

Snapshot t

Mental Health

Snapshot *Noun* [c] (UNDERSTANDING)

A piece of information or short description that gives an understanding of a situation at a particular time

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A plain language summary of research and evidence relating to the UK Armed Forces and veteran community

FiMT
forces in mind trust
Research Centre



About Snapshots

Snapshots are designed to aid understanding of the complex issues at play in relation to the Armed Forces, and to support decision-making processes by bridging the gaps between academic research, government and charitable policy, Service provision and public opinion. Snapshots are aimed primarily at those working in policy-making and Service provision roles for the Armed Forces, and are also useful to those seeking facts, figures and informed comment to empower a more objective discussion among the wider population, including the Armed Forces community and the media. The purpose of Snapshots is to review and interpret research and policy and to set out concise, plain language summaries to facilitate understanding and perception.

The Forces in Mind Trust Research Centre is producing a range of Snapshots covering many of the main themes and topics relating to the Armed Forces and veteran community. Due to the constant process of research and policy changes, Snapshots will be updated regularly in order to maintain their relevance. They will be hosted on the Veterans & Families Research Hub. Contributions and comments are welcome via the Veterans & Families Research Hub forum.

Disclaimer

Whilst Snapshots are produced using recognised research processes, they are written for a lay audience. They are a collation and summary of available academic and quality grey literature, to provide an overview of information on a particular theme or topic. Snapshots are written to inform and to disseminate a large body of literature in an accessible way to as wide an audience as possible. They are not intended to be, and should not be regarded as, rigorous searches or systematic reviews.

THIS MENTAL HEALTH SNAPSHOT IS FOR REFERENCE PURPOSES ONLY, TO DRAW AWARENESS TO THE PUBLISHED LITERATURE IN THIS FIELD. IT IS NOT, IN ANY WAY, A CLINICAL GUIDE AND DOES NOT ADVOCATE SPECIFIC DIAGNOSTIC CRITERIA OR THERAPIES.

Alongside academic papers, this Snapshot draws attention to social prescribing, a means of referral or signposting to non-clinical, often charity-led provision. Social prescribing provides a complementary means of access, via a link worker, to groups and services that offer practical and/or emotional support. In the long term, NHS England anticipate 1,000 new social prescribing link workers in place by 2020/21, part of the universal personalised care programme that anticipates at least 2.5 million people benefiting from personalised care by 2023/34.

About the author of this Snapshot

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About the Forces in Mind Trust Research Centre

The Forces in Mind Trust Research Centre was established in October 2017 within The Veterans & Families Institute for Military Social Research at Anglia Ruskin University. The Centre curates the Veterans & Families Research Hub, which provides advice and guidance to research-involved stakeholders and produces targeted research and related outputs. The Centre is funded by the Forces in Mind Trust, which commissions research to contribute to a solid evidence base from which to inform, influence and underpin policy-making and service delivery.

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Introduction and definitions

This Snapshot summarises themes and issues relating to mental health and healthcare provision for the Armed Forces Community, including Service personnel, veterans and their families. The Snapshot is organised around four headings: (1) Statutory provision across the nations; (2) The three stages of military life: in-Service, during transition and resettlement, and post Service; (3) Issues relating to mental health difficulties; and, (4) Families of serving personnel and veterans. It sets out policy responses and current structures of support, presenting research evidence where available. Although there is a significant amount of research available for US Armed Forces, **for the purposes of this Mental Health Snapshot, all literature contained herein is UK based.**

Armed Forces-relevant terms used for this Snapshot are defined below. The following terms are particularly important:

- The term **transition** is used to describe the period of (re)integration into civilian life from the Armed Forces. For the purposes of this Snapshot, it starts from the point in Service at which personnel start their resettlement process, and can continue for several years from discharge.
- **Resettlement** describes the formal processes and procedures by which transition is managed, and the formal support provided to Service leavers during transition. It starts with the activation of the resettlement process and continues until the end of resettlement provision.
- The term **Early Service Leaver (ESL)** covers those who get the minimum statutory resettlement support. ESLs are defined by the Ministry of Defence as ‘Service leavers who are discharged (a) compulsorily from the trained strength or untrained strength and lose entitlement to resettlement provision ... they would otherwise have because of the circumstances of their discharge (e.g. Compulsory Drugs Test failures); (b) at their own request from the trained strength or untrained strength, having completed less than four years’ continuous Service’.
- The term **veteran** is defined by the Ministry of Defence as anyone who has ‘served for at least a day in HM Armed Forces, whether as a Regular or a Reservist’.
- The conditions for **Medical Discharge** are met when a medical condition or fitness issue results in an individual being unable to ‘perform their duties and no alternative role can be found to suit their reduced functionality’.
- **Wounded, Injured and Sick** (often abbreviated to **WIS**) is the classification given to personnel who fulfil the criteria of being ‘medically unfit for Service or medically unfit for duty and receiving medical care,’(RAF), ‘unable to undertake their normal duties,’ (Army) and ‘unfit for Service in the maritime environment . . . who can only be employed for limited duties ashore’ (Royal Navy). So progress can be monitored, all serving WIS personnel in the Army are logged in the Wounded Injured and Sick Management Information System database (WISMIS).
- **Mental health** is defined by NHS England as: ‘a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment. Levels of mental health are influenced by the conditions people are born into, grow up in, live and work in’.

A review was undertaken of the available UK evidence relating to the mental healthcare provision of Service personnel, veterans and their families, using standard reviewing techniques such as searching electronic databases, hand searching of references from relevant articles and reports, and a review of

websites from government and relevant organisations. This Snapshot is written in conjunction with the accompanying [Physical Health Snapshot](#). The [Veterans & Families Research Hub](#) is also an invaluable source of relevant literature.

Healthcare Provision for the Armed Forces Community

Commitment to Armed Forces Healthcare

It must firstly be acknowledged that there is a lack of consensus regarding the reporting of veterans and non-veterans of working age (16-64) and whether health problems limit their activity. An annual population survey suggests that there is no difference in the self-reported general health of veterans and non-veterans. For example, 35% of veterans and 36% non-veterans aged 16-64, and 18% of veterans and 19% of non-veterans aged 65+, reported their general health as very good. However, a further study suggests that veterans are more at risk of reporting a long-term illness such as depression, hearing or sight loss and musculoskeletal problems. Moreover, research shows that military personnel are more likely to demonstrate symptoms of common mental disorders than that of the general population.

The Armed Forces Covenant sets out the commitment made by the UK Government to provide healthcare to the Armed Forces community. The Covenant states that the Armed Forces community ‘should face no disadvantage’ and ‘enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area they live’, retaining NHS waiting list positions should they have to move due to the Service person being posted. The Armed Forces Covenant makes provision for ‘special consideration’ in some cases, especially for those such as the injured or bereaved. This is particularly prevalent for those wounded, injured and sick and is often overlooked. Veterans should also receive priority treatment where it relates to a condition which results from their Service in the Armed Forces, subject to clinical need.

Following the Strategic Defence and Security Review of 2010, the UK Surgeon General was directed to merge the delivery of primary healthcare from the three single Service organisations to a unified Defence Primary Healthcare. The specialist services comprised the Regional Rehabilitation Units, the Departments of Community Mental Health and the Occupational Health/Occupational Medicine Departments. These had previously been organised under distinct single Service or lead-Service arrangements.

The NHS is a key organisation delivering the UK Government’s commitment to the Covenant, in relation to mental (and physical) healthcare across the UK and within each devolved nation. In the UK, policymakers working in the area of healthcare have reaffirmed their commitment to the Covenant via the introduction of new legislation and guidance. The Scottish Government introduced the Community Health Index to identify more easily serving personnel and their families. In Wales, new guidance has been issued to GPs and healthcare professionals on priority treatment for veterans, whilst Northern Ireland’s Health and Social Care authorities continue to monitor NHS waiting times for military families.

Healthcare Delivered in Partnership

The latest annual Covenant report reiterates that, in order to improve the way healthcare is delivered, organisations need to work in partnership. Joint service delivery from the MOD and NHS England, Scotland and Wales provides a more integrated and comprehensive healthcare service, for both

Armed Forces (Regular and Reserve) and civilian populations, including veterans and their families. Whilst Armed Forces (Occupational, Operational, Primary Care, Rehabilitation and Mental) healthcare is the MOD's responsibility whilst personnel are in Service, it is the NHS's responsibility to provide most other healthcare services for the Armed Forces community, including serving, ex-serving personnel and their families. This support includes Reservists not on active duty and individuals who have acquired veteran status. There are also pathways where the MOD and NHS can provide effective joint care. Furthermore, as will be explored in this Snapshot, the UK military charity sector is a substantial partner in providing resources and support to veterans and their families.

In an attempt to coordinate efforts to uphold the Covenant between the multiple players at local and national levels (MOD, Department of Health & Social Care, NHS of each devolved nation, charitable sector, local authorities and elsewhere), in March 2019 the [Integrated Personal Commissioning for Veterans Framework](#) (IPC4V) was [launched](#). The IPC4V seeks to ensure that organisations work together to provide support for the small number of Armed Forces personnel with complex and enduring physical, neurological and mental health conditions that are attributable to injury whilst in Service, with the aim of giving individuals more choice and control over how their care is planned and delivered.

In addition to the Covenant, in 2018, the first [Veterans' Strategy](#) was published, reaffirming the UK Government's commitment to veterans. The Strategy lists health and wellbeing as one of six key themes affecting veterans' lives and reasserts the need for collaboration between the public, private and charitable sectors. The Strategy says the outcome for health and wellbeing should be that "[a]ll veterans enjoy a state of positive physical and mental health and wellbeing, enabling them to contribute to wider aspects of society."

Healthcare provision within the Devolved Nations

Mental Healthcare Provision across the UK

When personnel leave the Armed Forces, responsibility for veterans' primary healthcare is transferred to the NHS and veterans access primary care in the same way as civilians. In some instances, there is veteran-specific support for those with particular mental health conditions, where the condition is due to Service.

This veteran-specific support for veterans and their families differs across the UK. As [introduced next in this Snapshot](#), each devolved nation is responsible for providing healthcare, in accordance with the needs of those veterans and their families living within that nation.

A [review of mental health support for veterans across the UK](#) in 2017 highlighted a number of commonalities and considerations for supporting veterans with mental health needs across the nations, including: (1) Strategic planning and the assessment of needs and a lack of focus on care pathways and subsequent responses; (2) The need for support on transition from the Armed Forces to civilian life, including accessible, relevant and appropriate information; (3) The importance of the charitable sector in providing support, as well as Veterans' Champions in health services and local authorities; and (4) The need to upskill those in primary care and the need for veteran specific, specialist NHS provision.

A [UK wide study](#) of the mental and physical health differences of treatment-seeking veterans across the nations found (using English veterans as a baseline comparison) help-seeking veterans in Northern

Ireland tended to be older, have experienced less childhood adversity, joined the military after the age of 18 and took longer to seek help. Northern Irish veterans also had higher levels of obesity, sensory and mobility problems. Scottish and Welsh veterans had a higher risk of smoking and alcohol misuse, although no differences were found in mental health presentations.

[Mental Healthcare Provision in Scotland](#)

The Scottish Veterans Commissioner released a [significant report](#) in 2018 that describes the key principles of the Scottish perspective on veterans' health to be 'to protect vital specialist services currently required by veterans with severe and enduring conditions, and secondly, to plan for their long term care'.

A [review of mental health support for Scottish veterans](#) in 2017 agreed that Scotland has one of the most robust mental health and related health provision for veterans in the UK and was found to have a thriving specialist statutory and voluntary sector. However, some gaps in provision remain, notably: a need for existing resources to be appropriately targeted and maximised in order to meet the needs of veterans, their families and their carers; on-going collaboration of provision between specialist and mainstream services was recommended, to support those living in rural and urban areas; and a need for a more co-ordinated approach between the statutory and voluntary sectors, to improve local, multi-agency partnerships.

The Scottish Government currently funds the [Veterans First Point Network](#), provided as part of the NHS in Scotland. The Veterans First Point Network offers a point of contact for veterans and their families who require support for a range of needs, including support for their mental health. It is reported that investment will be provided for this service until 2020 by the Scottish Government and NHS Scotland.

The [Scottish Government](#) sets out provision for the wider Armed Forces and veterans, including a veteran's right to priority healthcare treatment, in the report [Renewing Our Commitments](#). There are [Armed Forces & Veterans Champions](#) on local authority and NHS Boards across Scotland. Champions advocate for veterans and Service personnel to ensure needs are met and reflected in local healthcare service plans. [NHS Inform](#), Scotland's national health information service, sets out health rights for veterans and details how veterans can receive support for healthcare needs. It is worth noting that [Veterans Scotland](#) gathers together resources and advice from a number of organisations that support veterans in key areas, including with their health needs; while the [Veterans-Assist](#) website makes these resources searchable.

A [retrospective study of suicide amongst Scottish veterans](#), in comparison to people having no record of military Service found that there was no statistical difference in suicides between veterans and non-veterans, and no overall difference in long-term risk of suicide between veterans and non-veterans. The incidence of suicide was lower in younger veterans and higher in veterans aged over 40. Early Service Leavers were at non-significantly increased risk, but were at increased risk in the older age groups. Women veterans were found to have a significantly higher risk of suicide than non-veteran women. A study among UK veterans found that [risk factors associated with suicidal ideation](#) in this sample were significantly higher in veterans who were unemployed, Early Service Leavers, taking less than five years to seek help, and those who had a history of childhood adversity.

[Mental Healthcare Provision in Wales](#)

A [review of mental health support in Wales](#) in 2016 highlights key areas in terms of the mental health of Welsh veterans, including: a lack of strategic focus and co-ordination across sectors and regions,

issues around long-term sustainability of support programmes and the need for robust data on the veteran community. Female veterans, veterans with a dual diagnosis, veterans within the CJS and veterans' families were highlighted as key groups where data is lacking. The need for improvement to support at the point of resettlement and identifying veterans as a group in their own right with unique needs was also suggested.

A [Welsh Health Circular](#) policy document sets out the commitment of Health Boards and NHS Trusts in Wales to provide healthcare priority to veterans, in accordance with the Covenant. The same policy document states that there are champions for veterans and for the wider Armed Forces community, to advocate for veterans and Service personnel to ensure needs are met and reflected in local healthcare service plans. NHS Wales also offers a module on '[Veterans' health and wellbeing](#)' that can be taken by GPs as part of their continuing professional development and which is funded by the Welsh Government. The module was developed to assist health workers in understanding better the specific health and wellbeing issues that veterans and their families may face.

[Mental Healthcare Provision in Northern Ireland](#)

In Northern Ireland, the 'Armed Forces Liaison Forum' ensures equitable access to health and social care services by members of the Armed Forces, families and veterans, where there are specialised needs. General healthcare needs are met through GP services local to military establishments.

A [review of mental health support in Northern Ireland](#) in 2017 highlighted a number of key areas: the problems with identification of veterans (in part due to on-going concerns around personal safety and that of their families). issues with help-seeking, and GPs' lack of awareness of the specific needs of veterans. Further, there is the need for early intervention and to reduce stigma around mental health in veterans, the need for community-based support, and the lack of a mental trauma service. It was reported that female veterans were overlooked, as were the needs of veterans' families, particularly in relation to adolescent suicide, and alcohol and drug abuse. Difficulties also remain in introducing Armed Forces Covenant legislation, due to the history of the Troubles in Northern Ireland.

The [Northern Ireland Veterans' Health and Well-Being Study](#) provides significant insight into the services providing support to veterans in Northern Ireland, and aims to establish improved understanding of the current and future health needs of veterans. The study is ongoing and will comprise a series of reports, several of which are already published. The first report in the series, [Supporting and Serving Military Veterans in Northern Ireland](#), concludes that in Northern Ireland there is a 'fairly expansive network of supports and services available to veterans based in Northern Ireland . . . [but] there is a notable lack of formal information sharing between organisations and across sectors'. This is reflected in a lack of easily accessible, wider online information that details veteran healthcare provision in Northern Ireland. The same report confirms that veterans in Northern Ireland receive statutory support as part of the wider population, and there are no veteran-specific services or priority treatment. However, the report also suggests that, despite challenges surrounding the visibility of veterans in Northern Ireland, and the challenges facing those who provide support for them, there is a clear 'demonstration by service providers to ensure equitable provision for those veterans living in Northern Ireland'.

A report on understanding [the needs of Service Leaver families](#) further identifies the significant issue that is specific to former members of the Armed Forces or their families in Northern Ireland, that is, the 'on-going level of threat' associated with identification, which was highlighted as a major cause of high levels of mental distress and illness.

Mental Healthcare Provision in England

Within [NHS Improvement](#) provision, [accreditation](#) was introduced for 'Veteran Aware' hospitals that meet the criteria for offering the best care to veterans. This initiative is part of the Veterans Covenant Hospital Alliance (VCHA). A new [manifesto](#) for the VCHA was released in February 2019; 25 hospitals have so far been accredited. The current goal is to have 75 NHS providers accredited by the end of 2019 and the outcome of this objective is yet to be released. This is due to be extended to other types of provision (for example, Mental Health, Ambulances, Community services). In a similar vein to Veteran Aware hospitals, GPs can sign up to become accredited as 'veteran friendly' under a [national scheme introduced in 2018](#), to improve medical care and treatment for former Armed Forces personnel. The scheme is backed by NHS England and the Royal College of General Practitioners (RCGP). It has been [reported](#) and [publicised](#) that General Medical Services GP forms ([GMS1 form](#)) have been amended nationally to include a question regarding the identification of veterans by GPs, to facilitate access to healthcare priority treatment.

The NHS Veterans' Mental Health [Transition, Intervention and Liaison \(TIL\) Service](#), formerly known as London Veterans' Service, is a free mental health service dedicated for all ex-serving members of the UK Armed Forces, including Service personnel who are making the transition to civilian life including reservists. They work with any veterans and those transitioning from military to civilian life who live in: London, Greater London, East /West Sussex, Surrey, Kent and Medway. [Services are also available](#) in the North, the Midlands, the East and South West of England.

Veterans' Mental Healthcare Provision

[The House of Commons Defence Committee Report](#) on the Mental Health of the Armed Forces suggests that the public perception that most Service personnel leave the Armed Forces experiencing mental health issues is harmful to veterans. The vast majority leave with no ill-effects and have a positive experience from their time in Service. The support and sense of community offered by the military environment might have improved the mental health in some, or at least delayed the onset of pre-existing conditions. This distorted public perception may be amplifying the stigma surrounding veterans' mental health, discouraging them from seeking help, and overly focusing attention on PTSD, when in reality, common mental health disorders (known as CMDs), such as depression, are much more prevalent. However, it has to be recognised that PTSD is a more common health disorder and is [higher in veterans](#) than in the general public. Further we need to question [whether it is right to compare](#) the work of military personnel to the general public in terms of health outcomes. [The rates for CMDs](#) (e.g. depression or anxiety) in serving and ex-Service personnel are broadly similar to the general population, although the distinction needs to be made between what is defined as a common problem, what people seek help for and what causes the most suffering. The limitations of Government data mean that it is likely to underestimate significantly the total number of serving personnel and veterans with mental health conditions; but the true figure is still likely to be small. However, data from the [KCMHR Cohort Study](#) in 2018 show a rate of 17% for PTSD in veterans whose last deployment was in a combat role. The UK military regular [personnel appear to have remained resilient](#), in spite of prolonged combat missions in Iraq and Afghanistan.

The [Ministry of Defence reported](#) that the rates of diagnosed mental health conditions in serving Armed Forces personnel have nearly doubled over the last decade to around 3%: slightly lower than the rate in the general public. However, this is the figure only for those who seek help. Findings from

this report suggest that the true rate of veterans with mental health conditions could be as high as 10%. Between phases [two](#) and [three](#) of a longitudinal study of veterans who served in Iraq and Afghanistan, there is evidence of a trend effect for an increase in PTSD over time and when looking at veterans only, the rates of probable PTSD are far higher. The prevalence of alcohol misuse has reduced slightly at the third phase.

A [systematic review](#) undertaken to identify the needs of the veteran community analysed literature published between 2003 and 2013 and found 28 papers were identified as relating to mental health (including PTSD and suicide), the use of alcohol, trauma, hearing loss, cancer and obesity. It was found that Early Service Leavers were the most vulnerable to mental and physical health problems, and that alcohol was often used as a coping mechanism. It was concluded that the impact of Service life on the veteran will have long lasting psychological and physical outcomes.

Most veterans receive healthcare through NHS primary care, and as such, primary healthcare professionals need a greater awareness of Armed Forces culture and a more nuanced understanding of the specific needs of veterans and their families. For example, [research](#) published in 2014 suggested that 47% of GPs did not know how many veterans they were caring for, 75% of GPs had not seen the RCGP (Royal College of General Practitioners) leaflet on veterans' health, and fewer than 2% had used the RCGP on-line learning resource for understanding the veteran context. GPs in turn commented that they needed more information on how to assess veterans and to where they could refer veterans.

A 2014 [report](#) drew attention to data that suggested more than a third of GPs did not know the priority/disadvantage criteria for veterans, as per the Covenant stipulation, and those that did know had received the information through the media. The [Armed Forces Covenant](#) states that priority care should be subject to 'clinical need', which could potentially invalidate claims for priority for veterans, if the needs of a civilian patient are more severe at the point of needing treatment.

In relation to the responsibility of NHS England to [commission](#) services for veterans, new [research](#) published in 2019 suggests there are inconsistencies in 'adopting the principles' of the Covenant and a lack of 'commitment to and understanding of policy guidance . . . for commissioning veteran-specific services'. The research concludes that there is a need to make improvements to commissioning practices for veterans.

In an effort to increase the visibility of veterans within civilian healthcare provision, [from 2018](#) the information collected on GP registration forms includes further details of veterans, which will be used to allow healthcare professionals to identify personnel, veterans and their families and establish areas of need.

It is [suggested](#) similarly that civilian nurses who deliver primary care need educational preparation to understand the specific needs of veterans, as they will often be an important first point of contact for veterans accessing healthcare. This [paper proposes](#) that: 'nurses providing care require an understanding of the unique experiences and specific health needs of veterans to deliver evidence-based care'.

MOD research suggests that health professionals need training specifically to counter stereotypes about veterans, and more information about the military context to support their assessment and onward referral of veterans' needs. Having acknowledged this, there are examples of projects that have been initiated with the aim of closing this training gap. For example, the [Military Human](#) training

series, run by York St John University, includes three courses designed to increase awareness of the health and mental health of the Armed Forces community. The courses are designed to enable front line staff, including within healthcare professions, to gain insight into Armed Forces culture and use this knowledge to tailor relevant support for veterans and their families. One initiative that explores a [mental health service adapted for Armed Forces veterans](#) and family members using Cognitive Behavioural Therapy methods found that the adaptation of the service helped to accommodate help-seeking barriers. However, treatment for veterans with PTSD and their family members in this specific study required further research. Additional studies in this area suggest that the way [individuals report mental health](#) stigmatisation is not static and the stigma fluctuates in proportion to the frequency and severity of psychological symptoms.

Mental Health Provision whilst in Service

A recent Covenant [Annual Report](#) recognises that, as well as provision for Service-attributable injury, it is important that personnel with serious illness, and their family members, receive support. The 'Defence Personnel with a Significant Illness' project aims to support the needs of those personnel and their families with caring responsibilities. Families are supported through diagnoses, treatment and recovery, with the serving member helped back into Service employment where achievable.

MOD Healthcare Provision

In the UK, all Service personnel receive medical treatment and healthcare provision through the Ministry of Defence's [Defence Medical Services](#) (DMS). The primary role of the DMS is to promote, protect and restore the health of Service personnel so they are medically 'fit for task'. The DMS is staffed by 11,000 Service personnel (7,500 Regular and 3,500 Reserve) and 2,200 civilian personnel, and provides healthcare to the 144,900 (as [reported](#) October 2018) UK regular forces personnel. Mental health services are delivered through a network of Departments of Community Mental Health (DCMHs), Mental Health Teams (MHTs) and some additional locations have a dedicated permanent Community Mental Health Nurse. In some circumstances, family dependants of Service personnel or entitled civilians may also receive treatment from DMS staff, as well as other countries' personnel overseas, such as on permanent military bases and in areas of conflict. Research seeking to understand the [issues that cause UK military personnel to seek help](#) found that experiencing a stressful and emotional mental health or alcohol problem was highest among current DCMH help seekers. Recognising that help was required and being prompted by a significant other were the main drivers for help-seeking among DCMH attendees.

The DMS treat personnel in the UK, overseas and at sea. The provision of general practice and specialised occupational health services are delivered through Defence Primary Healthcare (DPHC), which was piloted in 2013 and announced full operating capability in 2014. An [academic review](#) published in 2016 discussed the decision to merge primary healthcare for each of the three UK single Services into the unified DPHC. It concluded that the DPHC was 'one of the largest UK military medicine changes in delivery for a generation'.

Serving personnel are more likely to present with [Common Mental Disorders \(CMDs\)](#) compared to those selected from the general population study and employed in other occupations. A survey completed by [deployed Royal Navy personnel](#), which measured the prevalence of CMD and PTSD found that these characteristics were more frequently reported in the maritime environment than on land-based deployments. Experiencing problems at home and exposure to potentially traumatic

events were associated with experiencing poorer mental health. Higher morale led to greater cohesion and better leadership with fewer psychological symptoms.

A further study of Service Leavers and personnel in Service focused on the influence of [social networks and social participation outside work on CMD](#), including symptoms of depression, anxiety and alcohol misuse. Service leavers were found to present with reported CMD and additionally, PTSD symptoms. The increased risk of CMD (but not PTSD symptoms) was partially accounted for by the reduced levels of social integration among the Service Leavers. Maintaining social networks in which most members are still in the military is associated with alcohol misuse for both groups, but it is related to CMD and PTSD symptoms for Service Leavers only.

Research exploring the [mental health effect of deployment on military medical staff](#) found that overall rates of self-reported mental health disorders were similar for both frontline and base staff. However, frontline staff reported more PTSD symptoms than other roles, which may have been related to working in more hostile environments and more challenging roles whilst deployed and on returning home.

[Trauma Risk Management \(TRiM\)](#) is a peer-led, occupational mental health support process that aims to identify and assist UK military personnel with persistent mental ill health related to potentially traumatic events. This was a randomised control study, where some patients were allocated to receive TRiM, whilst others did not receive TRiM, in order to determine which group were more likely to go on to seek help from mental health services after. TRiM recipients were significantly more likely to seek help from mental health services than a similar potentially traumatic event exposed group that did not receive TRiM; however, TRiM recipients experienced more persistent mental ill-health symptoms and hazardous alcohol use over the period of follow-up, despite seeking help.

A study investigating the use of [Third Location Depression \(TLD\)](#), an activity undertaken by UK Armed Forces to allow personnel to begin to psychologically 'unwind' after deploying, found no evidence to suggest that TLD promotes better post deployment readjustment. The study found a positive impact upon alcohol use and mental health in those who have served and taken part, or been exposed to combat. This study suggests that TLD is a useful post deployment transitional activity that may help to improve PTSD symptoms and alcohol use in UK AF personnel.

[NHS Statutory Arrangements](#)

Mental healthcare provision for the Armed Forces within the UK is delivered in partnership with the [National Health Service \(NHS\)](#). The NHS has a dedicated [web portal of information](#) and links to how members of the Armed Forces community, including veterans and their families, can access NHS services. NHS England is responsible for all secondary and community health services for the Armed Forces in England. Different arrangements exist for the NHS in all devolved administrations of the UK (Wales, Scotland and Northern Ireland), as healthcare is the responsibility of each nation.

NHS [commissioning intentions](#) for the Armed Forces community 2017 – 2019 state the mental health priorities to be the improvement of the pathway for Service personnel and families as they leave the Service, with a particular focus on mental health. The NHS England Armed Forces Commissioning Team has commissioned support for the DMS registered population: mental health services (for veterans and their families, if DMS registered) and mental health in community and inpatient for serving personnel (but not their families). Libor funding has been made available to NHS England to fund England-wide mental health services.

An NHS England [report](#) recognises the statutory duty of the NHS to commission services for the Armed Forces community and this is always under review. The current version of the [NHS Constitution](#) specifically references the Armed Forces Covenant and therefore allows the NHS to provide ‘priority services’ for the Armed Forces community, where the Constitution prohibits such commissioning. The NHS [is required to commission](#) certain services for members of the Armed Forces and their families, to uphold high standards of care and quality, in line with the commitment made by the UK Government under the [Covenant](#). This directive comes from the [Secretary of State’s Mandate](#) and is defined in [Section 15 of the Health and Social Care Act 2012](#).

MOD/NHS Partnership

To inform decisions regarding the commissioning of clinical services, the MOD produces statistics on the number of Armed Forces and entitled civilian personnel with a DMS registration. The [latest figures](#) show 170,554 with a DMS registration, a decrease of 1.3% from the year previous, which sits in line with the changing size of the Armed Forces “required by the MOD to achieve success in its military tasks.”

There is a [Partnership Agreement](#) between the MOD and NHS England that outlines the commissioning of health services in England for the Armed Forces. There are Ministry of Defence Hospital Units (MDHUs), which are military healthcare facilities embedded within NHS Trusts and civilian hospitals. There are five MDHUs located in the UK. There is also the [Royal Centre for Defence Medicine](#) (RCDM) located in Queen Elizabeth Hospital, [University Hospitals Birmingham NHS Foundation Trust](#), Birmingham. The RCDM provides medical support to military operational deployments, as well as providing secondary and specialist care for members of the Armed Forces. The RCDM is also a training centre for Defence personnel and focuses on medical research. Furthermore, the influence of Armed Forces medical staff and capabilities within NHS institutions has driven innovation and changes within the wider NHS.

The [location](#) of the new DMRC is close to both the [RCDM](#) and the [University Hospitals Birmingham NHS Foundation Trust](#) and there are hopes that this will help to enable the joined up care, involving multiple healthcare professionals, needed to deliver complex rehabilitation.

Charitable Healthcare Provision for the Armed Forces Community

Charities play a substantial role in mental healthcare initiatives for the serving Armed Forces community (Post Service charitable support for veterans is discussed [here](#)). Mental health charitable providers promote the recovery, fitness and good health of the Armed Forces, including specific services targeted at the wounded, injured and sick (WIS). For example, the DMRC [acknowledges](#) the long-standing partnership between providers of medical and healthcare for the Armed Forces, such as the NHS, and MOD welfare and healthcare services, and charities; tri-Service charities including [Combat Stress](#), [Help for Heroes](#), [The Royal British Legion](#) and [SSAFA](#) are [noted](#) as being ‘principally associated with the activities [undertaken] in the DMRC’. [Help for Heroes](#) and [The Royal British Legion](#) are formal partners in the [Defence Recovery Capability \(DRC\)](#).

A [Directory of Social Change 2017 report](#) on mental health provision suggests that 76 Armed Forces charities provide mental health support. Of these 76 charities, 62 provide non-clinical treatment, 36% partner with the NHS, 68% of mental health charities partner with other charities, 45% provide counselling and 40% provide a helpline for advice.

Transition and Resettlement

Medical Discharge

Approximately half of personnel medically discharged leave as a result of multiple medical conditions. During 2017-2018, 1,769 Army, 486 Naval Service and 196 RAF personnel were medically discharged. Certain demographic groups were significantly more likely to medically discharge: females in the Naval Service and RAF; other ranks (i.e. personnel from any of the three Services who are not Officers); Warrant Officers; non-commissioned Officers and ordinary soldiers with the rank of Private or regimental equivalent); Royal Marines in the Naval Service; and, Untrained Personnel in the Army. Untrained in the Army is defined as personnel who have not completed Phase 1 training.

Medically discharged personnel who leave the Armed Forces prior to completion of their contract may be entitled to additional payments as part of their military pension. The Armed Forces Compensation Scheme (AFCS) compensates for claims from personnel and veterans where injury and illness has been caused or made worse by Service.

In 2019, a study was undertaken to estimate the number of military personnel who may experience physical or psychological health problems that may be associated with their military Service. The results of this study highlight that the difficulties personnel may face are largely musculoskeletal or mental health related. These findings may help with planning the provision of future physical and mental health care and support for those who serve in the UK Armed Forces.

A study has highlighted the number of young service personnel who have sustained a combat-related visual impairment has increased. Mental health problems were found to be prevalent among visually impaired younger ex-Servicemen, irrespective of the cause of their impairment, whether in combat or non-combat. For female veterans, approximately 1 in 10 women with a visual impairment screened positive for probable depression, probable PTSD or alcohol misuse, and 1 in 5 fulfilled the criteria for probable anxiety disorder. Over time, the women in this study applied positive coping strategies, including having a positive attitude and re-learning skills. However, sustaining a visual impairment negatively affects psychosocial well-being in female ex-Service personnel and some did turn to negative coping strategies, including alcohol misuse and reporting a lack of help-seeking when needed.

Barriers to care and stigma

Research suggests a significant association between cohesion, mental health stigmatisation and perceived barriers to care. Fears of being viewed as weak and lacking in stoicism create beliefs of legitimacy around stigma and mental health issues. Concerns regarding being treated differently by leaders was most frequently endorsed, and thinking less of a help-seeking team member and unawareness of potential sources of help were least common. Further barriers to help-seeking, gathered from opinion on a study about screening for mental health disorders in the Armed Forces include: unwillingness to receive advice, a wish to deal with any problems themselves and a belief that military personnel should be strong enough to cope with any difficulties. Participants in one study believed that overcoming barriers to participating in screening and seeking help would be best achieved by making screening compulsory, alongside the necessity for more training for Welfare Officers in how to respond to mental health.

A report highlighting the issues for Service Leavers (SLs) identified that participants often raised mental health as one of the most important issues in relation to the health and well-being of SLs and

their families. Incidents of alcohol misuse and domestic violence were also included in their findings. Initiatives such as '[Big White Wall](#)', peer support by other veteran 'buddies' and broadening the existing Military Annual Training Tests (MATTs) to include training on mental health, relationships and civilian life skills were suggested as opportunities to support veterans and their families. [Peer support](#) programmes, through buddy systems, appear to foster positive feelings of well-being through camaraderie, and to counter the negative effects of PTSD.

Help-seeking

It was acknowledged in their [Service Leaver report](#) that the MOD should undertake a shift in thinking in order to avoid veterans being viewed as weak for seeking support. Further, that supporting veterans would have a positive impact on the goals of the military organisation. Loss of credibility and trust associated with [help-seeking](#) for medical reasons were found in a further study. Those experiencing psychological symptoms appeared to minimise the effects of stigma by seeking out a socially accepted route into care, such as the medical consultation, whereas those who experienced a subjective mental health problem appeared willing to seek help from any source.

A study assessing the prevalence of general medical problems, stress or emotional problems and alcohol problems, reported by members of the Armed Forces [after deployment to Iraq or Afghanistan](#) found help-seeking for stress or emotional problems was further associated with being female, holding a lower rank, having functional impairment, and meeting criteria for two or more mental health problems. Being divorced or separated was positively associated with non-medical help-seeking for stress or emotional problems. Help-seeking for alcohol problems was associated with current mental disorders. Medical help-seeking for stress or emotional problems was uncommon and was related to meeting criteria for two or more mental health problems. Commissioned officers were reluctant to seek medical help for stress or emotional problems. Help-seeking for alcohol problems increased if personnel were experiencing additional mental health problems.

A study of participants referred to a national mental health charity found that 63% of referrals reported a [Traumatic Brain Injury](#) (TBI). Significant associations were observed between reporting a TBI, suffering from depression, and problems with anger. The study reported a burden of mental health needs and high prevalence rates of reporting TBI within help-seeking veterans. The participants who reported a TBI also reported an increased risk of experiencing mental health difficulties. A further review of [mild Traumatic Brain Injury](#) (mTBI) revealed a high incidence rate of depression, anger and PTSD for veterans who met the criteria for mTBI, indicating the need for thorough screening and assessment who report such symptoms.

The stigma associated with disclosure of alcohol misuse and mental health symptoms often leads to a [lack of help-seeking](#). A study identifying [post deployment sleep difficulties](#) suggests that detection of problems with alcohol use and mental health issues could be enhanced by inquiring about sleep problems, which may be less stigmatising than direct mental health enquiries.

Given the potential barriers to accessing support, there is a need to investigate more accessible, flexible and cost-effective methods of delivering psychological therapies to veterans. One such alternative has been the use of [remote access technology](#) (e.g. video conferencing over the internet) to deliver psychological talking therapies, often referred to as tele-therapy. Analysis has shown that internet-based Cognitive Behavioural Therapy (CBT) can be effective in reducing symptoms in adults

with moderate depression; and there is some evidence to suggest that tele-therapy can be effective in treating military veterans with PTSD.

Other Factors Associated with Mental Health Difficulties

Veteran Gambling

Research on veteran gambling revealed that coping with debt and financial worries can also lead to, or exacerbate, mental health problems. The interaction between mental health and problem gambling in veterans is therefore complex. Dealing with an often-hidden gambling problem after active Service may lead to adverse personal and social consequences, and the risk of gambling-related harm may be exacerbated by pre-existing mental health conditions. For instance, veterans who suffer from PTSD may be at heightened risk of developing a gambling problem. Similarly, in civilian populations, problem gambling is associated with a range of mental health challenges such as mood disorders, substance abuse, anxiety and neurotic symptoms. It is therefore important to assess the impact of gambling-related problems in UK Armed Forces veterans alongside their Service history, financial management concerns and mental health problems.

Alcohol Misuse

Alcohol misuse in UK military personnel represents a significant and well-known health concern. There is a large body of literature regarding the co-occurring misuse of alcohol with mental health symptoms. A pilot study assessing the practicality of introducing an enhanced mental health assessment (EMHA) into all routine and discharge medicals of the UK Armed Forces found that the vast majority of patients were found to have no mental health problems, although indicators of high levels of risky drinking were evident. Further exploration of excessive drinking habits from this study identified that alcohol is part of the UK military culture and may foster social cohesion in moderation. Research relating to help-seeking behaviours in veterans who are reluctant to, or have difficulty in, accessing help for alcohol problems, found that participants appear to excuse or normalise their excessive alcohol consumption, which led to a delay in meaningful engagement with alcohol misuse services.

Similar findings from a study on brief alcohol interventions suggest that hazardous drinking, which increases the risk of mental harm or results in consequences to mental health, is higher in the UK military compared to the general population. Research looking specifically at cohorts of women who had served in the Gulf and Iraq Wars had similar findings, that the deployment effect in women is similar to that described in men, although psychological distress and chronic fatigue was more common in women and alcohol misuse was more common in men. Data suggests that military women are drinking around three times the rate of their civilian counterparts, compared to military men who drink around twice as much. A longitudinal study investigating alcohol consumption and mental health disorder found that individuals with a mental health problem appeared more likely to either be drinking at a high level or to be abstaining from use. Research investigating the prevalence of co-morbidity between PTSD and alcohol misuse found strong evidence, with common mental disorders highly associated with probable PTSD in individuals with alcohol misuse.

The third phase of a military cohort study has examined the prevalence of mental disorders and alcohol misuse at the end of the British involvement in the Iraq and Afghanistan conflicts, whether this differed between serving and ex-serving regular personnel and by deployment status. The prevalence was 6.2% for probable post-traumatic stress disorder, 21.9% for common mental disorders

and 10.0% for alcohol misuse. Deployment to Iraq or Afghanistan and a combat role during deployment were associated with significantly worse mental health outcomes and alcohol misuse in ex-serving regular personnel but not in currently serving regular personnel. The findings highlight an increasing prevalence of post-traumatic stress disorder and a lowering prevalence of alcohol misuse compared with previous findings, and stresses the importance of continued surveillance during Service and beyond.

Violent Behaviour

Concurrently with alcohol misuse, violent offending has been highlighted in relation to mental health symptoms as a cause for concern. A systematic review of studies on violent behaviour among military personnel in the UK or US, following deployment to Iraq and or Afghanistan, found that in both countries, rates were increased among combat-exposed, former serving personnel. The majority of studies analysed suggested a small to moderate association between combat exposure and post deployment physical aggression and violence. Several studies found that violence increased with intensity and frequency of exposure to combat traumas. The review's findings support the role of PTSD between combat and post deployment violence and the importance of alcohol, especially if comorbid with PTSD. A further study has found that factors related to anger and aggression included unemployment due to ill health and a perceived lack of family support. Co-morbid mental health difficulties were also a factor for anger and aggression.

A data linkage cohort study investigated the effect of deployment, combat and post-deployment mental health problems on violent offending, relative to pre-existing risk factors. Findings suggest that alcohol misuse and aggressive behaviour might be appropriate targets for interventions, but any action must be evidence based. PTSD, although less prevalent, is also a risk factor for violence, especially hyperarousal symptoms. Hyperarousal symptoms include sleeping problems, difficulties concentrating, irritability, anger and angry outburst, constant anxiety, being easily scared or startled and self-destructive behaviour. If this hyperarousal is diagnosed, it should be appropriately treated and the patient monitored for any associated risks. The complexity of co-ordinating services, such as alcohol misuse and mental health problems, often leads to fragmented and convoluted health and social care provision. This is a particular issue for Early Service Leavers.

A report examining the exposure to combat and post-deployment mental health problems found risk factors for violence both inside and outside the family environment following return from deployment. Family violence was significantly associated with having left Service, while stranger violence was associated with younger age, male gender, being single, having a history of antisocial behaviour as well as having left Service.

A study of the Liaison and Diversion (L&D) services, available at the point of arrest when veterans enter the criminal justice system, found that L&D services did not consider PTSD as a separate diagnosis and staff lacked an awareness of the role of trauma in offending behaviour. More training, and the need for Trauma Informed Care was highlighted.

Reservists are an under researched area with regard to mental health. The prevalence of self-reported violent behaviour among UK Reservists found the association with violence was similar for those deployed in either a combat role or non-combat role. Violence was also strongly associated with mental health risk factors (PTSD, common mental disorders, and alcohol misuse). This study demonstrated higher levels of self-reported post-deployment violence in UK Reservists who had

served in either Iraq or Afghanistan. Deployment, irrespective of the role, was associated with higher levels of violent behaviour among Reservists. The results also emphasize the risk of violent behaviour associated with post-deployment mental health problems.

Charitable Healthcare Provision for veterans

A report by the Directory of Social Change on [Armed Forces Charities' Mental Health Provision](#) found that 91% of the charities in the sector support veterans and 71% spouses and partners. 71% of charities support serving personnel. 45% of charities provide counselling, 40% advice and helpline support and 40% provide recreational activities.

Charities provide ongoing support to WIS veterans when the individual transitions back into their everyday home environment, providing advice and advocacy to support individuals in accessing other forms of help and support, with over 90% of Armed Forces charities delivering signposting services, over 88% delivering mentoring services and 76.5% operating helplines directly, although the number of 24 hour support lines is not known.

For veterans who want to find out what support is offered by charities to meet healthcare needs, the [Veterans' Gateway](#) coordinates and signposts to available support, raising awareness of Service-charity provision across the UK. This coordination of support and signposting from Veterans' Gateway also includes signposting to NHS services.

[Research](#) found that there is extensive collaboration between charities and other voluntary sector organisations to deliver care and support to veterans, and between charities themselves – over three-fifths of charities partnered with other voluntary sector organisations.

The positive effects on well-being and rehabilitation are highlighted in [a systematic review](#) of sport and activity programmes, reviewing nature-based interventions and initiatives for veterans with physical and mental health needs. A [further study](#) highlights the sense of respite facilitated by undertaking physical activity for PTSD sufferers.

There is recognition in [recent veteran population data](#) that a significant proportion of the veteran community is ageing. It is [reported](#) that 63% of veterans are aged 65 and over. Many Service charities make a point of including, promoting to, and in some cases directly focusing on, older veterans. The [Defence Medical Welfare Service](#) looks after the older veteran community and makes a specific point of differentiating the medical care they provide for the older veteran community.

The Family Context

The Families Federations take on a significant amount of work in coordinating support, assistance and advocacy for the wider Armed Forces community, including veterans and their family members. There are Families Federations for the [Army](#), [Royal Air Force](#) and [Royal Navy](#).

[Recent research](#) brings new evidence and emphasis to the importance of assessing how families cope when a veteran is recovering from mental health conditions and differentiates between the needs of the veteran and family member involved in the caring relationship. This in turn suggests that family members require tailored and individualised support to aid coping that may be different to the healthcare support required by the veteran.

The same [research](#) showed that, when caring for the health of a veteran, the main family carer may ignore their own health needs; for example, the study reported a high instance of carers with multiple health needs caring for veterans who might also have multiple health needs. To support the efforts of families in caring for the veteran, the research suggested that health professionals, such as General Practitioners and Nurses, need greater awareness and training regarding the potential specific needs of veterans. [Research](#) published in 2017 finds that family members caring for WIS personnel would appreciate “proactive, direct and sustained communication from support service providers’. The report suggests that ‘family care coordinators’ would be of benefit to provide continuous and consistent care to families.

A study investigating whether deployment of UK military personnel to Iraq was associated with an overall increase in negative [relationship change](#) found no association, after adjustment for significant sociodemographic characteristics. The research suggests that trauma experience itself mostly does not influence negative relationship change, and that the stability of the relationship and levels of interpersonal conflict both pre- and post-deployment are important. Personnel at risk of relationship breakdown are those who display symptoms of PTSD, are binge drinkers or misuse alcohol, have difficulty adjusting post-deployment, have argumentative relationships, and are more likely to be younger personnel with no children and who are serving in the lower ranks of the military.

Research undertaken to review the literature to understand the secondary causes of PTSD, known as [secondary trauma stress](#) (STS), found that the strongest evidence of STS was with partners of help-seeking veterans with PTSD. It highlighted the lack of available literature surrounding all groups, including children and adult children of parents with PTSD. A further study focusing on [the experiences of partners of veterans with PTSD](#) found that women needed to negotiate a number of factors when living with veterans with combat related trauma. They had to subdue their own emotional and behavioural responses, faced dilemmas about whether the veteran was unwell or ‘bad’, had to challenge the narrative of the veteran as a hero and had to attempt to negotiate multiple roles in the veteran’s return to civilian life. Evidence presented in a [further study](#) suggests there may be a considerable burden of mental illness associated with the partners supporting veterans with PTSD, with additional findings of alcohol problems, depression, generalised anxiety and probable PTSD in the partners themselves.

More attention has also been brought to the needs of children of Armed Forces or veteran families who may be young carers. A [project report](#) identified that young carers from Armed Forces families may be particularly vulnerable, as they also have to contend with other factors of military life, such as mobility and the need to relocate and change schools, and the impact of deployment on their wellbeing. However, the report also points out that these young carers can be resilient, adaptable and proud of their family’s way of life.

Conclusion

This Snapshot outlines mental health provision for the Armed Forces community, including veterans and wider family members, and presents some of the key mental health concerns for the Armed Forces. It is worth noting that the mental health of the Armed Forces community should be considered in parity, where appropriate, with other needs, but this Snapshot concentrates on mental health only.

The Armed Forces Covenant sets out the commitment made by the UK Government to provide healthcare for the Armed Forces. Therefore, members of the Armed Forces should not face disadvantage as a result of Service in their access to mental healthcare.

A number of recurring themes have emerged regarding the issues of identification of veterans with a mental health need and the perceived stigma in help-seeking. Many articles have focused on the co-occurrences of mental health presentation and alcohol misuse and issues in relation to violent behaviour. PTSD appears to be widely recognised, although difficulties remain around self-reporting and in cases, a lack of medical diagnosis. A lack of research remains in respect of the needs of veterans' families and female veterans. The necessity for collaboration and partnership working between statutory and charitable services is cited regularly.

The formal partnership between NHS England and the MOD aims to provide joint initiatives across the full range of health needs for the Armed Forces community. For veterans and their families, it is important that, including during the transition phase out of the military, and particularly at the level of Primary care, families have clear guidance about how to access the support that exists.

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