Veterans in Care Homes: An International Scoping Review to Inform UK Policy and Practice

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ABSTRACT

Context: In contrast to the mental and physical health needs of veterans, veterans’ social care needs remain relatively neglected by policymakers and researchers.

Objective: To inform UK veterans policy and practice by drawing together the expectedly limited international research base on veterans in care homes.

Method: An international scoping review of peer-reviewed and grey research literature was conducted, informed by Levac et al.’s (2010) six-stage process.

Findings: Thirty-three papers were found to meet the inclusion/exclusion criteria. The papers’ contents typically fell into one or more of the following themes: social connection, care preferences and autonomy, and military-related physical and mental health needs.

Limitations: Very little (n = 1) UK-situated research was found, with the majority of retrieved papers (n = 24) being US-based, impeding transferability and relevancy of the findings to a UK context.

Implications: Veterans’ social care needs were found to be a largely underexplored area of research, especially in the UK. There is a pressing need for UK veterans’ policymakers to redress existing imbalances in the focus of policy and research by raising the status and importance of the social care needs of UK veterans, as has been achieved on the mental and physical health fronts.
BACKGROUND

Social care in the UK has long been considered the poor relation of NHS-provided healthcare, comparatively neglected in terms of the attention, priority, and, hence, state funding, it receives (Edwards, 2021; Wanless, 2006). This is despite the multiple ongoing, and arguably worsening, crises in social care concerning waiting lists (ADASS, 2023), under-funding (Care England, 2023), staff shortages (Waltzman, 2022), and the resultant spillover effects these have for the opt-prioritised healthcare services due to their symbiotic and inextricable relationship with one another (Flinders and Scobie, 2022). The social care needs of specific populations, such as UK armed forces veterans, appear to hold a similarly marginal position in veterans’ policy and research compared to the mental and physical health needs of this same population. The recent Veterans and Strategy Action Plan 2022–2024 (OVA, 2022), for example, has scant mention of the social care needs of veterans amongst its multiple commitments to advancing mental and physical health through funding, service improvement, and research.

Veterans’ care homes have long histories in the UK, whose common purpose has traditionally been to provide for the physical and mental health needs of soldiers injured in war. Internationally, many veterans’ care homes were founded upon similar social contract justifications, with governmental commitments to provide for the ongoing care, medical needs, and potentially lifelong hardship and disability that may have resulted from their service (Yang et al., n.d.; VA, 2023). With the earliest UK veterans care home established over 300 years ago (Royal Hospital Chelsea, est. 1692) and others created in response to the casualties of World War I (e.g., Erskine est. 1916; RBLI est. 1919; Royal Star and Garter est. 1916), there has understandably been a change to the scope and eligibility criteria for specialist veterans’ care homes in the UK over time. Veterans’ care home provisions now extend far beyond their initial remit of providing for the physical and mental health needs of male soldiers, with entry criteria having expanded to include female personnel and veteran family members, and towards the meeting of an increasingly complex set of social care needs.

With limited state-committed funding for specialist veteran social care in the UK, most veteran care home beds are currently provided by military-related charitable organisations. How many of the UK’s estimated 2.2 million veterans over 70 years of age (MoD, 2019) are currently being cared for in institutional settings (specialist or otherwise) has, until recently, remained reliant on estimation. With the inclusion of a veteran identity question appearing for the first time on the 2021 England and Wales census, there is now a more formalised indication of the number of veterans currently residing in institutionalised care settings such as nursing, care, and residential homes in these two nations. In 2021, 36,813 veterans (2% of the total veteran population) in England and Wales lived in ‘communal establishments’ including care homes and other non-care-related institutionalised settings such as prisons and student accommodation (ONS, 2022). Yet, PTSD is thought to be underdiagnosed in both older veterans (Jacobs and Dinoff, 2012) and individuals with dementia (Hutchinson et al., 2021). Misdiagnosis may also play a role due to symptoms being misattributed to, or indistinguishable from, behavioural and psychological symptoms of dementia (BPSD) (Bruneau et al., 2020; Hutchinson et al., 2021). A lack of awareness around delayed-onset post-traumatic stress disorder (DOPTS), which may manifest amongst older veterans with dementia in their later years, may also contribute to the underdiagnosis of PTSD in older veterans (Hutchinson et al., 2021).
Care home residents, in general, are an underserved population in research compared to other healthcare demographics, with limited staff and institutional experience of research, restrictive inclusion criteria, and assumed complexities around consent cited as barriers to their inclusion (Nocivelli et al., 2023). Accordingly, the circumstances under which sub-demographics of care home residents such as veterans live and are cared for also remain underexplored (Fleuty et al., 2021). Given the potential for there to be service-connected conditions, and hence, service-informed care needs to exist or emerge amongst veterans in institutional care settings, there is a need to better understand this population. Mapping the existing research landscape around this demographic was determined as an appropriate starting point from which future research, practice, and policy developments relating to this demographic could be based. Therefore, a scoping review, a method well-suited to mapping bodies of literature that are yet to be synthesised (Peters et al., 2021), was initiated as a means of answering the following questions:

- What is known about the social care needs of veterans residing in care home settings in the international research literature?
- What military-connected health needs are present amongst veterans in care homes, and do these affect how they are cared for?

### METHODS

The purpose of a scoping review is to map the breadth of a body of evidence and identify knowledge gaps (Anderson et al., 2020) rather than appraising the quality and bias of the evidence retrieved (Calatrava et al., 2022). A scoping review was therefore deemed the most appropriate method of sourcing literature on an underexplored, and yet to be synthesised, topic area such as veterans in institutionalised social care. The six-stage scoping review process by Levac et al. (2010) guided the conduct of the scoping review, with the PRISMA-ScR guidelines (Tricco et al., 2018) used to structure how the scoping review’s findings were presented. Levac et al.’s (2010) scoping review process was chosen over others, such as those proposed by Arksey and O’Malley (2005) and Peters et al. (2021), for two key reasons. Firstly, Levac et al. (2010) emphasise flexibility in the scoping review process, which allowed for a continual and iterative consultation process with the veteran care home funders of this study. This was important as it allowed for the search strategy and research questions to be adjusted and refined after the first initial search, in an attempt to generate findings that were neither too broad nor too narrow to be of relevance to clinical practice. Consequently, no scoping review protocol was registered prior to the scoping review process beginning. Secondly, Levac et al. (2010) support thematic analysis of scoping review findings, in contrast to the recommendations of Peters et al. (2021), who favour a more descriptive presentation of results.

### IDENTIFICATION OF STUDIES

Four databases—EBSCOhost Military and Government collection, ProQuest Social Science Premium collection, Applied Social Sciences Index & Abstracts (ASSIA) (via ProQuest), and Scopus—were used to identify peer-reviewed research articles. Searches of the Forces in Mind Trust research report repository (www.fim-trust.org/reports/), Google, and http://www.greylit.org/ were conducted in order to source research in the grey literature space. All data sources were searched in May 2022. Combinations of free-text keywords and pre-

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<td>“Aged care facilit*”</td>
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Table 1 Keywords.
defined MeSH headings (see Table 1) were utilised in the search, dependent on the database. Research relating to veterans in all forms of institutionalised care settings, except for short-term rehabilitation and day care, was included as part of this scoping review. Therefore, the term ‘care home’ henceforth is used as an umbrella term under which institutionalised care settings for veterans of all dependencies, from residential to nursing homes, are included.

SCREENING PROCESS

In keeping with the continual collaboration advocated by Levac et al. (2010), the study’s funder collaborated in the refinement of the inclusion/exclusion criteria (see Box 1).

Box 1 Inclusion/Exclusion criteria

**Inclusion**
- Research articles (peer reviewed and grey literature research included)
- Research conducted with an institutionalised veteran population sample
- Research conducted with the staff of institutionalised veterans where the topic is the preferences or behaviours of veteran residents
- Research on the care of medical or psychiatric conditions amongst veterans that have the potential to be service-connected e.g. PTSD and TBI
- 2000 onwards

**Exclusion**
- Articles not written in English
- News articles and journalistic publications
- Policy and legislation documents
- Survey instrument validation studies
- High/national level data analysis of outcomes (e.g. medical or financial) across different veteran nursing home providers
- Economic analyses
- Medical research and clinical trials on non-service-connected health conditions
- Research conducted with staff that is not directly related to veterans e.g. nurses perceptions of extended roles and quality improvement interventions
- Studies on veteran receiving care in the community (e.g. veterans foster homes)
- Papers where the institutionalised veteran sample was mixed with a non-institutionalised or civilian sample
- Veterans that were temporarily residents of a rehabilitation facility (e.g. for substance use)
- Studies on non-UK country specific topics with limited transferability to a UK context – e.g. hurricane evacuations

Grey literature was included due to the funder’s awareness that previous research had been commissioned and published on UK veterans care homes in this space in the recent past. A cut-off point for the year 2000 was agreed upon with the funder to exclude results that were least likely to be of relevance to current care home practices. The initial search revealed many, predominately US-based, medical research papers conducted with a veteran’s care home population, yet without relevance or reference to their lives as veterans. The Veterans Affairs system is the ‘largest integrated health care delivery system in the United States’, which amasses a vast quantity of data on multiple data points from its six million users (Fink et al., 2022). The convenience this provides to medical researchers could, at least in part, explain the volume of medical research conducted with US veteran care home populations. Therefore, studies were excluded if the title and abstract indicated that the research had been conducted on, but not about, veteran care home residents. However, as one of the research questions sought to understand how military-connected health needs affect veteran care provisions, medical research studies with care home-situated veterans that explicitly mentioned a connection between the veterans’ service and the health need under inquiry, such as traumatic brain injury, were the exception to this rule and were included.

**DATA CHARTING**

Date of publication, type of publication (journal article or grey literature), country, study population (i.e., veteran only, staff, or mixed sample), and gender breakdown were of interest and were hence the data points that each study was charted against, alongside the study’s aims, methods, design and methodology, and a summary of the findings. Following this, a more inductive analysis of each study’s findings was conducted. A process of highlighting and memoing key findings occurred during a reading of each paper’s full text. This was followed by the categorisation and ascription of keywords to each paper, which allowed for the development of three overarching themes. With this scoping review’s focus centred around mapping and synthesising the existing knowledge base, no quality appraisal of the retrieved papers was attempted. Data charting and thematic analysis were completed by one researcher in June 2022.

**RESULTS**

Following automatic and manual duplicate removal of the 2,602 studies retrieved, 2,342 studies remained for screening. Each study had a title and abstract screened for relevance by one researcher. Those that remained following this initial screening process (n = 120) had their full texts accessed and screened against the
inclusion/exclusion criteria. Following the application of the inclusion/exclusion criteria, a total of 33 papers remained, comprising the final papers upon which this scoping review is based.

Each stage of the screening process is detailed in the Prisma diagram (see Diagram 1).

An extraction table with summaries of each study as per the previously determined data points can be found in Supplementary Table 1.

CHARACTERISTICS OF SELECTED PAPERS

Of the 33 final papers, 31 of these were peer-reviewed journal articles (Akram et al., 2021; Brennan et al., 2018; Brennan and SooHoo, 2020; Buchanan et al., 2004; Chang et al., 2011; Chueh and Chang, 2014; Curyto et al., 2020; Durkin et al., 2012; Jacobs and Dinoff, 2012; Jutkowitz et al., 2019; Kang et al., 2021a; Kang et al., 2021b; Kaup et al., 2017; Kostka and Jachimowicz, 2010; Kracker et al., 2011; Lane et al., 2016; Lemke and Schaefer, 2010; Mares et al., 2002; McCarthy et al., 2004; Nedjat-Haiem et al., 2015; Page and Hinrichs, 2017; Palmer et al., 2018; Parker et al., 2018; Saivar, 2004; Simons et al., 2021; Slama and Bergman-Evans, 2000; Van Orden et al., 2021; Wiersma, 2008), one was a PhD thesis (Saivar, 2004), and another a grey literature research report (Reynolds and Paget, 2015). The majority of studies were conducted in the US (n = 24) (Akram et al., 2021; Brennan et al., 2018; Brennan and SooHoo, 2020; Buchanan et al., 2004; Curyto et al., 2020; Durkin et al., 2012; Jacobs and Dinoff, 2012; Jutkowitz et al., 2019; Kang et al., 2021a; Kang et al., 2021b; Kaup et al., 2017; Kostka and Jachimowicz, 2010; Kracker et al., 2011; Lane et al., 2016; Lemke and Schaefer, 2010; Mares et al., 2002; McCarthy et al., 2004; Nedjat-Haiem et al., 2015; Page and Hinrichs, 2017; Palmer et al., 2018; Parker et al., 2018; Saivar, 2004; Simons et al., 2021; Slama and Bergman-Evans, 2000; Van Orden et al., 2021). The remainder were conducted in Taiwan (n = 4, Chang et al., 2011; Chueh and Chang, 2014; Tsai et al., 2009; Tsai et al., 2012), Canada (n = 2, Ritchie et al., 2022; Wiersma, 2008), New Zealand (n = 1, Tong et al., 2010), UK (n = 1, Reynolds and Paget, 2015), and Poland (n = 1, Kostka and Jachimowicz, 2010). Most of the studies were conducted with a veteran resident sample (n = 31), with only two studies conducted with a sample of staff only (Lane et al., 2016; Palmer et al., 2018). Of the 31 studies with veteran resident samples, 12 had male only samples (Buchanan et al., 2004; Chang et al., 2011; Chueh and Chang, 2014;
Jacobs and Dinoff, 2012; Kracker et al., 2011; Lane et al., 2016; Nedjat-Haiem et al., 2015; Page and Hinrichs, 2017; Ritchie et al., 2022; Tsai et al., 2009; Tsai et al., 2012; Wiersma, 2008), and 14 had male majority samples of 89%+ reflecting the gender split in the wider veteran population (Brennan et al., 2018; Brennan and SooHoo, 2020; Curyto et al., 2020; Durkin et al., 2012; Jutkowitz et al., 2019; Kang et al., 2021a; Kaup et al., 2021b; Kracker et al., 2011; Lemke and Schaefer, 2010; Mares et al., 2002; McCarthy et al., 2004; Saivar, 2004; Slama and Bergman-Evans, 2000; Tsai et al., 2009). Eight had multiple or mixed-methods designs (Akram et al., 2021; Kang et al., 2021a; Kang et al., 2021b; Lane et al., 2016; Reynolds and Paget, 2015; Ritchie et al., 2022; Simons et al., 2021; Tong et al., 2010), seven used qualitative methods (Nedjat-Haiem et al., 2015; Page and Hinrichs, 2017; Palmer et al., 2018; Parker et al., 2018; Tsai et al., 2012; Van Orden et al., 2021; Wiersma, 2008), and one was a clinical case study (Jacobs and Dinoff, 2012). The findings of the 33 studies were found to correspond with one or more of the following three themes: social connection, care preferences and autonomy, and military-related physical and mental health needs. How each of the studies’ findings mapped onto each theme is presented in the theme chart.

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**THEME 1 – SOCIAL CONNECTION**

Of the 33 studies retrieved, 15 related to the social connection needs of care home-situated care veterans (Akram et al., 2021; Buchanan et al., 2004; Chueh and Chang, 2014; Kang et al., 2021a; Kracker et al., 2011; Lane et al., 2016; Mares et al., 2002; Nedjat-Haïem et al., 2015; Reynolds and Paget, 2015; Simons et al., 2021; Slama and Bergman-Evans, 2000; Tsai et al., 2009; Tsai et al., 2012; Van Orden et al., 2021; Wiersma, 2008). Slama and Bergman-Evans (2000) found residents of a US veterans’ home experienced feelings of loneliness, helplessness, and boredom at rates of 51%, 40%, and 40%, respectively. Boredom was associated with social isolation in two of the retrieved studies (Slama and Bergman-Evans, 2000; Reynolds and Paget, 2015). Feeling understimulated and bored in the company of older veterans was found to be a barrier to social connection amongst younger working-age veterans (Reynolds and Paget, 2015). Social withdrawal by veterans with dementia from other veterans with dementia was also rooted in prior negative interactions, communication difficulties, and/or a fear of their own deteriorating cognitive decline that those with more advanced dementia served to remind them of (Wiersma, 2008).

The impact of social connection on the wellbeing of veteran residents was explored by four studies (Akram et al., 2021; Mares et al., 2002; Reynolds and Paget, 2015; Tsai et al., 2009). Reynolds and Paget (2015) found a worsening of mental and physical health symptoms amongst some of the younger veterans who were withdrawn and isolated. Tsai et al. (2009) also found that poor social engagement was associated with depression, cognitive impairment, and unsettled relationships amongst veteran residents in Taiwan. Perceived conflict within the care home environment negatively affected general well-being amongst mentally ill veteran residents (Mares et al., 2002). Conversely, Akram et al. (2021) found that social connection improved during participation in a group exercise intervention, leading to increased satisfaction and improved social engagement amongst veteran residents.

The importance of social connections within and outside of the care home environment was highlighted by five studies (Buchanan et al., 2004; Kracker et al., 2011; Mares et al., 2002; Nedjat-Haïem et al., 2015; Tsai et al., 2012). Male veteran residents were less likely to have never been married but more likely to be divorced compared to male civilian residents in nursing home facilities (Buchanan et al., 2004), with a lack of social and family support found to contribute to end-of-life psychosocial distress (Nedjat-Haïem et al., 2015). Conversely, strong social ties with care home staff acted as a buffer against suicidal ideation amongst older veterans (Tsai et al., 2012). Additionally, the value of TV-watching in minimising social isolation by providing a connection to the outside world was emphasised by Kracker et al. (2011). The demographics of the community surrounding the care home also affected social connections, with veterans in lower-income neighbourhoods reporting more frequent contact with friends and significant others outside of the home, potentially due to feeling less stigmatised socialising in these neighbourhoods (Mares et al., 2002).

Two studies that explored interventions explicitly aimed at addressing social connection and loneliness amongst veteran residents (Lane et al., 2016; Van Orden et al., 2021) both concluded positive effects. Lane et al. (2016) found that interaction with an animatronic toy seal improved mood states and behaviour indicators amongst veterans with dementia. Van Orden et al. (2021) also reported that robot pets helped reduce anxiety and increase interaction with other residents and staff during the COVID-19 pandemic.

**MILITARY SOCIAL CONNECTION**

Although most of the above studies explored the social connection of veterans in care homes without reference to or consideration for their military-related social lives, five papers did explore this unique need for connection amongst veteran residents (Chueh and Chang, 2014; Kang et al., 2021a; Reynolds and Paget, 2015; Simons et al., 2021; Wiersma, 2008). Reynolds and Paget (2015) found that some veterans in care homes desired connections to the wider veteran community, doing so by participating in service-related social events outside of the home. Developing appropriate connections with other veterans within the care home environment is also an important social need for institutionalised veterans. Simons et al. (2021) found social connections amongst veterans to...
be built around commonalities such as deployments and gender, providing a sense of camaraderie and understanding that could not always be accessed with their caregivers. However, Kang et al. (2021a) found evidence on the potential harms of social interaction amongst veterans, finding that overstimulation can trigger behavioural symptoms of dementia in veterans with and without PTSD.

Reminiscence of military memories was discussed in two studies (Chueh and Chang, 2014; Wiersma, 2008). Wiersma (2008) found that place and context may influence and evoke different topics of reminiscence amongst veterans. Whereas the content of voluntary reminiscence amongst veterans within the home environment was often centred on their military lives, reminiscence and shared discussions outside of the unit (on a summer camp) would more often focus on hobbies, families, and their lives outside of the military. The implementation of a more formalised programme of group reminiscence therapy was found by Chueh and Chang (2014) to generate positive effects on depressive symptoms and increase connection and meaning amongst participants.

THEME 2 – CARE PREFERENCES AND AUTONOMY

Fifteen of the 33 studies had findings relating to the care preferences and autonomy of veterans within care homes (Akram et al., 2021; Chang et al., 2011; Curyto et al., 2020; Durkin et al., 2012; Kang et al., 2021b; Kostka and Jachimowicz, 2010; Nedjat-Haiem et al., 2015; Page and Hinrichs, 2017; Palmer et al., 2018; Parker et al., 2018; Reynolds and Paget, 2015; Ritchie et al., 2022; Saivar, 2004; Simons et al., 2021; Wiersma, 2008). A disconnect between how veterans perceived their own preferences, choices, and autonomy and how these were viewed by their carers was noted by five of these (Chang et al., 2011; Durkin et al., 2012; Kang et al., 2021b; Palmer et al., 2018; Parker et al., 2018). Tensions around resident choice were found to occur between residents, staff, and the wider organisation (Palmer et al., 2018), with Chang et al. (2011) finding significant disparities between veterans and their carers regarding their perceived rehabilitation potential. Conflicts between veterans and their carers regarding care home routines, such as eating and waking times, also acted as triggers for the behavioural symptoms of dementia in those with and without PTSD (Kang et al., 2021b). Parker et al. (2018) also found a disconnect between staff and resident values towards autonomy and control, with medical authority sometimes outcompeting the needs and preferences of the individual, in part due to the perceived risks of deviating from medical protocols. Veterans were not always confident in raising concerns about staff, however, with 26% of participants reportedly hesitant due to their fear of receiving retaliatory poor care (Durkin et al., 2012). Contrary to the studies that found diminished autonomy amongst veterans, two studies reported positive changes to veterans’ sense of empowerment. Empowerment and a regained sense of freedom were experienced by one veteran resident who pursued and successfully overturned his guardianship and conservatorship (Page and Hinrichs, 2017). Self-empowerment was also achieved amongst veteran residents following participation in a group exercise programme (Akram et al., 2021).

Differences in care preferences between demographics were noted by three studies (Curyto et al., 2020; Palmer et al., 2018; Saivar, 2004). Saivar (2004) found that although no significant differences were found in care preferences between male and female residents, those who had previous experience of nursing home residency were more likely to be satisfied with their care than those without. Curyto et al. (2020), however, found that male residents and veterans were less consistent in their preferences at two time points compared to a civilian nursing home sample. Veteran residents also placed significantly lower importance on choosing their own bedtimes than non-veterans administration nursing home sample, while placing significantly more importance on consuming alcohol and outdoor activities (Curyto et al., 2020). The veteran status of staff was also considered to impact the care preferences of veteran residents, with Palmer et al. (2018) reporting that older male nursing assistants who were veterans themselves had a stricter attitude towards the care preferences of their veteran residents.

A loss of independence was reported among care home-situated veterans in four studies (Nedjat-Haiem et al., 2015; Reynolds and Paget, 2015; Wiersma, 2008; Simons et al., 2021), in addition to a loss of control, privacy, and familiar routines noted by Nedjat-Haiem et al. (2015). A perceived lack of autonomy was also a cause of distress for veterans in four studies (Nedjat-Haiem et al., 2015; Reynolds and Paget, 2015; Simons et al., 2021; Wiersma, 2008). Sub-demographics of veterans, such as those with dementia and those who previously had very active lives, were found to experience this distress more acutely (Kang et al., 2021b; Reynolds and Paget, 2015; Wiersma, 2008). In contrast, a study by Kostka and Jachimowicz (2010) found residents in a veterans’ home had more favourable attitudes regarding the degree of control they had over their lives than a community dwelling comparator group, perhaps due to their admission to the home being entirely voluntary.

Veterans’ military backgrounds may also have an influence on their attitudes towards autonomy, or lack thereof, in the care home. Reynolds and Paget (2015) proposed that veterans who identify strongly with a military culture that values physical capability may experience greater distress due to the loss of a physically active life upon entering a care home. The restricted environment of a care home also has the potential
to trigger past traumas in the veteran (Ritchie et al., 2022), with similarities being drawn between restricted freedoms in the care home and prior internment as a prisoner of war (Wiersma, 2008).

THEME 3- MILITARY-RELATED PHYSICAL AND MENTAL HEALTH NEEDS

Eleven of the 33 studies reported on military-related physical and mental health needs of veteran residents (Brennan et al., 2018; Brennan and SooHoo, 2020; Jacobs and Dinoff, 2012; Jutkowitz et al., 2019; Kang et al., 2021a; Kang et al., 2021b; Kaup et al., 2017; Lemke and Schaefer, 2010; McCarthy et al., 2004; Ritchie et al., 2022; Tong et al., 2010). In their research of the oral health needs of New Zealand veteran’s home residents, Tong et al. (2010) found oral health amongst this population to be similar to that of civilian populations in aged-care facilities. Nevertheless, due to the potential for service-related circumstances, which may affect dental health in later life, and the impact of co-occurring, potentially service-connected issues such as PTSD and alcohol misuse, which are known to impact oral health, service history should be taken into account when assessing the oral health needs of veterans in care homes. Identifying and assessing military-related medical and mental health needs, however, can be challenging (Jacobs and Dinoff, 2012). Undifferentiated somatization disorder (USD) in a veteran, characterised by medically unexplained physical symptoms likely arising from psychological or emotional distress, was found to be likely service-connected by Jacobs and Dinoff (2012), who cautioned against diagnosing USD when there is a possibility that somatic PTSD may also be likely.

The co-occurrence of PTSD and dementia amongst veteran care home residents poses additional challenges for care providers, as identified by Ritchie et al. (2022). Ritchie et al. (2022) generated three themes relating to the care of veterans with both PTSD and dementia. Firstly, although the symptoms of PTSD and dementia may appear similar on the surface, there are nuances between them, with co-occurring PTSD being characterised by additional symptoms such as increased fear intensity, nightmares, aggression, suspicion, and withdrawal. Secondly, veterans with co-occurring PTSD require more complex support than those with dementia alone, as usual care strategies may be ineffective or counterproductive. Lastly, echoing the recommendations of Tong et al. (2010) and Jacobs and Dinoff (2012), Ritchie et al.’s (2022) third theme—‘knowing the veterans life story’—advocates for staff to get to know the veterans’ history, including military experiences, to provide a lens through which current symptoms could be understood. However, veterans with co-occurring PTSD and dementia may be reluctant to share these experiences if they are trauma-related (Ritchie et al., 2022).

In their study of how behavioural symptoms of dementia manifest in veterans with and without a PTSD diagnosis, Kang et al. (2021a) found that veterans with PTSD were more likely to exhibit rejection of care and aggressive behaviours alongside their verbal refusals of care compared to those without PTSD. A further study by Kang et al. (2021b) investigated rejection of care in veterans with dementia and found it to be affected by interpersonal triggers, depression, anxiety, and cognitive status. Combat exposure did not have a significant effect on the rejection of care or aggression.

In an analysis of nursing home resident data, McCarthy et al. (2004) found that a service-connected disability was associated with an increased likelihood of verbal disruptions but a decreased risk of inappropriate behaviour. Substance abuse and dependence were negatively associated with physical aggression and socially inappropriate behaviours. Lemke and Schaefer (2010), however, did not replicate the negative association between substance use disorder (SUD) and aggression found by McCarthy et al. (2004). Instead, they found no significant differences between residents with and without SUD in terms of disruptive behaviours. Yet, residents with SUD were also over twice as likely to have PTSD (Lemke and Schaefer, 2010).

Jutkowitz et al. (2019) found that homeless veterans in nursing homes were more likely to have substance use disorders, mental health conditions, and dementia compared to previously stably housed veterans. Older veterans with traumatic brain injuries (TBI) were also significantly more likely to have a history of depression, substance abuse, current depressive symptoms, and current PTSD (Kaup et al., 2017). Brennan et al. (2018) observed differences between demographic groups in pain reporting and pain relief requests in veterans’ care homes. Veterans with SUD reported severe pain at the highest frequency, followed by those with PTSD, depressive disorder, serious mental illness, and dementia. Brennan and SooHoo (2020) found that individuals with depression, PTSD, or SUD were more likely to experience adverse pain trajectories, while those with severe mental illness or dementia were less likely. Yet, while veterans with PTSD were more likely to obtain pain treatment, those with dementia and severe mental illness were more likely to receive no treatment at all for this (Brennan et al. 2018).

DISCUSSION

Overall, the scoping review revealed an international research base that was limited and disparate regarding the social care needs of care home-residing veterans. Yet, as varied as the literature appeared to be, the findings were nonetheless amenable to being thematised around three broad areas: social connection, military-related physical and mental health needs, and care preferences and autonomy. While veterans had similar
social connection, care preference, and autonomy needs to those that would be expected amongst a civilian care home population, e.g., social isolation, boredom, and a sense of limited autonomy within the care home environment, veteran residents also had additional or differing social care needs that arose due to their military backgrounds. A need for military-connected social bonds was found amongst veteran residents who chose to engage in military-connected social activities and friendships with other veteran residents. Voluntary or structured reminiscence activities were also found to be useful catalysts for veterans in developing social connections and alleviating depressive symptoms. Despite the benefits that military-connected social bonds can bring to veterans, unilateral proposals to increase military-connected offerings within the care home environment as a means of enhancing wellbeing (Demos, 2019) should be carefully considered. Within-group differences amongst veterans were noted by many of the retrieved papers, mirroring a growing acceptance amongst researchers and policymakers to acknowledge diversity amongst the veteran population rather than viewing veterans, institutionalised or otherwise, as a homogeneous group (Parry et al., 2022; Perrier, 2021). While some veterans may enjoy a continued connection to the military and their veteran identity in the care home environment (Reynolds and Paget, 2015), others may feel ambivalent, disinterested, or find reminiscence about their military service distressing (Simons et al., 2021; Wiersma, 2008). This distress may be especially problematic when other co-morbidities, such as dementia and challenging behaviour, are present. Since 2012, there has been a 17% decline in care home beds and a 12% decline in nursing home bed availability across the UK (Nuffield Trust, 2023). Against this backdrop of limited institutional care facilities, military specialist care home providers need to consider that for some residents, their decision to select their care home may have been a pragmatic, ambivalent, or reluctant decision rather than one grounded in a desire for a military-replicating care home environment. Therefore, the potential for variations in the degree to which military social connection is desired, or indeed rejected, by veteran residents despite their residency in a military-connected environment should be considered as a possibility for each individual veteran resident.

Likewise, within-group differences amongst veteran residents in respect to attitudes towards autonomy and routine were found among the scoping review’s final papers. Although some veterans may transition and acculturate well from one ‘total institution’ (Goffman, 1961), i.e., the military, to a care home, some may not. Whereas Reynolds and Paget (2015) found veteran residents to be more comfortable with features of institutional care settings, such as regular bedtimes and mealtimes, than civilian residents (Curyto et al., 2020), other studies found veterans who had difficulty with routines and perceived restrictions on their autonomy, with the potential for both attitudes to have their foundations in service-related experiences. As choice is potentially a determinant of resident satisfaction (Kostka and Jachimowicz, 2010), a more nuanced and person-centred approach (Davies et al., 2023) to each individual resident’s preferences, attitudes towards autonomy, their veteran identity, and the degree of involvement and social connection they desire is recommended during the initial and ongoing care planning of residents. As the scoping review did not identify qualitative research that explored preferences and attitudes amongst institutionalised veteran residents themselves, further research centred around this topic is necessary.

In addition to the military-connected social care needs that were found to be occurring among care home-situated veterans, military-connected health needs were found amongst this same population. Although only a minority of British veterans are thought to experience PTSD (3.4%) or dementia (1.8%) (Finnegan and Randles, 2022), the scoping review findings highlight the complexity of how these conditions manifest and can be managed amongst care home-situated veterans. Given the possibility for under- or misdiagnosis of PTSD and lesser recognised conditions such as DOPTSD, especially when dementia is also present, there remains a need for increased awareness, research, assessment, and management of these conditions in older institutionalised veterans. Specialist care homes are well-placed for concentrating and building expertise in the care of veterans with service-connected ageing needs, with some UK-based care homes already making inroads in the development of service-connected specialist ageing care programmes (Hutchinson et al., 2021). As the National Service and WWII generation of veterans continues to age (Fadeeva et al., 2022), the number of veterans is expected to decrease through 2028 and beyond, with a greater proportion of veterans expected to be comprised of working-age veterans (MoD, 2019), albeit with increasingly complex needs. Nevertheless, developing specialist veteran gerontological care is a worthwhile endeavour, not just for the residents of these specialist care homes, but so these services can be developed and expanded to the benefit of veterans who may reside in civilian care homes without immediate access to service-informed or specialist assessment provisions. Given that recent evidence has demonstrated that improving veteran social care in the UK can alleviate pressure on the NHS (Di Lemma et al., 2020), improving and investing in the development of veteran-informed social care may also have far greater implications beyond that of the individual veteran.
LIMITATIONS

As the purpose of this scoping review was to map the evidence base, individual studies were not subjected to critical appraisal. Given the breadth and variety of retrieved research studies, further interrogation of the research questions and existing evidence base, e.g., via systematic review, at present is unlikely to reveal any deeper insights than those gathered as part of this scoping review. Nevertheless, there is value in pursuing primary research and evidence synthesis around some of the many topic areas noted (such as DOPTSD and veteran preferences), albeit superficially by the scoping review, in greater depth.

International social care and nursing home research is notoriously difficult to synthesise due to the complex mix of veterans’ policy, social care policy, funding systems, bed availability, eligibility criteria, cultural context, and demographics that create a unique composition of social care provisions in each country (Katz, 2011; Nocivelli et al., 2023). This was also the case with regards to the scoping review, which was also affected by the scoping review’s findings being largely drawn from a non-UK base, further hindering the transferability of many of this scoping review’s findings to UK contexts.

CONCLUSION

The current body of evidence relating to the social care needs of veterans who reside in care homes is limited, broad, and disparate. That only one of the studies identified as part of this scoping review was conducted in the UK further highlights the neglect of the social care needs of this population in terms of research funding and priority in comparison to other areas of veterans’ research in the UK, such as mental and physical health (OVA, 2022).

Nevertheless, the scoping review found that veterans in residential care homes experience challenges akin to those experienced by non-military-connected care home residents, such as difficulties in forming and maintaining social connections and personal autonomy. However, veteran residents may have their attitudes and experiences of social connection and autonomy shaped by their military background, which may also depend on how positively they connect and identify with their military service. Veterans in care homes also have the potential to have military-connected physical and mental health care needs for which non-military-informed care may be ineffective or counterproductive. That within-group variation regarding the degree and direction of influence that military service may have on veteran residents’ social care needs was also found, emphasises the need for personalised, military-informed care planning amongst both specialist and non-specialist care home providers.

NOTE

1 Iford Park Polish Home (est. 1948) remains the exception to this rule as the only veterans’ care home in the UK that continues to be operated by the Ministry of Defence (MoD).

SUPPLEMENTARY FILE

The Supplementary file for this article can be found as follows:

- Supplementary Table 1. Summary of included studies. DOI: https://doi.org/10.31389/jltc.259.s1

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The authors have no competing interests to declare.

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