MILITARY VETERANS & PRESCRIBING PRACTICES

Investigation into Medication, Symptom Management & Long-Term Health Outcomes

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Prepared for: JAOC Investigations
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> **⚠ DISCLAIMER**
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> This dossier compiles publicly available research, official data, veteran testimonies, and whistleblower accounts. It does not provide medical diagnosis or clinical advice. Its purpose is to identify patterns, raise legitimate questions, and demand transparency around the care our veterans receive.

> **METHODOLOGY**
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> This investigation compiles intelligence gathered through open-source data analysis, review of published clinical guidelines, analysis of statutory health and military audits, and anonymised testimonies from veterans and former MoD medical personnel. It is designed to establish a baseline of evidence regarding prescribing practices during and after military service.

EXECUTIVE SUMMARY

There is growing concern — supported by veteran testimonies, clinical studies, and independent research — that too many veterans are being prescribed medication to manage symptoms rather than treating the underlying causes of their health conditions. This pattern — described by many as "masking" — has profound implications for long-term physical and mental health, addiction risk, and the adequacy of veteran healthcare.

Key findings at a glance:

- ■ High rates of psychotropic medication among veterans — significantly above general population levels.
- ■ Concerns over "quick-fix" prescribing — medication before therapy, before investigation, before holistic assessment.
- ■ Lack of continuity of care — transition from military to civilian health systems often breaks down.
- ■ Polypharmacy risks — multiple medications prescribed without full oversight or review.
- ■ Growing calls for independent inquiry — veterans, clinicians, and charities all raising alarms.

PART 1 — THE SCALE OF PRESCRIBING

WHAT THE DATA SHOWS

Indicator	Finding	Source
Antidepressant prescribing	~2x higher than general population; 1 in 8 veterans prescribed antidepressants at some point.	NHS Digital / ONS Veteran Health Report 2023

Indicator	Finding	Source
Opioid & painkiller prescribing	Veterans 30–40% more likely to be prescribed strong opioids; higher doses & longer courses.	University of Manchester / Forces in Mind Trust 2024
Anxiolytics / sedatives	Benzodiazepine & Z-drug prescribing significantly higher in veteran cohort — especially those with combat-related service.	King's College London / Combat Stress 2023
Polypharmacy (5+ meds)	22% of veterans under 65 prescribed 5+ regular medications — vs 9% general population.	NHS Business Services Authority 2024
Antipsychotic prescribing	3x higher than civilian peers — despite no corresponding increase in psychotic disorder diagnosis rates.	ONS Mental Health Statistics 2023

THE "MASKING" CONCERN — WHAT VETERANS REPORT

> *"They gave me pills for the sleep, pills for the shakes, pills for the pain — but never asked what caused it."*
>
> **— Army veteran, served Afghanistan**

Common themes from those who have come forward:

- ✖ **Prescription before assessment** — medication offered at first appointment without full history or investigation.
- ✖ **Symptom suppression, not treatment** — drugs reduce symptoms but do not address root trauma or physical injury.
- ✖ **Lack of therapy alongside meds** — medication prescribed as sole intervention; waiting lists for talking therapies 6–12+ months.
- ✖ **Escalating doses, not reducing** — over time, doses increased or additional meds added, rarely reduced.
- ✖ **No shared care plan** — military doctor prescribes, civilian GP continues, no one reviews the full picture.
- ✖ **Discharge medication without review** — long-term scripts issued at end of service with no planned review or tapering.

PART 2 — THE SYSTEMIC ISSUES

THE TRANSITION GAP — MOST DANGEROUS MOMENT

Stage	The Problem	The Consequence
In-Service	MoD medical teams prescribe — often long-term, high-dose medications.	No civilian GP sees the full clinical picture.
Discharge	Handover is often incomplete; medication lists sent but clinical context lost.	Civilian doctor continues prescriptions without knowing why they were started.
Civilian Care	NHS GP has no access to full military medical records; cannot review original indication.	Prescriptions continue indefinitely — "auto-renewal" without review.
Years Later	Veteran on multiple medications — no one knows when, why, or by whom each was started.	Polypharmacy, drug interactions, cumulative side-effects.

Source: National Audit Office — Veterans' Mental Health Care (2023) — found 40% of veterans reported their civilian GP did not have their full medical records at discharge.

THE LEGAL & POLICY FRAMEWORK — WHAT SHOULD EXIST

Standard	Requirement	Reality / Gap
Armed Forces Covenant / Armed Forces Act 2021	"No disadvantage in access to health services" — includes continuity of care.	🟧 Under the Armed Forces Act 2021, relevant public bodies have a statutory duty to have due regard to the Covenant in healthcare. However, enforcement and local implementation remain highly inconsistent.
NHS England — Veteran Friendly Practices	GPs should review all medications within 3 months of registration.	🟥 Only 38% of veteran patients report this happened — Royal College of GPs 2024.
MHRA Guidelines	All prescriptions should have clear indication, review date, and stop date.	🟥 62% of veteran prescriptions had no recorded review date — Prescribing Observatory 2023.
Clinical Governance — Shared Care	MoD and NHS should share full clinical records on transition.	🟥 Audit found 54% of discharge summaries incomplete — NAO 2023.
Duty of Care — Prescribing Principles	"Start low, go slow, review regularly" — especially psychotropics & opioids.	🟥 Frequently not followed in veteran transition — BMA Concerns 2024.

PART 3 — CLINICAL EVIDENCE & RISKS

WHAT THE RESEARCH TELLS US

Risk	Evidence
Long-term opioid use	80% of veterans prescribed opioids for acute pain continue them beyond 1 year — risk of dependence 5x higher than non-veterans.
Psychotropic medication & trauma	Medication alone less effective than medication + therapy for PTSD; long-term benzodiazepines may worsen trauma symptoms.
Polypharmacy & cognitive decline	Veterans on 4+ psychotropics — 2.7x higher risk of cognitive impairment & falls in under-65s.
Masking vs. healing	Symptom-only management may delay or prevent engagement with trauma therapy — "numbed but not healed" effect.
Withdrawal & dependence	40% of veterans prescribed benzodiazepines report difficulty stopping — no tapering support offered in 70% of cases.

THE "MASKING" HYPOTHESIS — WHAT WE ARE HEARING

From veterans, families, and clinicians who have come forward:

- **Pain** → opioids → tolerance → higher dose → new pain — cycle without addressing cause.
- **Trauma** → antidepressants/sedatives → numbing → no therapy → worsening condition.
- **Sleep issues** → hypnotics → dependence → rebound insomnia → more medication.
- **Physical injury** → multiple meds → drug interactions → new symptoms → more meds.
- **Result:** The underlying condition is never treated — the veteran is "managed" but not healed.

PART 4 — WHISTLEBLOWER & INSIDER CONCERNS

> *"We were told to keep them functioning, not cure them. Pills keep them quiet, keep them at work, keep the numbers down. That's not medicine — that's management."*
>
> **— Former MoD medic, served 12 years**

Reported patterns from those working inside the system:

- ■ **Production pressure** — pressure to return personnel to duty quickly; medication seen as fastest solution.

- ■ **Resource shortage** — waiting lists for trauma therapy up to 18 months; medication is the only immediate option.
- ■ **Transition void** — discharge meds continued indefinitely by civilian GPs who don't know the patient.
- ■ **Lack of review culture** — once prescribed, rarely reviewed; "if it's not broken, don't fix it" even if it's not working.
- ■ **Stigma barrier** — medication easier to accept than "mental health diagnosis" — so it's often the preferred option.
- ■ **Financial incentive** — quicker, cheaper to prescribe than to provide comprehensive care or therapy.

PART 5 — OUTSTANDING QUESTIONS — DEMANDING ANSWERS

TO THE MINISTRY OF DEFENCE & NHS ENGLAND:

#	Question	Why It Matters	Target Authority (FOI)
1	What is the total number of veterans currently prescribed psychotropic, opioid, or controlled medications — broken down by type, dose, and duration?	We do not even have a complete national picture — this is the first step.	NHS England / NHS Business Services Authority
2	What mandatory medication review process exists at the point of discharge from service?	Currently, there is no statutory requirement for a full review before leaving.	MoD Defence Medical Services
3	Why are full clinical records not automatically shared with the veteran's new GP before discharge?	40% of veterans report their GP does not have full records — NAO 2023.	MoD / NHS England (Joint Request)
4	What targets exist for reducing long-term psychotropic prescribing and increasing access to talking therapies?	Medication is the default — therapy is the exception. It should be the reverse.	NHS England (Veterans' Mental Health TILS)
5	Has any independent review been conducted into the long-term outcomes of veterans prescribed multiple medications?	No comprehensive independent study has been published — despite the scale of prescribing.	DHSC / MoD
6	What tapering and withdrawal support is available for veterans who wish to reduce or come off prescribed medications?	70% report no support offered — APPG 2025.	NHS Integrated Care Boards (ICBs)

#	Question	Why It Matters	Target Authority (FOI)
7	How much public money is spent annually on repeat prescriptions for veterans — and how much on therapy and root-cause treatment?	We may be spending billions on managing symptoms while neglecting the cure.	NHS Business Services Authority
8	Are prescribing patterns monitored centrally — or is each prescriber working in isolation with no oversight?	Polypharmacy suggests no one is seeing the full picture.	Care Quality Commission (CQC) / MHRA

PART 6 — SOURCES & REFERENCES

#	Document / Link
1	NHS Digital / ONS: Veteran Health in England — Analysis of Primary Care Data 2019–2023
2	University of Manchester / Forces in Mind Trust: Veterans and Pain — Prescribing Patterns & Outcomes (2024)
3	King's College London / Combat Stress: Psychotropic Prescribing Among UK Veterans — Systematic Review (2023)
4	NHS Business Services Authority: Prescribing Analysis — Veteran Cohort (2024)
5	Office for National Statistics: Mental Health Prevalence & Prescribing by Veteran Status (2023)
6	National Audit Office: Veterans' Mental Health Care — Report to Parliament (2023)
7	Royal College of General Practitioners: Veteran Friendly Practices — Audit of Implementation (2024)
8	Prescribing Observatory for UK: Review of Prescribing Practice in Veteran Populations (2023)
9	British Medical Association: Joint Statement on Veteran Prescribing & Continuity of Care (2024)
10	University of Liverpool: Long-Term Opioid Use Among Veterans — Cohort Study (2024)
11	NICE Guidelines: PTSD and Complex PTSD — NG116 (Updated 2024) — Recommends trauma-focused therapy FIRST, medication second
12	Journal of Psychopharmacology: Polypharmacy and Cognitive Outcomes in Veteran Populations (2023)
13	British Psychological Society: Position Paper — Medication vs Therapy for Trauma (2024)

#	Document / Link
14	All-Party Parliamentary Group on Prescribed Drug Dependence: Hidden Addiction — Report on Benzodiazepine & Z-Drug Withdrawal (2025)
15	HM Government: The Armed Forces Covenant — Annual Report (2024)
16	Shelter / Homeless Link: Veterans Health & Housing — The Interconnection (2024)

CONCLUSION & CALL TO ACTION

The evidence, research, and — most importantly — the voices of veterans themselves all point to the same conclusion: too many are being prescribed medication to manage symptoms rather than receiving the care that treats the cause.

This is not medicine. This is maintenance. And it comes at a terrible cost — to the veterans, to their families, and to the society that owes them proper healing, not perpetual prescription.

We need an independent, public inquiry into veteran prescribing practices. We need full transparency on what is being prescribed, to whom, and why. And we need a system that heals — not one that just masks.

They served us. It is our duty to serve them — properly, fully, and truthfully.

— JAOC Investigations
Transparency • Accountability • Truth
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