. Many interviewees expressed surprise at the lack of systematic screening and support offered after their positive test. There was an indication from some interviewees that they might have been receptive to support had it been offered at the time when they had tested positive – a time when they described feeling distressed and particularly isolated. This may, for some, have provided a golden opportunity for a motivational discussion promoting mental health awareness, readiness to change, and for other supporting protective factors to help promote the likelihood (or at least potential for) a more successful transition. Few said they were offered any help after their positive test.

While CDT failure is treated as an administrative issue – there is no routine medical involvement process – the *Fall Out* study highlights an opportunity for improvements in practice to help mitigate the well-documented risks facing this cohort. Most participants in the study self-classified their in-service drug use behaviours as 'recreational', rather than addictive, but arguably there remains a compelling case for screening individuals dismissed because of a failed CDT for early indications of problematic substance misuse. Indeed, several interviewees remarked on the lack of support on offer post-CDT:

> *[They] didn't even ask if I needed drugs counselling, if I needed help, why did I do it? There was nothing like that, I was told to leave camp and then they would be in touch.*

The literature indicates that this group might, of course, be reluctant to engage with such help. Such crisis points, however, can open up opportunities for engagement. Some respondents did consult with the medical centre or Padre after the CDT result, but experiences of these channels of support were *ad hoc*, informal and perceived to have been of limited value. While in recent years, screening for mental health disorders are incorporated into final medicals, very few participants mentioned their experiences of this or recognised this to be the purpose of questions posed by medical staff.

> *The only one who ever asked about feelings was when we had to go and get one of our final medicals, the doctor and then asked: "how are you feeling?" and all that kind of stuff.*

Some examples emerged from participant narratives, of mental health interventions which were instigated by the COC or by peers in response to episodes of self-destructive and highly risky behaviour; it took these individuals to reach a point of crisis before interventions were forthcoming. One soldier, who reported a documented history of suicide attempts during his service, was told to

pack his bags and leave the camp almost immediately after the CDT result was returned. The soldier then went on a 'drunk-driving rampage' and was discovered outside of the barracks of another regiment and referred by a peer to their Medical Centre.

> *Yeah, I had to leave straightaway. I got marched into my room, had to pack a bag and then go. I thought it was fucking disgusting, like just you've got to go, so I lost my head with it and that's how I went on the rampage. I got absolutely rat-arsed, and I was driving my car down the motorway and found myself in Nottingham the next day. One of my mates took me to the Med centre and that's when he started the process of making me talk to someone. Then they referred me to the hospital because they thought, you're at a very high risk and you need to go to hospital. I had to stay there for a while. It was like, yeah grab your bags and fuck off out. I mean, what kind of mentality is that? You just don't do that to people. Maybe they realised that they should give this guy a hand before he goes. That's when I got referred to the Welfare Officer, and it took me a while to gain the trust to speak to him, but then I did start telling him things and why I was the way I was. I got a bit of help from him and through DCMH for four weeks before my discharge.*

Finally, two veterans mentioned having been signposted to local Alcoholics Anonymous services in the community – offers which they did not follow up.

As noted above, evidence from participant accounts highlights a significant opportunity to review practice to help improve the outcomes of this potentially vulnerable cohort.

6.10.2 RECOMMENDATION: All service personnel testing positive for drugs should be routinely screened for substance misuse and mental health difficulties and be signposted to and encouraged to use support services.

Where resources are available, these assessment tools should be administered by impartial, qualified professionals.

6.10.3 RECOMMENDATION: The Ministry of Defence and NHS providers across the UK should work together to develop a joint protocol for managing those who test positive for drug use.

This protocol should be mindful of the following approaches and considerations:

- **Extra Time.** Additional consideration should be given to those who joined the military at a young age (pre 18 years old). Evidence from this and other studies suggest that this cohort is the least prepared to negotiate some of the practicalities of civilian life (paying bills, apply for housing, etc.). Premature and unexpected discharge (through positive CDT) often deny these ESLs sufficient time to acquire these essential life skills.
- **Contextualising substance misuse.** Consideration should be given to a system for assessing the extent to which an individual's drug use may be linked to youth and/or immaturity rather than more entrenched substance reliance/addiction.
- **Avoiding Learned Helplessness**. Every effort should be made, even after a decision to discharge, to minimise exposure to additional harmful processes at a critical point of transition to civilian life (e.g. minimising shaming and bleakness about future prospects).
- **Support.** Consideration should be given to a model which provides practical mental health and resettlement support that spans the Armed Forces to civilian transition. This should be non-judgmental, proactive, outreaching, relationship-based (due to ESLs decreased likelihood of engagement), co-produced with ESLs with experience, and evaluated for cost effectiveness.

- **Screening.** Routine assessment screening for substance use should be conducted in primary care and other settings to mobilise prevention efforts for those with emergent problems. Alcohol and Drug disorder disclosures should signal clinicians to carefully query patients regarding childhood adversity, and, conversely, indications or revelations of childhood adversity exposure should also prompt alcohol and drug screening.

6.11 Key Points

⇒ Few argued with the Forces 'right' to dismiss them for taking drugs, but many felt aggrieved by a perceived disparity in the disciplinary treatment of service personnel found to have committed infractions while drunk compared with those caught by CDT. Some called for a more rehabilitative and holistic approach to drug use in the Armed Forces.

⇒ All the participants were familiar with the Armed Forces' zero tolerance policy on drug use. Prior to their positive CDT, however, most considered the risk of being caught to be minimal. Few had seriously considered the potential short- and long-term consequences of a CDT discharge.

⇒ The research uncovered marked inconsistencies in the treatment of individuals once they had failed a CDT, although among those discharged since 2018 (*n*=6), most reported a more standardised experience. For most, the period immediately following the CDT was characterised by anxiety and uncertainty.

⇒ There were some reports of harsh and humiliating treatment in the aftermath of a positive CDT. These included ostracization, verbal dressing downs, separation from peers and being called out/shamed in front of colleagues. This treatment reportedly had lasting impacts on some individuals and compounded existing feelings of vulnerability, isolation and shame.

⇒ While awaiting discharge, some had engaged in self-destructive behaviours and continued substance use. Interviewees talked of high levels of shame over drug test failures and being discharged from the Armed Forces – feelings that were often long lasting.

⇒ Very few of the participants received psychological, social, or transition support post CDT, all of which are arguably pivotal to the likelihood of a successful transition.

⇒ None of the participants recalled receiving support for drug use or mental health difficulties in the immediate aftermath of a failed drug test.

⇒ Only a few participants reported using time constructively pre-discharge to prepare for transition. Those who did so reported supportive and informed CoC and/or empathetic and supportive peers. They recognised the positive contribution that these sources of support had made to their post-military life chances.

7 Transition

In this section we briefly consider the transition support available to ESLs, before exploring the transition experiences of the research participants and the perceived impact of their CDT discharges on employment, social relationships, substance misuse and mental health.

7.1 Transition support

Historically, ESLs have had limited access to transition support. Prior to 2002, the management of personnel discharge was the responsibility of individual services with entitlements for those discharged for disciplinary reasons often decided at unit level. Entitlements were often likely to comprise some basic provisions (e.g. the issue of travel warrants), if anything at all (Caddick et al., 2017). The publication of Issue1 of JSP 534, *The Tri Service Resettlement and Employment Support Manual* (2002), unified guidance across the Armed Forces. In 2004, along with an updated Issue2 of JSP 534, JSP 575, *Early Service Leavers Guidance for Resettlement Staff* set out details of the "reduced provision" of resettlement support that should be made available to ESLs. The last iteration of JSP 575 (2010) states this as follows:

> *ESL are **not** entitled to access the resettlement support detailed in JSP 534, the Tri-Service Resettlement Manual, but they are entitled to a reduced provision. As a minimum, they are to receive a mandatory resettlement brief and a one to one resettlement interview given at unit level.*

In recognition of mounting evidence and concerns that ESLs are disproportionally disadvantaged and are at an elevated risk of unemployment, homelessness, unemployment and mental health issues, the MoD, in 2011, commissioned evaluations of ESL provision. Forces in Mind Trust supported the evaluation of the Future Horizons (ESL) Programme (FHP) at Catterick Garrison (Fossey & Hacker Hughes, 2013). This demonstrated positive employment outcomes for those who participated. As a result, more transition support was made available to ESLs through the CTP contract awarded by the MoD in 2015 (Godier, 2018).

While it was beyond our remit to fully investigate and analyse in detail unit-level support on offer to ESLs across the Armed Forces, it is important to note that the support each interviewee should or would have had access to has changed over time and may have been specific to a particular unit and/or Service. The sample for *Fall Out* included participants from all three branches of the Armed Forces who had been discharged from service between 0.5 to 23 years prior to interview (median 4.75 years). Three of the participants had left the Armed Forces prior the publication of JSP 575 and as such would have been eligible for only cursory support at the discretion of their CoC. A further six participants left the Armed Forces between 2004 and 2014 and were therefore entitled to the minimum of a resettlement brief and interview. Half of the sample, in theory, would then have been eligible for CTP Future Horizons.

Findings from *Fall Out*, however, evidence very low levels of engagement with this support. **Only two soldiers mentioned having been offered CTP/Future Horizons. They both declined**. One because he felt it was of no value to him at the time; the other because he was told he would have to pay for the courses himself. The fact that none of the remaining seven participants eligible for this support could recall being offered access or engaging with the service is notable. A number of factors could account for this. At the time of interview, ESLs were required to 'opt in' explicitly in order to access CTP and it may be the case that this 'model' does not work in the best interests of ESLs facing discharge as a result of a CDT. The manner in which some had been treated prior to discharge may also have done little to encourage or motivate them to engage with CTP. Some had

been made to feel that they had limited future prospects and may have become despondent as a result. They may also have felt reluctant to engage in additional form-filling over and above that required to complete their discharge.

It was clear from participants' accounts across the whole sample (not just those eligible for CTP) that the emotional state of individuals during the 'exit interview' and the turbulent period between CDT and discharge was not conducive to clear thinking. This may have impacted on the data we were able to obtain from the research subjects. Many participants, for example, could not recall whether they had been offered help or not. Only a few participants reported receiving or being offered any form of resettlement assistance at all following their positive CDT result. The discharge process for a number of the participants seemed more focused on the administrative requirements (such as returning kit, etc.) than it was on helping individuals achieve a successful transition:

> *I don't remember having any interview like that [at] all, any things that I should do, etc. I don't think there was anything like that. It was a case of just "Do this in this time", hand your stuff back in and we had to go and do all the bits, file bits of paperwork and that was it. I would say we were literally left to be there until our time was up. Other than being helped by mates within the blocks, I wouldn't say there was much help on offer, unfortunately.*

7.1.1 RECOMMENDATION: All service personnel discharged through CDT should be referred to Future Horizons for advice and support. Evidence from *Fall Out* indicates a need to review the referral process to encourage greater levels of engagement with the programme.

7.2 Employment

More than one half of the participants said that they had found it relatively easy to find a job after discharge, but there were many reports of temporary and unsatisfying work. Three respondents had experienced difficulties; one had experienced homelessness and was currently unemployed; one was unemployed but in training.

The high levels of employment among the respondents may, to some extent, reflect the self-selecting nature of the sample; we were unable, for example, to capture broader experiences of those who were currently homeless or detained in the Criminal Justice System, etc. That said, the overall level of employment among our participants broadly reflected veterans' employment rates across Britain – according to the MoD's figures in 2019, 79% of working age veterans were in employment (MoD, 2019d).

Only a few of the respondents reported that their CDT result had had a direct negative impact on their ability to find work. These were, for example, individuals among the sample who had applied or would otherwise have sought employment in sectors such as security services, that required more detailed background checks. A minority expressed concerns that the record of their CDT failure was likely to come to the fore in these circumstances and hinder their long-term employment prospects:

> *It [CDT discharge] will affect your life forever. I wanted to do security when I left [but]… most decent firms who are reputable and pay a decent wage, will ask for your red book. The moment they see admin discharge they know exactly what that means… It will change your life forever. You will have a shit life for a few years.*

> *I can't go in the [ORGANISATION NAME] or I can't be a security guard because it would come up that I was kicked out for drugs. It kind of pissed me off because even though I got kicked out they make sure I can't get a decent job... I tried the [ORGANISATION NAME] and they said, were you in*

> *the army? And I got the papers and they came back saying, sorry we can't accept your application.*

For the most part, participants tended to avoid these employment sectors, which is unfortunate given the overlaps of requisite core competencies and transferable skills. One respondent had, however, successfully applied to the Police Force, partly to 'test the system'.

All service personnel discharged as a result of drug misuse (identified through a positive CDT, individuals admitting drug use, or those receiving a civil conviction for drug possession) have their drug use recorded on their discharge documentation (AFB 108). Precise instruction on the provision of testimonials in these instances are contained in policy document 'Army General Administration Instruction (AGAI) 064', a short version of which is available online. The full version of AGAI 064 is not open source and would have to be obtained by submitting a Freedom of Information request. The following extract from AGAI 064 has been provided by Army HQ for use here:

> ***Provisions following a CO's determination***
>
> *64.086. Testimonial on discharge. All SP who are discharged from the Army for misuse of drugs are to have their AFB 108 annotated accordingly. The aim of this measure is to deter drug misuse in the Army by ensuring that SP are aware of the longer-term consequences of such misuse. The terminology to be used is as follows:*
>
> *a. In the case of a positive CDT – 'Service terminated for a positive drug test in respect of a Class [A, B or C] drug or drug subject to a temporary drug control order currently in force'. In this instance the military conduct should be graded as unsatisfactory.*
>
> *b. In the case of those who admit the misuse of a controlled drug – 'Service terminated following the admission of taking a Class [A, B or C] drug or drug subject to a temporary drug control order currently in force'.*
>
> *c. In the case of those who have received a civil conviction for possession of drugs – 'Service terminated following the possession of a Class [A, B or C] drug'.*

According to the *Fall Out* participants, veterans were not, however, routinely required to show potential employers a copy of their service records (AFB 108). Unsurprisingly, none of the participants disclosed their CDT discharge voluntarily during job interviews nor had shown an employer their AFB 108. When asked why they had left the Armed Forces, participants constructed their own narratives such as: 'it wasn't for me'; 'I joined to get a trade', etc. A few remained largely sceptical that their CDT discharge would ever come to light despite the fact that some had been told by their COC that a positive CDT would hinder or restrict civilian employment opportunities. Among the study participants, there were no reports of employers seeking references directly from the MOD. At the time of writing, we have been unable to clarify with Armed Forces People the formal guidance relating to the provision of references for veterans requested by civilian employers and whether this guidance precludes reference to drug use and/or drug-related discharge.

For those wishing to return to military service, however, their discharge for CDT had obvious consequences. At the time of interview, those discharged for drug use were prevented from reapplying. Among the sample there were some, despite their discharge experiences, who wished to go back:

> *But just because it hasn't affected me doesn't mean it won't affect me. I want to be in the military still…*

A number of veterans were able to circumvent formal job applications; finding work through family businesses or those run by friends. These respondents recognised that having such connections had smoothed the employment aspect of the transition process for them, but opportunities were reliant on inter-personal relationships being strong (e.g. families and friends being non-judgemental about CDT failure, or unaware):

> *Even at the time of coming out I didn't know that I was going to be able to work with them again, because I didn't know how it was all going to go when I got back home. I was quite worried about what was going to happen afterwards, when I was back out on Civvy Street in terms of like, work-wise and everything. If I didn't have the family business to fall back on, God knows what I would be doing now.*

For those without personal or family routes into employment, there were common reports of flitting between jobs. Most recognised the importance of lining up work and earning a wage at an early juncture and as such accepted casual or temporary work before deciding on longer-term career plans; roles mentioned in this context included labouring, sales, domestic care, and catering.

While most said that they had found it relatively easy to find work, remaining in those jobs had proven more difficult. There were many examples of participants being ill-equipped and struggling to adapt to non-military working environments and cultures:

> *When I got kicked out of the Army [2014], I was homeless and I was in a support Veteran's place, and I've got a girlfriend now and she's helping me, but it's just been job to job, vacancy to vacancy. … I've just managed to find a job, [making hospital food] it's not good pay but it's a job, you know what I mean? I've been there like three weeks.*

> *I got sacked a lot. I also had a bit of a temper, unresolved anger issues! It's not the Army's fault; everyone in the infantry is aggressive. If someone got into me and they didn't have three stripes, they could get hit. That's the thing about Civvy Street: you can't hit people! It's really not the thing to do.*

Among the sample there were respondents who had been recruited young or as school-leavers, who had little or no experience of work in civilian life, employment rights and practices, basic work and money management skills or their obligations within civilian employment settings. Their time in the military had little prepared them for life 'outside of the wire' nor had they had the time, given the manner and speed of their discharge, to acquire essential life skills that enabled them to function effectively in civilian contexts. Some, for example, reported falling foul of commission-heavy sales jobs and had fallen into financial difficulties when faced with inconsistent pay packets.

7.2.1 RECOMMENDATION: The Armed Forces should ensure that transition support includes training that sufficiently prepares ESLs for work in civilian contexts. This training is particularly critical for those who joined at an early age/as school-leavers and those (such as CDT discharges) who have limited time to prepare for transition.

There was a recognition among this cohort of ESLs that finding meaningful employment was fundamental to successful resettlement and transition experiences:

> *Yeah. If you don't get back into work quite quick, it gets harder and harder. You've got bills and everything to worry about and each thing makes each thing worse. You need one thing to land right first and then you can get the first step and keep going.*

Some respondents had been able to secure civilian employment before being discharged through more formal application processes, referrals or personal connections. There were reports of walking out of the camp gates and into full-time positions within a matter of days; one soldier even worried

that he would not be discharged in time to take up his new role. Others were less organised, motivated or equipped to find work; or perhaps less able to process the life and employment implications of the pending decision on their discharge.

7.3 Family

Separation from the Armed Forces is acknowledged as a high-risk period in terms of veteran outcomes – particularly for ESLs. For many of the participants in the *Fall Out* study, this period of separation was made all the more challenging because of the shame and embarrassment they felt as a result of their drug discharge.

Transition for the *Fall Out* cohort appeared to pose particular challenges for familial and wider social relationships. **Half of the sample described feelings of shame and guilt** and talked of a negative effect on their family or on significant relationships, including: extended period of non-contact with family; relationship break-ups; loss of support; issues with child custody and access; and eviction from marital and family homes:

> *They were ashamed of me. The whole family were. It affected me for a good couple of years. I have had problems with drugs since then. I have been to a drugs counsellor since then. It has had a big impact on my life. It did. Much more than I thought it would.*

Several participants had initially kept their CDT discharge a secret from their families, although this secrecy proved an additional source of stress on relationships. A few described how their parents and partners had inadvertently found out about the manner of their discharge which had led to temporary breaks in intra-family communications and 'evictions' from family homes.

Others who had military family connections talked of an even greater sense of shame and guilt; an overriding sense of 'letting the side down' and of tarnishing family reputations. At the time of interview, some of the participants had yet to inform their parents about the circumstances of their discharge for fear of being judged or of it irrevocably impacting on personal and family dynamics:

> *I never really told them the truth. I just said I'd had an Admin Discharge. They still don't know about the CDT fail.*

Others described a reluctance to return to their hometown, and having to face the shame of others finding out about their CDT failure:

> *I couldn't go back to my mum's… My mum's very open with [people in her community] there's nothing secret, so it took me a couple of years before I went back.*

Two participants in the *Fall Out* study had been denied access to their children following their discharge. While this was not necessarily perceived to be a direct result of the CDT failure per se, there was an indication that mental health and continued drug use in these cases had played a part in these family breakdowns. These individuals did make some correlations between their drug discharge and their persistent self-destructive behaviours.

Based on research into the mental health and life chances of veterans (see, for example, Seifert et al., 2011), it seems clear that the combined loss of family support systems and unit comradeship would seem particularly damaging at this key stage of adjustment and transition. Seamone et al. (2014) hypothesise that dishonourable discharge, and the range of problems that underpin such an event, is likely to have a knock-on effect on families who become the carer for a veteran with multiple problems attempting to reintegrate into civilian and family life. In the case of a veteran with trauma, there may also be vicarious experiences of trauma absorbed by families. Phillips (2018)

suggests that such unresolved difficulties have broader implications beyond the individual veteran, potentially undermining key protective relationships.

7.4 Housing

Early services leavers have been noted to have higher risk of unstable housing and homelessness (Elbogen et al., 2018). **In contrast to the evidence from the academic literature, however, the majority of respondents in the *Fall Out* study reported being able to move back with family (and particularly parents) following their CDT discharge**. While this process was not always trouble free, most said that family relationships were strong enough to withstand the inherent difficulties of an early exit from the military.

There were, however, some accounts of more difficult transition journeys. As noted above, for example, not all parents were aware of the failed drug test. One interviewee was forced to leave the family home after his relations had been made aware of his CDT failure. Another described rapidly deteriorating family and personal relationships at this point; his exit from military service marked the beginning of a downward spiral culminating in homelessness and attempted suicide. Fortunately, this individual eventually accessed a residential placement and he reported significant improvements in his health and wellbeing as a result. However, this will have been an expensive and debilitating crisis that might have been avoided with better preventative transitional management and support.

It is unlikely that accounts of respondents in this study reflect the breadth of accommodation experiences of service leavers discharged as a result of a positive CDT; a caveat again must be the self-selecting nature of the research sample. During the recruitment phase of the project, for example, the research team had preliminary discussions with veterans who were in sheltered accommodation. Unfortunately, it was not possible to secure the participation of these individuals in the study.

7.5 Substance misuse after discharge

There are mixed reports in studies concerning the extent to which substance misuse continues after departure from the Armed Forces (Norman et al., 2014; Golub & Bennet 2014; Derefinko et al., 2018). Generally, research tells us that drug use tends to decrease once recruits enter military life (primarily due to high levels of censure) and then increases again (although often not reverting to pre-military levels) after separation (Golub & Bennet, 2014).

On the other hand, many studies note alcohol use increasing when people join the Armed Forces with mixed findings on the extent to which these potentially hazardous levels of intake decrease, are maintained or increase after discharge (Derefinko et al., 2018).

Factors increasing the likelihood of enduring substance dependency after discharge include:

- Family difficulties (Bohnert et al., 2011)
- Employment problems (Bohnert et al., 2011)
- Having PTSD symptoms (Norman et al., 2014)
- Having an 'avoidant coping style' characterised by a tendency to use substances to avoid or distance oneself from problems and help-seeking rather than facing difficulties head on and working through solutions (Norman et al., 2014)
- Criminal behaviour (Bohnert et al., 2011)
- Other than honourable discharge.

Those who persisted with substance misuse after transition from the Armed Forces were noted to experience more difficulties with transition from the military and engaged in higher-risk activities after separation (including driving whilst under the influence of substances, anger management problems and hurting someone) (Norman et al*.,* 2014).

In terms of protective factors, there was also evidence that marriage, or a long-term relationship, may be protective in relation both to alcohol and cannabis use, and may reduce binge-drinking as well as reducing the risk of mental illness (Duncan et al., 2006; Kelley et al., 2015; Hoopsick et al., 2019).

Further studies investigating the transitional progress of those discharged following misconduct, found that nearly a third of these veterans had alcohol dependency. These veterans were also more likely to have a family history of depression and substance misuse (Elbogen et al., 2018).

After discharge, the majority of participants in this study continued to use drugs and/or alcohol. Three-quarters declared post-service drug use, four-fifths alcohol use. At the time of interview, two reported receiving professional help for drug or alcohol dependency and one described himself as being in recovery. More described ongoing patterns of cocaine, cannabis and potentially hazardous alcohol use for which they were not seeking support:

> *I still look at it as a problem [with cocaine] and it's an argument I have with myself regularly and I think, I don't need to do it and I'd probably have a better night if I'd just drink. I do see it as a problem but not as much as someone who uses every weekend. If I were going out every weekend and had the money would I be using every weekend? Probably, yeah.*

> *[I smoke cannabis] pretty much every day to be honest. This is since the Army and things just got worse and worse and it's something I'm trying to get out of but it's so difficult.*

Those who failed CDT for steroids/performance enhancers also reported continuing to use them. The consensus among this cohort was that they were in control of their substance misuse and were well-informed of the potential risks and side-effects. Despite the fact that they had lost the careers in the Armed Forces as a result of their substance misuse, none perceived their *current* use of performance enhancers as problematic; one even suggested that being free from the threat of drug testing enabled him to manage his usage more effectively. This was in contrast to some of the accounts of those who continued to use 'recreational' drugs. One soldier reported daily cannabis use; another a decade-long battle with cocaine that he had only recently begun to address.

The consensus was, with one or two notable exceptions, that levels of alcohol intake had reduced since leaving the Armed Forces, largely as a result of life-style changes including work, partner and family commitments. Weekend bingeing was still mentioned by a high proportion of the participants, but when compared with in-service patterns of consumption, these 'episodes' were perceived to involve less alcohol and be less frequent.

Evidence from academic studies notes that substances are commonly used as a source of solace, escape and relaxation in military culture (Derefinko et al., 2018). There is also a sizeable body of literature on the use of substances as a form of self-medication in the Armed Forces (Thandi et al., 2015). Turning to substances to help navigate highly stressful feelings and transitions was a significant theme in the *Fall Out* study. For example, in the immediate aftermath of discharge (and in some cases before the official paperwork had been processed) several spoke of bingeing on drugs or alcohol as a way to cope:

> *I took everything, just to block it all out really. Everything, mainly cocaine, but also pills, MDMA and really hitting the drink. Being a bit of a mong really.*

Some continued to struggle with very conflicting feelings about their drug use. On the one hand, it had led to a significant crisis in their life; on the other hand, it was something that they turned to for comfort when they then had to negotiate the stressful consequences of their departure from the Armed Forces:

> *After I left the Army, even though cannabis had probably ruined me, it was also something that I turned to as well. I probably smoke a lot more cannabis now than when I was in the Army.*

Some talked about other negative drug experiences and revealed feelings of self-loathing:

> *The coke […] I couldn't do it anymore. Just the negative connotations I have with it, where it's got me…My mind would be on overdrive thinking like… and getting down and depressed thinking, 'Yeah you've made your bed now'. It got to be like 4 to 5 in the morning, reflecting on all I've done. I made a mistake, that's what I did. I really do regret my actions.*

While most did not blame the manner of their discharge for their post-service drug use, some did recognise associations between their discharge, deterioration in their wellbeing and their subsequent misuse of substances:

> *To be honest, it [cocaine] has been massive in my life again…I am in charge of my own decisions at the end of the day and I am a grown bloke, but I know for a fact that the way I was kicked out has not helped me in the head. It suffers, do you know what I mean?*

> *[I used] coke on nights out and carried on quite regularly until a few years ago. Basically, it was costing me a lot of money. The nosebleeds after a night out were horrendous. So, I thought: "This is a sign", I am not saying I have been squeaky-clean ever since. I know I have done it when I have been absolutely rat-arsed, it's not something I do any more or seek out because there is a lot of shame involved with my Army career.*

Finally, a few mentioned using drugs as a means of managing mental health, neurodevelopmental or physical difficulties. One interviewee said he used cannabis to manage a range of complex and chronic physical and mental health issues.

Evidence from US studies tell us that those leaving the Armed Forces due to misconduct or for other than honourable discharges have higher risk of poor mental health, problematic substance misuse, and face higher risks when transitioning back out to civilian life (Elbogen et al., 2018). When considering such data, we need to be aware that the service and welfare landscape in the US varies significantly from that available in the UK. However, these findings are important in highlighting vulnerable groups (e.g. those exiting via dishonourable separations and particularly those with a substance misuse disorder). These are likely to be a similar subgroup to those considered in the *Fall Out* study.

7.6 Support service experiences

Only one participant (with very complex needs) received some degree of care coordination supporting his transition back to the community. He was linked up with a community psychiatric nurse at the point of transition. Although he did not consider this support to be particularly helpful at the time, he was able to appreciate that it had helped him to access more tailored support at a later date. Others, (some of whom were presenting with self-destructive behaviours and who described a history of suicidal ideation) received neither care package, nor monitoring for their transition.

A small number had approached their GP (one after a car crash resulting in a diagnosis of depression). GP assistance was described as largely unhelpful (and sometimes stigmatising) – primarily involving medication which led one interviewee to feel further 'incapacitated'. As mentioned earlier, others were linked up with support only following damaging and costly crises.

A small number went on to approach veterans' services which included the British Legion, SSAFA, Combat Stress, Help for Heroes and Veterans in Crisis. Approaches resulted in help with housing, adjustment life skills, and PTSD, but interviewees described some variability in the quality and usefulness of the support they received.

Veterans in Crisis and Combat Stress received the most consistently positive feedback, with locally-based support provision receiving high praise from individual users. **The most positive experiences of veterans' services involved workers who understood the military context, were empathetic and non-judgemental and could provide timely and practical support – not only for health and social challenges, but also with the attainment of practical skills and training.** This finding aligns closely with evidence from the literature. A range of studies provide an overview of characteristics which are associated with more attractive types of support for veterans. These include the following:

- Having access to culturally appropriate and relatable mental health support for veterans, ideally delivered by providers who are independent of the Armed Forces but who understand the military context and experience (Derefinko et al., 2018; Farrand et al., 2018).
- Support based on relationships that build trust and avoid referring veterans onto someone else (Farrand et al., 2018).
- Derefinko and colleagues (2018) also make the case for relationship-based peer-to-peer navigators or support programmes for vulnerable veterans which they view as validating common challenges (such as feelings of isolation during transition, practical adjustment difficulties, help seeking etc).
- Having a menu of choice which dovetails with person-centred needs. This includes a choice of face to face, telephone and video support (Derefinko et al., 2018; Farrand et al., 2018).
- Services co-produced and designed with veterans (Derefinko et al., 2018).
- Support that is private, convenient and confidential (Farrand et al., 2018).
- Help that is focused, practical and skills-based in nature (Farrand et al., 2018).

Other important elements of support based on the literature include:

- Routine adoption in military life of trauma-aware and trauma-informed approaches. This approach involves always looking beyond surface presentation to pinpoint what may be driving behaviours, and involves strengthening occupational protective factors. Protective factors for ESLs may include reinforcing a sense of purpose, promoting protective and positive peer relationships, and facilitating supportive family relationships. All of these points can help to contain and minimise the escalation of trauma symptoms (Carroll et al., 2017).
- Greater effort to address military alcohol-endorsing norms and culture (Fear et al., 2007).
- A care-coordination approach for higher risk veterans to help them transition more seamlessly to civilian life. Care-coordination recognises that people often have multiple needs and that they need someone who can both identify and work with the person to mobilise and ensure that they get the help they need across service boundaries and other types of service divides. In the US, good care-coordination was seen to rely on 'ongoing collaborations' between the Department of Defense and their Veterans Alliance system as a starting point for more seamless care for multiple needs across transitions. For the UK, this would involve greater collaborative commissioning and joint working between the Ministry of Defence, NHS England and NHS Improvement (NHSE&I) and the landscape of community

providers for veterans' health, social, welfare and occupational support (Cheney et al., 2018).

7.7 Signposting & tailoring support

Evidence from *Fall Out* highlights a need to better signpost and tailor support. With so many organisations offering both general and targeted support to veterans, some participants had found it **difficult to identify the most appropriate service**. Furthermore, some admitted being unsure whether they, as CDT discharges, were **eligible** to seek help from particular veterans' support organisations.

7.7.1 RECOMMENDATION: The Armed Forces should carefully assess the social circumstances of each CDT positive individual to determine potential vulnerability and identify the most appropriate supporting agencies. This assessment could use the extant HARDFACTS framework and would provide standardised tools for the management and measurement of transition.

7.8 Key Points

⇒ Historically, ESLs have been entitled to very limited transition support. In recognition of mounting evidence that ESLs are disproportionally disadvantaged and are at an elevated risk of unemployment, homelessness, unemployment and mental health issues, this situation is increasingly being addressed. From 2015, all ESLs, including those dismissed as a result of a CDT, have been eligible for the CTP Future Horizons Programme.

⇒ Of the sample, half were eligible for the CTP programme, but only two recalled being offered it. Both declined.

⇒ More than half of the participants said that they had found it relatively easy to find a job after discharge, but there were many reports of temporary and unsatisfying work. A number of veterans were able to circumvent formal job applications, finding work through family businesses or those run by friends.

⇒ Some also struggled to adapt to civilian working cultures and practices. This was particularly evident among those who had joined the Armed Forces at an early age and had little experience of adulthood outside of the military.

⇒ The majority of respondents in the *Fall Out* study reported being able to move back with family (and particularly parents) following their CDT discharge, although some had not been forthcoming with the reason for their dismissal. There were, however, accounts of more difficult and chaotic transition journeys that included periods of homelessness and breakdown of family relationships.

⇒ The majority of participants continued using drugs and alcohol after leaving the Armed Forces. At the time of interview, two reported receiving professional help for drug or alcohol dependency and one described himself as being in recovery. More described ongoing patterns of cocaine, cannabis and potentially hazardous alcohol use for which they were not seeking support.

⇒ Four participants said that they had a current diagnosis of a mental health issue; others still had formal mental health assessments pending. Two-thirds perceived a decline in their mental health following a CDT failure and discharge.

⇒ Respondents recounted various pathways of support through GPs and veterans' services but accessing the most appropriate support was not always straightforward. Barriers to accessing this support included the stigma attached to seeking help for mental health issues, and lack of awareness of the help available to them and their eligibility for it. A couple of participants also reported feeling unworthy of help from veterans' services because of the manner in which they had been discharged.

8 Subject Matter Experts' perspectives

Key informants were approached as 'subject matter experts' (SMEs; n =6) regarding substance misuse by virtue of their roles within organisations offering support, advice and treatment to veterans. The SMEs represented a number of organisations from policy, statutory and third sector provision. Each of the expert respondents identified a number of key issues related to service provision and treatment for veterans discharged as a result of a CDT, or who have been identified as experiencing a substance misuse problem.

8.1 Spiralling problems

SME's described seeing veteran-clients experiencing multiple problems and issues at the same time, and that such problems often amounted to life 'spiralling' out of control. As one respondent stated: "*that's quite common and it's usually, it's just an ever decreasing spiral and descent into misery really*" (Vol Sec). This respondent described spiralling problems as follows:

> *So, it's usually relationship breakdown, it's usually poor mental health, it's not accepting of your change in status after you've left the military, it's being unemployed, it's homelessness, not owning a home, not having the status amongst your peers or significant others. All those issues are about unhappiness, and they try and use drugs and alcohol as a way to step out of that and avoid dealing with that. (Vol Sec)*

As the above quote illustrates, substance abuse can be used as a way of dealing with existing problems through 'self-medicating'. Inevitably, however, substance abuse can also be the cause of further problems, putting additional barriers in the way of transition and life beyond the military – a process that is already fraught with complexity and challenge. SME's frequently highlighted problems with seeking and maintaining employment, and with interpersonal relationships as a result of drug misuse problems:

> *There are usually difficulties getting into work or remaining in work. Some of that is due to being dishonourably discharged. They probably have some difficulties with relationships at times and may be estranged from their children and ex-partners. Interpersonally they are difficult and probably have some antisocial traits in their personality and they are probably using again, a substance above recommended level be that alcohol or some illicit substances. (Statutory)*

Likewise, problems with housing and relocation were identified for individuals leaving the military after failing a CDT:

> *If they were living on camp, then they've got issues of where they're going to live. They've got issues like are they moving back? Because you could be posted anywhere in the country or abroad, will they be travelling back to their home town which could be the other end of the country? Then they don't have a GP, they don't have a dentist, they don't have housing, they don't have access to drug and alcohol services. So basically, they've just got nothing. (Vol Sec)*

8.2 Pre-existing vulnerabilities

Consistent with the notion of spiralling problems, SME's also reported that in cases where veterans had been discharged after failing a CDT, drug misuse problems may be a sign of (or continuation of) problems and vulnerabilities that existed before they joined the military. Moreover, there was a perception among our respondents that a desire to escape from adverse childhood circumstances (whereby drug misuse may have been an issue) could be the driver for individuals to enlist in the

first place, and returning to such circumstances may result in the exacerbation of these vulnerabilities. The following responses are representative of this opinion amongst the SME's we consulted:

> *From anecdotal evidence that is around, you kind of get the impression that those who will be falling foul [of a CDT] will be those that are coming from adverse childhood experience or from lower socio-economically deprived areas where they may have come from a background where there may have been drugs present there, and therefore whilst they may be within the confines of the Armed Forces, it may be better in terms of shielding them from some of that. But actually, if they fall foul of that you might then be compounding that if somebody then goes back to an area where drugs use is an issue*. (Vol Sec)

> *They tend to be fairly young and tend to be infantry regiment. They may have had a fairly difficult background prior to joining. They have probably experimented with drugs prior to joining the service. They may have some forensic history also, and they leave and come back to the same areas of Wales where they probably originated from and often pick up with the same peer-group who they knocked about with before they joined the army. Usually army, but not always.* (Statutory)

The presence of pre-existing vulnerabilities in substance misusing veterans suggests that in some cases, problems may be entrenched and may require more complex or prolonged forms of support and intervention.

8.3 Holistic support

Given the complex and entrenched nature of problems that our respondents identified, each felt that there was a **need for *holistic* support following a CDT discharge, in order to provide substance misusing veterans** with the care they needed. Such support would help veterans deal with not only substance abuse, but also underlying problems with mental health, housing issues, debt, gambling, etc.:

> *What I would say is that what they need the most is the holistic support, and this is why our outreach service is useful for people who have developed or have come to us with a substance misuse issue. Because actually, having a drugs misuse issue, or a substance misuse problem will underlie a number of other issues. So somebody may not have housing, they may not have employment because of it, they may – we know that if you're a homeless veteran then you're more likely to be suffering from alcoholism than a drugs misuse problem but that actually there are a very small number of homeless veterans who have a drugs misuse problem who are on the street. So all of those issues need to be addressed in a holistic way to ensure that somebody receives support – you can't solve one without the other. If someone's in debt, they'll continue to be in debt if they've got a drugs misuse problem. So when you say what form of support do these veterans need the most – what they need is somebody that will assess their case on a wider basis and say 'ok, well what support can we offer you to get you out of any problems that you're having?' (Vol Sec)*

For one SME the need for holistic support was underscored by the perception that underlying substance misuse issues was usually or always a mental health issue:

> *Q: So, in terms of mental health, do you think that's the most common reason for abusing substances?*
>
> *SME: Yeah well, I mean there is no other reason for using drugs or alcohol, other than you're unhappy. It's pretty simple really. (Vol Sec)*

Likewise, this respondent also described that the severity of substance misuse problems was often unrecognised or not fully appreciated when veterans came into contact with support services:

> *And like everybody else when it comes to alcohol and drugs, they'll always not tell you the truth about it. So, if somebody tells you they're drinking two or three pints a week, that's always a massive underestimation.* (Vol Sec)

As we noted from conversations with ex-service personnel, not all perceived their early or in-military substance misuse as necessarily being driven by 'unhappiness' – some suggesting it was a rite of passage, enjoyable, just what young people did, etc. That said, it was evident from their accounts that some substance misuse correlated with factors such as career disaffection, adverse childhood experiences and mental health challenges – opinions that align more closely with the perspective provided by the SME representative above.

The need for holistic support to assist veterans with the multiplicity of issues surrounding and/or underlying substance misuse further underscored the need for coordination amongst service providers, including veterans' charities, the NHS, local authorities, and other agencies where relevant. Indeed, as one SME commented, "*On the ground we link up with Veterans Aid, we link up with Tom Harrison House, we link up with Combat Stress, the idea being that whether it is a veteran-specific issue or not, whatever the issue we try and make sure they get the most appropriate forms of support*."

8.4 Lack of support on discharge

Contrasted with the need for holistic support was the feeling amongst SME's that there was a lack of transition support as well as other support services for veterans discharged as a result of failing a CDT. This opinion was captured succinctly by one of our respondents:

> *The big issue is they're not plugged into services that can support them, which I think should be mandatory. If you're going to discharge someone for drugs the least you should do is make a referral to a drug service, in that individual's area where he's eventually going to land. (Vol Sec)*

Likewise, another respondent questioned whether the military were right to simply discharge personnel without linking them up with appropriate forms of support:

> *There's a consequence with actions. But I think, you know, times change and a lot more young people are using recreational drugs, and I think the barrier is like an accept – it's whether they believe they have a duty of care to the individual. And at the moment, to discharge someone with no aftercare, I think they don't believe that they have a duty of care. (Vol Sec)*

The above quote also suggests that the military have not kept pace with societal changes, pressures, and the context within which young people may be using drugs (e.g., 'recreationally' as opposed to more 'serious' drug-taking behaviours) (see also 8.5 below). Our interviewees suggested that the military's approach to drug misuse could be perceived as too intolerant, that the discharge process for people failing a CDT was unnecessarily harsh, and that the military has a duty of care that it is failing to meet in such cases.

Furthermore, some respondents also put forward a case for in-service support for personnel with alcohol and substance misuse to be strengthened:

> *I say there needs to be while they're serving, there should be levels of support built in there, not just left to the whim of a duty officer, or a duty NCO, who says 'Look, this is going on'. You know what I mean? There has to be – I think the whole problem with the military is that it has to be*

> *professionalised when it comes to social care, and all its difficulties and problems. The idea that some corporal would be able to go on to give the right advice in the event of a safeguarding or child protection issue as a result of somebody's drug or alcohol misuse, I don't think that's anywhere near the way it should be now. (Vol Sec)*

8.5 CDT discharge may not reflect 'misuse'

Whilst our respondents were unanimous in calling for stronger and more holistic forms of support – both during and post-services – for veterans discharged after failing a CDT, they also argued for a nuanced approach to understanding and dealing with drug-related issues. Specifically, it was felt that there are different degrees or severities of drug misuse and that it was important to understand these differences when considering what the 'support' needs of veterans were. As one respondent commented:

> *I think the problem is that a compulsory discharge via drugs doesn't necessarily relate to how much of a substance misuse issue someone may have. It could be that they have a massive substance misuse issue and they've just been caught and therefore are out. Or it could be that they went off for leave one weekend, had a good time, came back and happened to get caught, and that was bad enough to fall foul of the rules. (Vol Sec)*

Similarly, the SME's emphasised that the 'type' of drug misuse problem may vary with the specific illicit substance or 'class' of drugs that were at issue in a particular case. Substance use was described as an evolving social phenomenon that the military did not fully appreciate or understand:

> *See, over the years as I have aged the younger generation have had far more exposure to other drugs, particularly amphetamines and ecstasy during the club scene, which continues. And then there are the synthetic drugs that have come along like Spice and MCAT and all those other synthetic made drugs. I think this population that are joining the military today have been exposed to that. It has become normalised to be a young person who has been exposed to drugs in your teenage years, a bit of experimentation at school, going out clubbing. I'm pretty sure the stats say that young people drink less alcohol than my cohort did at 16 to 20, but they probably use more illicit substances than my cohort did. I think it's an evolving societal beast and therefore maybe the military are lagging behind that and some of their policies one could say are slightly outdated and don't take into account the exposure that young people have to navigate now. (Statutory)*

Accordingly, taboos around drug use in the military – and particularly the zero tolerance policy – were in some respects considered to be archaic, and even hypocritical given that personnel can persist with extremely high levels of alcohol use and remain in service, whilst one 'slip up' with regard to drugs resulted, unnecessarily, in the loss of a military career. The following comments from one NHS General Practitioner are representative of this view, expressed by all of our SME's:

> *Wearing my college GP's hat, you know, there is certainly a very strong argument that certainly the softer drugs should be treated exactly the same as you know, alcohol, obviously you would then remove it from criminal activity, which is actually one of the major issues. It's not particularly the drugs, the drugs can be dealt with the same as we did with alcohol, but actually, the criminal activity that goes with it, which is actually the fundamental problem. (Statutory)*

The SME respondents advocated the potential for a more tempered or nuanced approach to dealing with drug misuse in the military, including meaningful attempts to understand the contextual factors that might surround drug misuse in the Armed Forces.

8.6 Key Points

Subject Matter Experts (SMEs) described:

⇒ veteran-clients as often experiencing multiple problems at the same time;

⇒ some clients misuse substances as a way of coping, often compounding problems and putting additional barriers in the way of the transition process from military to civilian life – a challenging process in itself;

⇒ links between veteran-client drug use, CDT discharge and pre-existing vulnerabilities;

⇒ escaping challenging home environments and ACEs (as evidenced by research) as a motivating factor for some to join the military, and the return to such environments post-discharge being a potential catalyst to exacerbate their existing vulnerabilities;

⇒ a need for holistic support following a CDT discharge to not only address substance misuse, but also underlying problems with mental health, housing issues, debt, gambling, etc.;

⇒ the need for holistic support to assist veterans with the multiplicity of issues surrounding and/or underlying substance misuse, which would helpfully be achieved by improving coordination amongst service providers, including veterans' charities, the NHS, local authorities, and other agencies where relevant;

⇒ the important role the military could play in helping this vulnerable cohort by adopting a more nuanced approach to the understanding and management of drug misuse, to recognise differing drug-use behaviours, and to enable the most appropriate support.

9 Conclusion

The *Fall Out* study is the first research of its kind in the UK to focus on the in-service and transition experiences of a cohort of ESLs discharged for failing a CDT. The participant narratives highlight often complex and at times, harrowing and potentially damaging individual journeys into, through and then transitioning out of the Armed Forces. While each individual journey is unique, there are a number of experiential commonalities that point to genuine opportunities to improve the potential outcomes for this specific cohort of ESLs, many of whom entered the Armed Forces hoping for a better life.

Overall, findings from qualitative interviews in this study suggest that those failing drug tests during service appear to be a particularly vulnerable subgroup of this ESL cohort who are more likely to face co-existing and sometimes multiple difficulties. Yet, by their own account, they are less likely than other colleagues to be supported as they negotiate the challenging transition back to civilian life. In some ways the process of discharge appeared to exacerbate further their vulnerability and make transition more challenging. The research noted a high potential for these ESLs to slip between the cracks of military and public health care systems, often with significant knock-on effects on families who became carers and buffers for their difficulties. In a few examples, difficulties led to costly and distressing escalation into crisis before formal and trauma-informed help was made available.

Many of this cohort were young and impulsive risk takers who tended to see drug use as normal among their peer group. Without exception, respondents said that their alcohol consumption increased after joining the Armed Forces. Many became heavy drinkers; some claimed that this impaired their decision making about drugs. Although all had been exposed to drug use before joining the Armed Forces, not all had been drug users. A third of the sample began using drugs during their military careers. Most respondents shared an experience of disaffection with their personal and/or professional circumstances in the period leading up to their career-terminating CDT and cited this as a contributing factor to their decision to take the drugs implicated. Three of the respondents claimed to have deliberately failed the CDT to facilitate an early discharge from the Armed Forces.

After testing positive for drugs, only a few of the interviewees said they had been referred to either medical or pastoral care, despite many exhibiting clear signs of mental distress and several reporting long histories in service of mental health conditions, including suicide attempts. None were offered formal or informal assessment for substance misuse. A small number self-sought non-medical support (in the form of the Padre or Welfare officer) but with no follow up community care. Only one of these veterans described a process of 'care coordination' to ensure continuity of support once back in the community. Very few received assistance with transition planning to secure employment or accommodation after discharge. Many interviewees also described a highly punitive response from the Chain of Command, which, for many, caused them to feel unworthy of help.

Before discharge, the majority of this cohort suffered from high levels of shame, anxiety, isolation and ostracization from colleagues. Given the importance of unit bonds and friendships as a protective factor supporting good mental health and outcomes in military life, it is of concern that this appeared to have broken down so dramatically at the challenging point of navigating back to civilian life for what this study has shown to be a particularly vulnerable group. Some described substance misuse binges at this time to manage these intensifying feelings. Post-test and discharge processes were therefore experienced as harmful and relatively long lasting in effect. The impact of the discharge, in many cases, also resulted in marriage or family breakdowns, homelessness, and, for a few the emergence of PTSD symptoms. Many found help through veterans' services and charities such as Combat Stress, but for some, it took years before they were able to address substance misuse or mental health difficulties.

The majority of participants had been able to find some form of civilian employment. There were, however, many reports of temporary or commission-only work, periods of unemployment and a reliance on work within family businesses which did not necessarily provide opportunities for career progression, stability or fulfilment.

Most participants accepted culpability for their discharge; ultimately it was their decision to take drugs, they had been caught and were having to live with the consequences. Many, however, felt that the Armed Forces had fallen short in their duty of care and could have done more to help optimise their chances of a successful transition. For many in this sample, being discharged from the military was more akin to being banished from a tribe, or excommunicated from a religion, than merely being sacked from a job. Many raged at the perceived inequity in the Forces between the lax treatment of those who misused alcohol, or were even alcoholics, compared to the intolerant response to those who had used a different recreational drug. It would seem sensible that the solution should not be to punish alcohol users more harshly to redress this inequity; but rather to treat all those who misuse substances with understanding, and to offer timely and effective assistance, whether they are discharged or not.

Evidence from this study highlights the need to address what were described as punitive post-test and discharge processes. Many described protracted periods of uncertainty in the aftermath of a positive CDT; some felt ostracised by peers and/or the CoC; some were physically separated from their colleagues; while others were assigned restricted duties. Without exception, participants in the *Fall Out* research emphasised strong peer-bonds and a sense of belonging as some of the most positive and defining aspects of their military experience; being extricated suddenly from these, left many with a profound sense of isolation, loss, and in some instances, shame.

That the Forces have the right to discharge personnel who are in violation of policy is not in question; none of the participants would contest this fact either, although many in the study felt themselves to have been highly proficient in their military roles and felt that they were deserving of a second chance. The issue is how the discharge process is managed to minimise further harms and ensure that the it does not exacerbate underlying problems.

10 Recommendations

Based on the findings of the research and, where applicable, making reference to existing evidence from academic literature, we offer the following summary and recommendations.

10.1 Developing a culture of peak mental fitness

Evidence from *Fall Out* suggests that there may be scope, organisationally, for the Armed Forces to take a more proactive approach to monitoring and identifying when a service person's mental health might be deteriorating, and to provide early support (e.g. informal conversations on wellbeing; access to talking therapies or counselling, brief assessment, etc.).

The Armed Forces have the potential to mobilise protective occupational factors and experiences (such as unit bonding, occupational opportunities, physical fitness regimes and problem-solving skills) which appear associated with optimal physical, mental and professional performance. This approach is not about indulging staff, or even preventing days off sick (although this is important as mental illness is now a leading cause of long-term sickness absence and of exclusion from the labour market in developed countries) (Milligan-Saville et al., 2017). It also prevents 'presenteeism', where an employee is in work but is not functioning at anywhere near their optimum level. So, just as the Armed Forces might have organisational processes in place to encourage the workforce to maximise its physical health, it would ideally also have in place processes to maximise optimal mental health functioning and to minimise exposure to unnecessary occupational hazards. In this regard, studies indicate that it is essential to reduce exposure to workplace bullying.

The *Fall Out* study suggests that the Armed Forces may attract many recruits with pre-service vulnerabilities (some linked to exposure to historical trauma) who join the military hoping for a turning point in their lives and to escape deprived environments. The effective management of this cohort, therefore, is fraught with complexity, as evidenced by existing research literature and the participants' accounts.

Those with pre-service vulnerabilities are at higher risk of a range of costly and impairing health and social difficulties across their lifetime. There is some evidence, however, that aspects of the Armed Forces' context and culture (e.g. unit bonding, a sense of belonging, promoting problem solving skills and opportunities) provide an environment which is protective of those with such pre-service problems (Sciaraffa et al, 2018). There is also some indication in studies that exposure to other aspects of military life (e.g. alcohol endorsing culture, potential bullying (Takizawa, 2015), anti-help seeking cultural norms, and, in this instance, the process of post-CDT discharge) can worsen mental health and undermine peak mental health fitness and an individual's ability to thrive.

10.1.1 RECOMMENDATION: The Armed Forces should take a more proactive approach to monitoring and identifying when a service person's mental health might be deteriorating, and to provide early support (such as informal conversations on wellbeing; access to talking therapies or counselling, brief assessment, etc.).

10.1.2 RECOMMENDATION: The Chain of Command (CoC) should build on current mental health promotion efforts that proactively seek to monitor those with pre-service mental health vulnerabilities (such as substance misuse, hardship, neglect, abandonment, abuse, etc.).

10.1.3 RECOMMENDATION: The Armed Forces should consistently mobilise protective occupational factors and experiences (such as unit bonding, occupational opportunities, physical fitness regimes and problem-solving skills) which appear associated with optimal physical, mental and professional performance.

10.1.4 RECOMMENDATION: The CoC should actively seek to minimise avoidable occupational harms (such as bullying, ostracization, excessive drinking, boredom) likely to further exacerbate developmental trauma and military performance.

10.1.5 RECOMMENDATION: The Armed Forces should provide trauma and mental health awareness training for personnel managers an. Education at this level should also include Making Every Contact Count (MECC) training to ensure that the resilience and mental fitness of serving personnel are optimised.

10.1.6 RECOMMENDATION: The Armed Forces should provide additional training for staff with 'pastoral' roles (Welfare Officers, Padres, etc.), often the first point of contact for personnel with mental health concerns, to ensure they are able to recognise situations where clinical interventions are required.

10.2 Inconsistent and damaging discharge processes

Fall Out revealed marked inconsistencies in the ways administrative procedures (JSP 835) were applied following a positive CDT result. Evidence from this research also highlighted examples of harsh and humiliating treatment that, according to some, exacerbated mental health issues, and increased levels of stress and anxiety. In extreme cases, poor treatment post CDT resulted in patterns of self-destructive behaviour. In most cases, the discharge process left this potentially vulnerable group ill-prepared for the challenges of transition and largely unsupported.

There needs to be greater awareness that the CDT discharge process can be a trigger for mental health issues, PTSD and further substance misuse.

10.2.1 RECOMMENDATION: Greater efforts should be made to ensure clarity, consistency and transparency in the application of JSP 835 guidance on the management of CDT failures at a Tri-Service level.

10.2.2 RECOMMENDATION: *Fall Out* evidences the need for a process review and training on the administration of the guidance to ensure that all staff involved understand the potential impact of overly punitive treatment on mental health and successful transitions. Training should emphasise the importance of the following:

- **Timeliness of communications** – individuals should be kept fully informed at all times of case progress.
- **Respectful treatment** – regardless of CDT result.
- **Consideration** – care and support of a potentially vulnerable cohort likely to struggle post-service.
- **Raise awareness of links** – between demeaning, belittling, unsupportive, isolating treatment, and poor mental health and transition outcomes.
- **The positive role of supportive peers/CoC** – can help CDT dischargees to be practically and emotionally prepared for the challenges of transition.

10.3 Mental health and substance misuse assessment and support

The *Fall Out* study makes a compelling case for screening individuals who fail CDT for indications of problematic substance misuse and mental health issues.

10.3.1 RECOMMENDATION: All service personnel testing positive for drugs should be routinely screened for substance misuse and mental health difficulties.

Where resources are available, these assessment tools should, ideally, be administered by impartial, qualified professionals.

10.3.2 RECOMMENDATION: The Ministry of Defence and NHS providers across the UK should work together to develop a joint protocol for managing those who test positive for drug use and be alert to underlying factors or complexities.

This protocol should be mindful of the following approaches and considerations:

- Additional considerations should be given to those who joined the military at a young age (pre 18 years old). Evidence from this and other studies suggest that this cohort is the least prepared to negotiate some of the practicalities of civilian life (paying bills, applying for housing, etc.). Premature and unexpected discharge (through positive CDT) often afford these ESLs insufficient time to acquire these essential life skills.
- Consideration should be given to a system for assessing the extent to which an individual's drug use may be linked to youth and/or immaturity rather than more entrenched substance reliance tendencies.
- Every effort should be made, even after decisions to discharge, to minimise exposure to additional harmful processes at a critical point of transition to civilian life (e.g. minimising shaming and bleakness about future prospects).
- Consideration should be given to a model which provides practical, mental health and resettlement support that spans Armed Forces to civilian transition. This should be

non-judgmental, proactive, outreaching, relationship-based (due to ESLs decreased likelihood of engagement), co-produced with/involving with peers/those with lived experience and evaluated for cost effectiveness.

- Routine assessment screening for substance use should be conducted in primary care and other settings to mobilise selective and indicated prevention efforts for those with emergent problems. Alcohol and Drug disorder disclosures should signal clinicians to carefully query patients regarding childhood adversity, and, conversely, childhood adversity exposure should also prompt alcohol and drug screening.

10.4 Early detection and intervention

Management staff should be educated to develop alertness to early risk factors identified in the research and literature review. For example, spotting those with avoidant-coping styles, with gambling or other impulse-control issues. Service personnel are more likely to engage in harmful substance misuse if their sense of military belonging deteriorates or is compromised, if they become socially isolated, or when their protective family or Unit relationships break down. These early detection and intervention efforts should also address related mental health problems that manifest as self-medication with drugs and alcohol. The use of interventions by the CoC, and a stepped approach to accessible NICE-recommended substance misuse and mental health support might, in the long run, prevent costly loss of trained strength.

The Forces already have excellent responses to, and treatment of trauma, in serving personnel. We are suggesting that this expertise be harnessed and re-applied to the proactive care for those at risk of substance misuse in an effort to stem the outflow of trained strength through CDT discharge. Training for the CoC should include awareness and identification of 'red flags' for potential drug and alcohol misuse, particularly in the under 25 age group. These can include, for example:

- Physical changes or deterioration
- Aggressive or emotional outbursts
- Isolation from peers
- Death/divorce or separation in the family
- Disciplinary offences
- Requests for leave or transfer
- Career frustrations such as denied promotion, courses, etc.
- Incidents of public shaming or humiliation (e.g. 'dressing down')
- Gambling or debt problems
- Excessive alcohol use

10.4.1 RECOMMENDATION: The Armed Forces should embed an evidence-based early intervention approach to de-escalating risk of substance misuse difficulties emerging.

10.4.2 RECOMMENDATION: The Armed Forces should develop awareness training for the CoC to identify the triggers for 'reactive' drug misuse among serving personnel.

- The Armed Forces should explore ways in which data on Adverse Childhood Experiences and pre-service vulnerabilities might be collated (at recruitment stage) to improve the management of and outcomes for these individuals/cohorts.
- Practices that can re-awaken or and exacerbate past trauma (e.g. treating individuals with disrespect and unfairness/ making them feel powerless and insignificant) should be addressed.

10.4.3 RECOMMENDATION: Better data are required to establish baseline measures of drug and alcohol use within UK military contexts.

Data collection should be carried out by independent and credible research institutions/suppliers with a proven track record of military research to assure data quality and instil confidence among participants (guaranteeing anonymity, understanding the cultural landscape, etc.) Baseline data could then be used to:

- Counter misconceptions of substance misuse within the Armed Forces - the *perception* that substance misuse is allowed or endorsed is associated with higher rates of *actual* substance use (Fear et al., 2007).
- Feed into substance misuse-education programmes.
- Inform behavioural change initiatives aimed at reducing the prevalence of drug and alcohol use within UK Armed Forces.

In the US, the *Health-Related Behaviors Survey* comprehensively assesses health behaviours (including drug alcohol and substance misuse), overall wellbeing of US service personnel and how these factors potentially impact on readiness. Aspects of this may serve as one useful model from which to develop UK specific tools.

10.5 Deterring drug and alcohol misuse

Evidence from this study suggests that the military drinking culture may inadvertently be encouraging other forms of intoxication.

10.5.1 RECOMMENDATION: Building on existing guidance and directives, organisational action to both address alcohol-endorsing cultures and reduce excessive drinking levels, should continue to be priorities for the UK Armed Forces.

Evidence from this study suggests that key deterrence messages are being ignored or subsumed by stronger cultural norms. All were aware of the zero-tolerance policy, but many were prepared to risk taking drugs, judging that there was a low risk of being caught by CDT. The majority also associated alcohol with drug-taking behaviours. The necessity of change within a post-pandemic environment could now present a timely opportunity to review substance-misuse education delivery.

10.5.2 RECOMMENDATION: The Armed Forces should review its current substance misuse programme with a view to developing a coherent, Tri-Service approach. An update model for the education might usefully consider online, interactive and inclusive e-learning programmes, tailored to individuals' level and learning style with follow-up information and support, as required. In addition, evaluation tools should be built into any new service provision to enable the measurement of outcomes.

10.6 Signposting & tailoring support

Evidence from *Fall Out* highlights a need to better signpost and tailor support. With so many organisations offering both general and targeted support to veterans, some participants had found it difficult to identify and link with the service most appropriate to their specific needs. Furthermore, some admitted being unsure whether they, as CDT discharges, were eligible to seek help from particular veterans' support organisations.

10.6.1 RECOMMENDATION: The Armed Forces should carefully assess the social circumstances of each CDT positive individual to determine potential vulnerability and identify the most appropriate supporting agencies. This assessment could use the extant HARDFACTS framework and would provide standardised tools for the management and measurement of transition.

Fall Out highlighted low levels of engagement with the Future Horizons Programme despite the fact that is has been demonstrated to improve employment outcomes and was (for half the sample) one of the few transition support services that was available them as CDT discharges.

10.6.2 RECOMMENDATION: All service personnel discharged through CDT should be referred to Future Horizons for advice and support. Evidence from *Fall Out* indicates a need to review the referral process, to identify barriers to engagement and to encourage greater levels of uptake with the programme.

Evidence from *Fall Out* suggests that some CDT discharges struggled to adjust to the world of civilian employment after transition.

10.6.3 RECOMMENDATION: The Armed Forces should ensure that transition support includes training that sufficiently prepares ESLs for work in civilian contexts. This training is particularly critical for those who joined at an early age/as school-leavers and those (such as CDT discharges) who have limited time to prepare for transition.

10.7 Advancing the state of the art

As the first UK-focused study exploring this cohort of ESLs, the research has highlighted some potentially fruitful areas of further enquiry. Some of our recommendations for future research are outlined below:

This study provides some early stage evidence on pre-service risk factors that may increase the chances of later in-service substance reliance (e.g. having certain numbers or combinations of Adverse Childhood Experiences). With further research, such risk and protective factors may be of use to recruitment, career management and holistic support strategies.

10.7.1 RECOMMENDATION: More research is needed on such pre-service risk factors to explore the feasibility of a proactive approach to improve career management strategies, personnel welfare and reduce costly attrition. Collecting base-line data on wellbeing, for example, could potentially provide a practical and measurable proxy of pre-service vulnerabilities that could inform career planning, helping all personnel to realise their potential.

10.7.2 RECOMMENDATION: Further UK research is needed on the outcomes of UK ESL subgroups and other high-risk leavers (e.g. those leaving due to misconduct/substance misuse). This study represents a significant starting point, but access to this hard-to-reach audience has proven challenging – participants were recruited 'in the community' after discharge from the Armed Forces. Closer collaboration with the MoD to facilitate access to ESL cohorts before discharge may well prove beneficial in terms of securing a larger sample size and further insight.

10.7.3 RECOMMENDATION: An economic evaluation should be completed of the costs to the Armed Forces associated with ESL and substance-misuse or conduct-related discharges, in order to track outcomes, assess the economic benefits of more intensive intervention, and establish where and how costs might be reduced and within what time frame.

10.7.4 RECOMMENDATION: The millennium birth cohort was 17 years of age at the last data sweep. This data could usefully be explored to better understand the pre-service profiles of those joining the Armed Forces. The Millennium Cohort Study would provide useful background data on childhood mental health status, educational and socio-economic circumstances, parental mental health difficulties, parental substance misuse, etc. This research could potentially help refine decisions to optimise the support and management of those recruits with existing vulnerabilities.

10.7.5 RECOMMENDATION: More high-quality research and evaluation is required on 'across the transition' care coordination approaches. In the US, for example, a proactive texting follow-up support system has early stage evidence of efficacy and is currently being trialled further. (Peterson et al., 2018). In the UK, Contact[20] is a group of charities and academics that work with the NHS and the MoD with the aim of improving access to support for health and wellbeing for the military community. It is currently working on collaborative transition care pathways including common assessment systems, casework management and quality accreditation criteria). We would emphasise the importance of ensuring that the research, development and application of care coordination approaches are inclusive of those discharged as a result of drug misuse.

[20] Further information on Contact, including details of its partner organisations, is available at: https://www.contactarmedforces.co.uk

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