Describing the feasibility of using case management in a specialist forensic substance misuse intervention for UK veterans: a case study

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ABSTRACT
Veterans with mental health problems are a high-risk group for substance misuse difficulties and are over-represented in forensic settings. Yet, there are few substance misuse services available for this population. Evidence suggests that case management can provide effective interventions for veterans with substance misuse problems. However, there is little research to show its effectiveness in the UK. The present study reported on the implementation and preliminary outcomes of the Veterans Forensic Substance Misuses Service (VFSMS), piloted within a prison setting, to demonstrate the feasibility of the service. The VFSMS operated in four stages: Assessing needs, developing case management plans, providing bespoke support and developing discharge plans. Case studies were used to demonstrate this process, with measures of alcohol use and recovery showing outcomes for each case. Findings from three case studies suggested that case management was a feasible approach, with a range of interventions being used, including substance misuse and mental health services, plus housing and employment services. Outcome measures suggested that alcohol and substance misuse recovery improved following the VFSMS intervention. While the scope of the findings is limited, they suggested that case management is a feasible substance misuse intervention, with preliminary findings showing improvements in substance misuse outcomes.

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Introduction
Veterans with mental health problems have been highlighted as a high-risk group for substance misuse difficulties. Compared to civilians, those who have served in the military are almost twice as likely to suffer from alcohol problems, with 67% of men and 49% of women in the UK military classifying as having a drinking problem, compared to only 38% of men and 16% of
women in the general population (Fear et al., 2007). UK veterans are also more likely to present with substance misuse problems relating to drugs, with 5.2% reporting drug dependence compared to only 3.5% of civilians (Woodhead et al., 2011).

Different explanations have been proposed for the higher rate of substance misuse in veterans. Some research has emphasised the influence during service of military culture on fostering substance misuse problems, including the ‘macho subculture’, where competitiveness and masculinity are encouraged, as well as the use of alcohol for team bonding and dealing with distress (Jones & Fear, 2011; Keats, 2010). Following deployment, rates of substance misuse appear to increase, with many military personnel using substances as a coping mechanism following trauma (Jacobson et al., 2008). Indeed, mental health difficulties are associated with substance misuse, with evidence showing that veterans with depression or posttraumatic stress disorder (PTSD) are more likely to report alcohol misuse as those without depression or PTSD (Head et al., 2016; Jakupcak et al., 2010). Furthermore, following the conflicts in Iraq and Afghanistan, 11% of US soldiers were found to meet criteria for either a drug or alcohol disorder (Seal et al., 2011).

Research suggests that veterans are at an even greater risk of substance misuse compared to serving personnel due to problems adjusting back to civilian life (Thompson et al., 2011). Studies have demonstrated that only a small proportion of veterans with mental health difficulties actually seek help due to not knowing where to go, believing civilian services will not help and the stigma surrounding mental health (Mittal et al., 2013). Moreover, veterans who misuse drugs or alcohol have been shown to drop out of treatment before completing it (Van Minnen, Amtz, & Keijsers, 2002). Research has shown that the average time it takes veterans to seek help for their health difficulties can be as long as 11 years after leaving the military (Murphy, Weijers, Palmer, & Busuttil, 2015). As veterans wait for longer to access national statutory alcohol services, they are more likely to seek support at an older age than civilians and be admitted for longer (Murphy, Palmer, Westwood, Busuttil, & Greenberg, 2016).

Data suggests that the majority of ex-service personnel go on to do well after leaving the military (Iversen et al., 2005). However, there is evidence from the US that links combat exposure to self-reports of criminal behaviour (Black et al., 2005; Booth-Kewley, Larson, Alderton, Farmer, & Highfill-McRoy, 2009), and some reports have shown that 9.1% of prisoners in England and Wales have served in the armed forces (NAPO, 2009). This is reinforced by Ministry of Defence analyses, which suggest that veterans make up the largest occupational group in UK prisons (Ministry of Defence [MoD], 2010). While the number of veterans in forensic settings might be due to their military experiences, it is also the case that many military personnel recruited are from areas of social deprivation and increased crime
The combined evidence of veterans being at increased likelihood of having substance misuse difficulties and their over-representation in prisons suggests that substance misuse interventions for veterans are required in forensic settings.

In light of the unique difficulties faced by military veterans, a greater level of support and more assertive approach is needed. Researchers have highlighted the importance of clinicians having specialist knowledge on military culture and traumatic experiences when treating veterans, as opposed to the standardised treatment given by statutory services (Hoge, 2011). Case management has been suggested as a viable option due to its person-centred nature, adapting to the needs of the individual and, therefore, being able to accommodate the specialised needs of veterans (Mohamed, Neale, & Rosenheck, 2009).

Case management involves a healthcare professional assessing, planning and coordinating treatments for the individual, such as referring them to the right services and working with them throughout the entire process. Eight principles of case management have been previously described (Center for Substance Abuse Treatment, 1998): offer a single point of contact with health and social care systems; be driven by client need; provide advocacy; be community-based; be pragmatic; be anticipatory; be flexible; and be culturally sensitive.

Combining military knowledge with individualistic care is proposed to help veterans feel more comfortable accessing support, which will encourage them to get help sooner and improve their overall outcomes (Neale & Rosenheck, 1995). Research has previously shown that case management produces positive results in individuals suffering from mental health difficulties and substance misuse as it is able to provide rounded care to address all difficulties (Essock et al., 2006), and that veterans who are case-managed are more likely to continue engaging in services for longer and have better outcomes as a result (Siegal & Rapp, 2002). Compared to services offering interventions for single problems, case management has been found to improve all aspects of veterans’ lives (Siegal et al., 1996). As such, a specialised military case management service could help to improve treatment engagement and reduce overall mental health and substance misuse difficulties in veterans. Despite this, there is currently a deficit of services focused on providing substance misuse support in forensic settings and even less aid for veteran populations in particular.

Combat Stress (CS) is a national charity providing specialist mental health services to military veterans, which receives approximately 2500 new referrals per annum (Murphy et al., 2015) from a variety of sources (e.g. General Practitioners (GPs), National Health Service (NHS), charities, self-referrals). The present paper outlines the implementation by CS of a Veterans Forensic Substance Misuse Service (VFSMS), providing case management support to veterans with substance misuse difficulties in prison.
Published clinical audits identified that Veterans accessing CS had significant rates of alcohol and illicit substance misuse disorders presenting comorbidly with mental illness primarily PTSD and depression (Busuttil, 2010). Substance misuse disorders were preventing engagement into appropriate treatment for underlying mental illness (Busuttil, 2011a, 2011b; Hill & Busuttil, 2008). An internal service paper was written proposing a case management model aimed at ensuring engagement of those suffering from dual diagnosis both with addiction services as well as mental health services (Busuttil & Taylor, 2012).

The service was set up as a pilot intervention, with a view to assessing the feasibility of the approach in this specific population. The paper describes the service in detail before reporting on assessments of its feasibility, as well as using case studies to illustrate the process of delivering the service and its outcomes.

**Method**

**Setting**

The VFSMS was set up in August 2017 to provide case management support to UK veterans with substance misuse difficulties in prison. This in-reach pilot was part of a wider pilot project comprising a total of 11 sites across the UK. The service was based at a low to medium secure prison in the North of England, which has links to other prisons in the local areas. CS approached a number of local prisons with a view to setting up the VFSMS. The chosen site was selected due to its commitment to supporting veterans in custody and presence of a dedicated Veteran in Custody Officer who could identify those suitable to engage with the service. This meant that the service would be able to capture both those veterans who have just been sentenced to explore what support is available, and those who are due to be released to assist with their transition back into the community.

The chosen site was a Category B local prison, with an occupational capacity of 750 which manages both medium and low security prisoners. It accepts all adult male prisoners including 18- to 21-year-olds. There is a specific Recovery wing within the prison, where daily substance misuse groups and meetings are held to address misuse and develop relapse prevention plans and coping strategies. Veterans engaging with the VFSMS have the option to be located on the Recovery Wing. Veterans in the prison also have priority access to mental health services including trauma therapy.

**Service description**

The VFSMS pilot services were developed in 2014 following funding from the LIBOR fund and the Scottish Lottery Fund. CS adopted a service
model which employed substance misuse nurses employed by CS. Veterans were case managed on a one-to-one basis and were linked into local substance misuse statutory services who were partnering the CS substance misuse nurse practitioners. The substance misuse nurse practitioners were located within statutory community services, Accident and Emergency (A & E)-based addictions teams and the VFSMS prison in-reach project described here.

Clinical governance, performance and quality control were informed by the national CS Clinical Governance structure. A new subgroup was set up for the VFSMS and reported on a quarterly basis. Liaison with the host statutory services was conducted on a regular basis by this subgroup.

The VFSMS offered support through a variety of mediums, tailored to the individual’s specific needs. The service worked to assess veterans’ needs, engage them with appropriate services, support them through their transition and work towards release and discharge. The VFSMS contained one substance misuse nurse practitioner, responsible for assessment and intervention with all individuals referred to the service. The VFSMS intervention was delivered in four stages:

**Assessment**
When a veteran was in custody and identified as having a substance misuse problem, they were referred to the VFSMS and subsequently completed an assessment within the prison with the veterans’ substance misuse nurse practitioner. This assessment comprised of a risk assessment, exploration of the individual’s substance misuse difficulties and identification of additional psychological, social or physical needs.

**Case management plan**
A case management plan was then created to engage the individual with the appropriate services to meet their needs, whether solely with the VFSMS or through referrals to external agencies that provided support within prison or after release.

**Individual and group support**
Once a case management plan was agreed, the trained substance misuse practitioner provided one-to-one, face-to-face support, dependent on the individual’s needs. This could have included psycho-educational, emotion regulation strategies and psychological therapeutic interventions such as graded exposure for trauma and anxiety. Service users were also able to access group psycho-educational sessions held at the prison sites, where appropriate.

Progress was monitored on a regular basis and reviewed by both the practitioner and the service user using outcome measures described below.
The case management plan was then updated accordingly. The frequency of the reviews was determined by the severity of the individual’s substance misuse problem as well as their position in their sentence. For instance, a veteran at the beginning of a long sentence who was regularly engaging with a range of services may have been reviewed on a three-monthly basis while a veteran coming to the end of their sentence and preparing for release may have been reviewed on a weekly basis. Nevertheless, a review was conducted at a minimum of every 3 months.

**Discharge plan**

Finally, an ongoing plan was created to support the individual around their release from prison or discharge from the VFSMS. This plan may have included community support, referral to mental health, welfare needs or veteran-specific services. Service users were discharged from the VFSMS when they showed evidence of either being abstinent from, or significantly reduced their substance misuse. Alternatively, they were discharged if they chose to self-discharge, did not engage, or when the practitioner believed the individual’s condition had stabilised and they no longer required support.

This study was approved by the CS research committee for ethical suitability. Participants were given information about the case study research and gave informed consent for the collection of data.

**Outcome measures**

The substance misuse nurse practitioner within the VFSMS provided case reports for a sample of three veterans who engaged in the service, in order to demonstrate how the service was implemented. Each report provided background information about the individual, details of the assessment, the case management plan, any support provided and the plan for discharge. The reports also contained information about any factors relating to the engagement of the individual, how many sessions they attended and missed, as well as details about other services that were involved in the supporting the individual. The case studies reported in the present study were selected so as to provide a range and variety of cases, as well demonstrating what were deemed to be ‘typical’ cases to engage with the service.

Feasibility was explored by looking at how many participants engaged with the service once they had been referred, as well gauging the level of engagement, i.e. whether participants attended sessions and continued to engage with services once they had been assessed and referred on.

An individual’s progress during the intervention was monitored using two measures. Firstly, the *Recovery Star* measure (Dickens, Weleminsky,
Onifade, & Sugarman, (2012) was used to assess areas of functioning typically affected by substance misuse. As such, it was used as a proxy measure of substance misuse severity. The Recovery Star is a self-report measure across 10 domains: managing mental health, physical health and self-care, living skills, social networks, work, relationships, addictive behaviour, responsibilities, identity and self-esteem, and trust and hope. The construct validity of the Recovery Star has been previously reported (Dickens et al., 2012).

Secondly, the Alcohol Use Disorders Identification Test (AUDIT; Babor, Higgins-Biddle, Saunders, & Monteiro, 2001) was used to assess alcohol misuse. This 10-item self-report measure gives an overall score to assess alcohol-related risk. Scores of 0–7 indicate no harmful consumption. Hazardous drinking is indicated by a score of 8–15, while harmful drinking/mild dependence by scores of 16+ (Babor et al., 2001).

Results

Case studies

Three case studies are described in order to illustrate the intervention in practice.

Demographics

All individuals were male with an age range of 28–39 years. One individual’s primary substance problem concerned drugs (cocaine), with the others being alcohol-related. All individuals had some form of mental health difficulty, such as PTSD, anxiety, depression, and one had a personality disorder. In terms of education, all cases had GCSE (General Certificate of Secondary Education) level or equivalent. Two individuals described themselves as being in relationships, with the other one as currently single. The average length of sentence was 6.4 months, with a variety of offences, including burglary, violence and driving offences. Individuals had spent an average of 4.8 years (range 2–7) serving in the military. The average time since leaving the military was 11 years (range 7–15). At the time of writing, 33 individuals had been referred to the service, with 30 having engaged in an assessment, and a further 3 awaiting assessment. After engaging initially, three veterans disengaged from the service. This was due to either being transferred to another site out of the area, opting not to engage in any service within custody, and, after assessment, determining that no need for further support.

Participant 1 (D)

Assessment. At assessment, D’s main concerns related to his alcohol misuse, which he described had developed from 2006 in order to help him cope
with emotional stress. His level of alcohol intake meant he was unable to maintain employment, he had lost his place in supported accommodation, stopped engaging in hobbies, and had lost contact with family members due to his behaviour while under the influence. D also reported having had frequent presentations at A & E citing suicidal ideation.

**Case management plan.** Based on the initial assessment, the case management plan for D included formal support to reduce substance misuse and education on the effects of alcohol on offending behaviour and mental health, as well as support with mental health concerns and relapse prevention. Additionally, help finding accommodation was required, as D had been refused permission to reside with his sister.

**Individual and group support.** D was referred to work with a Psychological Well-being Practitioner within the prison to complete psychological therapy for anxiety. He also completed an anger management intervention while on the recovery wing at the prison. Following his release from prison, D was supported with attendance at Probation services and in getting specialised accommodation for veterans which included 24-h support.

D was seen by his clinician on 19 occasions during his engagement with the service, which totalled approximately 28 h of contact time. He attended every appointment that was scheduled both in custody and in the community. From assessment to discharge, D engaged with the service for a total of 16 weeks.

**Discharge plan.** D was linked in with Project Nova, a programme coordinated by UK veterans’ charity Walking with the Wounded, aimed at supporting veterans with a forensic history. Contact was maintained following release from prison to assist with ongoing contact with services.

**Outcomes.** D reported improvements in mental health following his engagement with the VFSMS. There were no further presentations at A & E hospital departments, or reports of suicidal ideation and D described being involved in hobbies and activities with other veterans which had further served to improve his mood.

At admission, D’s AUDIT score was 35 which is in the top bracket indicating alcohol dependence. On discharge this had reduced to 6, classified as low risk. He reported two lapses of alcohol use but no full relapse and remained abstinent at follow-up. D’s Recovery Star measures increased from 52 to 72 from assessment to follow-up, showing particular increases in areas of addictive behaviour, identity and self-esteem, and managing mental health.
D’s case was a good example of the importance of a holistic approach. Issues related to substance misuse and offending were connected with mental health which, when addressed, had subsequent positive outcomes in other areas.

**Participant 2 (M)**

**Assessment.** At assessment, M’s main difficulty was with cocaine use, which was on a daily basis, used to block out negative thoughts, and was a barrier to him being in employment. M also explained that it had ruined his relationships with his daughter and ex-partner. M reported that he had suffered with anxiety and depression for over 3 years, and also displayed symptoms of PTSD.

**Case management plan.** M’s case management plan included interventions for mental health, drug use and employment.

**Individual and group support.** While in custody, M attended groups and one-to-one support sessions relating to sleep hygiene and relapse prevention, which included the development of relapse prevention plans. After his release, M was supported in liaison with Probation services, as well as being linked in with veterans support groups in the community, such as veterans retreats which allowed him to re-engage with hobbies and learn new skills. M was also referred to the Poppy Factory, a veteran’s charity aimed at getting veteran into employment. The substance misuse nurse practitioner actively supported him once in the community, such as helping to ensure he attended different services and providing support in between appointments.

M attended eight one-to-one sessions with the clinician overall, totalling approximately 12 h of contact, which does not include several additional telephone contacts. He did not miss any scheduled appointments either in custody or in the community. At the time of writing, M had been engaging with the service for 15 weeks and was still receiving support.

**Discharge plan.** As well as ongoing engagement with community veterans groups, M was referred to CS to address his mental health difficulties.

**Outcomes.** M reported being substance-free at follow-up which was verified by drug-testing carried out by Probation services. From his engagement with the Poppy Factory, M was able to secure employment following his discharge. M was low risk for alcohol misuse at assessment, and remained so at follow-up. His Recovery Star score increased from 49 at assessment, to 74 at follow-up, with improvements across all domains, particularly in work, relationships and addictive behaviour.
Feedback from M indicated that he was initially suspicious of the service and did not want help. However, because case management offered a personalised approach, the clinician was able to travel to meet him. This personalised service was, anecdotally, important in demonstrating that the service was genuine and caring, which aided engagement.

**Participant 3 (J)**

**Assessment.** At assessment, J identified alcohol use to be his main difficulty prior to being in custody. He described using alcohol to self-medicate and manage feelings of depression and anxiety, adding that he felt too ashamed to seek help from his GP. This was the first time he was gaining support. Alcohol misuse had led to him losing his job and a breakdown in his relationship. Owing to the nature of J’s offence, time was taken in the assessment to carry out a risk assessment to determine what services he would be able to attend in the community.

**Case management plan.** J’s case management plan included interventions for his alcohol use and mental health. He explained that he did not feel able to attend groups in the prison, so the plan comprised of one-to-one work only, as well as liaison with other services in the community.

**Individual support.** J attended five one-to-one sessions while in custody. He received support for his alcohol use and relapse prevention, as well as for emotion management and sleep hygiene. While in custody, his clinician liaised with services in the community and prior to his release, J had secured supported accommodation specialising in veterans’ care.

J did not miss any scheduled appointments and was available for telephone contacts following his release. From assessment to discharge, J engaged with the service for a total of 14 weeks.

**Discharge plan.** At discharge, J was referred to CS for support with his mental health difficulties. He was also linked in with local drug and alcohol services to continue the work he had begun on relapse prevention.

**Outcomes.** J’s score of 33 on the AUDIT at assessment placed him in the category suggestive of alcohol dependence. At follow-up his score had reduced to 19, which placed him in the category below, although still indicative of harmful drinking. His score on the Recovery Star increased from 52 to 73, with the highest level of improvement in addictive behaviour. J has been engaging with medical services in the community and getting help for depression, meaning he was no longer using alcohol to self-medicate. He reported improvements in his ability to accept help and was now in employment.
While the nurse practitioner in this case did not have a lot of direct involvement with J, the case management approach had a positive impact by liaising with the right services for that individual, and ensuring he accessed help in the right places.

Discussion

This paper described a pilot service for UK veterans that used a case management approach for tackling substance misuse difficulties in a forensic setting. The service was set up in a prison in the UK, with affiliations to two separate prisons in the local area. The service was co-ordinated by a single clinician, operating across the three prison sites and in the community. A case management approach was used to ensure that veterans referred to the service received support that was holistic and tailored towards their specific needs.

Findings from three case studies were used to describe the process of delivering the intervention, which comprised of four stages: assessment, developing a case management plan, one-to-one and group support, and developing a discharge plan. As well as clinician reports, each veteran’s progress was monitored using the AUDIT and Recovery Star measures. Following their involvement with the VFSMS, all three cases described improvements in their substance misuse, which was supported by scores on the different outcome measures. Given the small sample and lack of control within the design, this provides only tentative evidence about the effectiveness of this intervention.

In terms of feasibility, the findings showed that the uptake of the service following referral was high, with only three people dropping out of the service. The case studies showed that, for these participants, attendance rates were high, and all of them went on to engage with different services. A number of different services became involved in each case through the liaison work of the VFSMS clinician, depending on the specific needs of each individual. The most commonly involved services were those relating to drug and alcohol use, mental health, employment and accommodation. In addition, veteran-specific organisations were often involved, to help to re-engage the individual in activities and prepare them for work. This holistic approach meant that many services could be involved directly and perhaps increased the likelihood of the veteran engaging in those services due to the liaison work of the VFSMS clinician.

Clinical implications

The present paper provides some emerging support for the use of case management in cases of substance misuse. Based on these findings, case management has the potential to provide a useful framework through which interventions can be accessed by individuals. Theories of behaviour change such as the Stages of Change model and Theory of Planned Behaviour
have been used previously to inform substance misuse interventions (Bashirian, Hidarnia, Allahverdipour, & Hajizadeh, 2012; Zemore & Ajzen, 2014), and could be integrated into case management approaches to ensure that interventions are targeted in the right way depending on the individual’s readiness to change (Enguidanos, 2001).

Case management is a good example of integrated care, whereby clients can receive support for various difficulties within one holistic treatment approach, as demonstrated by the case studies in the present study. Research has suggested that such integrated approaches can lead to better substance misuse outcomes (Graeber, Moyers, Griffith, Guajardo, & Tonigan, 2003; James, Preston, Koh, & Spencer, 2004; Kavanagh et al., 2004). There is a good case for using a case management approach, with evidence showing its effectiveness in reducing substance misuse (Essock et al., 2006), and its successful use for any years with veterans in America (Mohamed et al., 2009; Siegal & Rapp, 2002).

It has been demonstrated that military veterans can take a long time after finishing their service to seek help for mental health-related difficulties (Murphy et al., 2015). This was shown in the final case study here where alcohol was being used to self-medicate amidst feelings of shame about seeking support. The results from this pilot showed that very few individuals disengaged from the VFSMS once they had started. Additionally, the fact that individuals continued to engage with the VFSMS after their release from custody suggests that they found the intervention worthwhile and meaningful. As was shown in the three case studies, a personalised and holistic approach means that an individual can gain support for many needs at one time, for example securing accommodation and employment, alongside tackling substance misuse and mental health difficulties.

Following this pilot project, considerations are being made regarding how to expand the service to make it more widely available. Expanding the service would provide a number of challenges that should be considered. For instance, an effective case management service requires effective links between the main site and community services, which would need to be established before clients access the service to ensure smooth transitions to and between different services. Additionally, given the high rate of comorbidity between substance misuse and mental health, any community case management service would need to be fully integrated within the treatment pathway of CS, to ensure that mental health needs are regularly reviewed alongside substance misuse.

**Limitations and future research**

The VFSMS was intentionally set up as a pilot intervention to test the feasibility of offering a case management approach to this specific population. As such, it was beyond the scope of the service to implement any large-scale trials of effectiveness at this stage. Nevertheless, the lack of any
experimental design, rigorous outcome measures and small sample from a single site does limit the scope of the findings and the extent to which they can be generalised. However, the study benefits from having real-world, external validity. The study would also have benefited from longer-term follow-up of each case to assess the impact of the interventions over time.

The Recovery Star was used as an outcome measure for each participant’s functioning in relation to their substance misuse. However, the actual level of substance use was not quantitatively measured other than via interview at assessment and follow-up. Future research could make use of more formal measures to more accurately assess the impact on substance misuse.

Given that these initial findings demonstrate the potential usefulness of the VFSMS, a larger scale trial of its effectiveness would be welcome. Trials in which VFSMS are compared against existing services would further our understanding of its efficacy. Even in the absence of any comparison group, a larger scale trial with more rigorous outcome measures and a much larger sample size would be beneficial.

Conclusions

This paper reported findings from a pilot intervention using case management to support veterans in a forensic setting with substance misuse difficulties. While the limitations of the study limit their interpretability, early indications are that this could be a very useful method of co-ordinating support for this group and assisting them in various ways, not just in relation to their substance use. There is a clear need for evidence on a larger scale to corroborate and build upon these findings. If the early promise of this approach is borne out, there could be widespread positive implications for this population, with a service model that could potentially be adapted to benefit individuals from different populations with far-ranging needs.

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